

[Fourth Reprint]

SENATE, No. 13

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:

Senator JOHN J. MATHEUSSEN

District 4 (Camden and Gloucester)

Senator JACK SINAGRA

District 18 (Middlesex)

Co-Sponsored by:

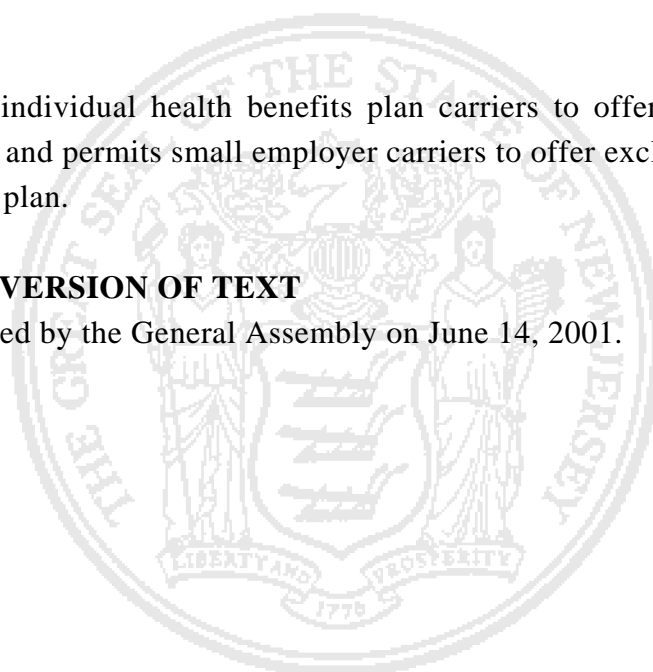
Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano, McNamara, Assemblywoman Vandervalk, Assemblymen Gregg, Guear, Assemblywomen Greenstein, Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As amended by the General Assembly on June 14, 2001.



(Sponsorship Updated As Of: 6/15/2001)

1 AN ACT concerning health insurance and supplementing
 2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
 3 ³[(C.17:27A-17 et seq.)] (C.17B:27A-17 et seq.)³.

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

7
 8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
 10 reform in 1992 for the individual ²[and small group markets] market²
 11 that provided guaranteed-issue, guaranteed-renewal coverage, with a
 12 prohibition against rating on the basis of health status and ²[removing
 13 most] limiting² preexisting condition exclusions ²[from] in² policies,
 14 the plans that were established by the ²[respective boards] New Jersey
 15 Individual Health Coverage Program Board² did not offer sufficient
 16 variety or options to insureds in terms of the range of coverages that
 17 are provided under the standard plans;

18 b. The original intent of the Legislature was to give policyholders
 19 a wider range of coverage options, including policies that provide
 20 reimbursement for basic and essential health care services but do not
 21 contain either the traditional mandated benefits to which the standard
 22 plans are subject or reimbursement for services which the consumer
 23 can more economically pay for himself, rather than having those
 24 services paid for through a third-party system, which adds significantly
 25 to the cost;

26 c. The ²[boards of the]² New Jersey Individual Health Coverage
 27 Program ²[and the New Jersey Small Employer Health Benefits
 28 Program] Board² elected to provide little variance in the coverage
 29 provided under the standard plans; rather, reductions in premium cost
 30 can be obtained primarily through increasing the deductibles to
 31 substantial sums, which defeats the objective of making the policies
 32 affordable, in that large deductibles represent large out-of-pocket
 33 expenses;

34 d. In the absence of any affirmative action by ²[either] the² board
 35 to remedy this situation, it is the purpose of this bill to create a policy
 36 that is more affordable than the options that presently exist; even
 37 though the benefit package is not as rich as the existing plans, the
 38 benefit ²[plans] plan² provided by this act will make health insurance
 39 more accessible to many individuals ²[and small groups]² that do not

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and 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 SHH committee amendments adopted November 9, 2000.

² Senate floor amendments adopted December 4, 2000.

³ Assembly ABI committee amendments adopted June 4, 2001.

⁴ Assembly floor amendments adopted June 14, 2001.

1 have the economic resources to afford the existing plans while still
 2 providing essential coverage.

3 e. It is to the interest of the State and of all health care providers
 4 that as many people have access to reasonably affordable health
 5 insurance as possible, for this reduces the amount of charity care that
 6 providers provide as well as the amount of bad debt that must be
 7 absorbed by providers each year.

8

9 2. a. Notwithstanding the provisions of P.L.1992, c.161
 10 (C.17B:27A-2 et seq.), every carrier ¹that writes individual health
 11 benefits plans pursuant to P.L.1992, c.161¹ shall offer a health benefits
 12 plan in the individual health insurance market that includes only the
 13 coverages enumerated in this section, as follows:

14 90 days hospital room and board - \$500 ²[deductible] copayment² per
 15 hospital stay;

16 Outpatient and ambulatory surgery ²- \$250 copayment per surgery²;

17 Physicians' fees connected with hospital care, including general acute
 18 care and surgery;

19 ²Physicians' fees connected with outpatient and ambulatory surgery²
 20 ^{3,3}

21 Anesthesia and the administration of anesthesia;

22 Coverage for newborns;

23 Treatment for complications of pregnancy;

24 ¹[IV Solutions] Intravenous solutions¹, blood and blood plasma;

25 Oxygen and the administration of oxygen;

26 Radiation and x-ray therapy;

27 ²[Physical] Inpatient physical² therapy and hydrotherapy ^{3,3}

28 ²Outpatient physical therapy² - ²30 visits annually per covered
 29 person-² \$20 ²[deductible for outpatient treatment] copayment per
 30 treatment²;

31 Dialysis - inpatient or outpatient;

32 Inpatient diagnostic tests and \$500 annual aggregate ²per covered
 33 person² for out-of-hospital diagnostic tests;

34 Laboratory fees for treatment in hospital;

35 Delivery room fees;

36 Operating room fees;

37 ²[Intensive] Special² care unit;

38 Treatment room fees;

39 Emergency room services for medically necessary treatment ²- \$100
 40 copayment per visit²;

41 Pharmaceuticals dispensed in hospital;

42 Dressings;

43 Splints;

44 ²[Treatment for Nervous and Mental Conditions- 30 Days inpatient or
 45 outpatient- 30% copayment] Treatment for biologically-based
 46 mental illness, as defined in ³subsection a. of section 6 of³

- 1 P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no
2 coinsurance - \$500 copayment per inpatient stay, 30 days
3 outpatient with 30% coinsurance²;
4 Alcohol and Substance Abuse Treatment - 30 days inpatient or
5 outpatient - 30% ²[copayment] coinsurance²;
6 ²Childhood immunizations in accordance with the provisions of
7 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
8 adult immunizations;²
9 Wellness benefit - \$600 ²[per year] annual aggregate per covered
10 person², \$50 ²annual² deductible, 20% coinsurance per service;
11 and
12 Physicians visits¹[per year]¹ for diagnosed illness or injury - to ³[an]
13 a³ ²\$700 annual² aggregate ²[of \$700 per year] per covered
14 person².
15 b. A carrier shall offer the benefits on an indemnity basis, with the
16 option that: (1) coverage is restricted to health care providers in the
17 carrier's network ¹[or preferred provider organization]^{1 2}, including
18 an exclusive provider organization, or the carrier's preferred provider
19 organization²; ¹[and] or¹ (2) coverage is provided through health care
20 providers in the carrier's network ¹[or preferred provider
21 organization]^{1 2} or preferred provider organization² with an out-of-
22 network option with ²[a]² 30% ²[copayment] coinsurance² in
23 addition to whatever other ²[copayment] coinsurance² may be
24 applicable under the policy.
25 c. With respect to all policies or contracts issued pursuant to this
26 section, the premium rate charged by a carrier to the highest rated
27 individual or class of individuals shall not be greater than 350% of the
28 premium rate charged for the lowest rated individual or class of
29 individuals purchasing this health benefits plan, provided, however,
30 that the only factors upon which the rate differential may be based are
31 age, gender, and geography. ²[Policies or contracts issued pursuant
32 to this section shall be rated separately from the five standard plans,
33 in accordance with their own loss experience.] Rates applicable to
34 policies or contracts issued pursuant to this section shall reflect past
35 and prospective loss experience for benefits included in such policies
36 or contracts, and shall be formulated in a manner that does not result
37 in an unfair subsidization of rates applicable to policies issued pursuant
38 to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the
39 result of differences in levels of benefits offered.²
40 d. Carriers may offer enhanced or additional benefits for an
41 additional premium amount in the form of a rider or riders, each of
42 which shall be comprised of a combination of enhanced or additional
43 benefits, in a manner which will avoid adverse selection to the extent
44 possible.
45 e. The provisions of P.L.1992, c.¹[162] 161¹ (C.17B:27A-2 et

1 seq.) shall apply to this section to the extent that they are not contrary
2 to the provisions of this section, including but not limited to,
3 provisions relating to ¹preexisting conditions,¹ guaranteed issue, ³and³
4 calculation of loss ratio² [, and the liability for assessment]². ³[²With
5 respect to liability for assessment, the board shall establish a separate
6 formula for calculating the amount of the aggregate liability of a
7 carrier that is attributable and allocated to health benefits plans issued
8 pursuant to this act. The formula shall provide for an equitable
9 allocation of a carrier's assessment pursuant to section 11 of P.L.1992,
10 c.161 (C.17B:27A-11), so that persons covered by the health benefits
11 plan provided for in this act do not bear a disproportionate burden of
12 a carrier's assessment in their premium, taking into account the
13 differential in benefit levels under the health benefits plans provided
14 for in this act and those health benefits plans issued pursuant to
15 P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into
16 account the relative loss experience, relative actuarial value based on
17 benefits offered, relative loss ratio, relative administrative expenses,
18 and such other items as the board deems appropriate.²]³

19 f. No later than ²[120 days] one year² following enactment of this
20 act, every carrier shall make an informational filing with the
21 ²[commissioner] board², which shall include the policy form, the
22 premiums to be charged for the coverage, and the anticipated loss
23 ratio. If the ²[commissioner] board² has not disapproved the form
24 within 30 days, the form shall be ¹deemed¹ approved.

25 g. Every carrier ²[and every insurance producer] that writes
26 individual health benefits plans pursuant to P.L.1992, c.161
27 (C.17B:27A-2 et seq.) shall make available and² shall make a good
28 faith effort to market the contract or policy established pursuant to this
29 section. ²[If the board determines that such a good faith effort has not
30 been made, they shall recommend to the commissioner that the carrier
31 be subject to a fine of not more than \$5,000, which shall be levied by
32 the commissioner pursuant to the provisions of the "Penalty
33 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).]
34 A carrier who is in violation of this section shall be subject to the
35 provisions of N.J.S.17B:30-1.²

36
37 ²3. The New Jersey Individual Health Coverage Program Board,
38 in consultation with the New Jersey Small Employer Health Benefits
39 Program Board, shall evaluate the effectiveness of this act in providing
40 affordable health care coverage and whether the health benefits plan
41 established in this act or a similar plan should be made available to
42 small employers.

43 The boards shall report to the Legislature and Governor two years
44 after the effective date of this act on their evaluation of the health
45 benefits plan established in this act and shall include in their report the
46 number of policies or contracts sold, the premiums charged and the

1 effect, if any, that the health benefits plan has had on the five standard
2 health benefits plans offered to individuals in the State. The report
3 shall also include the boards' recommendations with respect to
4 expanding the number of, or making modifications to, the standard
5 health benefits plans currently offered to small employers to include
6 the health benefits plan established pursuant to this act or a similar
7 plan.²

8
9 ⁴4. In addition to the five health benefits plans offered by a carrier
10 on the effective date of this act, a carrier that writes individual health
11 benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may
12 also offer one or more of the plans through the carrier's network of
13 providers, with no reimbursement for any out-of-network benefits
14 other than emergency care, urgent care, and continuity of care. A
15 carrier's network of providers shall be subject to review and approval
16 or disapproval by the Commissioner of Banking and Insurance, in
17 consultation with the Commissioner of Health and Senior Services,
18 pursuant to regulations promulgated by the Department of Banking
19 and Insurance, including review and approval or disapproval before
20 plans with benefits provided through a carrier's network of providers
21 pursuant to this section may be offered by the carrier. Policies or
22 contracts written on this basis shall be rated in a separate rating pool
23 for the purposes of establishing a premium, but for the purpose of
24 determining a carrier's losses, these policies or contracts shall be
25 aggregated with the losses on the carrier's other business written
26 pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).⁴

27
28 ⁴^[24. 3] ^{5.} ⁴ ^[A] In addition to the five health benefits plans
29 offered by a carrier on the effective date of this act, a³ carrier that
30 writes small employer health benefits plans pursuant to P.L.1992,
31 c.162 (C.17B:27A-17 et seq.) may ³also³ offer one or more of the
32 ³[five health benefits]³ plans ³[, but shall not offer all five, as policies
33 or contracts that require the policy holder or contract holder to receive
34 plan benefits solely]³ through the carrier's network of providers, with
35 no reimbursement for any out-of-network benefits other than
36 emergency care, urgent care, and continuity of care. ³A carrier's
37 network of providers shall be subject to review and approval or
38 disapproval by the Commissioner of Banking and Insurance, in
39 consultation with the Commissioner of Health and Senior Services,
40 pursuant to regulations promulgated by the Department of Banking
41 and Insurance, including review and approval or disapproval before
42 plans with benefits provided through a carrier's network of providers
43 pursuant to this section may be offered by the carrier.³ Policies or
44 contracts written on this basis shall be rated in a separate rating pool
45 for the purposes of establishing a premium, but for the purpose of
46 determining a carrier's losses, these policies or contracts shall be

1 aggregated with the losses on the carrier's other business written
2 pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et
3 seq.).²

4

5 ²[4.] ⁴[5.²] 6.⁴ This act shall take effect ²[immediately] on the
6 270th day following enactment, but the New Jersey Individual Health
7 Coverage Program Board may take such anticipatory administrative
8 action in advance as shall be necessary for the implementation of the
9 act².