

[Third Reprint]

SENATE, No. 1557

STATE OF NEW JERSEY
213th LEGISLATURE

INTRODUCED APRIL 7, 2008

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SYNOPSIS

Expands NJ FamilyCare, establishes mandate for health care coverage of children, makes various reforms to individual and small employer insurance markets and certain dependent coverage; appropriates \$1 million.

CURRENT VERSION OF TEXT

As reported by the Senate Budget and Appropriations Committee on June 19, 2008, with amendments.

(Sponsorship Updated As Of: 6/24/2008)

1 AN ACT concerning health care coverage ¹~~and~~,¹ revising parts of
2 statutory law ¹~~and making an appropriation~~¹.

3
4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6
7 1. (New section) The Legislature finds and declares:

8 a. There are an estimated 1.25 million residents of the State
9 who have no health insurance coverage, of which over 240,000 are
10 children, and the number of uninsured residents is increasing each
11 year;

12 b. While employer-sponsored health care coverage in the State
13 is well above the national average and has been a major factor in
14 keeping the number of uninsured lower than in many states, because
15 of the rising cost of the coverage, increasing numbers of employers
16 are considering dropping coverage for their employees and
17 dependents, or are requiring employees to share in a greater
18 percentage of premium costs and to bear larger copayments and
19 coinsurance, which is making health care coverage increasingly
20 unaffordable to low and moderate income working families;

21 c. Persons without health insurance coverage receive less
22 preventive care, poorer treatment for both minor and serious
23 chronic and acute illnesses, and in many cases live shorter lives
24 than comparable insured populations;

25 d. Many uninsured are forced to seek health care in
26 inappropriate settings such as hospital emergency rooms because
27 they cannot obtain needed health care services in a convenient and
28 more cost-effective setting such as a primary care provider's office
29 or clinic, which contributes to higher health care costs;

30 e. The uninsured are commonly billed at higher rates than
31 those who have health care coverage. Health care costs have
32 become a leading cause of bankruptcy in this country, and those
33 without insurance are most at risk;

34 f. The State has recognized the importance of increasing access
35 to health care coverage and, over the last several years, has enacted
36 several reforms to make health care coverage more affordable and
37 accessible to residents of the State. Among these reforms are the
38 expansions of coverage under the State Medicaid and NJ
39 FamilyCare programs. Despite these efforts, too many low income
40 parents and children lack access to health care coverage;

41 g. In order to ensure that more low income parents in the State
42 have access to health care coverage and all children in the State are
43 covered under a health plan, thus moving closer to providing

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 SHH committee amendments adopted May 15, 2008.

²Senate SBA committee amendments adopted May 19, 2008.

³Senate SBA committee amendments adopted June 19, 2008.

1 universal coverage for all residents of this State, it is necessary to
2 further expand coverage for parents under the NJ FamilyCare
3 Program, and mandate that all children in the State have health care
4 coverage, either through public programs or private coverage; and

5 h. In order to make insurance coverage more affordable to
6 residents and small businesses in this State, and to stabilize
7 enrollment in, and the costs of, individual and small employer
8 health benefits plans, it is also necessary to adopt comprehensive
9 reform measures to the insurance marketplace.

10

11 2. (New section) a. Beginning one year after the date of
12 enactment of this act, all residents of this State 18 years of age and
13 younger shall obtain and maintain health care coverage that
14 provides hospital and medical benefits. The coverage may be
15 provided through an employer-sponsored or individual health
16 benefits plan, the Medicaid program, NJ FamilyCare Program, or
17 the NJ FamilyCare Advantage buy-in program.

18 b. As used in this section:

19 "Medicaid" means the New Jersey Medical Assistance and
20 Health Services Program established pursuant to P.L.1968, c.413
21 (C.30:4D-1 et seq.).

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

24 "NJ FamilyCare Advantage" means the buy-in program
25 established pursuant to subsection j. of section 5 of P.L.2005, c.156
26 (C.30:4J-12).

27

28 3. Section 4 of P.L.2005, 156 (C.30:4J-11) is amended to read
29 as follows:

30 4. As used in this act:

31 "Commissioner" means the Commissioner of Human Services.

32 "Department" means the Department of Human Services.

33 "Medicaid" means the New Jersey Medical Assistance and
34 Health Services Program established pursuant to P.L.1968, c.413
35 (C.30:4D-1 et seq.).

36 "NJ FamilyCare" or "program" means the NJ FamilyCare
37 Program established pursuant to sections 3 through 5 of P.L.2005,
38 156 (C.30:4J-10 through C.30:4J-12).

39 "Poverty level" means the official federal poverty level based on
40 family size, established and adjusted under Section 673(2) of
41 Subtitle B, the "Community Services Block Grant Act," Pub.L.97-
42 35 (42 U.S.C. s.9902(2)).

43 "Qualified applicant" means:

44 a. a child under 19 years of age: (1) whose family gross income
45 does not exceed 350% of the poverty level; (2) who has no health
46 insurance, as determined by the commissioner, and is ineligible for
47 Medicaid; (3) who is a resident of this State; and (4) who is a
48 citizen of the United States, or has been lawfully admitted for

1 permanent residence into and remains lawfully present in the United
2 States;

3 b. a parent or caretaker: (1) whose gross family income does
4 not exceed 200% of the poverty level; (2) ~~who is enrolled in NJ~~
5 ~~FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et~~
6 ~~al.); (3)~~ who has no health insurance, as determined by the
7 commissioner, and is ineligible for Medicaid; ~~[(4)]~~ (3) who is a
8 resident of this State; and ~~[(5)]~~ (4) who is a citizen of the United
9 States, or has been lawfully admitted for permanent residence into
10 and remains lawfully present in the United States; and

11 c. a single adult or couple without dependent children: (1)
12 whose family gross income does not exceed 100% of the poverty
13 level; (2) who is enrolled in NJ FamilyCare on the effective date of
14 P.L.2005, c.156 (C.30:4J-8 et al.) and is ineligible for Medicaid; (3)
15 who is a resident of this State; and (4) who is a citizen of the United
16 States, or has been lawfully admitted for permanent residence into
17 and remains lawfully present in the United States.

18 (cf: P.L.2005, c.156, s.4)

19

20 4. Section 5 of P.L.2005, c.156 (C.30:4J-12) is amended to
21 read as follows:

22 5. a. The purpose of the program shall be to provide subsidized
23 health insurance coverage, and other health care benefits as
24 determined by the commissioner, to children under 19 years of age
25 and their parents or caretakers and to adults without dependent
26 children, within the limits of funds appropriated or otherwise made
27 available for the program.

28 The program shall require families to pay copayments and make
29 premium contributions, based upon a sliding income scale. The
30 program shall include the provision of well-child and other
31 preventive services, hospitalization, physician care, laboratory and
32 x-ray services, prescription drugs, mental health services, and other
33 services as determined by the commissioner.

34 b. The commissioner shall take such actions as are necessary to
35 implement and operate the program in accordance with the State
36 Children's Health Insurance Program established pursuant to 42
37 U.S.C.s.1397aa et seq.

38 c. The commissioner:

39 (1) shall, by regulation, establish standards for determining
40 eligibility and other program requirements, including, but not
41 limited to, restrictions on voluntary disenrollments from existing
42 health insurance coverage;

43 (2) shall require that a parent or caretaker who is a qualified
44 applicant purchase coverage, if available, through an employer-
45 sponsored health insurance plan which is determined to be cost-
46 effective and is approved by the commissioner, and shall provide
47 assistance to the qualified applicant to purchase that coverage,
48 except that the provisions of this paragraph shall not be construed to

1 require an employer to provide health insurance coverage for any
2 employee or employee's spouse or dependent child;

3 (3) may, by regulation, establish plans of coverage and benefits
4 to be covered under the program, except that the provisions of this
5 section shall not apply to coverage for medications used exclusively
6 to treat AIDS or HIV infection; and

7 (4) shall establish, by regulation, other requirements for the
8 program, including, but not limited to, premium payments and
9 copayments, and may contract with one or more appropriate
10 entities, including managed care organizations, to assist in
11 administering the program. The period for which eligibility for the
12 program is determined shall be the maximum period permitted
13 under federal law.

14 d. The commissioner shall establish procedures for determining
15 eligibility, which shall include, at a minimum, the following
16 enrollment simplification practices:

17 (1) A streamlined application form as established pursuant to
18 subsection k. of this section;

19 (2) Require new applicants to submit no more than one recent
20 pay stub from the applicant's employer, or, if the applicant has more
21 than one employer, no more than one from each of the applicant's
22 employers, to verify income. In the event the applicant cannot
23 provide a recent pay stub, the applicant may submit another form of
24 income verification as deemed appropriate by the commissioner. If
25 an applicant does not submit income verification in a timely
26 manner, before determining the applicant ineligible for the program,
27 the commissioner shall seek to verify the applicant's income by
28 reviewing available Department of the Treasury or Department of
29 Labor and Workforce Development records concerning the
30 applicant, or such other records as the commissioner determines
31 appropriate.

32 The commissioner may establish such retrospective auditing or
33 income verification procedures as he deems appropriate, such as
34 sample auditing and matching reported income with records of the
35 Department of the Treasury or the Department of Labor and
36 Workforce Development or such other records as the commissioner
37 determines appropriate.

38 If the commissioner elects to match reported income with
39 confidential records of the Department of the Treasury, the
40 commissioner shall require an applicant to provide written
41 authorization for the Division of Taxation in the Department of the
42 Treasury to release applicable tax information to the commissioner
43 for the purposes of establishing income eligibility for the program.
44 The authorization, which shall be included on the program
45 application form, shall be developed by the commissioner, in
46 consultation with the State Treasurer;

47 (3) Online enrollment and renewal, in addition to enrollment
48 and renewal by mail. The online enrollment and renewal forms

1 shall include electronic links to other State and federal health and
2 social services programs;

3 (4) Continuous enrollment;

4 (5) Simplified renewal by sending an enrollee a preprinted
5 renewal form and requiring the enrollee to sign and return the form,
6 with any applicable changes in the information provided in the
7 form, no later than 30 days after the date the enrollee's annual
8 eligibility expires. The commissioner may establish such auditing or
9 income verification procedures as he deems appropriate, as
10 provided in paragraph (1) of this subsection; and

11 (6) Provision of program eligibility-identification cards that are
12 issued no more frequently than once a year.

13 e. The commissioner shall take, or cause to be taken, any
14 action necessary to secure for the State the maximum amount of
15 federal financial participation available with respect to the program,
16 subject to the constraints of fiscal responsibility and within the
17 limits of available funding in any fiscal year. In this regard,
18 notwithstanding the definition of "qualified applicant," the
19 commissioner may enroll in the program such children or their
20 parents or caretakers who may otherwise be eligible for the
21 Medicaid program in order to maximize use of federal funds that
22 may be available pursuant to 42 U.S.C. s.1397aa et seq.

23 f. Subject to federal approval, a child shall be determined
24 ineligible for the program if the child was voluntarily disenrolled
25 from employer-sponsored group insurance coverage within six
26 months prior to application to the program.

27 g. The commissioner shall provide, by regulation, for
28 presumptive eligibility for the program in accordance with the
29 following provisions:

30 (1) A child who presents himself for treatment at a general
31 hospital, federally qualified or community health center, local
32 health department that provides primary care, or other State
33 licensed community-based primary care provider shall be deemed
34 presumptively eligible for the program if a preliminary
35 determination by hospital, health center, local health department or
36 licensed health care provider staff indicates that the child meets
37 program eligibility standards and is a member of a household with
38 an income that does not exceed 350% of the poverty level;

39 (2) The provisions of paragraph (1) of this subsection shall also
40 apply to a child who is deemed presumptively eligible for Medicaid
41 coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

42 (3) The parent or caretaker of a child deemed presumptively
43 eligible pursuant to this subsection shall be required to submit a
44 completed application for the program no later than the end of the
45 month following the month in which presumptive eligibility is
46 determined;

1 (4) A child shall be eligible to receive all services covered by
2 the program during the period in which the child is presumptively
3 eligible; and

4 (5) The commissioner may, by regulation, establish a limit on
5 the number of times a child may be deemed presumptively eligible
6 for NJ FamilyCare.

7 h. The commissioner, in consultation with the Commissioner of
8 Education, shall administer an ongoing enrollment initiative to
9 provide outreach to children throughout the State who may be
10 eligible for the program.

11 (1) With respect to school-age children, the commissioner, in
12 consultation with the Commissioner of Education and the Secretary
13 of Agriculture, shall develop a form that provides information about
14 the NJ FamilyCare and Medicaid programs and provides an
15 opportunity for the parent or guardian who signs the school lunch
16 application form to give consent for information to be shared with
17 the Department of Human Services for the purpose of determining
18 eligibility for the programs. The form shall be attached to, included
19 with, or incorporated into, the school lunch application form.

20 The commissioner, in consultation with the Commissioner of
21 Education, shall establish procedures for schools to transmit
22 information attached to, included with, or provided on the school
23 lunch application form regarding the NJ FamilyCare and Medicaid
24 programs to the Department of Human Services, in order to enable
25 the department to determine eligibility for the programs.

26 (2) The commissioner or the Commissioner of Education, as
27 applicable, shall:

28 (a) make available to each elementary and secondary school,
29 licensed child care center, registered family day care home, unified
30 child care agency, local health department that provides primary
31 care, and community-based primary care provider, informational
32 materials about the program, including instructions for applying
33 online or by mail, as well as copies of the program application
34 form.

35 The entity shall make the informational and application materials
36 available, upon request, to persons interested in the program; and

37 (b) request each entity to distribute a notice at least annually, as
38 developed by the commissioner, to households of children attending
39 or receiving its services or care, informing them about the program
40 and the availability of informational and application materials. In
41 the case of elementary and secondary schools, the information
42 attached to, included with, or incorporated into, the school lunch
43 application form for school-age children pursuant to this
44 subparagraph shall be deemed to meet the requirements of this
45 paragraph.

46 i. Subject to federal approval, the commissioner shall, by
47 regulation, establish that in determining income eligibility for a

1 child, any gross family income above 200% of the poverty level, up
2 to a maximum of 350% of the poverty level, shall be disregarded.

3 j. The commissioner shall establish a NJ FamilyCare coverage
4 buy-in program through which a parent or caretaker whose family
5 income exceeds 350% of the poverty level may purchase coverage
6 under NJ FamilyCare for a child under the age of 19, who is
7 uninsured and was not voluntarily disenrolled from employer-
8 sponsored group insurance coverage within six months prior to
9 application to the program. The program shall be known as NJ
10 FamilyCare Advantage.

11 The commissioner shall establish the premium and cost sharing
12 amounts required to purchase coverage, except that the premium
13 shall not exceed the amount the program pays per month to a
14 managed care organization under NJ FamilyCare for a child of
15 comparable age whose family income is between 200% and 350%
16 of the poverty level, plus a reasonable processing fee.

17 k. The commissioner, in consultation with the Rutgers Center
18 for State Health Policy, shall develop a streamlined application
19 form for the NJ FamilyCare and Medicaid programs.

20 ³1. Subject to federal approval, the Commissioner of Human
21 Services shall establish a hardship waiver for part or all of the
22 premium for an eligible child under the NJ FamilyCare program. A
23 parent or caretaker may apply to the commissioner for a hardship
24 waiver in a manner and form established by the commissioner. If
25 the parent or caretaker can demonstrate to the satisfaction of the
26 commissioner, pursuant to regulations adopted by the
27 commissioner, that payment of all or part of the premium for the
28 parent or caretaker's child presents a hardship, the commissioner
29 shall grant the waiver for a prescribed period of time.³

30 (cf: P.L.2005, c.156, s.5)

31

32 5. (New section) The Commissioner of Human Services shall
33 apply for such waivers as may be necessary to implement the
34 provisions of section 4 of P.L.2005, c.156 (C.30:4J-11) and to
35 secure federal financial participation for NJ FamilyCare
36 expenditures under the State Children's Health Insurance Program
37 pursuant to 42 U.S.C.s.1397aa et seq.

38

39 6. (New section) Notwithstanding the provisions of section 3 of
40 P.L.2004, c.113 (C.26:2H-18.59i) to the contrary, a hospital shall
41 not submit charity care claims to the Department of Health and
42 Senior Services for health care services provided to a child under 19
43 years of age who presents at a hospital for emergency care and who
44 may be deemed presumptively eligible for NJ FamilyCare coverage
45 pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) or Medicaid coverage
46 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

1 7. (New section) a. Beginning with the 2008 tax year and for
2 each tax year thereafter, the Department of the Treasury shall
3 require that each individual ²[taxpayer] who files a resident New
4 Jersey Gross Income Tax return² indicate on the taxpayer's income
5 tax return whether the taxpayer and dependents, if applicable, has
6 health insurance coverage on the date of filing of the return.

7 b. The department shall³[, in consultation with the
8 Commissioner] transmit to the Department³ of Human Services³[,
9 administer an ongoing enrollment initiative to identify and provide
10 outreach to] information permitting the Department of Human
11 Services to identify³ taxpayers who are uninsured and may be
12 eligible to enroll in the Medicaid or NJ FamilyCare program. ³[As
13 part of the initiative, the department shall send an application for
14 the Medicaid or NJ FamilyCare program, as applicable, to any
15 taxpayer who reports on the tax return form that he or his
16 dependents do not have health insurance coverage and who, based
17 on the income reported on the tax return form and the tax payer's
18 family size, may be eligible for either of the State's health care
19 coverage programs.] The Department of Human Services shall use
20 this information in furtherance of its Medicaid and NJ FamilyCare
21 outreach and enrollment initiative established pursuant to section 26
22 of P.L., c. (C.)(pending before the Legislature as this bill).³

23 c. As used in this section:

24 "Medicaid" means the New Jersey Medical Assistance and
25 Health Services Program established pursuant to P.L.1968, c.413
26 (C.30:4D-1 et seq.).

27 "NJ FamilyCare" or "program" means the NJ FamilyCare
28 Program established pursuant to P.L.2005, ²[156] c.156² (C.30:4J-
29 8 et al.).

30
31 8. R.S.54:50-9 is amended to read as follows:

32 54:50-9. Nothing herein contained shall be construed to prevent:

33 a. The delivery to a taxpayer or the taxpayer's duly authorized
34 representative of a copy of any report or any other paper filed by
35 the taxpayer pursuant to the provisions of this subtitle or of any
36 such State tax law;

37 b. The publication of statistics so classified as to prevent the
38 identification of a particular report and the items thereof;

39 c. The director, in the director's discretion and subject to
40 reasonable conditions imposed by the director, from disclosing the
41 name and address of any licensee under any State tax law, unless
42 expressly prohibited by such State tax law;

43 d. The inspection by the Attorney General or other legal
44 representative of this State of the reports or files relating to the
45 claim of any taxpayer who shall bring an action to review or set
46 aside any tax imposed under any State tax law or against whom an

1 action or proceeding has been instituted in accordance with the
2 provisions thereof;

3 e. The examination of said records and files by the
4 Comptroller, State Auditor or State Commissioner of Finance, or by
5 their respective duly authorized agents;

6 f. The furnishing, at the discretion of the director, of any
7 information contained in tax reports or returns or any audit thereof
8 or the report of any investigation made with respect thereto, filed
9 pursuant to the tax laws, to the taxing officials of any other state,
10 the District of Columbia, the United States and the territories
11 thereof, providing said jurisdictions grant like privileges to this
12 State and providing such information is to be used for tax purposes
13 only;

14 g. The furnishing, at the discretion of the director, of any
15 material information disclosed by the records or files to any law
16 enforcing authority of this State who shall be charged with the
17 investigation or prosecution of any violation of the criminal
18 provisions of this subtitle or of any State tax law;

19 h. The furnishing by the director to the State agency
20 responsible for administering the Child Support Enforcement
21 program pursuant to Title IV-D of the federal Social Security Act,
22 Pub.L.93-647 (42 U.S.C. s.651 et seq.), with the names, home
23 addresses, social security numbers and sources of income and assets
24 of all absent parents who are certified by that agency as being
25 required to pay child support, upon request by the State agency and
26 pursuant to procedures and in a form prescribed by the director;

27 i. The furnishing by the director to the Board of Public
28 Utilities any information contained in tax information statements,
29 reports or returns or any audit thereof or a report of any
30 investigation made with respect thereto, as may be necessary for the
31 administration of P.L.1991, c.184 (C.54:30A-18.6 et al.) and
32 P.L.1997, c.162 (C.54:10A-5.25 et al.);

33 j. The furnishing by the director to the Director of the Division
34 of Alcoholic Beverage Control in the Department of Law and
35 Public Safety any information contained in tax information
36 statements, reports or returns or any audit thereof or a report of any
37 investigation made with respect thereto, as may be relevant, in the
38 discretion of the director, in any proceeding conducted for the
39 issuance, suspension or revocation of any license authorized
40 pursuant to Title 33 of the Revised Statutes;

41 k. The inspection by the Attorney General or other legal
42 representative of this State of the reports or files of any tobacco
43 product manufacturer, as defined in section 2 of P.L.1999, c.148
44 (C.52:4D-2), for any period in which that tobacco product
45 manufacturer was not or is not in compliance with subsection a. of
46 section 3 of P.L.1999, c.148 (C.52:4D-3), or of any licensed
47 distributor as defined in section 102 of P.L.1948, c.65 (C.54:40A-

1 2), for the purpose of facilitating the administration of the
2 provisions of P.L.1999, c.148 (C.52:4D-1 et seq.);

3 l. The furnishing, at the discretion of the director, of
4 information as to whether a contractor or subcontractor holds a
5 valid business registration as defined in section 1 of P.L.2001, c.134
6 (C.52:32-44);

7 m. The furnishing by the director to a State agency as defined in
8 section 1 of P.L.1995, c.158 (C.54:50-24) the names of licensees
9 subject to suspension for non-payment of State tax indebtedness
10 pursuant to P.L.2004, c.58 (C.54:50-26.1 et al.);

11 n. The release to the United States Department of the Treasury,
12 Bureau of Financial Management Service, or its successor of
13 relevant taxpayer information for purposes of implementing a
14 reciprocal collection and offset of indebtedness agreement entered
15 into between the State of New Jersey and the federal government
16 pursuant to section 1 of P.L.2006, c.32 (C.54:49-12.7);

17 o. The examination of said records and files by the
18 Commissioner of Health and Senior Services, the Commissioner of
19 Human Services, the Medicaid Inspector General, or their
20 respective duly authorized agents, pursuant to section 5 of
21 P.L.2007, c.217 (C.26:2H-18.60e)², section 3 of P.L.1968, c.413
22 (C.30:4D-3), or section 5 of P.L.2005, c.156 (C.30:4J-12)²;

23 p. The furnishing at the discretion of the director of employer
24 provided wage and tax withholding information contained in tax
25 reports or returns filed pursuant to N.J.S.54A:7-2, 54A:7-4 and
26 54A:7-7, to the designated municipal officer of a municipality
27 authorized to impose an employer payroll tax pursuant to the
28 provisions of Article 5 (Employer Payroll Tax) of the "Local Tax
29 Authorization Act," P.L.1970, c.326 (C.40:48C-14 et seq.), for the
30 limited purpose of verifying the payroll information reported by
31 employers subject to the employer payroll tax.

32 (cf: P.L.2007, c.294, s.2)

33

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

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

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

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

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

4 "Commissioner" means the Commissioner of Banking and
5 Insurance.

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

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

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

37 "Department" means the Department of Banking and Insurance.

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

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

47 "Federally defined eligible individual" means an eligible person:
48 (1) for whom, as of the date on which the individual seeks coverage

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

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

23 "Governmental plan" has the meaning given that term under Title
24 I, section 3 of Pub.L.93-406, the "Employee Retirement Income
25 Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental
26 plan established or maintained for its employees by the Government
27 of the United States or by any agency or instrumentality of that
28 government.

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

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

38 "Health benefits plan" means a hospital and medical expense
39 insurance policy; health service corporation contract; hospital
40 service corporation contract; medical service corporation contract;
41 health maintenance organization subscriber contract; or other plan
42 for medical care delivered or issued for delivery in this State. For
43 purposes of this act, health benefits plan shall not include one or
44 more, or any combination of, the following: coverage only for
45 accident, or disability income insurance, or any combination
46 thereof; coverage issued as a supplement to liability insurance;
47 liability insurance, including general liability insurance and
48 automobile liability insurance; stop loss or excess risk insurance;

1 workers' compensation or similar insurance; automobile medical
2 payment insurance; credit-only insurance; coverage for on-site
3 medical clinics; and other similar insurance coverage, as specified
4 in federal regulations, under which benefits for medical care are
5 secondary or incidental to other insurance benefits. Health benefits
6 plans shall not include the following benefits if they are provided
7 under a separate policy, certificate or contract of insurance or are
8 otherwise not an integral part of the plan: limited scope dental or
9 vision benefits; benefits for long-term care, nursing home care,
10 home health care, community-based care, or any combination
11 thereof; and such other similar, limited benefits as are specified in
12 federal regulations. Health benefits plan shall not include hospital
13 confinement indemnity coverage if the benefits are provided under
14 a separate policy, certificate or contract of insurance, there is no
15 coordination between the provision of the benefits and any
16 exclusion of benefits under any group health benefits plan
17 maintained by the same plan sponsor, and those benefits are paid
18 with respect to an event without regard to whether benefits are
19 provided with respect to such an event under any group health plan
20 maintained by the same plan sponsor. Health benefits plan shall not
21 include the following if it is offered as a separate policy, certificate
22 or contract of insurance: Medicare supplemental health insurance
23 as defined under section 1882(g)(1) of the federal Social Security
24 Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the
25 coverage provided under chapter 55 of Title 10, United States Code
26 (10 U.S.C. s.1071 et seq.); and similar supplemental coverage
27 provided to coverage under a group health plan.

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

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

41 Individual health benefits plan shall not include a certificate
42 issued under a policy or contract issued to a trust, or to the trustees
43 of a fund, which trust or fund is an employee welfare benefit plan,
44 to the extent the "Employee Retirement Income Security Act of
45 1974" (29 U.S.C. s.1001 et seq.) preempts the application of
46 P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

6 "Member" means a carrier that issues or has in force health
7 benefits plans in New Jersey. Member shall not include a carrier
8 whose combined average Medicare, Medicaid, and NJ FamilyCare
9 **[and NJ KidCare]** enrollment represents more than 75% of its
10 average total enrollment for all health benefits plans or whose
11 combined Medicare, Medicaid, and NJ FamilyCare **[and NJ**
12 **KidCare]** net earned premium for the two-year calculation period
13 represents more than 75% of its total net earned premium for the
14 two-year calculation period.

15 "Modified community rating" means a rating system in which the
16 premium for all persons covered **[by a contract is formulated based**
17 **on the experience of all persons covered by that contract, without**
18 **regard to age, sex, occupation and geographical location, but which**
19 **may differ by health status. The term modified community rating**
20 **shall apply to contracts and policies issued prior to the effective**
21 **date of this act which are subject to the provisions of subsection e.**
22 **of section 2 of this act.] under a policy or contract for a specific**
23 **health benefits plan and a specific date of issue of that plan is the**
24 **same without regard to sex, health status, occupation, geographical**
25 **location or any other factor or characteristic of covered persons,**
26 **other than age.**

27 The rating system shall provide that the premium rate charged by
28 the carrier for the highest rated individual or class of individuals
29 shall not be greater than 350% of the premium rate charged for the
30 lowest rated individual or class of individuals purchasing the same
31 individual health benefits plan. The rate differential among the
32 premium rates charged to individuals covered under the same
33 individual health benefits plans shall be based on the actual or
34 expected experience of persons covered under that plan; provided,
35 however, that the rate differential may also be based upon age. The
36 factors upon which the rate differential is applied shall be consistent
37 with regulations promulgated by the commissioner, which shall
38 include age classifications established, at a minimum, in five year
39 increments. There may be a reasonable differential among the
40 premium rates charged for different family structure rating tiers
41 within an individual health benefits plan or for different health
42 benefits plans offered by the carrier.

43 "Net earned premium" means the premiums earned in this State
44 on health benefits plans, less return premiums thereon and
45 dividends paid or credited to policy or contract holders on the
46 health benefits plan business. Net earned premium shall include the
47 aggregate premiums earned on the carrier's insured group and

1 individual business and health maintenance organization business,
2 including premiums from any Medicare, Medicaid, or NJ
3 FamilyCare or **[NJ KidCare]** contracts with the State or federal
4 government, but shall not include premiums earned from contracts
5 funded pursuant to the "Federal Employee Health Benefits Act of
6 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss
7 insurance coverage issued by a carrier in connection with any self
8 insured health benefits plan, or Medicare supplement policies or
9 contracts.

10 "NJ FamilyCare" means the NJ FamilyCare **[Health Coverage]**
11 Program established pursuant to **[P.L.2000, c.71 (C.30:4J-1 et**
12 **seq.)]** P.L.2005, c.156 (C.30:4J-8 et al.).

13 **["NJ KidCare" means the Children's Health Care Coverage**
14 **Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et**
15 **seq.).]**

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

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

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

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

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

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

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

44 "Two-year calculation period" means a two calendar year period,
45 the first of which shall begin January 1, 1997 and end December 31,
46 1998.

47 (cf: P.L.2001, c.349, s.1)

1 10. Section 2 of P.L.1992, c.161 (C.17B:27A-3) is amended to
2 read as follows:

3 2. a. An individual health benefits plan issued on or after
4 **【August 1, 1993 shall be subject to the provisions of this act】** the
5 effective date of 'this section of' P.L. , c. (pending before the
6 Legislature as this bill) shall be subject to the rating provisions
7 established in P.L. , c. (pending before the Legislature as this bill)³;
8 except that for the four years next following the effective date of
9 this section, in the case of a person who is 55 years of age or older
10 who purchases a health benefits plan on or after that effective date,
11 the annual rate increase for that person shall be limited to the lower
12 of 15% or the medical trend assumption used by the carrier to
13 project claims³.

14 In the case of an individual health benefits plan issued to a
15 covered person prior to the effective date 'this section of' of P.L.
16 , c. (pending before the Legislature as this bill) and renewed
17 thereafter, for the ³**【five】** four³ years next following '【enactment of
18 P.L. , c. (pending before the Legislature as this bill)】 that
19 effective date¹, the annual rate increase filed for the plan shall be
20 limited to the lower of 15% or the medical trend assumption used
21 by the carrier to project claims.

22 b. **【(1) An individual health benefits plan issued on an open**
23 **enrollment, modified community rated basis or community rated**
24 **basis prior to August 1, 1993 shall not be subject to sections 3**
25 **through 8, inclusive, of this act, unless otherwise specified therein.**

26 (2) An individual health benefits plan issued other than on an
27 open enrollment basis prior to August 1, 1993 shall not be subject
28 to the provisions of this act, except that the plan shall be liable for
29 assessments made pursuant to section 11 of this act.

30 (3) A group conversion contract or policy issued prior to August
31 1, 1993 that is not issued on a modified community rated basis or
32 community rated basis, shall not be subject to the provisions of this
33 act, except that the contract or policy shall be liable for assessments
34 made pursuant to section 11 of this act.

35 (4) Notwithstanding any other provision of law to the contrary,
36 an individual health benefits plan issued by a hospital service
37 corporation or medical service corporation prior to the effective
38 date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to
39 the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that
40 the plan shall guarantee renewal pursuant to subsection b. of section
41 5 of P.L.1992, c.161 (C.17B:27A-6).

42 (5) Notwithstanding any other provision of law to the contrary,
43 an individual health benefits plan issued by a hospital service
44 corporation or medical service corporation to an eligible person or
45 federally defined eligible individual after the effective date of
46 P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the
47 provisions of subsections c. and d. of section 2, subsection b. of

1 section 3, section 5, subsection b. of section 6, and subsections c.,
2 d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3,
3 C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall
4 not be subject to the remaining provisions of P.L.1992, c. 161.】

5 ³[(Deleted by amendment, P.L. , c.) (pending before the
6 Legislature as this bill).】

7 (1) An individual health benefits plan issued on an open
8 enrollment, modified community rated basis or community rated
9 basis prior to August 1, 1993 shall not be subject to sections 3
10 through 8, inclusive, of P.L.1992, c.161 (C.17B:27A-4 through
11 17B:27A-9), unless otherwise specified therein.

12 (2) An individual health benefits plan issued other than on an
13 open enrollment basis prior to August 1, 1993 shall not be subject
14 to the provisions of this act, except that the plan shall be liable for
15 assessments made pursuant to section 11 of P.L.1992, c.161
16 (C.17B:27A-12).

17 (3) A group conversion contract or policy issued prior to August
18 1, 1993 that is not issued on a modified community rated basis or
19 community rated basis, shall not be subject to the provisions of this
20 act, except that the contract or policy shall be liable for assessments
21 made pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-12).

22 (4) Notwithstanding any other provision of law to the contrary,
23 an individual health benefits plan issued by a hospital service
24 corporation or medical service corporation prior to the effective
25 date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to
26 the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that
27 the plan shall guarantee renewal pursuant to subsection b. of section
28 5 of P.L.1992, c.161 (C.17B:27A-6).

29 (5) Notwithstanding any other provision of law to the contrary,
30 an individual health benefits plan issued by a hospital service
31 corporation or medical service corporation to an eligible person or
32 federally defined eligible individual after the effective date of
33 P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the
34 provisions of subsections c. and d. of section 2, subsection b. of
35 section 3, section 5, subsection b. of section 6, and subsections c.,
36 d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3,
37 C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall
38 not be subject to the remaining provisions of P.L.1992, c. 161.³

39 c. 【After August 1, 1993, an individual who is eligible to
40 participate in a group health benefits plan that provides coverage for
41 hospital or medical expenses shall not be covered by an individual
42 health benefits plan which provides benefits for hospital and
43 medical expenses that are the same or similar to coverage provided
44 in the group health benefits plan, except that an individual who is
45 eligible to participate in a group health benefits plan but is currently
46 covered by an individual health benefits plan may continue to be
47 covered by that plan until the first anniversary date of the group

1 health benefits plan occurring on or after January 1, 1994.]
2 ~~'[(Deleted by amendment, P.L. , c.) (pending before the~~
3 ~~Legislature as this bill).]~~

4 After August 1, 1993, an individual who is eligible to participate
5 in a group health benefits plan that provides coverage for hospital
6 or medical expenses shall not be covered by an individual health
7 benefits plan which provides benefits for hospital and medical
8 expenses that are the same or similar to coverage provided in the
9 group health benefits plan, except that an individual who is eligible
10 to participate in a group health benefits plan but is currently
11 covered by an individual health benefits plan may continue to be
12 covered by that plan until the first anniversary date of the group
13 health benefits plan occurring on or after January 1, 1994.¹

14 d. ~~【Except as otherwise provided in subsection c. of this~~
15 ~~section, after August 1, 1993, a person who is covered by an~~
16 ~~individual health benefits plan who is a participant in, or is eligible~~
17 ~~to participate in, a group health benefits plan that provides the same~~
18 ~~or similar coverages as the individual health benefits plan, and a~~
19 ~~person, including an employer or insurance producer, who causes~~
20 ~~another person to be covered by an individual health benefits plan~~
21 ~~which person is a participant in, or who is eligible to participate in a~~
22 ~~group health benefits plan that provides the same or similar~~
23 ~~coverages as the individual health benefits plan, shall be subject to~~
24 ~~a fine by the commissioner in an amount not less than twice the~~
25 ~~annual premium paid for the individual health benefits plan,~~
26 ~~together with any other penalties permitted by law.】 ~~'[(Deleted by~~
27 ~~amendment, P.L. , c.) (pending before the Legislature as this~~
28 ~~bill).]~~~~

29 Except as otherwise provided in subsection c. of this section,
30 after August 1, 1993, a person who is covered by an individual
31 health benefits plan who is a participant in, or is eligible to
32 participate in, a group health benefits plan that provides the same or
33 similar coverage as the individual health benefits plan, and a
34 person, including an employer or insurance producer, who causes
35 another person to be covered by an individual health benefits plan
36 which person is a participant in, or who is eligible to participate in a
37 group health benefits plan that provides the same or similar
38 coverage as the individual health benefits plan, shall be subject to a
39 fine by the commissioner in an amount not less than twice the
40 annual premium paid for the individual health benefits plan,
41 together with any other penalties permitted by law.¹

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

43 (cf: P.L.1997, c.146, s.2)

44

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

1 3. a. No later than 180 days after the effective date of **[this**
2 **act]** 'this section of' P.L. , c. (pending before the Legislature as
3 this bill), a carrier shall, as a condition of issuing small employer
4 health benefits plans in this State, also offer individual health
5 benefits plans. The plans shall be offered on an open enrollment,
6 modified community rated basis, pursuant to the provisions of this
7 act**;** except that a carrier shall be deemed to have satisfied its
8 obligation to provide the individual health benefits plans by paying
9 an assessment or receiving an exemption pursuant to section 11 of
10 this act**]** and P.L. , c. (pending before the Legislature as this
11 bill). Every carrier that issues small employer health benefits plans
12 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall make a
13 good faith effort to market individual health benefits plans.

14 b. A carrier shall offer to an eligible person a choice of **[five]**
15 at least three individual health benefits plans **[any of which may**
16 **contain provisions for managed care]** established by the board
17 pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7). One plan
18 shall be a basic health benefits plan**;** one plan shall be a managed
19 care plan and three plans shall include enhanced benefits of
20 proportionally increasing actuarial value**].** A carrier may elect to
21 convert any individual contract or policy forms in force on the
22 effective date of **[this act]** P.L. , c. (pending before the Legislature
23 as this bill) to any of the **[five]** benefit plans, except that the carrier
24 may not convert more than 25% of existing contracts or policies
25 each year, and the replacement plan shall be of no less actuarial
26 value than the policy or contract being replaced.

27 **[Notwithstanding the provisions of this subsection to the**
28 **contrary, at any time after three years after the effective date of this**
29 **act, the board, by regulation, may reduce the number of plans**
30 **required to be offered by a carrier.]**

31 Notwithstanding the provisions of this subsection to the contrary,
32 a health maintenance organization which is a qualified health
33 maintenance organization pursuant to the "Health Maintenance
34 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.)
35 shall be permitted to offer a basic health benefits plan in accordance
36 with the provisions of that law in lieu of the **[five]** plans required
37 pursuant to this subsection.

38 c. (1) A basic health benefits plan shall provide the benefits set
39 forth in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section 57
40 of P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991, c.187
41 (C.26:2J-4.3), as the case may be.

42 (2) Notwithstanding the provisions of this subsection or any
43 other law to the contrary, a carrier may, with the approval of the
44 board, modify the coverage provided for in sections 55, 57, and 59
45 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3,
46 respectively) or provide alternative benefits or services from those
47 required by this subsection if they are within the intent of this act or

1 if the board changes the benefits included in the basic health
2 benefits plan.

3 (3) A contract or policy for a basic health benefits plan provided
4 for in this section may contain or provide for coinsurance or
5 deductibles, or both, except that no deductible shall be payable in
6 excess of a total of \$250 by an individual or \$500 by a family unit
7 during any benefit year; and no coinsurance shall be payable in
8 excess of a total of \$500 by an individual or by a family unit during
9 any benefit year.

10 (4) Notwithstanding the provisions of paragraph (3) of this
11 subsection or any other law to the contrary, a carrier may provide
12 for increased deductibles or coinsurance for a basic health benefits
13 plan if approved by the board or if the board increases deductibles
14 or coinsurance included in the basic health benefits plan.

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

19 (6) The provisions of section 27 of P.L.1985, c.236 (C.17:48E-
20 27) and section 7 of P.L.1988, c.71 (C.17:48E-27.1) with respect to
21 rate filings shall not apply to individual health plans issued on or
22 after the effective date of this act.

23 d. Every group conversion contract or policy issued after the
24 effective date of this act shall be issued pursuant to this section;
25 except that this requirement shall not apply to any group conversion
26 contract or policy in which a portion of the premium is chargeable
27 to, or subsidized by, the group policy from which the conversion is
28 made.

29 e. 【If all five of the individual health benefits plans are not
30 established by the board by the effective date of P.L.1993, c.164
31 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the
32 five health benefits plans by offering each health benefits plan as it
33 is established by the board; however, once the board establishes all
34 five plans, the carrier shall be required to offer the five plans in
35 accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et
36 al.).】 (Deleted by amendment, P.L. , c.)(pending before the
37 Legislature as this bill).

38 f. In addition to the rider packages provided for in subsection
39 c. of section 6 of P.L.1992, c.161 (C.17B:27A-7), every carrier may
40 offer, in connection with the health benefits plans required to be
41 offered by this section, any number of riders which may ¹【revise
42 the coverage offered by the plans in any way, provided, however,
43 that any form of such rider or amendment thereof which decreases
44 benefits or decreases the actuarial value of one of the plans shall be
45 filed for informational purposes with the board and for approval by
46 the commissioner before such rider may be sold】 add benefits or
47 increase the actuarial value of any of the plans¹. Any ¹such¹ rider

1 or amendment thereof ~~'[which adds benefits or increases the~~
2 actuarial value of one of the plans]¹ shall be filed with the board for
3 informational purposes before ~~'[such] the'~~ rider may be sold. The
4 added premium ~~'[or reduction in premium]'~~ for each rider ~~'[, as~~
5 applicable.]' shall be listed separately from the premium for the
6 standard plan.

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

15 (cf: P.L.1994, c.102, s.1)

16

17 12. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to
18 read as follows:

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

24 90 days hospital room and board - \$500 copayment per hospital
25 stay;

26 Outpatient and ambulatory surgery- \$250 copayment per surgery;

27 Physicians' fees connected with hospital care, including general
28 acute care and surgery;

29 Physicians' fees connected with outpatient and ambulatory surgery;

30 Anesthesia and the administration of anesthesia;

31 Coverage for newborns;

32 Treatment for complications of pregnancy;

33 Intravenous solutions, blood and blood plasma;

34 Oxygen and the administration of oxygen;

35 Radiation and x-ray therapy;

36 Inpatient physical therapy and hydrotherapy;

37 Outpatient physical therapy - 30 visits annually per covered person-

38 \$20 copayment per treatment;

39 Dialysis - inpatient or outpatient;

40 Inpatient diagnostic tests and \$500 annual aggregate per covered
41 person for out-of-hospital diagnostic tests;

42 Laboratory fees for treatment in hospital;

43 Delivery room fees;

44 Operating room fees;

45 Special care unit;

46 Treatment room fees;

- 1 Emergency room services for medically necessary treatment - \$100
2 copayment per visit;
3 Pharmaceuticals dispensed in hospital;
4 Dressings;
5 Splints;
6 Treatment for biologically-based mental illness, as defined in
7 subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90
8 days inpatient with no coinsurance - \$500 copayment per inpatient
9 stay, 30 days outpatient with 30% coinsurance;
10 Alcohol and Substance Abuse Treatment - 30 days inpatient or
11 outpatient - 30% coinsurance;
12 Childhood immunizations in accordance with the provisions of
13 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
14 adult immunizations;
15 Wellness benefit - \$600 annual aggregate per covered person, \$50
16 annual deductible, 20% coinsurance per service; and
17 Physicians visits for diagnosed illness or injury - to a \$700 annual
18 aggregate per covered person.
- 19 b. A carrier shall offer the benefits on an indemnity basis, with
20 the option that: (1) coverage is restricted to health care providers in
21 the carrier's network, including an exclusive provider organization,
22 or the carrier's preferred provider organization; or (2) coverage is
23 provided through health care providers in the carrier's network or
24 preferred provider organization with an out-of-network option with
25 30% coinsurance in addition to whatever other coinsurance may be
26 applicable under the policy.
- 27 c. With respect to all policies or contracts issued pursuant to
28 this section, the premium rate charged by a carrier to the highest
29 rated individual or class of individuals shall not be greater than
30 350% of the premium rate charged for the lowest rated individual or
31 class of individuals purchasing this health benefits plan, provided,
32 however, that the only factors upon which the rate differential may
33 be based are age, gender, and geography. 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
36 policies or contracts, and shall be formulated in a manner that does
37 not result in an unfair subsidization of rates applicable to policies
38 issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2
39 et seq.) as the result of differences in levels of benefits offered.
- 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
43 additional benefits, in a manner which will avoid adverse selection
44 to the extent possible.
- 45 e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.)
46 shall apply to this section to the extent that they are not contrary to
47 the provisions of this section, including but not limited to,

1 provisions relating to preexisting conditions, guaranteed issue, and
2 calculation of loss ratio.

3 f. No later than one year following enactment of this act, every
4 carrier shall make an informational filing with the **[board]**
5 commissioner, which shall include the policy form, the premiums to
6 be charged for the coverage, and the anticipated loss ratio. If the
7 **[board]** commissioner has not disapproved the form within 30
8 days, the form shall be deemed approved.

9 g. Every carrier that writes individual health benefits plans
10 pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make
11 available and shall make a good faith effort to market the contract
12 or policy established pursuant to this section. A carrier who is in
13 violation of this section shall be subject to the provisions of
14 N.J.S.17B:30-1.

15 (cf: P.L.2001, c.368, s.2)

16

17 13. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to
18 read as follows:

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

39 (cf: P.L.2001, c.368, s.4)

40

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

43 5. An individual health benefits plan issued pursuant to section
44 3 of this act is subject to the following provisions:

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

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

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

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

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

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

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

19 (3) **[board]** approval by the commissioner of a request by
20 the individual carrier to not renew a particular type of health
21 benefits plan, in accordance with rules adopted by the **[board]**
22 commissioner. After receiving **[board]** approval by the
23 commissioner, a carrier may not renew a type of health benefits
24 plan only if the carrier: (a) provides notice to each covered
25 individual provided coverage of this type of the nonrenewal at least
26 90 days prior to the date of the nonrenewal of the coverage; (b)
27 offers to each individual provided coverage of this type the option
28 to purchase any other individual health benefits plan currently being
29 offered by the carrier; and (c) in exercising the option to not renew
30 coverage of this type and in offering coverage as required under (b)
31 above, the carrier acts uniformly without regard to any health
32 status-related factor of enrolled individuals or individuals who may
33 become eligible for coverage;

34 (4) **[board]** approval by the commissioner of a request by the
35 individual carrier to cease doing business in the individual health
36 benefits market. A carrier may not renew all individual health
37 benefits plans only if the carrier: (a) first receives approval from
38 the **[board]** commissioner; and (b) provides notice to each
39 individual of the nonrenewal at least 180 days prior to the date of
40 the expiration of such coverage. A carrier ceasing to do business in
41 the individual health benefits market may not provide for the
42 issuance of any health benefits plan in the individual **[market]** or
43 small employer markets during the five-year period beginning on
44 the date of the termination of the last health benefits plan not so
45 renewed; and

46 (5) In the case of a health benefits plan made available by a
47 health maintenance organization carrier, the carrier shall not be

1 required to renew coverage to an eligible individual who no longer
2 resides, lives, or works in the service area, or in an area for which
3 the carrier is authorized to do business, but only if coverage is
4 terminated under this paragraph uniformly without regard to any
5 health status-related factor of covered individuals.

6 (cf. P.L.1997, c.146, s.3)

7

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

10 6. The **[board]** commissioner shall **[establish]** approve the
11 policy and contract forms and benefit levels to be made available by
12 all carriers for the health benefits plans required to be issued
13 pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall
14 adopt such modifications to one or more plans as the board
15 determines are necessary to make available a "high deductible
16 health plan" or plans consistent with section 301 of Title III of the
17 "Health Insurance Portability and Accountability Act of 1996,"
18 Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical
19 savings accounts, within 60 days after the enactment of P.L.1997,
20 c.414 (C.54A:3-4 et al.). The **[board]** commissioner shall provide
21 the **[commissioner]** board with an informational filing of the policy
22 and contract forms and benefit levels it **[establishes]** approves.

23 a. The individual health benefits plans established by the board
24 may include cost containment measures such as, but not limited to:
25 utilization review of health care services, including review of
26 medical necessity of hospital and physician services; case
27 management benefit alternatives; selective contracting with
28 hospitals, physicians, and other health care providers; and
29 reasonable benefit differentials applicable to participating and
30 nonparticipating providers; and other managed care provisions.

31 b. An individual health benefits plan offered pursuant to
32 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a
33 limitation of no more than 12 months on coverage for preexisting
34 conditions. An individual health benefits plan offered pursuant to
35 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a
36 preexisting condition limitation of any period under the following
37 circumstances:

38 (1) to an individual who has, under creditable coverage, with no
39 intervening lapse in coverage of more than 31 days, been treated or
40 diagnosed by a physician for a condition under that plan or satisfied
41 a 12-month preexisting condition limitation; or

42 (2) to a federally defined eligible individual who applies for an
43 individual health benefits plan within 63 days of termination of the
44 prior coverage.

45 c. In addition to the **[five]** standard individual health benefits
46 plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4),
47 the board may develop up to five rider packages. Premium rates for

1 the rider packages shall be determined in accordance with section 8
2 of P.L.1992, c.161 (C.17B:27A-9).

3 d. After the board's establishment of the individual health
4 benefits plans required pursuant to section 3 of P.L.1992, c.161
5 (C.17B:27A-4), and notwithstanding any law to the contrary, a
6 carrier shall file the policy or contract forms with the **[board]**
7 commissioner and certify to the **[board]** commissioner that the
8 health benefits plans to be used by the carrier are in substantial
9 compliance with the provisions in the corresponding **[board]**
10 approved plans. The certification shall be signed by the chief
11 executive officer of the carrier. Upon receipt by the **[board]**
12 commissioner of the certification, the certified plans may be used
13 until the **[board]** commissioner, after notice and hearing,
14 disapproves their continued use.

15 e. Effective immediately for an individual health benefits plan
16 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
17 35.27 et al.) and effective on the first 12-month anniversary date of
18 an individual health benefits plan in effect on the effective date of
19 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health
20 benefits plans required pursuant to section 3 of P.L.1992, c.161
21 (C.17B:27A-4), including any plan offered by a federally qualified
22 health maintenance organization, shall contain benefits for expenses
23 incurred in the following:

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

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

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

46 The benefits provided pursuant to this subsection shall be
47 provided to the same extent as for any other medical condition

1 under the health benefits plan, except that a deductible shall not be
2 applied for benefits provided pursuant to this subsection; however,
3 with respect to a health benefits plan that qualifies as a high
4 deductible health plan for which qualified medical expenses are
5 paid using a health savings account established pursuant to section
6 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),
7 a deductible shall not be applied for any benefits provided pursuant
8 to this subsection that represent preventive care as permitted by that
9 federal law, and shall not be applied as provided pursuant to section
10 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall
11 apply to all individual health benefits plans in which the carrier has
12 reserved the right to change the premium.

13 f. Effective immediately for a health benefits plan issued on or
14 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
15 effective on the first 12-month anniversary date of a health benefits
16 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z
17 et al.), the health benefits plans required pursuant to section 3 of
18 P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses
19 incurred in the purchase of prescription drugs shall provide benefits
20 for expenses incurred in the purchase of specialized non-standard
21 infant formulas, when the covered infant's physician has diagnosed
22 the infant as having multiple food protein intolerance and has
23 determined such formula to be medically necessary, and when the
24 covered infant has not been responsive to trials of standard non-cow
25 milk-based formulas, including soybean and goat milk. The
26 coverage may be subject to utilization review, including periodic
27 review, of the continued medical necessity of the specialized infant
28 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 individual health benefits plans
32 in which the carrier has reserved the right to change the premium.

33 g. Effective immediately for an individual health benefits plan
34 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
35 35.27 et al.) and effective on the first 12-month anniversary date of
36 an individual health benefits plan in effect on the effective date of
37 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
38 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)
39 that qualify as high deductible health plans for which qualified
40 medical expenses are paid using a health savings account
41 established pursuant to section 223 of the federal Internal Revenue
42 Code of 1986 (26 U.S.C. s.223), including any plan offered by a
43 federally qualified health maintenance organization, shall contain
44 benefits for expenses incurred in connection with any medically
45 necessary benefits provided in-network which represent preventive
46 care as permitted by that federal law.

47 The benefits provided pursuant to this subsection shall be
48 provided to the same extent as for any other medical condition

1 under the health benefits plan, except that a deductible shall not be
2 applied for benefits provided pursuant to this subsection. This
3 subsection shall apply to all individual health benefits plans in
4 which the carrier has reserved the right to change the premium.
5 (cf: P.L.2005, c.248, s.13)

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

9 8. a. ~~【The board shall make application to the Hospital Rate~~
10 ~~Setting Commission on behalf of all carriers for approval of~~
11 ~~discounted or reduced rates of payment to hospitals for health care~~
12 ~~services provided under an individual health benefits plan provided~~
13 ~~pursuant to this act.】~~ (Deleted by amendment, P.L. , c.)(pending
14 before the Legislature as this bill).

15 b. ~~【In addition to discounted or reduced rates of hospital~~
16 ~~payment, the】~~ The board shall make application on behalf of all
17 carriers for any other subsidies, discounts, or funds that may be
18 provided for under State or federal law or regulation. A carrier may
19 include 【discounted or reduced rates of hospital payment and other】
20 subsidies or funds granted to the board to reduce its premium rates
21 for individual health benefits plans subject to this act.

22 c. A carrier shall not issue individual health benefits plans on a
23 new contract or policy form pursuant to this act until an
24 informational filing of a full schedule of rates which applies to the
25 contract or policy form has been filed with the ~~【board】~~
26 commissioner. The ~~【board】~~ commissioner shall ~~【forward】~~ provide
27 a copy of the informational filing to the ~~【commissioner and the】~~
28 Attorney General and the board.

29 d. ~~【A carrier shall make an informational filing with the board~~
30 ~~of any change in its rates for individual health benefits plans~~
31 ~~pursuant to section 3 of this act prior to the date the rates become~~
32 ~~effective. The board shall file the informational filing with the~~
33 ~~commissioner and the Attorney General. If the carrier has filed all~~
34 ~~information required by the board, the filing shall be deemed to be~~
35 ~~complete.】~~ A carrier desiring to increase or decrease premiums for
36 any contract or policy form may implement that increase or
37 decrease upon making an informational filing with the
38 commissioner of that increase or decrease, along with the actuarial
39 assumptions and methods used by the carrier in establishing that
40 increase or decrease. The commissioner may disapprove any
41 informational filing on a finding that it is incomplete and not in
42 substantial compliance with P.L.1992, c.161 (C.17B:27A-2 et seq.),
43 or that the rates are inadequate or unfairly discriminatory.

44 e. (1) Rates shall be formulated on contracts or policies
45 required pursuant to section 3 of this act so that the anticipated
46 minimum loss ratio for a contract or policy form shall not be less
47 than ~~【75%】~~ 80% of the premium. The carrier shall submit with its

1 rate filing supporting data, as determined by the [board]
2 commissioner, and a certification by a member of the American
3 Academy of Actuaries, or other individuals in a format acceptable
4 to the [board and to the] commissioner, that the carrier is in
5 compliance with the provisions of this subsection.

6 (2) [Following the close of each calendar year, if the board
7 determines that a carrier's loss ratio was less than 75% for that
8 calendar year, the carrier shall be required to refund to policy or
9 contract holders the difference between the amount of net earned
10 premium it received that year and the amount that would have been
11 necessary to achieve the 75% loss ratio.]

12 Each calendar year, a carrier shall return, in the form of
13 aggregate benefits for all of the policy or contract forms offered by
14 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161
15 (C.17:B:27A-4), at least 80% of the aggregate premiums collected
16 for all of the policy or contract forms during that calendar year.
17 Carriers shall annually report, no later than August 1 of each year,
18 the loss ratio calculated pursuant to this section for all of the policy
19 or contract forms for the previous calendar year. In each case in
20 which the loss ratio fails to comply with the 80% loss ratio
21 requirement, the carrier shall issue a dividend or credit against
22 future premiums for all policy or contract holders, as applicable, in
23 an amount sufficient to assure that the aggregate benefits paid in the
24 previous calendar year plus the amount of the dividends and credits
25 equal 80% of the aggregate premiums collected for the policy or
26 contract forms in the previous calendar year. All dividends and
27 credits shall be distributed by December 31 of the year following
28 the calendar year in which the loss ratio requirements were not
29 satisfied. The annual report required by this subsection shall include
30 a carrier's calculation of the dividends and credits applicable to all
31 policy or contract forms, as well as an explanation of the carrier's
32 plan to issue dividends or credits. The instructions and format for
33 calculating and reporting loss ratios and issuing dividends or credits
34 shall be specified by the commissioner by regulation. Those
35 regulations shall include provisions for the distribution of a
36 dividend or credit in the event of cancellation or termination by a
37 policyholder.

38 f. [Notwithstanding the provisions of P.L.1992, c.161
39 (C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed
40 pursuant to this section by a carrier which insured at least 50% of
41 the community-rated individually insured persons on the effective
42 date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required
43 to produce a loss ratio which when combined with the carrier's
44 administrative costs and investment income results in self-
45 sustaining rates prior to January 1, 1996, for individual policies or
46 contracts issued prior to August 1, 1993. The carrier shall, not later
47 than 30 days after the effective date of P.L.1994, c.102
48 (C.17B;27A-4 et al.), file with the board for approval, a plan to

1 achieve this objective.】 (Deleted by amendment, P.L., c.)(pending
2 before the Legislature as this bill).
3 (cf: P.L.1994, c.102, s.2)

4
5 17. Section 10 of P.L.1992, c.161 (C.17B:27A-11) is amended
6 to read as follows:

7 10. The program shall have the general powers and authority
8 granted under the laws of New Jersey to insurance companies,
9 health service corporations and health maintenance organizations
10 licensed or approved to transact business in this State, except that
11 the program shall not have the power to issue health benefits plans
12 directly to either groups or individuals.

13 The board shall have the specific authority to:

14 a. assess members their proportionate share of program losses
15 and administrative expenses in accordance with the provisions of
16 section 11 of this act, and make advance interim assessments, as
17 may be reasonable and necessary for organizational and reasonable
18 operating expenses and estimated losses. An interim assessment
19 shall be credited as an offset against any regular assessment due
20 following the close of the fiscal year;

21 b. establish rules, conditions, and procedures pertaining to the
22 sharing of program losses and administrative expenses among the
23 members of the program;

24 c. **【review rate applications and form filings submitted by**
25 **carriers in accordance with this act;】** (Deleted by amendment,
26 P.L. , c.)(pending before the Legislature as this bill).

27 d. define the provisions of individual health benefits plans in
28 accordance with the requirements of this act;

29 e. enter into contracts which are necessary or proper to carry
30 out the provisions and purposes of this act;

31 f. establish a procedure for the joint distribution of information
32 on individual health benefits plans issued pursuant to section 3 of
33 this act;

34 g. establish, at the board's discretion, standards for the
35 application of a means test for individual health benefits plans
36 issued pursuant to section 3 of this act;

37 h. establish, at the board's discretion, reasonable guidelines for
38 the purchase of new individual health benefits plans by persons who
39 already are enrolled in or insured by another individual health
40 benefits plan;

41 i. establish minimum requirements for performance standards
42 for carriers that are reimbursed for losses submitted to the program
43 and provide for performance audits from time to time;

44 j. sue or be sued, including taking any legal actions necessary
45 or proper for recovery of an assessment for, on behalf of, or against
46 the program or a member;

47 k. appoint from among its members appropriate legal, actuarial,
48 and other committees as necessary to provide technical and other

1 assistance in the operation of the program, in policy and other
2 contract design, and any other function within the authority of the
3 program;

4 l. borrow money to effect the purposes of the program. Any
5 notes or other evidence of indebtedness of the program not in
6 default shall be legal investments for carriers and may be carried as
7 admitted assets; and

8 m. contract for an independent actuary and any other
9 professional services the board deems necessary to carry out its
10 duties under P.L.1992, c.161 (C.17B:27A-2 et al.).

11 (cf: P.L.1993, c.164, s.6)

12

13 18. Section 11 of P.L.1992, c.161 (C.17B:27A-12) is amended
14 to read as follows:

15 11. The board shall establish procedures for the equitable
16 sharing of program losses among all members in accordance with
17 their total market share as follows:

18 a. (1) By March 1, 1999, and following the close of each two-
19 year calculation period thereafter, or on a different date established
20 by the board:

21 (a) every carrier issuing health benefits plans in this State shall
22 file with the board its net earned premium for the preceding two-
23 year calculation period; and

24 (b) every carrier issuing individual health benefits plans in the
25 State shall file with the board the net earned premium on health
26 benefits plans issued pursuant to paragraph (1) of subsection b. of
27 section 2 and section 3 of this act and the claims paid. If the claims
28 paid for all health benefits plans during the two-year calculation
29 period exceed 115% of the net earned premium and any investment
30 income thereon for the two-year calculation period, the amount of
31 the excess shall be the net paid loss for the carrier that shall be
32 reimbursable under this act.

33 (2) Every member shall be liable for an assessment to reimburse
34 carriers issuing individual health benefits plans in this State which
35 sustain net paid losses during the two-year calculation period,
36 unless the member has received an exemption from the board
37 pursuant to subsection d. of this section and has written a minimum
38 number of non-group person life years as provided for in that
39 subsection. The assessment of each member shall be in the
40 proportion that the net earned premium of the member for the two-
41 year calculation period preceding the assessment bears to the net
42 earned premium of all members for the two-year calculation period
43 preceding the assessment. Notwithstanding the provisions of this
44 subsection to the contrary, a medical service corporation or a
45 hospital service corporation shall not be liable for an assessment to
46 reimburse carriers which sustain net paid losses.

47 (3) A member that is financially impaired may seek from the
48 commissioner a deferment in whole or in part from any assessment

1 issued by the board. The commissioner may defer, in whole or in
2 part, the assessment of the member if, in the opinion of the
3 commissioner, the payment of the assessment would endanger the
4 ability of the member to fulfill its contractual obligations. If an
5 assessment against a member is deferred in whole or in part, the
6 amount by which the assessment is deferred may be assessed
7 against the other members in a manner consistent with the basis for
8 assessment set forth in this section. The member receiving the
9 deferment shall remain liable to the program for the amount
10 deferred.

11 b. The participation in the program as a member, the
12 establishment of rates, forms or procedures, or any other joint or
13 collective action required by this act shall not be the basis of any
14 legal action, criminal or civil liability, or penalty against the
15 program, a member of the board or a member of the program either
16 jointly or separately except as otherwise provided in this act.

17 c. Payment of an assessment made under this section shall be a
18 condition of issuing health benefits plans in the State for a carrier.
19 Failure to pay the assessment shall be grounds for forfeiture of a
20 carrier's authorization to issue health benefits plans of any kind in
21 the State, as well as any other penalties permitted by law.

22 d. (1) Notwithstanding the provisions of this act to the
23 contrary, a carrier may apply to the board, by a date established by
24 the board, for an exemption from the assessment and reimbursement
25 for losses provided for in this section. A carrier which applies for
26 an exemption shall agree to cover a minimum number of non-group
27 person life years on an open enrollment community rated basis,
28 under a managed care or indemnity plan, as specified in this
29 subsection, provided that any indemnity plan so issued conforms
30 with sections 2 through 7, inclusive, of P.L.1992, c.161
31 (C.17B:27A-3 through 17B:27A-8). For the purposes of this
32 subsection, non-group persons include individually enrolled
33 persons, conversion policies issued pursuant to this act, Medicare
34 cost and risk lives and Medicaid recipients; except that in
35 determining whether the carrier meets the minimum number of non-
36 group person life years required to be covered pursuant to this
37 subsection, the number of Medicaid recipients and Medicare cost
38 and risk lives shall not exceed 50% of the total. Pursuant to
39 regulations adopted by the board, the carrier shall determine the
40 number of non-group person life years it has covered by adding the
41 number of non-group persons covered on the last day of each
42 calendar quarter of the two-year calculation period, taking into
43 account the limitations on counting Medicaid recipients and
44 Medicare cost and risk lives, and dividing the total by eight.

45 (2) Notwithstanding the provisions of paragraph (1) of this
46 subsection to the contrary, a health maintenance organization
47 qualified pursuant to the "Health Maintenance Organization Act of
48 1973," Pub.L93-222 (42U.S.C. s.300e et seq.) and tax exempt

1 pursuant to paragraph (3) of subsection (c) of section 501 of the
2 federal Internal Revenue Code of 1986, 26U.S.C. s.501, may
3 include up to one third Medicaid recipients and up to one third
4 Medicare recipients in determining whether it meets its minimum
5 number of non-group person life years.

6 (3) The minimum number of non-group person life years
7 required to be covered, as determined by the board, shall equal the
8 total number of non-group person life years of community rated,
9 individually enrolled or insured persons, including Medicare cost
10 and risk lives and enrolled Medicaid lives, of all carriers subject to
11 this act for the two-year calculation period, multiplied by the
12 proportion that that carrier's net earned premium bears to the net
13 earned premium of all carriers for that two-year calculation period,
14 including those carriers that are exempt from the assessment.

15 (4) On or before March 1 of the first year of each two-year
16 calculation period, every carrier seeking an exemption pursuant to
17 this subsection shall file with the board a statement of its net earned
18 premium for the two-year calculation period. The board shall
19 determine each carrier's minimum number of non-group person life
20 years in accordance with this subsection.

21 (5) On or before March 1 of each year immediately following
22 the close of a two-year calculation period, every carrier that was
23 granted an exemption for the preceding two-year calculation period
24 shall file with the board the number of non-group person life years,
25 by category, covered for the two-year calculation period.

26 To the extent that the carrier has failed to cover the minimum
27 number of non-group person life years established by the board, the
28 carrier shall be assessed by the board on a pro rata basis for any
29 differential between the minimum number established by the board
30 and the actual number covered by the carrier.

31 (6) A carrier that applies for the exemption shall be deemed to
32 be in compliance with the requirements of this subsection if it has
33 covered 100% of the minimum number of non-group person life
34 years required.

35 (7) Any carrier that writes both managed care and indemnity
36 business that is granted an exemption pursuant to this subsection
37 may satisfy its obligation to cover a minimum number of non-group
38 person life years by issuing either managed care or indemnity
39 business, or both.

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

41 f. The loss assessment for the '2007-2008' two-year
42 calculation period '[in which P.L. , c. (pending before the
43 Legislature as this bill) takes effect]' shall be the last loss
44 assessment authorized under this section, and no further loss
45 assessments shall be calculated or collected; provided, however,
46 that nothing in this subsection shall relieve a carrier of its
47 obligations for loss assessments authorized under this section prior

1 to the effective date of ¹this section of¹ P.L. , c. (pending before
2 the Legislature as this bill).

3 (cf: P.L.1997, c.146, s.6)

4

5 19. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended
6 to read as follows:

7 5. A domestic mutual insurer which has converted from a
8 health service corporation pursuant to the provisions of sections 2
9 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48)
10 shall not renew individual hospital or medical insurance policies or
11 health service contracts originally issued prior to November 30,
12 1992, until it has made an informational filing with the [New Jersey
13 Individual Health Coverage Program Board, of a full schedule of
14 rates which are to apply to those contracts. The New Jersey
15 Individual Health Coverage Program Board shall forward a copy of
16 such filing to the] commissioner. The rates shall be formulated so
17 that the anticipated minimum loss ratio for such policy or contract
18 form shall not be less than [75%] 80% of the premium. Such
19 domestic mutual insurer shall submit with its rate filing supporting
20 data and a certification that the insurer is in compliance with the
21 anticipated loss ratio requirement. The content and form of the
22 supporting data and certification required pursuant to subsection e.
23 of section 8 of P.L.1992, c.161 (C.17B:27A-9) shall satisfy the
24 requirements of this section. Any other insurer may irrevocably
25 elect to become subject to the provisions of this section by written
26 notice to the commissioner[, except that such informational filing
27 by any other insurer shall be] in a format specified by the
28 commissioner [and shall be made directly to the commissioner and
29 not to the New Jersey Individual Health Coverage Program Board].
30 (cf: P.L.1995, c.196, s.5)

31

32 20. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to
33 read as follows:

34 1. As used in this act:

35 "Actuarial certification" means a written statement by a member
36 of the American Academy of Actuaries or other individual
37 acceptable to the commissioner that a small employer carrier is in
38 compliance with the provisions of section 9 of P.L.1992, c.162
39 (C.17B:27A-25), based upon examination, including a review of the
40 appropriate records and actuarial assumptions and methods used by
41 the small employer carrier in establishing premium rates for
42 applicable health benefits plans.

43 "Anticipated loss ratio" means the ratio of the present value of
44 the expected benefits, not including dividends, to the present value
45 of the expected premiums, not reduced by dividends, over the entire
46 period for which rates are computed to provide coverage. For
47 purposes of this ratio, the present values must incorporate realistic

1 rates of interest which are determined before federal taxes but after
2 investment expenses.

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

4 "Carrier" means any entity subject to the insurance laws and
5 regulations of this State, or subject to the jurisdiction of the
6 commissioner, that contracts or offers to contract to provide,
7 deliver, arrange for, pay for, or reimburse any of the costs of health
8 care services, including an insurance company authorized to issue
9 health insurance, a health maintenance organization, a hospital
10 service corporation, medical service corporation and health service
11 corporation, or any other entity providing a plan of health
12 insurance, health benefits or health services. The term "carrier"
13 shall not include a joint insurance fund established pursuant to State
14 law. For purposes of this act, carriers that are affiliated companies
15 shall be treated as one carrier, except that any insurance company,
16 health service corporation, hospital service corporation, or medical
17 service corporation that is an affiliate of a health maintenance
18 organization located in New Jersey or any health maintenance
19 organization located in New Jersey that is affiliated with an
20 insurance company, health service corporation, hospital service
21 corporation, or medical service corporation shall treat the health
22 maintenance organization as a separate carrier.

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

26 "Commissioner" means the Commissioner of Banking and
27 Insurance.

28 "Community rating" or "community rated" means a rating
29 methodology in which the premium charged by a carrier for all
30 persons covered by a policy or contract form is the same based upon
31 the experience of the entire pool of risks covered by that policy or
32 contract form without regard to age, gender, health status, residence
33 or occupation.

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

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

12 "Department" means the Department of Banking and Insurance.

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

18 "Eligible employee" means a full-time employee who works a
19 normal work week of 25 or more hours. The term includes a sole
20 proprietor, a partner of a partnership, or an independent contractor,
21 if the sole proprietor, partner, or independent contractor is included
22 as an employee under a health benefits plan of a small employer,
23 but does not include employees who work less than 25 hours a
24 week, work on a temporary or substitute basis or are participating in
25 an employee welfare arrangement established pursuant to a
26 collective bargaining agreement.

27 "Enrollment date" means, with respect to a person covered under
28 a health benefits plan, the date of enrollment of the person in the
29 health benefits plan or, if earlier, the first day of the waiting period
30 for such enrollment.

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

36 "Governmental plan" has the meaning given that term under Title
37 I, section 3 of Pub.L.93-406, the "Employee Retirement Income
38 Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental
39 plan established or maintained for its employees by the Government
40 of the United States or by any agency or instrumentality of that
41 government.

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

1 "Health benefits plan" means any hospital and medical expense
2 insurance policy or certificate; health, hospital, or medical service
3 corporation contract or certificate; or health maintenance
4 organization subscriber contract or certificate delivered or issued
5 for delivery in this State by any carrier to a small employer group
6 pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For
7 purposes of this act, "health benefits plan" shall not include one or
8 more, or any combination of, the following: coverage only for
9 accident or disability income insurance, or any combination thereof;
10 coverage issued as a supplement to liability insurance; liability
11 insurance, including general liability insurance and automobile
12 liability insurance; workers' compensation or similar insurance;
13 automobile medical payment insurance; credit-only insurance;
14 coverage for on-site medical clinics; and other similar insurance
15 coverage, as specified in federal regulations, under which benefits
16 for medical care are secondary or incidental to other insurance
17 benefits. Health benefits plans shall not include the following
18 benefits if they are provided under a separate policy, certificate or
19 contract of insurance or are otherwise not an integral part of the
20 plan: limited scope dental or vision benefits; benefits for long-term
21 care, nursing home care, home health care, community-based care,
22 or any combination thereof; and such other similar, limited benefits
23 as are specified in federal regulations. Health benefits plan shall
24 not include hospital confinement indemnity coverage if the benefits
25 are provided under a separate policy, certificate or contract of
26 insurance, there is no coordination between the provision of the
27 benefits and any exclusion of benefits under any group health
28 benefits plan maintained by the same plan sponsor, and those
29 benefits are paid with respect to an event without regard to whether
30 benefits are provided with respect to such an event under any group
31 health plan maintained by the same plan sponsor. Health benefits
32 plan shall not include the following if it is offered as a separate
33 policy, certificate or contract of insurance: Medicare supplemental
34 health insurance as defined under section 1882(g)(1) of the federal
35 Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage
36 supplemental to the coverage provided under chapter 55 of Title 10,
37 United States Code (10 U.S.C. s.1071 et seq.); and similar
38 supplemental coverage provided to coverage under a group health
39 plan.

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

45 "Late enrollee" means an eligible employee or dependent who
46 requests enrollment in a health benefits plan of a small employer
47 following the initial minimum 30-day enrollment period provided
48 under the terms of the health benefits plan. An eligible employee or

1 dependent shall not be considered a late enrollee if the individual: a.
2 was covered under another employer's health benefits plan at the
3 time he was eligible to enroll and stated at the time of the initial
4 enrollment that coverage under that other employer's health benefits
5 plan was the reason for declining enrollment, but only if the plan
6 sponsor or carrier required such a statement at that time and
7 provided the employee with notice of that requirement and the
8 consequences of that requirement at that time; b. has lost coverage
9 under that other employer's health benefits plan as a result of
10 termination of employment or eligibility, reduction in the number of
11 hours of employment, involuntary termination, the termination of
12 the other plan's coverage, death of a spouse, or divorce or legal
13 separation; and c. requests enrollment within 90 days after
14 termination of coverage provided under another employer's health
15 benefits plan. An eligible employee or dependent also shall not be
16 considered a late enrollee if the individual is employed by an
17 employer which offers multiple health benefits plans and the
18 individual elects a different plan during an open enrollment period;
19 the individual had coverage under a COBRA continuation provision
20 and the coverage under that provision was exhausted and the
21 employee requests enrollment not later than 30 days after the date
22 of exhaustion of COBRA coverage; or if a court of competent
23 jurisdiction has ordered coverage to be provided for a spouse or
24 minor child under a covered employee's health benefits plan and
25 request for enrollment is made within 30 days after issuance of that
26 court order.

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

32 "Member" means all carriers issuing health benefits plans in this
33 State on or after the effective date of this act.

34 "Multiple employer arrangement" means an arrangement
35 established or maintained to provide health benefits to employees
36 and their dependents of two or more employers, under an insured
37 plan purchased from a carrier in which the carrier assumes all or a
38 substantial portion of the risk, as determined by the commissioner,
39 and shall include, but is not limited to, a multiple employer welfare
40 arrangement, or MEWA, multiple employer trust or other form of
41 benefit trust.

42 "Plan of operation" means the plan of operation of the program
43 including articles, bylaws and operating rules approved pursuant to
44 section 14 of P.L.1992, c.162 (C.17B:27A-30).

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

1 "Preexisting condition exclusion" means, with respect to
2 coverage, a limitation or exclusion of benefits relating to a
3 condition based on the fact that the condition was present before the
4 date of enrollment for that coverage, whether or not any medical
5 advice, diagnosis, care, or treatment was recommended or received
6 before that date. Genetic information shall not be treated as a
7 preexisting condition in the absence of a diagnosis of the condition
8 related to that information.

9 "Program" means the New Jersey Small Employer Health
10 Benefits Program established pursuant to section 12 of P.L.1992,
11 c.162 (C.17B:27A-28).

12 "Small employer" means, in connection with a group health plan
13 with respect to a calendar year and a plan year, any person, firm,
14 corporation, partnership, or political subdivision that is actively
15 engaged in business that employed an average of at least two but
16 not more than 50 eligible employees on business days during the
17 preceding calendar year and who employs at least two employees
18 on the first day of the plan year, and the majority of the employees
19 are employed in New Jersey. All persons treated as a single
20 employer under subsection (b), (c), (m) or (o) of section 414 of the
21 Internal Revenue Code of 1986 (26 U.S.C.s.414) shall be treated as
22 one employer. Subsequent to the issuance of a health benefits plan
23 to a small employer and for the purpose of determining continued
24 eligibility, the size of a small employer shall be determined
25 annually. Except as otherwise specifically provided, provisions of
26 P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small
27 employer shall continue to apply at least until the plan anniversary
28 following the date the small employer no longer meets the
29 requirements of this definition. In the case of an employer that was
30 not in existence during the preceding calendar year, the
31 determination of whether the employer is a small or large employer
32 shall be based on the average number of employees that it is
33 reasonably expected that the employer will employ on business
34 days in the current calendar year. Any reference in P.L.1992, c.162
35 (C.17B:27A-17 et seq.) to an employer shall include a reference to
36 any predecessor of such employer.

37 "Small employer carrier" means any carrier that offers health
38 benefits plans covering eligible employees of one or more small
39 employers.

40 "Small employer health benefits plan" means a health benefits
41 plan for small employers approved by the commissioner pursuant to
42 section 17 of P.L.1992, c.162 (C.17B:27A-33).

43 "Stop loss" or "excess risk insurance" means an insurance policy
44 designed to reimburse a self-funded arrangement of one or more
45 small employers for catastrophic, excess or unexpected expenses,
46 wherein neither the employees nor other individuals are third party
47 beneficiaries under the insurance policy. In order to be considered
48 stop loss or excess risk insurance for the purposes of P.L.1992,

1 c.162 (C.17B:27A-17 et seq.), the policy shall establish a per person
2 attachment point or retention or aggregate attachment point or
3 retention, or both, which meet the following requirements:

4 a. If the policy establishes a per person attachment point or
5 retention, that specific attachment point or retention shall not be
6 less than \$20,000 per covered person per plan year; and

7 b. If the policy establishes an aggregate attachment point or
8 retention, that aggregate attachment point or retention shall not be
9 less than 125% of expected claims per plan year.

10 "Supplemental limited benefit insurance" means insurance that is
11 provided in addition to a health benefits plan on an indemnity non-
12 expense incurred basis.

13 (cf: P.L.1997, c.146, s.7)

14

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

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

36 (1) Basic inpatient and outpatient hospital care;

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

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

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

40 and

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

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

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

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

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

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

28 e. **[Notwithstanding the provisions of subsection a. of this**
29 **section to the contrary, the board may approve a health benefits**
30 **plan containing only medical-surgical benefits or major medical**
31 **expense benefits, or a combination thereof, which is issued as a**
32 **separate policy in conjunction with a contract of insurance for**
33 **hospital expense benefits issued by a hospital service corporation, if**
34 **the health benefits plan and hospital service corporation contract**
35 **combined otherwise comply with the provisions of P.L.1992, c.162**
36 **(C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the**
37 **contract combined may be allocated between the separate contracts**
38 **at the discretion of the carrier and the hospital service corporation.]**
39 (Deleted by amendment, P.L. , c.) (pending before the
40 Legislature as this bill).

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

1 Notwithstanding the provisions of this section to the contrary, a
2 health maintenance organization which is approved pursuant to
3 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
4 benefits plans formulated by the board and approved by the
5 commissioner which are in accordance with the provisions of that
6 law in lieu of the **[five]** plans required pursuant to this section,
7 except that the plans shall provide the same level of benefits as
8 required for a federally qualified health maintenance organization,
9 including any requirements concerning copayments by enrollees.

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

18 h. Notwithstanding the provisions of subsection a. of this
19 section to the contrary, the board may modify the benefits provided
20 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,
21 17B:26B-2 and 26:2J-4.3).

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

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

45 (2) The benefit riders provided for in paragraph (1) of this
46 subsection shall be subject to the provisions of section 2, subsection
47 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162

1 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-
2 24, 17B:27A-25, and 17B:27A-27).

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

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

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

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

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

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

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

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

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

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

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

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

47 (c) A health benefits plan issued by a carrier through an out-of-
48 State trust shall be permitted to be renewed or continued pursuant to

1 paragraph (1) of this subsection upon approval by the commissioner
2 and only if the benefits offered under the plan are at least equal to
3 the actuarial value and benefits coverage of the lowest standard
4 health benefits plan established by the board pursuant to subsection
5 a. of this section. For the purposes of meeting the requirements of
6 this subparagraph, carriers shall be required to file with the
7 commissioner the health benefits plans issued through an out-of-
8 State trust no later than 180 days after the date of enactment of
9 P.L.1995, c.340. A health benefits plan issued by a carrier through
10 an out-of-State trust that is not filed with the commissioner pursuant
11 to this subparagraph, shall not be permitted to be continued or
12 renewed after the 180-day period.

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

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

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

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

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

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

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

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

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

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

45 (3) Screening for newborn hearing loss by appropriate
46 electrophysiologic screening measures and periodic monitoring of
47 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
48 (C.26:2-103.1 et al.). Payment for this screening service shall be

1 separate and distinct from payment for routine new baby care in the
2 form of a newborn hearing screening fee as negotiated with the
3 provider and facility.

4 The benefits provided pursuant to this subsection shall be
5 provided to the same extent as for any other medical condition
6 under the health benefits plan, except that a deductible shall not be
7 applied for benefits provided pursuant to this subsection; however,
8 with respect to a small employer health benefits plan that qualifies
9 as a high deductible health plan for which qualified medical
10 expenses are paid using a health savings account established
11 pursuant to section 223 of the federal Internal Revenue Code of
12 1986 (26 U.S.C. s.223), a deductible shall not be applied for any
13 benefits that represent preventive care as permitted by that federal
14 law, and shall not be applied as provided pursuant to section 16 of
15 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to
16 all small employer health benefits plans in which the carrier has
17 reserved the right to change the premium.

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

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

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

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

43 n. Effective immediately for a health benefits plan issued on or
44 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
45 and effective on the first 12-month anniversary date of a small
46 employer health benefits plan in effect on the effective date of
47 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
48 required pursuant to this section that qualify as high deductible

1 health plans for which qualified medical expenses are paid using a
2 health savings account established pursuant to section 223 of the
3 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including
4 any plans offered by a State approved or federally qualified health
5 maintenance organization, shall contain benefits for expenses
6 incurred in connection with any medically necessary benefits
7 provided in-network that represent preventive care as permitted by
8 that federal law.

9 The benefits provided pursuant to this subsection shall be
10 provided to the same extent as for any other medical condition
11 under the health benefits plan, except that no deductible shall be
12 applied for benefits provided pursuant to this subsection. This
13 subsection shall apply to all small employer health benefits plans in
14 which the carrier has reserved the right to change the premium.
15 (cf: P.L.2005, c.248, s.15)

16

17 22. Section 5 of P.L.2001, c.368 (C.17B:27A-19.11) is amended
18 to read as follows:

19 5. In addition to the **[five]** standard health benefits plans
20 offered by a carrier on the effective date of this act, a carrier that
21 writes small employer health benefits plans pursuant to P.L.1992,
22 c.162 (C.17B:27A-17 et seq.) may also offer one or more of the
23 plans through the carrier's network of providers, with no
24 reimbursement for any out-of-network benefits other than
25 emergency care, urgent care, and continuity of care. A carrier's
26 network of providers shall be subject to review and approval or
27 disapproval by the Commissioner of Banking and Insurance, in
28 consultation with the Commissioner of Health and Senior Services,
29 pursuant to regulations promulgated by the Department of Banking
30 and Insurance, including review and approval or disapproval before
31 plans with benefits provided through a carrier's network of
32 providers pursuant to this section may be offered by the carrier.
33 Policies or contracts written on this basis shall be rated in a separate
34 rating pool for the purposes of establishing a premium, but for the
35 purpose of determining a carrier's losses, these policies or contracts
36 shall be aggregated with the losses on the carrier's other business
37 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-
38 17 et seq.).

39 (cf: P.L.2001, c.368, s.5)

40

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

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

- 1 a. A carrier may discontinue such coverage only if:
- 2 (1) The policyholder, contract holder, or employer has failed to
- 3 pay premiums or contributions in accordance with the terms of the
- 4 health benefits plan or the carrier has not received timely premium
- 5 payments; or
- 6 (2) The policyholder, contract holder, or employer has
- 7 performed an act or practice that constitutes fraud or made an
- 8 intentional misrepresentation of material fact under the terms of the
- 9 coverage;
- 10 b. (Deleted by amendment, P.L.1997, c.146).
- 11 c. The number of employees covered under the health benefits
- 12 plan is less than the number or percentage of employees required by
- 13 participation requirements under the health benefits policy or
- 14 contract;
- 15 d. Noncompliance with a carrier's employment contribution
- 16 requirements;
- 17 e. Any carrier doing business pursuant to the provisions of this
- 18 act ceases doing business in the small employer market, if the
- 19 following conditions are satisfied:
- 20 (1) The carrier gives notice to cease doing business in the small
- 21 employer market to the commissioner not later than eight months
- 22 prior to the date of the planned withdrawal from the small **[group**
- 23 **market]** employer market, during which time the carrier shall
- 24 continue to be governed by this act with respect to business written
- 25 pursuant to this act. For the purposes of this subsection, "date of
- 26 withdrawal" means the date upon which the first notice to small
- 27 employers is sent by the carrier pursuant to paragraph (2) of this
- 28 subsection;
- 29 (2) No later than two months following the date of the
- 30 notification to the commissioner that the carrier intends to cease
- 31 doing business in the small employer market, the carrier shall mail a
- 32 notice to every small business employer insured by the carrier, and
- 33 all covered persons, that the policy or contract of insurance will not
- 34 be renewed. This notice shall be sent by certified mail to the small
- 35 business employer not less than six months in advance of the
- 36 effective date of the nonrenewal date of the policy or contract;
- 37 (3) Any carrier that ceases to do business pursuant to this act
- 38 shall be prohibited from writing new business in the small employer
- 39 **[market]** and individual health benefits plan markets for a period of
- 40 five years from the date of termination of the last health insurance
- 41 coverage not so renewed;
- 42 f. In the case of policies or contracts issued in connection with
- 43 membership in an association or trust of employers, an employer
- 44 ceases to maintain its membership in the association or trust, but
- 45 only if such coverage is terminated under this provision uniformly
- 46 without regard to any health status-related factor relating to any
- 47 covered individual.
- 48 g. (Deleted by amendment, P.L.1995, c.50).

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

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

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

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

18 (cf: P.L.1997, c.146, s.10)

19
20 ¹[25.] 24.¹ Section 9 of P.L.1992, c.162 (C.17B:27A-25) is
21 amended to read as follows:

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

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

24 (3) ¹(a)¹ For all policies or contracts providing health benefits
25 plans for small employers issued pursuant to section 3 of P.L.1992,
26 c.162 (C.17B:27A-19), and including policies or contracts offered
27 by a carrier to a small employer who is a member of a Small
28 Employer Purchasing Alliance pursuant to the provisions of
29 P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged
30 by a carrier to the highest rated small group purchasing a small
31 employer health benefits plan issued pursuant to section 3 of
32 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than 200% of
33 the premium rate charged for the lowest rated small group
34 purchasing that same health benefits plan; provided, however, that
35 the only factors upon which the rate differential may be based are
36 age, gender and geography ¹[, and provided further, that such] ².
37 ³[In addition, rates may vary to reflect commissions and other
38 compensation actually paid as provided in subparagraph (c) of this
39 paragraph (3).]³ Such¹ factors ¹[are] shall be¹ applied in a manner
40 consistent with regulations adopted by the ¹[board] commissioner¹.
41 For the purposes of this paragraph (3), policies or contracts offered
42 by a carrier to a small employer who is a member of a Small
43 Employer Purchasing Alliance shall be rated separately from the
44 carrier's other small employer health benefits policies or contracts.

45 ¹(b)¹ A health benefits plan issued pursuant to subsection j. of
46 section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in
47 accordance with the provisions of section 7 of P.L.1995, c.340

1 (C.17B:27A-19.3), for the purposes of meeting the requirements of
2 this paragraph.

3 ³[(c) The amount of the commission or other compensation paid
4 to an insurance producer in connection with a policy or contract
5 issued to a small employer shall be disclosed to the small employer,
6 as provided in section 25 of P.L. , c. (pending before the
7 Legislature as this bill). Rates charged to a small employer shall
8 differ based on the actual compensation paid to an insurance
9 producer, in a manner consistent with regulations adopted by the
10 commissioner. Variations in rates attributable solely to differences
11 in commissions or other compensation paid are not subject to the
12 200% limitation provided in subparagraph (a) of this paragraph
13 (3).]³

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

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

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

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

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

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

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

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

33 A carrier which provides a health benefits plan to one or more
34 small employers through a policy issued to an association or trust of
35 employers after the effective date of P.L.1992, c.162 (C.17B:27A-
36 17 et seq.), shall be required to offer small employer health benefits
37 plans to non-association or trust employers in the same manner as
38 any other small employer carrier is required pursuant to P.L.1992,
39 c.162 (C.17B:27A-17 et seq.).

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

43 f. No insurance contract or policy subject to this act, including
44 a contract or policy entered into with a small employer who is a
45 member of a Small Employer Purchasing Alliance pursuant to the
46 provisions of P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be
47 entered into unless and until the carrier has made an informational
48 filing with the commissioner of a schedule of premiums, not to

1 exceed 12 months in duration, to be paid pursuant to such contract
2 or policy, of the carrier's rating plan and classification system in
3 connection with such contract or policy, and of the actuarial
4 assumptions and methods used by the carrier in establishing
5 premium rates for such contract or policy.

6 g. (1) Beginning January 1, 1995, a carrier desiring to increase
7 or decrease premiums for any policy form or benefit rider offered
8 pursuant to subsection i. of section 3 of P.L.1992, c.162
9 (C.17B:27A-19) subject to this act may implement such increase or
10 decrease upon making an informational filing with the
11 commissioner of such increase or decrease, along with the actuarial
12 assumptions and methods used by the carrier in establishing such
13 increase or decrease, provided that the anticipated minimum loss
14 ratio for all policy forms shall not be less than ~~75%~~ 80% of the
15 premium therefor as provided in paragraph (2) of this subsection.
16 The commissioner may disapprove any informational filing on a
17 finding that it is incomplete and not in substantial compliance with
18 P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are
19 inadequate or unfairly discriminatory. Until December 31, 1996,
20 the informational filing shall also include the carrier's rating plan
21 and classification system in connection with such increase or
22 decrease.

23 (2) Each calendar year, a carrier shall return, in the form of
24 aggregate benefits for all of the ~~five~~ standard policy forms
25 offered by the carrier pursuant to subsection a. of section 3 of
26 P.L.1992, c.162 (C.17B:27A-19), at least ~~75%~~ 80% of the
27 aggregate premiums collected for all of the standard policy forms,
28 other than alliance policy forms, and at least ~~75%~~ 80% of the
29 aggregate premiums collected for all of the non-standard policy
30 forms during that calendar year. A carrier shall return at least
31 ~~75%~~ 80% of the premiums collected for all of the alliances
32 during that calendar year, which loss ratio may be calculated in the
33 aggregate for all of the alliances or separately for each alliance.
34 Carriers shall annually report, no later than August 1st of each year,
35 the loss ratio calculated pursuant to this section for all of the
36 standard, other than alliance policy forms, non-standard policy
37 forms and alliance policy forms for the previous calendar year,
38 provided that a carrier may annually report the loss ratio calculated
39 pursuant to this section for all of the alliances in the aggregate or
40 separately for each alliance. In each case where the loss ratio fails
41 to substantially comply with the ~~75%~~ 80% loss ratio requirement,
42 the carrier shall issue a dividend or credit against future premiums
43 for all policyholders with the standard, other than alliance policy
44 forms, nonstandard policy forms or alliance policy forms, as
45 applicable, in an amount sufficient to assure that the aggregate
46 benefits paid in the previous calendar year plus the amount of the
47 dividends and credits shall equal ~~75%~~ 80% of the aggregate

1 premiums collected for the respective policy forms in the previous
2 calendar year. All dividends and credits must be distributed by
3 December 31 of the year following the calendar year in which the
4 loss ratio requirements were not satisfied. The annual report
5 required by this paragraph shall include a carrier's calculation of the
6 dividends and credits applicable to standard, other than alliance
7 policy forms, non-standard policy forms and alliance policy forms,
8 as well as an explanation of the carrier's plan to issue dividends or
9 credits. The instructions and format for calculating and reporting
10 loss ratios and issuing dividends or credits shall be specified by the
11 commissioner by regulation. Such regulations shall include
12 provisions for the distribution of a dividend or credit in the event of
13 cancellation or termination by a policyholder. For purposes of this
14 paragraph, "alliance policy forms" means policies purchased by
15 small employers who are members of Small Employer Purchasing
16 Alliances.

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

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

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

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

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

34 (cf: P.L.2003, c.163, s.1)

35
36 ¹[26.] 25.¹ (New section) a. An insurance producer licensed
37 pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.) who sells,
38 solicits, or negotiates health insurance policies or contracts to
39 residents of this State shall notify the purchaser of the insurance, in
40 writing, of the amount of any commission, service fee, brokerage,
41 or other valuable consideration that the producer will receive as a
42 result of the sale, solicitation or negotiation of the health insurance
43 policy or contract. If the commission, fee, brokerage, or other
44 valuable consideration is based on a percentage of premium, the
45 insurance producer shall include that information in the notification
46 to the purchaser.

47 b. ¹Upon seeking renewal of a license issued pursuant to
48 P.L.2001, c.210 (C.17:22A-26 et seq.), an insurance producer shall

1 report to the Commissioner of Banking and Insurance, in a form and
2 manner specified by the commissioner, how the producer is
3 compensated for the sale, solicitation, or negotiation of health
4 insurance policies and contracts, including the basis for determining
5 a commission, service fee, brokerage, or other valuable
6 consideration for the sale, solicitation, or negotiation of a health
7 insurance policy or contract. The insurance producer shall provide
8 such other information regarding compensation as the commissioner
9 deems appropriate.

10 c. Notwithstanding the provisions of any law to the contrary,
11 the commissioner shall not renew the license of an insurance
12 producer who is subject to the provisions of this section unless the
13 insurance producer provides the information required pursuant to
14 this section.

15 d.] b.¹ The commissioner may specify, by regulation, the
16 information that shall be provided by an insurance producer in the
17 notification to a purchaser of health insurance and the procedure for
18 providing the notification.

19

20 ¹26. (New section) The Commissioner of Human Services shall
21 establish an enhanced NJ FamilyCare outreach and enrollment
22 initiative to increase public awareness about the availability of, and
23 benefits to enrolling in, Medicaid, NJ FamilyCare, and the NJ
24 FamilyCare Advantage buy-in programs.

25 The initiative shall include culturally sensitive, Statewide and
26 local media public awareness campaigns addressing the availability
27 of health care coverage for parents and children under the Medicaid
28 and NJ FamilyCare programs and health care coverage for children
29 under the NJ FamilyCare Advantage buy-in program.

30 The initiative shall also include the provision of training and
31 support services, upon request, to community groups, legislative
32 district offices, and community-based health care providers to
33 enable these parties to assist in enrolling parents and children in the
34 applicable programs.¹

35

36 ¹27. (New section) The Commissioner of Human Services shall
37 establish an Outreach, Enrollment, and Retention Working Group to
38 develop a plan to carry out ongoing and sustainable measures to
39 strengthen outreach to low and moderate income families who may
40 be eligible for Medicaid, NJ FamilyCare, or NJ Family Care
41 Advantage, to maximize enrollment in these programs, and to
42 ensure retention of enrollees in these programs.

43 a. The members of the working group shall include:

44 (1) The Commissioners of Human Services, Health and Senior
45 Services, Banking and Insurance, Labor and Workforce
46 Development, Education, and Community Affairs, the Secretary of
47 Agriculture, and the Child Advocate, or their designees, who shall
48 serve ex officio; and

1 (2) Six public members appointed by the Commissioner of
2 Human Services who shall include: one person who represents
3 racial and ethnic minorities in this State; one person who represents
4 managed care organizations that participate in the Medicaid and NJ
5 FamilyCare programs; one person who represents the vendor under
6 contract with the Division of Medical Assistance and Health
7 Services to provide NJ FamilyCare eligibility, enrollment, and
8 health benefit coordinator services to the division; one person who
9 represents New Jersey Policy Perspective; one person who
10 represents the Association for Children of New Jersey; and one
11 person who represents Legal Services of New Jersey.

12 b. As part of the plan, the working group shall:

13 (1) determine if there are obstacles to enrollment of minorities in
14 the State in the Medicaid, NJ FamilyCare and NJ FamilyCare
15 Advantage programs due to ethnic and cultural differences and, if
16 so, develop strategies for the Department of Human Services to
17 overcome these obstacles and increase enrollment among
18 minorities;

19 (2) recommend outreach strategies to identify and enroll all
20 eligible children in the Medicaid, NJ FamilyCare and NJ
21 FamilyCare Advantage programs and to retain enrollment of
22 children and their parents in the programs;

23 (3) establish monthly enrollment goals for the number of
24 children who need to be enrolled in Medicaid, NJ FamilyCare, and
25 NJ FamilyCare Advantage in order to ensure that as many children
26 as possible who are eligible for these programs are enrolled within a
27 reasonable period of time, in accordance with the mandate
28 established pursuant to section 2 of P.L. , c. (C.) (pending before
29 the Legislature as this bill); and

30 (4) make such other recommendations to the Commissioner of
31 Human Services as the working group determines necessary and
32 appropriate to achieve the purposes of this section.

33 c. The working group shall organize as soon as practicable
34 following the appointment of its members and shall select a
35 chairperson and vice-chairperson from among the members. The
36 chairperson shall appoint a secretary who need not be a member of
37 the working group.

38 (1) The public members shall serve without compensation, but
39 shall be reimbursed for necessary expenses incurred in the
40 performance of their duties and within the limits of funds available
41 to the working group.

42 (2) The working group shall be entitled to call to its assistance
43 and avail itself of the services of the employees of any State, county
44 or municipal department, board, bureau, commission or agency as it
45 may require and as may be available to it for its purposes.

46 d. Upon completion of the plan, the working group shall report
47 on its activities to the chairmen of the Senate and Assembly
48 standing reference committees on health and human services, and

1 include a copy of the plan and any recommendations for legislative
2 action it deems appropriate.

3 e. The Commissioner of Human Services shall post the plan on
4 the department's Internet website and include a table showing the
5 monthly enrollment goals established in the plan and the actual new
6 and continued enrollments for that month. The commissioner shall
7 update the table monthly.

8 f. The Department of Human Services shall provide staff
9 support to the working group.¹

10

11 ¹28. There is appropriated to the Department of Human Services
12 from the General Fund \$1 million for the purpose of carrying out
13 the enhanced NJ FamilyCare outreach, enrollment, and retention
14 initiative established pursuant to section 26 of this act.¹

15

16 ³29. Section 1 of P.L.2005 c.375 (C.17:48-6.19) is amended to
17 read as follows:

18 1. a. As used in this section, "dependent" means a subscriber's
19 child by blood or by law who:

20 (1) is **less than** 30 years of age or younger;

21 (2) is unmarried;

22 (3) has no dependent of his own;

23 (4) is a resident of this State or is enrolled as a full-time student
24 at an accredited public or private institution of higher education;
25 and

26 (5) (a) is not actually provided coverage as a named subscriber,
27 insured, enrollee, or covered person under any other group or
28 individual health benefits plan, group health plan, church plan or
29 health benefits plan, or entitled to benefits under Title XVIII of the
30 Social Security Act, **Pub.L.89-97** Pub.L.74-271 (42 U.S.C.
31 s.1395 et seq.) at the time dependent coverage pursuant to this
32 section begins or will begin; and

33 (b) there is evidence of prior creditable coverage or receipt of
34 benefits under a benefits plan or by law as set forth in subparagraph
35 (a) of this paragraph.

36 b. (1) A hospital service corporation contract that provides
37 coverage for a subscriber's dependent under which coverage of the
38 dependent terminates at a specific age on or before the dependent's
39 30th birthday, and is delivered, issued, executed or renewed in this
40 State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved
41 for issuance or renewal in this State by the Commissioner of
42 Banking and Insurance on or after the effective date of this section
43 of P.L. , c. (pending before the Legislature as this bill), shall,
44 upon application of the dependent as set forth in subsection c. of
45 this section, provide coverage to the dependent after that specific
46 age, until the dependent's **30th** 31st birthday.

47 (2) Nothing herein shall be construed to require:

- 1 (a) coverage for services provided to a dependent before the
2 effective date of this section of P.L. , c. (pending before the
3 Legislature as this bill); or
- 4 (b) that an employer or other group policyholder pay all or part
5 of the cost of coverage for a dependent as provided pursuant to this
6 section.
- 7 c. (1) A dependent covered by a subscriber's contract, which
8 coverage under the contract terminates at a specific age on or before
9 the dependent's 30th birthday, may make a written election for
10 coverage as a dependent pursuant to this section, until the
11 dependent's 30th birthday:
- 12 (a) within 30 days prior to the termination of coverage at the
13 specific age provided in the contract;
- 14 (b) within 30 days after meeting the requirements for dependent
15 status as set forth in subsection a. of this section, when coverage for
16 the dependent under the contract previously terminated; or
- 17 (c) during an open enrollment period, as provided pursuant to
18 the contract, if the dependent meets the requirements for dependent
19 status as set forth in subsection a. of this section during the open
20 enrollment period.
- 21 (2) **【**For 12 months after the effective date of this section, a
22 dependent who qualifies for dependent status as set forth in
23 subsection a. of this section, but whose coverage as a dependent
24 under a subscriber's contract terminated under the terms of the
25 contract prior to the effective date of this section, may make a
26 written election to reinstate coverage under that contract as a
27 dependent pursuant to this section. **】** (Deleted by amendment,
28 P.L. , c. (pending before the Legislature as this bill)
- 29 d. (1) Coverage for a dependent who makes a written election for
30 coverage pursuant to subsection c. of this section shall consist of
31 coverage which is identical to the coverage provided to that
32 dependent prior to the termination of coverage at the specific age
33 provided in the contract. If coverage is modified under the contract
34 for any similarly situated dependents for coverage prior to the
35 termination of coverage at the specific age provided in the contract,
36 the coverage shall also be modified in the same manner for the
37 dependent.
- 38 (2) Coverage for a dependent who makes a written election for
39 coverage pursuant to subsection c. of this section shall not be
40 conditioned upon, or discriminate on the basis of, lack of evidence
41 of insurability.
- 42 e. (1) The subscriber's contract may require payment of a
43 premium by the subscriber or dependent, as appropriate, subject to
44 the approval of the Commissioner of Banking and Insurance, for
45 any period of coverage relating to a dependent's written election for
46 coverage pursuant to subsection c. of this section. The payment
47 shall not exceed 102% of the applicable portion of the premium
48 previously paid for that dependent's coverage under the contract

1 prior to the termination of coverage at the specific age provided in
2 the contract.

3 (2) The applicable portion of the premium previously paid for
4 the dependent's coverage under the contract shall be determined
5 pursuant to regulations promulgated by the Commissioner of
6 Banking and Insurance, based upon the difference between the
7 contract's rating tiers for adult and dependent coverage or family
8 coverage, as appropriate, and single coverage, or based upon any
9 other formula or dependent rating tier deemed appropriate by the
10 commissioner which provides a substantially similar result.

11 (3) Payments of the premium may, at the election of the payor,
12 be made in monthly installments.

13 f. Coverage for a dependent provided pursuant to this section
14 shall be provided until the earlier of the following:

15 (1) the date upon which the dependent is disqualified for
16 dependent status as set forth in subsection a. of this section;

17 (2) the date **[on]** upon which coverage ceases under the contract
18 by reason of a failure to make a timely payment of any premium
19 required under the contract by the subscriber or dependent for
20 coverage provided pursuant to this section. The payment of any
21 premium shall be considered to be timely if made within 30 days
22 after the due date or within a longer period as may be provided for
23 by the contract; or

24 (3) the date upon which the **[employer under whose]** contract **]**
25 under which coverage is provided to a dependent, ceases to provide
26 coverage to the subscriber.

27 Nothing herein shall be construed to permit a hospital service
28 corporation to refuse a written election for coverage by a dependent
29 pursuant to subsection c. of this section, based upon the dependent's
30 prior disqualification pursuant to paragraph (1) of this subsection,
31 other than a disqualification based on age or lack of evidence of
32 prior, creditable coverage or receipt of benefits.

33 g. Notice regarding coverage for a dependent as provided
34 pursuant to this section shall be provided to a subscriber by the
35 hospital service corporation:

36 (1) in the certificate of coverage or other equivalent document
37 prepared for subscribers **[by the hospital service corporation]** and
38 delivered on or about the date of commencement of the subscribers'
39 coverage; and

40 (2) **[by the subscriber's employer:**

41 (a) on or before the coverage of a subscriber's dependent
42 terminates at the specific age as provided in the contract;

43 (b) at the time coverage of the dependent is no longer provided
44 pursuant to this section because the dependent is disqualified for
45 dependent status as set forth in subsection a. of this section, except
46 this employer notice shall not be required when a dependent no
47 longer qualifies based upon paragraph (1) or (3) of subsection a. of
48 this section;

1 (c) before any open enrollment period permitting a dependent to
2 make a written election for coverage pursuant to subsection c. of
3 this section; and

4 (d) immediately following the effective date of this section, with
5 respect to information concerning a dependent's opportunity, for 12
6 months after the effective date of the section, to make a written
7 election to reinstate coverage under a contract pursuant to paragraph
8 (2) of subsection c. of this section] (Deleted by amendment,
9 P.L. , c. (pending before the Legislature as this bill)

10 (3) in a notice delivered to subscribers on a quarterly basis.

11 h. This section shall apply to those contracts in which the
12 hospital service corporation has reserved the right to change the
13 premium.³

14 (cf: P.L.2005, c.375, s.1)

15
16 ³30. Section 2 of P.L.2005, c.375 (C.17:48A-7.13) is amended
17 to read as follows:

18 2. a. As used in this section, "dependent" means a subscriber's
19 child by blood or by law who:

20 (1) is **less than** 30 years of age or younger;

21 (2) is unmarried;

22 (3) has no dependent of his own;

23 (4) is a resident of this State or is enrolled as a full-time student
24 at an accredited public or private institution of higher education;
25 and

26 (5) (a) is not actually provided coverage as a named subscriber,
27 insured, enrollee, or covered person under any other group or
28 individual health benefits plan, group health plan, church plan or
29 health benefits plan, or entitled to benefits under Title XVIII of the
30 Social Security Act, **Pub.L.89-97** Pub.L.74-271 (42 U.S.C.
31 s.1395 et seq.) at the time dependent coverage pursuant to this
32 section begins or will begin; and

33 (b) there is evidence of prior, creditable coverage or receipt of
34 benefits under a benefits plan or by law as set forth in subparagraph
35 (a) of this paragraph.

36 b. (1) A medical service corporation contract that provides
37 coverage for a subscriber's dependent under which coverage of the
38 dependent terminates at a specific age on or before the dependent's
39 30th birthday, and is delivered, issued, executed or renewed in this
40 State pursuant to P.L.1940, c.74 (C.17:48A 1 et seq.), or approved
41 for issuance or renewal in this State by the Commissioner of
42 Banking and Insurance on or after the effective date of this section
43 of P.L. , c. (pending before the Legislature as this bill), shall,
44 upon application of the dependent as set forth in subsection c. of
45 this section, provide coverage to the dependent after that specific
46 age, until the dependent's **30th** 31st birthday.

47 (2) Nothing herein shall be construed to require:

- 1 (a) coverage for services provided to a dependent before the
2 effective date of this section of P.L. , c. (pending before the
3 Legislature as this bill); or
- 4 (b) that an employer or other group policyholder pay all or part
5 of the cost of coverage for a dependent as provided pursuant to this
6 section.
- 7 c. (1) A dependent covered by a subscriber's contract, which
8 coverage under the contract terminates at a specific age on or before
9 the dependent's 30th birthday, may make a written election for
10 coverage as a dependent pursuant to this section, until the
11 dependent's 30th birthday:
- 12 (a) within 30 days prior to the termination of coverage at the
13 specific age provided in the contract;
- 14 (b) within 30 days after meeting the requirements for dependent
15 status as set forth in subsection a. of this section, when coverage for
16 the dependent under the contract previously terminated; or
- 17 (c) during an open enrollment period, as provided pursuant to
18 the contract, if the dependent meets the requirements for dependent
19 status as set forth in subsection a. of this section during the open
20 enrollment period.
- 21 (2) **【For 12 months after the effective date of this section, a**
22 **dependent who qualifies for dependent status as set forth in**
23 **subsection a. of this section, but whose coverage as a dependent**
24 **under a subscriber's contract terminated under the terms of the**
25 **contract prior to the effective date of this section, may make a**
26 **written election to reinstate coverage under that contract as a**
27 **dependent pursuant to this section.】** (Deleted by amendment,
28 P.L. , c. (pending before the Legislature as this bill)
- 29 d. (1) Coverage for a dependent who makes a written election for
30 coverage pursuant to subsection c. of this section shall consist of
31 coverage which is identical to the coverage provided to that
32 dependent prior to the termination of coverage at the specific age
33 provided in the contract. If coverage is modified under the contract
34 for any similarly situated dependents for coverage prior to the
35 termination of coverage at the specific age provided in the contract,
36 the coverage shall also be modified in the same manner for the
37 dependent.
- 38 (2) Coverage for a dependent who makes a written election for
39 coverage pursuant to subsection c. of this section shall not be
40 conditioned upon, or discriminate on the basis of, lack of evidence
41 of insurability.
- 42 e. (1) The subscriber's contract may require payment of a
43 premium by the subscriber or dependent, as appropriate, subject to
44 the approval of the Commissioner of Banking and Insurance, for
45 any period of coverage relating to a dependent's written election for
46 coverage pursuant to subsection c. of this section. The premium
47 shall not exceed 102% of the applicable portion of the premium
48 previously paid for that dependent's coverage under the contract

1 prior to the termination of coverage at the specific age provided in
2 the contract.

3 (2) The applicable portion of the premium previously paid for
4 the dependent's coverage under the contract shall be determined
5 pursuant to regulations promulgated by the Commissioner of
6 Banking and Insurance, based upon the difference between the
7 contract's rating tiers for adult and dependent coverage or family
8 coverage, as appropriate, and single coverage, or based upon any
9 other formula or dependent rating tier deemed appropriate by the
10 commissioner which provides a substantially similar result.

11 (3) Payments of the premium may, at the election of the payor,
12 be made in monthly installments.

13 f. Coverage for a dependent provided pursuant to this section
14 shall be provided until the earlier of the following:

15 (1) the date upon which the dependent is disqualified for
16 dependent status as set forth in subsection a. of this section;

17 (2) the date **[on]** upon which coverage ceases under the contract
18 by reason of a failure to make a timely payment of any premium
19 required under the contract by the subscriber or dependent for
20 coverage provided pursuant to this section. The payment of any
21 premium shall be considered to be timely if made within 30 days
22 after the due date or within a longer period as may be provided for
23 by the contract; or

24 (3) the date upon which the **[employer under whose]** contract,
25 under which coverage is provided to a dependent, ceases to provide
26 coverage to the subscriber.

27 Nothing herein shall be construed to permit a medical service
28 corporation to refuse a written election for coverage by a dependent
29 pursuant to subsection c. of this section, based upon the dependent's
30 prior disqualification pursuant to paragraph (1) of this subsection,
31 other than a disqualification based on age or lack of evidence of
32 prior, creditable coverage or receipt of benefits.

33 g. Notice regarding coverage for a dependent as provided
34 pursuant to this section shall be provided to a subscriber by the
35 medical service corporation:

36 (1) in the certificate of coverage or other equivalent document
37 prepared for subscribers **[by the medical service corporation]** and
38 delivered on or about the date of commencement of the subscribers'
39 coverage; and

40 (2) **[by the subscriber's employer:**

41 (a) on or before the coverage of a subscriber's dependent
42 terminates at the specific age as provided in the contract;

43 (b) at the time coverage of the dependent is no longer provided
44 pursuant to this section because the dependent is disqualified for
45 dependent status as set forth in subsection a. of this section, except
46 this employer notice shall not be required when a dependent no
47 longer qualifies based upon paragraph (1) or (3) of subsection a. of
48 this section;

1 (c) before any open enrollment period permitting a dependent to
2 make a written election for coverage pursuant to subsection c. of
3 this section; and

4 (d) immediately following the effective date of this section, with
5 respect to information concerning a dependent's opportunity, for 12
6 months after the effective date of the section, to make a written
7 election to reinstate coverage under a contract pursuant to paragraph
8 (2) of subsection c. of this section.】 (Deleted by amendment,
9 P.L. , c. (pending before the Legislature as this bill)

10 (3) in a notice delivered to subscribers on a quarterly basis.

11 h. This section shall apply to those contracts in which the
12 medical service corporation has reserved the right to change the
13 premium.³

14 (cf: P.L.2005, c.375, s.2)

15
16 ³31. Section 3 of P.L.2005, c.375 (C.17:48E-30.1) is amended to
17 read as follows:

18 3. a. As used in this section, "dependent" means a subscriber's
19 child by blood or by law who:

20 (1) is **【less than】** 30 years of age or younger;

21 (2) is unmarried;

22 (3) has no dependent of his own;

23 (4) is a resident of this State or is enrolled as a full-time student
24 at an accredited public or private institution of higher education;
25 and

26 (5) (a) is not actually provided coverage as a named subscriber,
27 insured, enrollee, or covered person under any other group or
28 individual health benefits plan, group health plan, church plan or
29 health benefits plan, or entitled to benefits under Title XVIII of the
30 Social Security Act, **【Pub.L.89-97】 Pub.L.74-271 (42 U.S.C.**
31 s.1395 et seq.) at the time the dependent coverage pursuant to this
32 section begins or will begin; and

33 (b) there is evidence of prior, creditable coverage or receipt of
34 benefits under a benefits plan or by law as set forth in subparagraph
35 (a) of this paragraph.

36 b. (1) A health service corporation contract that provides
37 coverage for a subscriber's dependent under which coverage of the
38 dependent terminates at a specific age on or before the dependent's
39 30th birthday, and is delivered, issued, executed or renewed in this
40 State pursuant to P.L.1985, c.236 (C.17:48E 1 et seq.), or approved
41 for issuance or renewal in this State by the Commissioner of
42 Banking and Insurance on or after the effective date of this section
43 of P.L. , c. (pending before the Legislature as this bill), shall,
44 upon application of the dependent as set forth in subsection c. of
45 this section, provide coverage to the dependent after that specific
46 age, until the dependent's **【30th】** 31st birthday.

47 (2) Nothing herein shall be construed to require:

- 1 (a) coverage for services provided to a dependent before the
2 effective date of this section of P.L. , c. (pending before the
3 Legislature as this bill); or
- 4 (b) that an employer or other group policyholder pay all or part
5 of the cost of coverage for a dependent as provided pursuant to this
6 section.
- 7 c. (1) A dependent covered by a subscriber's contract, which
8 coverage under the contract terminates at a specific age on or before
9 the dependent's 30th birthday, may make a written election for
10 coverage as a dependent pursuant to this section, until the
11 dependent's 30th birthday:
- 12 (a) within 30 days prior to the termination of coverage at the
13 specific age provided in the contract;
- 14 (b) within 30 days after meeting the requirements for dependent
15 status as set forth in subsection a. of this section, when coverage for
16 the dependent under the contract previously terminated; or
- 17 (c) during an open enrollment period, as provided pursuant to
18 the contract, if the dependent meets the requirements for dependent
19 status as set forth in subsection a. of this section during the open
20 enrollment period.
- 21 (2) **【For 12 months after the effective date of this section, a**
22 **dependent who qualifies for dependent status as set forth in**
23 **subsection a. of this section, but whose coverage as a dependent**
24 **under a subscriber's contract terminated under the terms of the**
25 **contract prior to the effective date of this section, may make a**
26 **written election to reinstate coverage under that contract as a**
27 **dependent pursuant to this section.】** (Deleted by amendment,
28 P.L. , c. (pending before the Legislature as this bill)
- 29 d. (1) Coverage for a dependent who makes a written election for
30 coverage pursuant to subsection c. of this section shall consist of
31 coverage which is identical to the coverage provided to that
32 dependent prior to the termination of coverage at the specific age
33 provided in the contract. If coverage is modified under the contract
34 for any similarly situated dependents for coverage prior to the
35 termination of coverage at the specific age provided in the contract,
36 the coverage shall also be modified in the same manner for the
37 dependent.
- 38 (2) Coverage for a dependent who makes a written election for
39 coverage pursuant to subsection c. of this section shall not be
40 conditioned upon, or discriminate on the basis of, lack of evidence
41 of insurability.
- 42 e. (1) The subscriber's contract may require payment of a
43 premium by the subscriber or dependent, as appropriate, subject to
44 the approval of the Commissioner of Banking and Insurance, for
45 any period of coverage relating to a dependent's written election for
46 coverage pursuant to subsection c. of this section. The premium
47 shall not exceed 102% of the applicable portion of the premium
48 previously paid for that dependent's coverage under the contract

1 prior to the termination of coverage at the specific age provided in
2 the contract.

3 (2) The applicable portion of the premium previously paid for
4 the dependent's coverage under the contract shall be determined
5 pursuant to regulations promulgated by the Commissioner of
6 Banking and Insurance, based upon the difference between the
7 contract's rating tiers for adult and dependent coverage or family
8 coverage, as appropriate, and single coverage, or based upon any
9 other formula or dependent rating tier deemed appropriate by the
10 commissioner which provides a substantially similar result.

11 (3) Payments of the premium may, at the election of the payor,
12 be made in monthly installments.

13 f. Coverage for a dependent provided pursuant to this section
14 shall be provided until the earlier of the following:

15 (1) the date upon which the dependent is disqualified for
16 dependent status as set forth in subsection a. of this section;

17 (2) the date **[on]** upon which coverage ceases under the contract
18 by reason of a failure to make a timely payment of any premium
19 required under the contract by the subscriber or dependent for
20 coverage provided pursuant to this section. The payment of any
21 premium shall be considered to be timely if made within 30 days
22 after the due date or within a longer period as may be provided for
23 by the contract; or

24 (3) the date upon which the **[employer under whose]** contract,
25 under which coverage is provided to a dependent, ceases to provide
26 coverage to the subscriber.

27 Nothing herein shall be construed to permit a health service
28 corporation to refuse a written election for coverage by a dependent
29 pursuant to subsection c. of this section, based upon the dependent's
30 prior disqualification pursuant to paragraph (1) of this subsection,
31 other than a disqualification based on age or lack of evidence of
32 prior, creditable coverage or receipt of benefits.

33 g. Notice regarding coverage for a dependent as provided
34 pursuant to this section shall be provided to a subscriber by the
35 health service corporation:

36 (1) in the certificate of coverage or other equivalent document
37 prepared for subscribers **[by the health service corporation]** and
38 delivered on or about the date of commencement of the subscribers'
39 coverage; and

40 (2) **[by the subscriber's employer:**

41 (a) on or before the coverage of a subscriber's dependent
42 terminates at the specific age as provided in the contract;

43 (b) at the time coverage of the dependent is no longer provided
44 pursuant to this section because the dependent is disqualified for
45 dependent status as set forth in subsection a. of this section, except
46 this employer notice shall not be required when a dependent no
47 longer qualifies based upon paragraphs (1) or (3) of subsection a. of
48 this section;

1 (c) before any open enrollment period permitting a dependent to
2 make a written election for coverage pursuant to subsection c. of
3 this section; and

4 (d) immediately following the effective date of this section, with
5 respect to information concerning a dependent's opportunity, for 12
6 months after the effective date of the section, to make a written
7 election to reinstate coverage under a contract pursuant to paragraph
8 (2) of subsection c. of this section] (Deleted by amendment,
9 P.L. , c. (pending before the Legislature as this bill)

10 (3) in a notice delivered to subscribers on a quarterly basis.

11 h. This section shall apply to those contracts in which the
12 health service corporation has reserved the right to change the
13 premium.³

14 (cf: P.L.2005, c.375, s.3)

15
16 ³32. Section 4 of P.L.2005, c.375 (C.17B:27-30.5) is amended
17 to read as follows:

18 4. a. As used in this section, "dependent" means an insured's
19 child by blood or by law who:

20 (1) is **less than** 30 years of age or younger;

21 (2) is unmarried;

22 (3) has no dependent of his own;

23 (4) is a resident of this State or is enrolled as a full-time student
24 at an accredited public or private institution of higher education;
25 and

26 (5) (a) is not actually provided coverage as a named subscriber,
27 insured, enrollee, or covered person under any other group or
28 individual health benefits plan, group health plan, church plan or
29 health benefits plan, or entitled to benefits under Title XVIII of the
30 Social Security Act, **Pub.L.89-97** Pub.L.74-271 (42 U.S.C.
31 s.1395 et seq.) at the time dependent coverage pursuant to this
32 section begins or will begin; and

33 (b) there is evidence of prior, creditable coverage or receipt of
34 benefits under a benefits plan or by law as set forth in subparagraph
35 (a) of this paragraph.

36 b. (1) A group health insurance policy that provides coverage for
37 an insured's dependent under which coverage of the dependent
38 terminates at a specific age on or before the dependent's 30th
39 birthday, and is delivered, issued, executed or renewed in this State
40 pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or
41 approved for issuance or renewal in this State by the Commissioner
42 of Banking and Insurance on or after the effective date of this
43 section of P.L. , c. (pending before the Legislature as this bill),
44 shall, upon application of the dependent as set forth in subsection c.
45 of this section, provide coverage to the dependent after that specific
46 age, until the dependent's **30th** 31st birthday.

47 (2) Nothing herein shall be construed to require:

- 1 (a) coverage for services provided to a dependent before the
2 effective date of this section of P.L. , c. (pending before the
3 Legislature as this bill); or
- 4 (b) that an employer or other group policyholder pay all or part
5 of the cost of coverage for a dependent as provided pursuant to this
6 section .
- 7 c. (1) A dependent covered by an insured's policy, which
8 coverage under the policy terminates at a specific age on or before
9 the dependent's 30th birthday, may make a written election for
10 coverage as a dependent pursuant to this section, until the
11 dependent's 30th birthday:
- 12 (a) within 30 days prior to the termination of coverage at the
13 specific age provided in the policy;
- 14 (b) within 30 days after meeting the requirements for dependent
15 status as set forth in subsection a. of this section, when coverage for
16 the dependent under the policy previously terminated; or
- 17 (c) during an open enrollment period, as provided pursuant to
18 the policy, if the dependent meets the requirements for dependent
19 status as set forth in subsection a. of this section during the open
20 enrollment period.
- 21 (2) **【For 12 months after the effective date of this section, a**
22 **dependent who qualifies for dependent status as set forth in**
23 **subsection a. of this section, but whose coverage as a dependent**
24 **under an insured's policy terminated under the terms of the policy**
25 **prior to the effective date of this section, may make a written**
26 **election to reinstate coverage under that policy as a dependent**
27 **pursuant to this section.】** (Deleted by amendment,
28 P.L. , c. (pending before the Legislature as this bill)
- 29 d. (1) Coverage for a dependent who makes a written election for
30 coverage pursuant to subsection c. of this section shall consist of
31 coverage which is identical to the coverage provided to that
32 dependent prior to the termination of coverage at the specific age
33 provided in the policy. If coverage is modified under the policy for
34 any similarly situated dependents for coverage prior to the
35 termination of coverage at the specific age provided in the policy,
36 the coverage shall also be modified in the same manner for the
37 dependent.
- 38 (2) Coverage for a dependent who makes a written election for
39 coverage pursuant to subsection c. of this section shall not be
40 conditioned upon, or discriminate on the basis of, lack of evidence
41 of insurability.
- 42 e. (1) The insured's policy may require payment of a premium by
43 the insured or dependent, as appropriate, subject to the approval of
44 the Commissioner of Banking and Insurance, for any period of
45 coverage relating to a dependent's written election for coverage
46 pursuant to subsection c. of this section. The premium shall not
47 exceed 102% of the applicable portion of the premium previously

1 paid for that dependent's coverage under the policy prior to the
2 termination of coverage at the specific age provided in the policy.

3 (2) The applicable portion of the premium previously paid for
4 the dependent's coverage under the policy shall be determined
5 pursuant to regulations promulgated by the Commissioner of
6 Banking and Insurance, based upon the difference between the
7 policy's rating tiers for adult and dependent coverage or family
8 coverage, as appropriate, and single coverage, or based upon any
9 other formula or dependent rating tier deemed appropriate by the
10 commissioner which provides a substantially similar result.

11 (3) Payments of the premium may, at the election of the payor,
12 be made in monthly installments.

13 f. Coverage for a dependent provided pursuant to this section
14 shall be provided until the earlier of the following:

15 (1) the date upon which the dependent is disqualified for
16 dependent status as set forth in subsection a. of this section;

17 (2) the date **[on]** upon which coverage ceases under the policy
18 by reason of a failure to make a timely payment of any premium
19 required under the policy by the insured or dependent for coverage
20 provided pursuant to this section. The payment of any premium
21 shall be considered to be timely if made within 30 days after the
22 due date or within a longer period as may be provided for by the
23 policy; or

24 (3) the date upon which the **[employer under whose]** policy,
25 under which coverage is provided to a dependent, ceases to provide
26 coverage to the insured.

27 Nothing herein shall be construed to permit an insurer to refuse a
28 written election for coverage by a dependent pursuant to subsection
29 c. of this section, based upon the dependent's prior disqualification
30 pursuant to paragraph (1) of this subsection, other than a
31 disqualification based on age or lack of evidence of prior, creditable
32 coverage or receipt of benefits.

33 g. Notice regarding coverage for a dependent as provided
34 pursuant to this section shall be provided to an insured by the
35 insurer:

36 (1) in the certificate of coverage or other equivalent document
37 prepared for insureds **[by the insurer]** and delivered on or about the
38 date of commencement of the insureds' coverage; and

39 (2) **[by the insured's employer**:

40 (a) on or before the coverage of an insured's dependent
41 terminates at the specific age as provided in the policy;

42 (b) at the time coverage of the dependent is no longer provided
43 pursuant to this section because the dependent is disqualified for
44 dependent status as set forth in subsection a. of this section, except
45 this employer notice shall not be required when a dependent no
46 longer qualifies based upon paragraph (1) or (3) of subsection a. of
47 this section;

1 (c) before any open enrollment period permitting a dependent to
2 make a written election for coverage pursuant to subsection c. of
3 this section; and

4 (d) immediately following the effective date of this section, with
5 respect to information concerning a dependent's opportunity, for 12
6 months after the effective date of the section, to make a written
7 election to reinstate coverage under a policy pursuant to paragraph
8 (2) of subsection c. of this section.](Deleted by amendment, P.L.
9 , c. (pending before the Legislature as this bill)

10 h. This section shall apply to those policies in which the insurer
11 has reserved the right to change the premium.³
12 (cf: P.L.2005, c.375, s.4)

13
14 ³33. Section 5 of P.L.2005, c.375 (C.17B:27A-19.16) is
15 amended to read as follows:

16 5. a. As used in this section, "dependent" means a covered
17 person's child by blood or by law who:

18 (1) is **[less than]** 30 years of age or younger;

19 (2) is unmarried;

20 (3) has no dependent of his own;

21 (4) is a resident of this State or is enrolled as a full-time student
22 at an accredited public or private institution of higher education;
23 and

24 (5) (a) is not actually provided coverage as a named subscriber,
25 insured, enrollee, or covered person under any other group or
26 individual health benefits plan, group health plan, church plan or
27 health benefits plan, or entitled to benefits under Title XVIII of the
28 Social Security Act, **[Pub.L.89-97]** Pub.L.74-271 (42 U.S.C.
29 s.1395 et seq.) at the time dependent coverage pursuant to this
30 section begins or will begin; and

31 (b) there is evidence of prior, creditable coverage or receipt of
32 benefits under a benefits plan or by law as set forth in subparagraph
33 (a) of this paragraph.

34 b. (1) A small employer health benefits plan that provides
35 coverage for a covered person's dependent under which coverage of
36 the dependent terminates at a specific age on or before the
37 dependent's 30th birthday, and is delivered, issued, executed or
38 renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et
39 seq.) or approved for issuance or renewal in this State by the
40 Commissioner of Banking and Insurance on or after the effective
41 date of this section of P.L. , c. (pending before the Legislature as
42 this bill), shall, upon application of the dependent as set forth in
43 subsection c. of this section, provide coverage to the dependent
44 after that specific age, until the dependent's **[30th]** 31st birthday.

45 (2) Nothing herein shall be construed to require:

1 (a) coverage for services provided to a dependent before the
2 effective date of this section of P.L. , c. (pending before the
3 Legislature as this bill); or

4 (b) that an employer pay all or part of the cost of coverage for a
5 dependent as provided pursuant to this section.

6 c. (1) A dependent covered by a covered person's plan, which
7 coverage under the plan terminates at a specific age on or before the
8 dependent's 30th birthday, may make a written election for
9 coverage as a dependent pursuant to this section, until the
10 dependent's 30th birthday:

11 (a) within 30 days prior to the termination of coverage at the
12 specific age provided in the plan;

13 (b) within 30 days after meeting the requirements for dependent
14 status as set forth in subsection a. of this section, when coverage for
15 the dependent under the plan previously terminated; or

16 (c) during a 30-day period in each year following the year
17 coverage terminates at the specific age as provided in the plan,
18 which period shall begin on the anniversary date on which the
19 dependent's coverage terminates at the specific age as provided in
20 the plan, if the dependent meets the requirements for dependent
21 status as set forth in subsection a. of this section during the 30-day
22 period.

23 (2) **[For 12 months after the effective date of this section, a**
24 **dependent who qualifies for dependent status as set forth in**
25 **subsection a. of this section, but whose coverage as a dependent**
26 **under a covered person's plan terminated under the terms of the plan**
27 **prior to the effective date of this section, may make a written**
28 **election to reinstate coverage under that plan as a dependent**
29 **pursuant to this section.]** (Deleted by amendment, P.L. , c.
30 (pending before the Legislature as this bill)

31 d. (1) Coverage for a dependent who makes a written election for
32 coverage pursuant to subsection c. of this section shall consist of
33 coverage which is identical to the coverage provided to that
34 dependent prior to the termination of coverage at the specific age
35 provided in the plan. If coverage is modified under the plan for any
36 similarly situated dependents for coverage prior to the termination
37 of coverage at the specific age provided in the plan, the coverage
38 shall also be modified in the same manner for the dependent.

39 (2) Coverage for a dependent who makes a written election for
40 coverage pursuant to subsection c. of this section shall not be
41 conditioned upon, or discriminate on the basis of, lack of evidence
42 of insurability.

43 e. (1) The covered person's plan may require payment of a
44 premium by the covered person or dependent, as appropriate,
45 subject to the approval of the Commissioner of Banking and
46 Insurance, for any period of coverage relating to a dependent's
47 written election for coverage pursuant to subsection c. of this
48 section. The premium shall not exceed 102% of the applicable

1 portion of the premium previously paid for that dependent's
2 coverage under the plan prior to the termination of coverage at the
3 specific age provided in the plan.

4 (2) The applicable portion of the premium previously paid for
5 the dependent's coverage under the plan shall be determined
6 pursuant to regulations promulgated by the Commissioner of
7 Banking and Insurance, based upon the difference between the
8 plan's rating tiers for adult and dependent coverage or family
9 coverage, as appropriate, and single coverage, or based upon any
10 other formula or dependent rating tier deemed appropriate by the
11 commissioner which provides a substantially similar result.

12 (3) Payments of the premium may, at the election of the payor,
13 be made in monthly installments.

14 f. Coverage for a dependent provided pursuant to this section
15 shall be provided until the earlier of the following:

16 (1) the date upon which the dependent is disqualified for
17 dependent status as set forth in subsection a. of this section;

18 (2) the date **[on]** upon which coverage ceases under the plan by
19 reason of a failure to make a timely payment of any premium
20 required under the plan by the covered person or dependent for
21 coverage provided pursuant to this section. The payment of any
22 premium shall be considered to be timely if made within 30 days
23 after the due date or within a longer period as may be provided for
24 by the plan; or

25 (3) the date upon which the **[employer under whose]** plan,
26 under which coverage is provided to a dependent, ceases to provide
27 coverage to the covered person.

28 Nothing herein shall be construed to permit a carrier to refuse a
29 written election for coverage by a dependent pursuant to subsection
30 c. of this section, based upon the dependent's prior disqualification
31 pursuant to paragraph (1) of this subsection, other than a
32 disqualification based on age or lack of evidence of prior, creditable
33 coverage or receipt of benefits.

34 g. Notice regarding coverage for a dependent as provided
35 pursuant to this section shall be provided to a covered person by the
36 carrier:

37 (1) in the certificate of coverage or other equivalent document
38 prepared for covered persons **[by the carrier]** and delivered on or
39 about the date of commencement of the covered persons' coverage;
40 and

41 (2) **[by the covered person's employer:**

42 (a) on or before the coverage of a covered person's dependent
43 terminates at the specific age as provided in the plan;

44 (b) at the time coverage of the dependent is no longer provided
45 pursuant to this section because the dependent is disqualified for
46 dependent status as set forth in subsection a. of this section, except
47 this employer notice shall not be required when a dependent no

1 longer qualifies based upon paragraph (1) or (3) of subsection a. of
2 this section;

3 (c) before the 30 day period in each year following the year
4 coverage terminates at the specific age as provided in the plan,
5 permitting a dependent to make a written election for coverage
6 pursuant to subsection c. of this section; and

7 (d) immediately following the effective date of this section, with
8 respect to information concerning a dependent's opportunity, for 12
9 months after the effective date of this section, to make a written
10 election to reinstate coverage under a plan pursuant to paragraph (2)
11 of subsection c. of this section.] (Deleted by amendment, P.L. , c.
12 (pending before the Legislature as this bill)

13 (3) in a notice delivered to covered persons on a quarterly basis.

14 h. This section shall apply to those plans in which the carrier
15 has reserved the right to change the premium.³

16 (cf: P.L.2005, c.375, s.5)

17

18 ³34. Section 6 of P.L.2005, c.375 (C.26:2J-10.3) is amended to
19 read as follows:

20 6. a. As used in this section, "dependent" means an enrollee's
21 child by blood or by law who:

22 (1) is **[less than]** 30 years of age or younger;

23 (2) is unmarried;

24 (3) has no dependent of his own;

25 (4) is a resident of this State or is enrolled as a full-time student
26 at an accredited public or private institution of higher education;
27 and

28 (5) (a) is not actually provided coverage as a named subscriber,
29 insured, enrollee, or covered person under any other group or
30 individual health benefits plan, group health plan, church plan or
31 health benefits plan, or entitled to benefits under Title XVIII of the
32 Social Security Act, [Pub.L.89-97] Pub.L.74-271 (42 U.S.C.
33 s.1395 et seq.) at the time dependent coverage pursuant to this
34 section begins or will begin; and

35 (b) there is evidence of prior, creditable coverage or receipt of
36 benefits under a benefits plan or by law as set forth in subparagraph
37 (a) of this paragraph.

38 b. (1) A health maintenance organization contract that provides
39 coverage for an enrollee's dependent under which coverage of the
40 dependent terminates at a specific age before the dependent's 30th
41 birthday, and is delivered, issued, executed or renewed in this State
42 pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) on or after the
43 effective date of this section of P.L. , c. (pending before the
44 Legislature as this bill), shall, upon the application of the dependent
45 as set forth in subsection c. of this section, provide coverage to the
46 dependent after that specific age, until the dependent's **[30th]** 31st
47 birthday.

1 (2) Nothing herein shall be construed to require:

2 (a) coverage for services provided to a dependent before the
3 effective date of this section of P.L. , c. (pending before the
4 Legislature as this bill); or

5 (b) that an employer or other group contract holder pay all or
6 part of the cost of coverage for a dependent as provided pursuant to
7 this section.

8 c. (1) A dependent covered by an enrollee's contract, which
9 coverage under the contract terminates at a specific age on or before
10 the dependent's 30th birthday, may make a written election for
11 coverage as a dependent pursuant to this section, until the
12 dependent's 30th birthday:

13 (a) within 30 days prior to the termination of coverage at the
14 specific age provided in the contract;

15 (b) within 30 days after meeting the requirements for dependent
16 status as set forth in subsection a. of this section, when coverage for
17 the dependent under the contract previously terminated; or

18 (c) during an open enrollment period, as provided pursuant to
19 the contract, if the dependent meets the requirements for dependent
20 status as set forth in subsection a. of this section during the open
21 enrollment period.

22 (2) **【For 12 months after the effective date of this section, a**
23 **dependent who qualifies for dependent status as set forth in**
24 **subsection a. of this section, but whose coverage as a dependent**
25 **under an enrollee's contract terminated under the terms of the**
26 **contract prior to the effective date of this section, may make a**
27 **written election to reinstate coverage under that contract as a**
28 **dependent pursuant to this section.】** (Deleted by amendment,
29 P.L. , c. (pending before the Legislature as this bill)

30 d. (1) Coverage for a dependent who makes a written election for
31 coverage pursuant to subsection c. of this section shall consist of
32 coverage which is identical to the coverage provided to that
33 dependent prior to the termination of coverage at the specific age
34 provided in the contract. If coverage is modified under the contract
35 for any similarly situated dependents for coverage prior to the
36 termination of coverage at the specific age provided in the contract,
37 the coverage shall also be modified in the same manner for the
38 dependent.

39 (2) Coverage for a dependent who makes a written election for
40 coverage pursuant to subsection c. of this section shall not be
41 conditioned upon, or discriminate on the basis of, lack of evidence
42 of insurability.

43 e. (1) The enrollee's contract may require payment under the
44 schedule of charges by the enrollee or dependent, as appropriate,
45 subject to the approval of the Commissioner of Banking and
46 Insurance, for any period of coverage relating to a dependent's
47 written election for coverage pursuant to subsection c. of this
48 section. The payment shall not exceed 102% of the applicable

1 portion of the schedule of charges previously paid for that
2 dependent's coverage under the contract prior to the termination of
3 coverage at the specific age provided in the contract.

4 (2) The applicable portion of the schedule of charges previously
5 paid for the dependent's coverage under the contract shall be
6 determined pursuant to regulations promulgated by the
7 Commissioner of Banking and Insurance, based upon the difference
8 between the contract's rating tiers for adult and dependent coverage
9 or family coverage, as appropriate, and single coverage, or based
10 upon any other formula or dependent rating tier deemed appropriate
11 by the commissioner which provides a substantially similar result.

12 (3) Payments under the schedule of charges may, at the election
13 of the payor, be made in monthly installments.

14 f. Coverage for a dependent provided pursuant to this section
15 shall be provided until the earlier of the following:

16 (1) the date upon which the dependent is disqualified for
17 dependent status as set forth in subsection a. of this section;

18 (2) the date **[on]** upon which coverage ceases under the contract
19 by reason of a failure to make a timely payment under any schedule
20 of charges required under the contract by the enrollee or dependent
21 for coverage provided pursuant to this section. The payment under
22 any schedule of charges shall be considered to be timely if made
23 within 30 days after the due date or within a longer period as may
24 be provided for by the contract; or

25 (3) the date upon which the **[employer under whose]** contract,
26 under which coverage is provided to a dependent, ceases to provide
27 coverage to the enrollee.

28 Nothing herein shall be construed to permit a health maintenance
29 organization to refuse a written election for coverage by a
30 dependent pursuant to subsection c. of this section, based upon the
31 dependent's prior disqualification pursuant to paragraph (1) of this
32 subsection, other than a disqualification based on age or lack of
33 evidence of prior, creditable coverage or receipt of benefits.

34 g. Notice regarding coverage for a dependent as provided
35 pursuant to this section shall be provided to an enrollee by the
36 health maintenance organization:

37 (1) in the certificate of coverage or other equivalent document
38 prepared for enrollees **[by the health maintenance organization]**
39 and delivered on or about the date of commencement of the
40 enrollees' coverage; and

41 (2) **[by the enrollee's employer:**

42 (a) on or before the coverage of an enrollee's dependent
43 terminates at the specific age as provided in the contract;

44 (b) at the time coverage of the dependent is no longer provided
45 pursuant to this section because the dependent is disqualified for
46 dependent status as set forth in subsection a. of this section, except
47 this employer notice shall not be required when a dependent no

1 longer qualifies based upon paragraph (1) or (3) of subsection a. of
2 this section;

3 (c) before any open enrollment period permitting a dependent to
4 make a written election for coverage pursuant to subsection c. of
5 this section; and

6 (d) immediately following the effective date of this section, with
7 respect to information concerning a dependent's opportunity, for 12
8 months after the effective date of the section, to make a written
9 election to reinstate coverage under a contract pursuant to paragraph
10 (2) of subsection c. of this section.](Deleted by amendment,
11 P.L. , c. (pending before the Legislature as this bill)

12 (3) in a notice delivered to enrollees on a quarterly basis.

13 h. This section shall apply to those contracts in which the
14 health maintenance organization has reserved the right to change
15 the schedule of charges.³

16 (cf: P.L.2005, c.375, s.6)

17

18 ³35. Section 7 of P.L.2005, c.375 (C.52:14-17.29k) is amended
19 to read as follows:

20 7. a. As used in this section, "dependent" means a covered
21 person's child by blood or by law who:

22 (1) is **[less than]** 30 years of age or younger;

23 (2) is unmarried;

24 (3) has no dependent of his own;

25 (4) is a resident of this State or is enrolled as a full-time student
26 at an accredited public or private institution of higher education;
27 and

28 (5) (a) is not actually provided coverage as a named subscriber,
29 insured, enrollee, or covered person under any other group or
30 individual health benefits plan, group health plan, church plan or
31 health benefits plan, or entitled to benefits under Title XVIII of the
32 Social Security Act, [Pub.L.89-97] Pub.L.74-271 (42 U.S.C.
33 s.1395 et seq.) at the time dependent coverage pursuant to this
34 section begins or will begin; and

35 (b) there is evidence of prior, creditable coverage or receipt of
36 benefits under a benefits plan or by law as set forth in subparagraph
37 (a) of this paragraph.

38 b. The State Health Benefits Commission shall ensure that
39 every contract purchased or renewed by the commission on or after
40 the effective date of P.L.2005, c.375 (C.17:48-6.19 et al.), prohibits
41 the termination of coverage of a dependent before the dependent's
42 23rd birthday by reason of age, and complies with the provisions of
43 **[P.L.2005, c.375 (C.17:48-6.19 et al.)]** this section of P.L. , c.
44 (pending before the Legislature as this bill) concerning the coverage
45 of a dependent by written election, as set forth in subsection d. of
46 this section, until the dependent's [30th] 31st birthday. [The cost of
47 coverage pursuant to this section shall be reimbursed by the

1 employee to the New Jersey State Health Benefits Program, in
2 accordance with a rate to be determined by the commission.】

3 c. Nothing within this section shall be construed to: (1) prevent
4 any contract purchased or renewed by the commission from
5 providing coverage for a dependent which terminates at a specific
6 age after the dependent child's 23rd birthday; or (2) require
7 coverage for services provided to a dependent before the effective
8 date of 【P.L.2005, c.375 (C.17:48-6.19 et al.)】 this section of
9 P.L. , c. (pending before the Legislature as this bill).

10 d. A dependent covered by a covered person's contract, which
11 coverage under the contract terminates at a specific age on or before
12 the dependent's 30th birthday, may make a written election for
13 coverage as a dependent pursuant to this section, until the
14 dependent's 30th birthday:

15 (a) within 30 days prior to the termination of coverage at the
16 specific age provided in the contract;

17 (b) within 30 days after meeting the requirements for dependent
18 status as set forth in subsection a. of this section, when coverage for
19 the dependent under the contract previously terminated; or

20 (c) during an open enrollment period, as provided pursuant to the
21 contract, if the dependent meets the requirements for dependent
22 status as set forth in subsection a. of this section.

23 e. (1) Coverage for a dependent who makes a written election for
24 coverage pursuant to subsection d. of this section shall consist of
25 coverage which is identical to the coverage provided to that
26 dependent prior to the termination of coverage at the specific age
27 provided in the contract. If coverage is modified under the contract
28 for any similarly situated dependents for coverage prior to the
29 termination of coverage at the specific age provided in the contract,
30 the coverage shall also be modified in the same manner for the
31 dependent.

32 (2) Coverage for a dependent who makes a written election for
33 coverage pursuant to subsection d. of this section shall not be
34 conditioned upon, or discriminate on the basis of, lack of evidence
35 of insurability.

36 f. (1) The covered person's contract may require payment of a
37 premium by the covered person or dependent, as appropriate, for
38 any period of coverage relating to a dependent's written election for
39 coverage pursuant to subsection d. of this section. The premium
40 shall not exceed 102% of the applicable portion of the premium
41 previously paid for that dependent's coverage under the contract
42 prior to the termination of coverage at the specific age provided in
43 the contract.

44 (2) The applicable portion of the premium previously paid for
45 the dependent's coverage under the contract shall be determined by
46 the commission, based upon the difference between the contract's
47 rating tiers for adult and dependent coverage or family coverage, as
48 appropriate, and single coverage, or based upon any other formula

1 or dependent rating tier deemed appropriate by the commission
 2 which provides a substantially similar result.

3 (3) Payments of the premium may, at the election of the payor,
 4 be made in monthly installments.

5 g. Coverage for a dependent provided pursuant to this section
 6 shall be provided until the earlier of the following:

7 (1) the date upon which the dependent is disqualified for
 8 dependent status as set forth in subsection a. of this section;

9 (2) the date upon which coverage ceases under the contract by
 10 reason of a failure to make a timely payment of any premium
 11 required under the contract by the covered person or dependent for
 12 coverage provided pursuant to this section. The payment of any
 13 premium shall be considered to be timely if made within 30 days
 14 after the due date or within a longer period as may be provided for
 15 by the contract; or

16 (3) the date upon which the contract, under which coverage is
 17 provided to a dependent, ceases to provide coverage to the covered
 18 person.

19 Nothing herein shall be construed to permit the commission to
 20 refuse a written election for coverage by a dependent pursuant to
 21 subsection d. of this section, based upon the dependent's prior
 22 disqualification pursuant to paragraph (1) of this subsection, other
 23 than a disqualification based on age or lack of evidence or prior,
 24 creditable coverage or receipt of benefits.

25 h. Notice regarding coverage for a dependent as provided
 26 pursuant to this section shall be provided to a covered person by the
 27 commission:

28 (1) in the certificate of coverage or other equivalent document
 29 prepared for covered persons and delivered on or about the date of
 30 commencement of the covered persons' coverage; and

31 (2) in a notice delivered to covered persons on a quarterly
 32 basis.³

33 (cf: P.L.2005, c.375, s.7)

34

35 ¹[27.] ³[29.] ³36.³ The Commissioner of Banking and
 36 Insurance shall, pursuant to the "Administrative Procedure Act,"
 37 P.L.1968, c.410 (C.52:14B-1 et seq.), adopt regulations necessary to
 38 implement ¹[the provisions] sections 9 through 25¹ ³and sections
 39 29 through 34³ of this act.

40

41 ¹[28.] ³[30.] ³37.³ Sections 1 through ¹[7 and 27] 8, 26
 42 through 28, 36 and this section¹ of this act shall take effect
 43 immediately and sections ¹[8] 9¹ through ¹[26] 25¹ ³and 29
 44 through 35³ of this act shall take effect on the 180th day after
 45 enactment ¹[and] , except that the 80% minimum loss ratio
 46 requirements in sections 16, 19, and 24 of this bill shall take effect
 47 on January 1 next following the date of enactment. Sections 9

1 through 25¹ ³and 29 through 35³ shall apply to all contracts and
2 policies that are delivered, issued, executed or renewed or approved
3 for issuance or renewal in this State on or after the effective date
4 'provided herein.' but the Commissioner of Banking and Insurance
5 may take such anticipatory administrative action in advance thereof
6 as shall be necessary for the implementation of this act.