ASSEMBLY, No. 2009

STATE OF NEW JERSEY

INTRODUCED MAY 13, 1996

By Assemblymen BATEMAN and GARRETT

AN ACT concerning individual and small employer health benefits plans and amending P.L.1992, c.161 and P.L.1992, c.162.

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

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

2. a. An individual health benefits plan issued on or after the effective date of this act shall be subject to the provisions of this act.

b. (1) An individual health benefits plan issued on an open enrollment, modified community rated basis or community rated basis prior to the effective date of this act shall not be subject to sections 3 through 8, inclusive, of this act, unless otherwise specified therein.

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

(3) A group conversion contract or policy issued prior to the effective date of this act that is not issued on a modified community rated basis or community rated basis, shall not be subject to the provisions of this act, except that the contract or policy shall be liable for assessments made pursuant to section 11 of this act.

c. After the effective date of this act, an individual who is eligible to participate in a group health benefits plan that provides coverage for hospital or medical expenses shall not be covered by an individual health benefits plan which provides benefits for hospital and medical expenses that are the same or similar to coverage provided in the group health benefits plan , except that an individual who is eligible to participate in a group health benefits plan but is currently covered by an individual health benefits plan may continue to be covered by that plan until the first anniversary date of the group plan occurring on or after January 1, 1994.

d. Except as otherwise provided in subsection c. of this section, after the effective date of this act, a person who is covered by an individual

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

health benefits plan who is a participant in, or is eligible to participate in, a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, and a person, including an employer or insurance producer, who causes another person to be covered by an individual health benefits plan which person is a participant in, or who is eligible to participate in a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, shall be subject to a fine by the commissioner in an amount not less than twice the annual premium paid for the individual health benefits plan, together with any other penalties permitted by law.

e. **[**Every individual health benefits plan issued prior to the effective date of this act shall be rated as follows:

(1) No later than 180 days after the effective date of this act, the premium rate charged by a carrier to the highest rated individual who purchased an individual health benefits plan prior to the effective date of this act shall not be greater than 150% of the premium rate charged to the lowest rated individual purchasing that same or a similar health benefits plan.

(2) During the period July 1, 1994 to June 30, 1995, the premium rate charged by a carrier to the highest rated individual who purchased an individual health benefits plan prior to the effective date of this act shall not be greater than 125% of the premium rate charged to the lowest rated individual purchasing that same or a similar health benefits plan.

(3) On and after July 1, 1995, every individual health benefits plan which was issued before the effective date of this act shall be community rated upon the date of its renewal.

(4) A carrier that issues an individual health benefits plan with modified community rating subject to the provisions of this subsection shall make an informational filing with the board whenever it adjusts or modifies its rates.**]** (Deleted by amendment, P.L. , c. .)

(cf: P.L.1993, c.164, s.2)

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

8. **[**a. The board shall make application to the Hospital Rate Setting Commission on behalf of all carriers for approval of discounted or reduced rates of payment to hospitals for health care services provided under an individual health benefits plan provided pursuant to this act.**]** (Deleted by amendment, P.L. , c. .)

b. **[**In addition to discounted or reduced rates of hospital payment, the**]** 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 **[**discounted or reduced rates of hospital payment and other**]** 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 board. The board shall forward the informational filing to the commissioner and the Attorney General.

d. A carrier shall make an informational filing with the board of any change in its rates for individual health benefits plans pursuant to section 3 of this act prior to the date the rates become effective. The board shall file the informational filing with the commissioner and the Attorney General. If the carrier has filed all information required by the board, the filing shall be deemed to be complete.

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 75% of the premium. The carrier shall submit with its rate filing supporting data, as determined by the board, and a certification by a member of the American Academy of Actuaries, or other individuals acceptable to the board and to the commissioner, that the carrier is in compliance with the provisions of this subsection.

(2) Following the close of each calendar year, if the board determines that a carrier's loss ratio was less than 75% for that calendar year, the carrier shall be required to refund to policy or contract holders the difference between the amount of net earned premium it received that year and the amount that would have been necessary to achieve the 75% loss ratio.**]** (Deleted by amendment, P.L. , c. .)

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

(cf: P.L.1994, c.102, s.2)

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

3. a. Except as provided in subsection f. of this section, every small employer carrier shall, as a condition of transacting business in this State, offer to every small employer the five health benefit plans as provided in this section. The board shall establish a standard policy form for each of the five plans, which except as otherwise provided in subsection j. of this section, shall be the only plans offered to small groups on or after January

1, 1994. One policy form shall contain the benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity carriers, one policy form shall be established which contains benefits and cost sharing levels which are equivalent to the health benefits plans of health maintenance organizations pursuant to the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.300e et seq.). The remaining policy forms shall contain basic hospital and medical-surgical benefits, including, but not limited to:

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

(3) Diagnostic tests, including X-rays;

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

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

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

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

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

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

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

e. Notwithstanding the provisions of subsection a. of this section to

the contrary, the board may approve a health benefits plan containing only medical-surgical benefits or major medical expense benefits, or a combination thereof, which is issued as a separate policy in conjunction with a contract of insurance for hospital expense benefits issued by a hospital service corporation, if the health benefits plan and hospital service corporation contract combined otherwise comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the contract combined may be allocated between the separate contracts at the discretion of the carrier and the hospital service corporation.

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

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

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

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

i. (1) In addition to the rider packages provided for in subsection d. of this section, every carrier may offer, in connection with the five health benefits plans required to be offered by this section, any number of riders which may revise the coverage offered by the five plans in any way, provided, however, that any form of such rider or amendment thereof which decreases benefits or decreases the actuarial value of one of the five plans shall be filed for informational purposes with the board and for approval by the commissioner before such rider may be sold. Any rider or amendment thereof which adds benefits or increases the actuarial value

of one of the five plans shall be filed with the board for informational purposes before such rider may be sold.

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

(2) The benefit riders provided for in paragraph (1) of this subsection shall be subject to the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19b., 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).

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

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

(a) shall offer coverage to all eligible employees and their dependents

within the membership of the association, multiple employer arrangement or out-of-State trust;

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

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

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

Notwithstanding the provisions of this subsection to the contrary, a carrier or out-of-State trust which writes the health benefits plans required pursuant to subsection a. of this section**[**,**]** shall be required to offer those plans to any small employer, association or multiple employer arrangement.

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

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

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

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

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

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

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

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

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

(9) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, any individual, who is eligible for small employer coverage under a policy issued, renewed, continued or reinstated pursuant to this subsection, but who would be subject to a preexisting condition exclusion under the small employer health benefits plan, or who is a member of a

small employer group who has been denied coverage under the small employer group health benefits plan for health reasons, may elect to purchase or continue coverage under an individual health benefits plan until such time as the group health benefits plan covering the small employer group of which the individual is a member complies with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

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

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

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

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

k. Effective immediately for a health benefits plan issued on or after the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.), the health benefits plans required pursuant to this section, including any plans offered by a State approved or federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

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

(2) All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier shall notify its insureds, in writing, of any

change in the health care services provided with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Insurance.

The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this section. This section shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

(cf: P.L.1995, c.340, s.2)

4. Section 7 of P.L.1995, c.340 (C.17B:27A-19.3) is amended to read as follows:

7. The commissioner, in consultation with the board, shall establish regulations governing the applicable rating methodology **[**and manner in which loss ratios shall be calculated**]** for health benefits plans permitted to be renewed or continued pursuant to the provisions of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19). In establishing these regulations, the commissioner may consider, but shall not be limited to, the impact of allowing these health benefits plans to continue to be rated separately from the standard health benefits plans established pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19) and on their own claims experience. If the commissioner determines that the continuation of separate rating pools adversely affects the small employer insurance market and serves to counter the public policy goals which led to the enactment of P.L.1992, c.162 (C.17B:27A-17 et seq.), the commissioner shall develop a methodology which creates a linkage between the standard health benefits plans established pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19) and the plans permitted to be continued or renewed pursuant to the provisions of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) for the purpose of rating and loss ratio calculation.

Regulations established under the provisions of this section shall detail all additional obligations of carriers continuing or renewing health benefits plans pursuant to the provisions of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) which are necessary to meet the general requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).

The regulations shall be adopted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) no later than 180 days following the effective date of this act. Until such time as the regulations are adopted, the health benefits plans shall continue to be rated and subject to the loss ratio calculations in accordance with applicable law in effect on the effective date of P.L.1995, c.340.

(cf: P.L.1995, c.340, s.7)

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

9. a. [(1) Beginning on the fourth 12-month anniversary date of any policy or contract issued in 1994, no small employer health benefits plan shall be issued in this State unless the plan is community rated.

(2) Beginning January 1, 1994 and upon the first 12-month anniversary date thereafter of the policy or contract, the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall not be greater than 300% of the premium rate charged to 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, and provided further, that such factors are applied in a manner consistent with regulations adopted by the board.

(3) Beginning on the second 12-month anniversary after the date established in paragraph (2) of this subsection of the policy or contract, the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan issued pursuant to subsection a. of 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, and provided further, that such factors are applied in a manner consistent with regulations adopted by the board.

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 paragraphs (1), (2) and (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.] (Deleted by amendment, P.L. , c. .)

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 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 a policy form shall not be less than 75% of the premium therefor**]**. **[**Until December 31, 1996, the**]** 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 each of the five 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 75% of the aggregate premiums collected for the policy form during that calendar year. Carriers shall annually report, no later than August 1st of each year, the loss ratio calculated pursuant to this section for each such policy form for the previous calendar year. In each case where the loss ratio for a policy fails to substantially comply with the 75% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with that policy form 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 75% of the aggregate premiums collected for the policy form in the previous calendar year. 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, 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.**]** (Deleted by amendment, P.L. , c. .)

(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.**]** (Deleted by amendment, P.L. , c. .)

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).

(cf: P.L.1995, c.340, s.3)

6. This act shall take effect immediately.

STATEMENT

This bill eliminates the requirements under the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program that insurers use community rating and that they maintain a 75% loss ratio on policies issued pursuant to those programs.

Eliminates requirements under individual and small employer health benefits programs that insurers use community rating and maintain 75% loss ratio.