SENATE, No. 1097

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED JANUARY 30, 2020

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS

Makes technical corrections to individual health coverage and small employer health benefits programs and to NJ FamilyCare.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning health insurance coverage and revising parts of statutory law.

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

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

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

b. The board shall make application on behalf of all carriers for any other subsidies, discounts, or funds that may be provided for under State or federal law or regulation. A carrier may include subsidies or funds granted to the board to reduce its premium rates for individual health benefits plans subject to this act.

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

d. A carrier desiring to increase or decrease premiums for any contract or policy form may implement that increase or decrease upon making an informational filing with the commissioner of that increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing that increase or decrease. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.161 (C.17B:27A-2 et al.), or that the rates are inadequate or unfairly discriminatory.

e. (1) Rates shall be formulated on contracts or policies required pursuant to section 3 of this act so that the anticipated minimum loss ratio for a contract or policy form shall not be less than 80% of the premium. The carrier shall submit with its rate filing supporting data, as determined by the commissioner, and a certification by a member of the American Academy of Actuaries, or other individuals in a format acceptable to the commissioner, that the carrier is in compliance with the provisions of this subsection.

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the policy or contract forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161 (C.17:B:27A-4), at least 80% of the aggregate premiums collected for all of the policy or contract forms during that calendar year. Carriers shall annually report, no later than August 1 of each year, the loss ratio calculated pursuant to this section for all of the policy or contract forms for the previous calendar year. In each case in

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 <u>thus</u> is new matter.

which the loss ratio fails to comply with the 80% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policy or contract holders, as applicable, in an amount **[**sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits equal 80% of the aggregate premiums collected for the policy or contract forms in the previous calendar year**]** equal to the difference between the amount of net earned premium it received that year and the amount of net earned premium that would have been necessary to achieve the 80% loss ratio. All dividends and credits shall be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this subsection shall include a carrier's calculation of the dividends and credits applicable to all policy or contract forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Those regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder.

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

(cf: P.L.2008, c.38, s.16)

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

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

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

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

(b) A health benefits plan issued pursuant to subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in

accordance with the provisions of section 7 of P.L.1995, c.340 (C.17B:27A-19.3), for the purposes of meeting the requirements of this paragraph.

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

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

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

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

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

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

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

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

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

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

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

g. (1) Beginning January 1, 1995, a carrier desiring to increase or decrease premiums for any policy form or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19) subject to this act may implement such increase or decrease upon making an informational filing with the

commissioner of such increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing such increase or decrease, provided that the anticipated minimum loss ratio for all policy forms shall not be less than 80% of the premium therefor as provided in paragraph (2) of this subsection. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are inadequate or unfairly discriminatory. Until December 31, 1996, the informational filing shall also include the carrier's rating plan and classification system in connection with such increase or decrease.

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the standard policy forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19), at least 80% of the aggregate premiums collected for all of the standard policy forms, other than alliance policy forms, and at least 80% of the aggregate premiums collected for all of the non-standard policy forms during that calendar year. A carrier shall return at least 80% of the premiums collected for all of the alliances during that calendar year, which loss ratio may be calculated in the aggregate for all of the alliances or separately for each alliance. Carriers shall annually report, no later than August 1st of each year, the loss ratio calculated pursuant to this section for all of the standard, other than alliance policy forms, non-standard policy forms and alliance policy forms for the previous calendar year, provided that a carrier may annually report the loss ratio calculated pursuant to this section for all of the alliances in the aggregate or separately for each alliance. In each case where the loss ratio fails to substantially comply with the 80% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with the standard, other than alliance policy forms, nonstandard policy forms or alliance policy forms, as applicable, in an amount **[**sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal 80% of the aggregate premiums collected for the respective policy forms in the previous calendar year**]** <u>equal to the difference between the amount of net earned premium it received that year and the amount of net earned premium that would have been necessary to achieve the 80% loss ratio</u>. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits applicable to standard, other than alliance policy forms, non-standard policy forms and alliance policy forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting

loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder. For purposes of this paragraph, "alliance policy forms" means policies purchased by small employers who are members of Small Employer Purchasing Alliances.

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

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

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

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

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

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

3. Section 25 of P.L.2008, c.38 (C.17:22A-41.1) is amended to read as follows:

25. a. An insurance producer licensed pursuant to P.L.2001, c.210 (C.17:22A-26 et al.) who sells, solicits, or negotiates health **[**insurance policies or contracts**]** <u>benefits plans</u> to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health **[**insurance policy or contract**]** <u>benefits plan</u>. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.

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

<u>c. As used in this section, “health benefits plan” means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier. For</u>

purposes of this section, "health benefits plan" shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plan shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C.s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

4. Section 6 of P.L.2008, c.36 (C.26:2H-18.59j) is amended to read as follows:

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

(cf: P.L.2012, c.17, s.230)

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

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

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

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

c. The commissioner:

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

(2) shall require that a parent or caretaker who is a qualified applicant purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner, and shall provide assistance to the qualified applicant to purchase that coverage, except that the provisions of this paragraph shall not be construed to require an employer to provide health insurance coverage for any employee or employee's spouse or dependent child;

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

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

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

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

(2) Require new applicants to submit one recent pay stub from the applicant's employer, or, if the applicant has more than one employer, one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. **[**If**]** However, if an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall then seek to verify the applicant's income by reviewing available Department of the Treasury and Department of Labor and Workforce Development records concerning the applicant, and such other records as the commissioner determines appropriate. The commissioner may verify a new applicant's income by reviewing available Department of the Treasury or Department of Labor and Workforce Development records concerning the applicant, or such other records as the commissioner determines appropriate, in lieu of considering an applicant's income verification, and may waive the applicant's submission of income verification if alternative verification is deemed satisfactory.

The commissioner shall establish retrospective auditing or income verification procedures, such as sample auditing and matching reported income with records of the Department of the Treasury and the Department of Labor and Workforce Development and such other records as the commissioner determines appropriate.

In matching reported income with confidential records of the Department of the Treasury, the commissioner shall require an applicant to provide written authorization for the Division of Taxation in the Department of the Treasury to release applicable tax information to the commissioner for the purposes of establishing income eligibility for the program. The authorization, which shall be included on the program application form, shall be developed by the commissioner, in consultation with the State Treasurer;

(3) Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

(4) Continuous enrollment;

(5) Simplified renewal by sending an enrollee a preprinted renewal form and requiring the enrollee to sign and return the form, with any applicable changes in the information provided in the form, prior to the date the enrollee's annual eligibility expires. The commissioner shall establish such auditing or income verification procedures, as provided in paragraph (2) of this subsection; and

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

e. The commissioner shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program,

subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year. In this regard, notwithstanding the definition of "qualified applicant," the commissioner may enroll in the program such children or their parents or caretakers who may otherwise be eligible for the Medicaid program in order to maximize use of federal funds that may be available pursuant to 42 U.S.C. s.1397aa et seq.

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

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

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

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

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

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

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

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

(1) With respect to school-age children, the commissioner, in consultation with the Commissioner of Education and the Secretary of Agriculture, shall develop a form that provides information about the NJ FamilyCare and Medicaid programs and provides an opportunity for the parent or guardian who signs the school lunch application form to give consent for information to be shared with the Department of Human Services for the purpose of determining

eligibility for the programs. The form shall be attached to, included with, or incorporated into, the school lunch application form.

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

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

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

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

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

i. Subject to federal approval, the commissioner shall, by regulation, establish that in determining income eligibility for a child, any gross family income above 200% of the poverty level, up to a maximum of 350% of the poverty level, shall be disregarded.

j. The commissioner shall establish a NJ FamilyCare coverage buy-in program **[**through which a parent or caretaker whose family income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child**]** <u>which may be purchased on behalf of a child who is a New Jersey resident</u> under the age of 19, <u>who is not otherwise eligible for Medicaid or NJ FamilyCare and</u> who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The program shall be known as NJ FamilyCare Advantage.

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

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

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

(cf: P.L.2008, c.53, s.2)

6. Section 7 of P.L.2008, c.38 (C.54A:8-6.2) is amended to read as follows:

7. a. Beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual who files a resident New Jersey Gross Income Tax return indicate on the taxpayer's income tax return whether the taxpayer and dependents, if applicable, has health insurance coverage on the date of filing of the return.

b. The department shall transmit to the Department of Human Services information permitting the Department of Human Services to identify taxpayers <u>and dependents</u> who are uninsured and may be eligible to enroll in the Medicaid or NJ FamilyCare program. The Department of Human Services shall use this information in furtherance of its Medicaid and NJ FamilyCare outreach and enrollment initiative established pursuant to section 26 of P.L.2008, c.38 (C.30:4J-18), as provided in section 26 of P.L.2008, c.38 (C.30:4J-18).

c. As used in this section:

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

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

(cf: P.L.2008, c.38, s.7).

7. Section 26 of P.L.2008, c.38 (C.30:4J-18) is amended to read as follows:

26. The Commissioner of Human Services shall establish an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about the availability of, and benefits to enrolling in, Medicaid, NJ FamilyCare, and the NJ FamilyCare Advantage buy-in programs.

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

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

c. As part of the initiative, the department shall send an application for the NJ FamilyCare program to any taxpayer identified by the Department of the Treasury pursuant to section 7 of P.L.2008, c.38 (C.54A:8-6.2) who reported on his New Jersey Gross Income Tax return that the taxpayer or his dependents are uninsured and who, based on the income reported on the tax return form and the taxpayer's family size, may be eligible for the NJ FamilyCare program. The department shall send the application to a taxpayer as soon as possible after receipt of the information from the Department of the Treasury.

(cf: P.L.2008, c.38, s.26)

8. This act shall take effect on the 30th day after enactment and shall apply to all contracts and policies that are delivered, issued, executed or renewed or approved for issuance or renewal in this State on or after the effective date provided herein.

STATEMENT

This bill makes various technical changes to the laws establishing the New Jersey Individual Health Coverage (IHC) and the New Jersey Small Employer Health Benefits (SEH) Programs, and to the NJ FamilyCare and charity care programs.

The bill revises the formula used for calculating refunds in both the IHC and SEH programs to restore the formula that was in effect prior to the enactment of P.L.2008, c.38 for the IHC program and to apply that formula to the SEH program as well. The formula specifies a refund which produces a loss ratio (after the refund reduces the premium) no less than the required 80% minimum.

The bill also clarifies language regarding transparency in broker commissions that was enacted in section 25 of P.L.2008, c.38 (C.17:22A-41.1), by specifying that the provisions only apply to the sale, solicitation, or negotiation of health benefits plans, rather than health insurance policies and contracts, as the section originally provided.

In addition, the bill amends section 6 of P.L.2008, c.36 (C.26:2H-18.59j) concerning charity care claims for services provided to children under 19 years of age to provide that hospitals shall not submit charity care claims for these children who present at the hospital for care (rather than just for "emergency" care, as the law currently provides) and who may be deemed presumptively eligible for NJ FamilyCare or Medicaid.

The bill also revises the provisions concerning verification of income eligibility in the NJ FamilyCare program to authorize the Commissioner of Human Services to verify a new applicant's income by reviewing available Department of the Treasury or Department of Labor and Workforce Development records concerning the applicant or such other records as the commissioner determines appropriate, in lieu of considering an applicant's income verification. The commissioner is also authorized to waive the applicant's submission of income verification if alternative verification is deemed satisfactory.

Further, the bill revises the provisions concerning the "crowd-out" period during which a child who was voluntarily disenrolled from employer-sponsored group insurance coverage is not eligible for NJ FamilyCare, to reduce the period of ineligibility from six to three months. The bill also revises the provisions concerning eligibility for the NJ FamilyCare "buy-in" program to provide that coverage may be purchased for any child who is a resident of New Jersey and who is not otherwise eligible for NJ FamilyCare or Medicaid, rather than limit eligibility to children whose family income exceeds 350% of the federal poverty level.

The bill also amends section 26 of P.L.2008, c.38 (C.30:4J-18), which established the enhanced NJ FamilyCare outreach and enrollment initiative, to provide that as part of the initiative the Department of Human Services shall send an application for the NJ FamilyCare program to any taxpayer identified by the Department of the Treasury who reported on his New Jersey Gross Income Tax return that the taxpayer or his dependents are uninsured and who, based on the income reported on the tax return form and the taxpayer's family size, may be eligible for NJ FamilyCare.

Finally, the bill makes a technical correction to section 7 of P.L.2008, c.38 (C.54A:8-6.2) directing the Department of the Treasury to require resident taxpayers to indicate on their tax returns whether the taxpayer and his dependents have health insurance coverage. The purpose of requiring this information is to enable the Department of Human Services to identify taxpayers and dependents who are uninsured and may be eligible to enroll in Medicaid or NJ FamilyCare.