ASSEMBLY, No. 1750

STATE OF NEW JERSEY

INTRODUCED MARCH 25, 1996

By Assemblymen IMPREVEDUTO and FELICE

AN ACT concerning supplemental health benefits plans and amending P.L.1992, c.161 and supplementing Title 17B of the New Jersey Statutes.

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

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

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

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

"Carrier" means an insurance company, health service corporation or health maintenance organization authorized to issue health benefits plans in this State. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier.

"Commissioner" means the Commissioner of Insurance.

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

"Department" means the Department of Insurance.

"Dependent" means the spouse or child of an eligible person, subject to applicable terms of the individual health benefits plan.

"Eligible person" means a person who is a resident of the State who is not eligible to be insured under a group health insurance policy or Medicare.

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

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

"Health benefits plan" means a hospital and medical expense

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

Matter underlined thus is new matter.

insurance policy; health service corporation contract; or health maintenance organization subscriber contract delivered or issued for delivery in this State. For purposes of this act, health benefits plan does not include the following plans, policies, or contracts: accident only, credit, disability, long-term care, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity coverage.

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

Individual health benefits plan shall not include : a. a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is established or adopted by two or more employers, by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, to insure employees of the employers or members of the unions or organizations ; or b. a supplemental health benefits plan.

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

"Member" means a carrier that is a member of the program pursuant to this act.

"Modified community rating" means a rating system in which the premium for all persons covered by a contract is formulated based on the experience of all persons covered by that contract, without regard to age, sex, occupation and geographical location, but which may differ by health status. The term modified community rating shall apply to contracts and policies issued prior to the effective date of this act which are subject to the provisions of subsection e. of section 2 of this act.

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from

any Medicare, Medicaid or HealthStart Plus contracts with the State or federal government, but shall not include any excess or stop loss coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

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

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

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

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

<u>"Supplemental health benefits plan" means a hospital and medical expense insurance policy or certificate delivered or issued for delivery in this State to an employee covered by an employer-based group health benefits plan or self-funded health benefits arrangement to cover hospital and medical expenses in supplement of specific or aggregate benefits limitations contained in the employer-based group plan.</u>

(cf: P.L.1995, c.291, s.7)

2. (New section) "Carrier" means any insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Commissioner" means the Commissioner of Insurance.

"Preexisting condition" means a condition that, during a specified period of not more than 12 months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the effective date of coverage.

"Supplemental health benefits plan" means a hospital and medical expense insurance policy or certificate delivered or issued for delivery in this State to an employee covered by an employer-based group health benefits plan or self-funded health benefits arrangement to cover hospital and medical expenses in supplement of specific or aggregate benefits limitations contained in the employer-based group plan.

3. (New section) No carrier shall deliver or issue for delivery a supplemental health benefits plan unless:

a. the supplemental health benefits plan is filed with and approved by the commissioner;

b. the supplemental health benefits plan is offered to all eligible applicants and their dependents and does not exclude any applicant or eligible dependent on the basis of an actual or expected health condition;

c. the supplemental health benefits plan offered is renewable with respect to all eligible individuals or dependents of an eligible individual at the option of the individual, except under the following conditions:

(1) nonpayment of the required premiums by the plan holder;

(2) fraud or misrepresentation of the plan holder with respect to coverage of eligible persons or dependents;

(3) any carrier doing business pursuant to the provisions of this act ceases doing business, provided the following conditions are satisfied:

(a) the carrier gives notice to cease doing business to the commissioner not later than eight months prior to the date of the planned withdrawal from the market, during which time the carrier shall continue to be governed by this section with respect to business written pursuant to this act;

(b) no later than two months following the date of the notification to the commissioner that the carrier intends to cease doing business in the supplemental health benefits plan market, the carrier shall mail a notice to every individual insured by the carrier under a supplemental health benefits plan that the plan will be terminated. This notice shall be sent by certified mail to the individuals not less than six months in advance of the effective date of the cancellation date of the plan;

d. the premium rate charged by a carrier to the highest rated individual purchasing a supplemental health benefits plan issued pursuant to this section is not greater than 300% of the premium rate charged to the lowest rated individual purchasing that same supplemental health benefits plan; provided, however, that the only factors upon which the rate differential may be based are age, gender and geography, and provided further, that such factors are applied in a manner consistent with regulations adopted by the commissioner;

e. the carrier returns in the form of aggregate benefits for the supplemental health benefits plan offered by the carrier at least 75% of the aggregate premiums collected for the plan during the previous three-year period. Carriers shall annually report to the commissioner, no later than August 1 of each year, the loss ratio calculated pursuant to this subsection for each supplemental health benefits plan for the previous calendar year;

f. it excludes coverage for preexisting conditions for no more than 24 months; and

g. the applicant for such coverage signs a statement on the application form that confirms that the applicant is already covered under a group health benefits plan or an employer-based self-funded health benefits arrangement.

Supplemental health benefits plans offered pursuant to this act shall not be subject to coordination of benefits with other health benefits plans.

4. (New section) The commissioner shall promulgate rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) as may be necessary to effectuate the purposes of this act.

5. This act shall take effect immediately.

STATEMENT

This bill permits the sale of supplemental health benefits plans provided:

- the supplemental health benefits plan is filed with and approved by the Commissioner of Insurance;
- the supplemental health benefits plan is guaranteed issue and guaranteed renewable;
- the supplemental health benefits plan meets the following rating requirements:
  (1) the premium rate charged by a carrier to the highest individual purchasing a supplemental health benefits plan issued pursuant to this section is not greater than 300% of the premium rate charged to the lowest rated individual purchasing that same supplemental health benefits plan; and
  (2) the only factors upon which the rate differential is based are age, gender and geography;
- the carrier must return in the form of aggregate benefits at least75% of the aggregate premiums collected for the plan during the previous three-year period;
- the applicant for a supplemental health benefits plan is already covered under an employer-based group health benefits plan or an employer-based self-funded health benefits arrangement; and
- the supplemental health benefits plan does not exclude benefits for preexisting conditions for more than 24 months.

Permits sale of supplemental health benefits plans under certain conditions.