ASSEMBLY, No. 2261

STATE OF NEW JERSEY

INTRODUCED JULY 18, 1996

By Assemblymen BATEMAN and GARRETT

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

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

1. (New section) a. Sections 1 through 4 of this 1996 amendatory and supplementary act shall be known and may be cited as the "Health Benefits Coverage Availability and Affordability Act of 1996."

b. For purposes of sections 1 though 4 of this act:

"Carrier" means carrier as defined in section 1 of P.L.1992, c.162 (17B:27A-17).

"Commissioner" means the Commissioner of Banking and Insurance.

2. (New section) a. There is created the New Jersey Health Coverage Reform Board, which shall be in, but not of, the New Jersey Department of Banking and Insurance.

b. The Board of Directors of the New Jersey Individual Health Coverage Program established pursuant to section 9 of P.L.1992, c.161 (17B:27A-10) and the Board of Directors of the New Jersey Small Employer Health Benefits Program established pursuant to section 12 of P.L.1992, c.162 (C.17B:27A-28) shall cease to exist on the effective date of this act, at which time the New Jersey Health Coverage Reform Board, created pursuant to subsection a. of this section, shall assume all the powers, functions and duties of the respective boards of directors of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program and shall administer these programs under the respective powers and authorities set forth in P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17B:27A-17 et seq.). Where in any law, rule, regulation, judicial or administrative proceeding, contract or otherwise, reference is made to either the New Jersey Individual Health Coverage Program Board or New Jersey

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.

Small Employer Health Benefits Program Board, the same shall mean the New Jersey Health Coverage Reform Board, hereinafter referred to as the "board."

c. The board shall have the additional authority: to collect, hold, place in escrow, invest, refund, reimburse, and otherwise spend or dispose of funds raised through assessments of member carriers, in accordance with the purposes of P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17B:27A-17 et seq.) and their respective plans of operations; and to compensate public board members appointed by the Governor for attendance at board and committee meetings, not to exceed $200 per meeting, over and above travel expenses, to be paid from the board's administrative assessment funds. The costs of effectuating the provisions of this section shall be treated as an assessable expense pursuant to section 10 of P.L.1992, c.161 (C.17B:27A-11).

d. The organizational meeting of the New Jersey Health Coverage Reform Board shall occur on the day of the first scheduled monthly meeting of the New Jersey Small Employer Health Benefits Program Board following the effective date of this act. Initially, the board shall consist of all the members of the boards of directors of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program, duly appointed or elected pursuant to section 9 of P.L.1992, c.161 (C.17B:27A-10) or section 13 of P.L.1992, c.162 (C.17B:27A-29), who shall serve out the remainder of their terms. Board members whose terms have expired and whose seats have not been filled as of the effective date of this act shall cease to serve on the board. After the effective date of this act the New Jersey Health Coverage Reform Board shall seek recommendations for new board members, subject to the commissioner's approval, from the organizations represented by comparable existing board members, as the terms of those board members, as determined by the commissioner, expire.

The new membership of the board shall be comprised of 15 members as follows:

(1) two representatives of small employers, one of whom shall be recommended by the New Jersey Business and Industry Association and one of whom shall be recommended by the National Federation of Independent Business of New Jersey, subject to the approval of the commissioner;

(2) one representative of hospitals, who shall be recommended by the New Jersey Hospital Association, subject to the approval of the commissioner;

(3) one representative of organized labor who shall be recommended by the New Jersey AFL-CIO, subject to the approval of the commissioner;

(4) one licensed health insurance producer, who shall be nominated

by the Governor and confirmed by the Senate;

(5) one physician licensed to practice medicine and surgery in this State, who shall be nominated by the Governor and confirmed by the Senate;

(6) one representative of self-employed individuals who shall be elected by State members of the National Association for the Self Employed;

(7) six representatives of carriers, one of whom shall be a representative of an authorized insurance company offering individual health benefits plans in New Jersey, who shall be elected by the carriers offering individual health benefits plans; one of whom shall be a representative of an approved health maintenance organization offering individual health benefits plans, who shall be elected by the carriers offering individual health benefits plans; two of whom shall be representatives of authorized insurance companies offering small employer health benefits plans, one of whom shall be a representative of a mutual health insurer of this State subject to Subtitle 3 of Title 17B of the New Jersey Statutes, and both of whom shall be elected by those carriers offering small employer health benefits plans; one of whom shall be a representative of an approved health maintenance organization offering small employer health benefits plans, who shall be elected by those carriers offering small employer health benefits plans; and one of whom shall be a representative of a health service corporation incorporated in New Jersey; and

(8) the commissioner and the Commissioner of Health, or their designees, who shall serve ex officio.

In the event that one or more representatives of the carrier designations pursuant to paragraph (7) of this subsection are not available to serve as members, the commissioner shall appoint a representative to serve as a board member until such time that a representative of that carrier designation becomes available to serve.

e. Within 90 days of the initial meeting of the New Jersey Health Coverage Reform Board, the board shall submit to the commissioner a plan of operation which shall establish the administration of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program under the New Jersey Health Coverage Reform Board pursuant to the provisions of this section. The plan of operation and any subsequent amendments thereto shall be submitted to the commissioner who shall, after notice and hearing, approve the plan if he finds that it is reasonable and equitable and sufficiently carries out the provisions of this section. The plan of operation shall become effective after the commissioner has approved it in writing. The plan or any subsequent amendments thereto shall be deemed approved if not expressly disapproved by the commissioner in writing within 90 days of receipt by the commissioner.

The plan of operation shall include, but not be limited to, the

following:

(1) A method of handling and accounting for assets and moneys of the program and an annual fiscal reporting to the commissioner;

(2) A means of providing for the filling of vacancies on the board, subject to the approval of the commissioner;

(3) The establishment of the New Jersey Guaranteed Acceptance Plan pursuant to section 3 of this act;

(4) Any additional matters which are appropriate to effectuate the provisions of this section.

Until such time as a new plan of operation is adopted by the New Jersey Health Coverage Reform Board and approved by the commissioner, the New Jersey Health Coverage Reform Board shall operate under the plans of operation of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program, as applicable, adopted pursuant to section 9 of P.L.1992, c.161 (C.17B:27A-10) and section 14 of P.L.1992, c.162 (C.17B:27A-30).

3. (New section) The New Jersey Health Coverage Reform Board shall establish the Guaranteed Acceptance Plan as follows:

a. Any person, which, for purposes of this section, includes a small employer, who has been domiciled in this State for six consecutive months shall be eligible for coverage under the Guaranteed Acceptance Plan if the person provides evidence to the board of:

(1) A notice of rejection or refusal to issue substantially similar coverage for health reasons by two carriers; or

(2) A refusal by two carriers to provide that coverage except at a rate exceeding the plan rate; or

A rejection or refusal to cover an applicant by an employer participating in a self-funded employer welfare benefit plan as provided by the "Employee Retirement Income Security Act of 1974" (ERISA), 29 U.S.C., §1001 et seq., shall not be sufficient evidence under this subsection.

b. The Guaranteed Acceptance Plan shall offer to a person qualified to receive coverage pursuant to subsections a. or c. of this section any of the standard health benefits plans approved by the board pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4).

c. The board shall promulgate a list of medical or health conditions for which a person shall be eligible for coverage under the Guaranteed Acceptance Plan without qualifying for coverage pursuant to subsection a. of this section. Persons shall be eligible for coverage upon demonstration to the board of the existence of any of the conditions on the list promulgated by the board.

d. The board shall appoint a carrier to administer the Guaranteed Acceptance Plan, based on criteria established by the board, which shall include, but not be limited to, the carrier's experience in

providing and servicing such a plan. The appointment of the administering carrier shall be subject to the approval of the commissioner.

e. No person who qualifies under subsection a. or subsection c. of this subsection shall be denied coverage under a health benefits plan issued pursuant to the Guaranteed Acceptance Plan, nor shall the issuance or renewal of a health benefits plan issued pursuant to the Guaranteed Acceptance Plan be conditioned on the health status or medical condition of an applicant. Every health benefits plan under the Guaranteed Acceptance Plan shall be issued on an annual guaranteed renewal basis.

f. Subsection e. of this section shall not be construed as preventing the exclusion of benefits under a policy or contract during the first 12 months, based on a preexisting condition for which the insured received treatment or was otherwise diagnosed during the six months immediately preceding the effective date of the policy or contract, except that the limitation shall not apply to an individual who has, under a prior health benefits policy or contract, with no intervening lapse in coverage, been treated or diagnosed by a physician for a condition under that policy or contract or satisfied a six-month preexisting condition limitation.

g. A policy or contract issued pursuant to the Guaranteed Acceptance Plan shall provide coverage up to a lifetime limit of $1,000,000 per covered individual.

h. Initial rates for policies and contracts issued under the Guaranteed Acceptance Plan shall be no greater than 150% of the average premium rate for the same or similar policy or contract, issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), as determined by the board. Subsequent rates shall be established by the board to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors deemed appropriate by the board. In no case shall rates for policies or contracts issued pursuant to the Guaranteed Acceptance Plan exceed 200% of the average rates, as determined by the board, applicable to a health benefits plan that is the same or similar to a health benefits plan issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4). All rates established pursuant this subsection shall be filed with the commissioner for approval. Rates shall be deemed approved if not expressly disapproved by the commissioner in writing within 30 days of the receipt of the filing by the commissioner.

i. The board shall establish procedures for the equitable sharing of any losses incurred by the carrier administering the Guaranteed Acceptance Plan established pursuant to this section as follows:

(1) By March 1, 1997 and following the close of each calendar year thereafter, on a date established by the commissioner:

(a) every carrier issuing health insurance or health maintenance organization subscriber contracts in this State shall file with the commissioner its net earned premium in the preceding calendar year; and

(b) The administering carrier shall file with the commissioner its net earned premium on Guaranteed Acceptance Plan policies or contracts and the claims paid and the administrative expenses attributable to those policies or contracts in the preceding calendar year; and

(2) No later than March 1, 1997 and following the close of each calendar year thereafter, on a date established by the commissioner, an administering carrier issuing policies or contracts under the Guaranteed Acceptance Plan shall file with the commissioner a statement of any net loss on those policies or contracts in the preceding calendar year, along with any supporting information required by the commissioner. For purposes of this subsection, a loss shall occur if the claims paid and reasonable administrative expenses for contracts and policies issued under the Guaranteed Acceptance Plan exceed the net earned premium and any investment income thereon.

j. (1) Every carrier authorized to provide health benefits plans, stop loss coverage or health maintenance organization subscriber contracts in this State shall be liable for an assessment to reimburse the administering carrier issuing contracts or policies pursuant to this section for any net loss incurred by the administering carrier in the previous year, unless the carrier has received an exemption from the commissioner pursuant to paragraph (3) of this subsection.

(2) The assessment of each carrier shall be in the proportion that the net earned premium of the carrier for all health benefits plans, stop loss coverage, and health maintenance organization subscriber contracts issued and renewed in the calendar year preceding the assessment bears to the net earned premium of all carriers for all health benefits plans, stop loss coverage, or health maintenance organization subscriber contracts issued or renewed in the calendar year preceding the assessment and shall be carried out in a form and manner to be determined by the commissioner.

(3) A carrier that is financially impaired may seek from the commissioner an exemption or a deferment in whole or in part from any assessment issued by the commissioner. The commissioner may exempt a carrier from an assessment or defer, in whole or in part, the assessment of a carrier if in the opinion of the commissioner, the payment of the assessment would endanger the ability of the carrier to fulfill its contractual obligations. If an assessment against a carrier is deferred in whole or in part or if the carrier is exempt from the assessment, the amount by which the assessment is deferred or the amount that a carrier is exempted from paying may be assessed against

the other carriers in a manner consistent with the basis for assessment set forth in this section.

k. Payment of an assessment made under this section shall be a condition of issuing health insurance policies or contracts and health maintenance organization subscriber contracts in the State for a carrier. Failure to pay the assessment shall be grounds for forfeiture of a carrier's authorization to issue such policies or contracts in the State, as well as any other penalties permitted by law.

l. Notwithstanding the provisions of this section to the contrary, no carrier shall be liable for an assessment to reimburse the administering carrier pursuant to this section in an amount which exceeds 35% of the net loss of the administering carrier. To the extent that this limitation results in any unreimbursed loss to the administering carrier, the unreimbursed loss shall be distributed among all carriers: (1) which owe assessments pursuant to subsection f. of this section; (2) whose assessments do not exceed 35% of the net loss of the administering carrier; and (3) who have not received an exemption pursuant to paragraph (3) of subsection j. of this section.

m. (1) Whenever the administering carrier reports a net loss to the commissioner pursuant to paragraph (2) of subsection i. of this section, the related operations of the administering carrier and any losses incurred by the administering carrier regarding health benefits plans issued pursuant to this section shall be subject to an audit conducted by a qualified independent certified public accountant prior to the imposition of any assessment pursuant to subsection j. of this section.

(2) The auditor shall be selected and approved by the New Jersey Health Coverage Reform Board through a competitive bidding process of certified public accountants qualified in New Jersey to perform such audits. The audit shall include:

(a) a review of the handling and accounting of assets and monies of the administering carrier;

(b) a determination that administrative expenses have been properly allocated and are reasonable;

(c) a review of the internal financial controls of the administering carrier;

(d) a review of the annual financial report of the administering carrier; and

(e) a review of the calculation by the commissioner of any assessments for net losses.

A copy of the audit and related management letters shall be delivered to the New Jersey Health Coverage Reform Board, to the commissioner and to each carrier to which the provisions of this section apply. The audit report shall be reviewed by the board. Upon recommendation of the board, the administering carrier shall implement any recommendations made by the auditor.

n. The board 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 section.

4. (New section) a. For the purposes of this section:

"Commissioner" means the Commissioner of Banking and Insurance.

"Eligible group of small employers" means a group of small employers which: (1) are engaged in the same type of trade or business; (2) are members of a common trade association, professional association, or other association; or (3) are affiliates of a common parent company.

"Exchange" means a Small Employers Health Benefits Exchange as provided for in subsection b. of this section.

"Health benefits plan" means a hospital or medical expense benefits coverage or dental expense coverage.

"Member" means a small employer which is a member of an exchange as provided for in subsection b. of this section.

"Small employer" means a person, including a self-employed individual, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding calendar year quarter, employed no more than 49 employees, the majority of whom are employed within the State of New Jersey; except that in the case of a small employer who is a member of an exchange because the employer is a member of a common trade association, professional association or other association, the restriction on the number of employees shall not apply. In determining the number of employees, businesses which are affiliated businesses shall be considered one employer, and the size of the small employer shall be determined annually. Except as otherwise specifically provided by the by-laws of an exchange, provisions of this subsection which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer.

"Trustee" means a member of the board of trustees of an exchange as provided for in subsection c. of this section.

b. Any eligible group of small employers may join together by means of a joint contract under the procedures established by this section for the purpose of providing or purchasing as a group health benefits plans for their employees and the employees' dependents. The joint contract shall be executed by all members of the exchange, which may be a corporation, and the entity thus created shall be known as a "Small Employers Health Benefits Exchange."

c. The exchange shall be governed by a board of trustees, elected by the members of the exchange, and shall be composed of not less than seven or more than nine members, as provided in the exchange's

by-laws. The trustees shall serve for terms of three years, and shall serve until their successors are elected and qualified. The by-laws shall provide for staggered terms. The trustees shall serve without compensation, except for reimbursement for actual expenses. At the annual meeting of the exchange, the members shall elect from among the trustees a chairperson, a treasurer, and a secretary, whose terms of office shall be no longer than one year. No trustee shall be elected for more than three consecutive terms.

d. The trustees shall, within 60 days of their initial election by the members, formulate by-laws for the operation of the exchange, which shall be ratified by a two-thirds majority of the members. The by-laws shall include, but not be limited to:

(1) The establishment of procedures for the organization and administration of the exchange;

(2) Procedures for the verification of eligibility and the assessment of members for their contributions to the exchange and for the collection of assessments which may be in default; provided that the assessments may vary only by size of group and shall not vary by reason of the health status, age, or occupation of any member or employee thereof;

(3) At the discretion of the trustees, procedures for the employment of a director of the exchange, whether on a full-time, part-time or consulting basis;

(4) Procedures for the selection and appointment of an administrator to pay claims on behalf of the exchange;

(5) Procedures for the obtaining of other professional services as may be needed from time to time, which may include, but not be limited to, utilization review services, case management services, claims review services, accounting services actuarial services, and legal services;

(6) Procedures for purchasing group health benefits plans or obtaining stop-loss insurance coverage, reinsurance or other services;

(7) Procedures for the withdrawal of a member from the exchange;

(8) Procedures for the admission of additional members to the exchange;

(9) Procedures for the expulsion of a member of the exchange;

(10) Procedures for the termination and liquidation of the exchange and the payment of its outstanding obligations.

e. Within 30 days after its election, the trustees shall file with the commissioner a certificate which shall list the members of the exchange, the names of the trustees and the chairperson, treasurer and secretary of the exchange, and the address at which communications for the exchange are to be received and service of process is to be made, a copy of the certificate of incorporation of the exchange, if any, and a copy of the joint contract to which members of the exchange are parties.

f. The health benefits plan to be provided by the plan shall be evidenced by a health benefits plan document which shall be distributed to member employers and shall contain a statement of all health benefits to be made available to the plan beneficiaries. The health benefits may include, but shall not be limited to, any or all of the following: hospital expense coverage, medical expense coverage, major medical coverage, or dental benefits. A plan providing a combination of hospital and medical expense coverage shall meet the requirements of this subsection. A health benefits plan document shall contain a statement of the deductibles and copayments applicable to the plan, as well as coverage limitations, exclusions and criteria for being eligible for the plan.

g. The trustees of the exchange shall require a capital deposit from every member upon the member's entry into the exchange, which shall remain on deposit in cash or in investments. The capital deposits and any surplus from operations shall form the exchange's reserve, the amount of which shall be established by the trustees from time to time in consultation with an actuary. If at any time the reserve is less than that required by this subsection, the members shall be assessed in an amount to make up the deficiency. In the event that there is a deficiency, the trustees shall notify the members of the deficiency. If the members fail to advance the sums necessary to satisfy the deficiency, the trustees may order that the exchange be liquidated in accordance with the exchange's by-laws.

h. No exchange shall begin providing health benefits to its members pursuant to the provisions of this act until its by-laws are adopted by the trustees and the capital deposits have been paid into the exchange in an amount, form and manner in accordance with the provisions of this section.

i. At least annually, the exchange shall file with the commissioner a financial statement for the preceding calendar year, in a form prescribed by the commissioner, along with a filing fee of $250.

j. Every exchange providing health benefits under this section on a self-insured basis shall purchase stop-loss coverage or reinsurance, either on an aggregate or individual attachment point basis, or both, from an insurer providing such coverage which is admitted or authorized to do business in this State pursuant to Title 17 of the Revised Statutes or Title 17B of the New Jersey Statutes and which has a financial rating of A- or better, or its equivalent, from a national rating agency, or which is eligible to write surplus lines coverage in this State pursuant to Title 17 of the Revised Statutes.

k. The exchange may employ any consultant, administrator or clerical personnel as are provided for in the by-laws, provided that any consultant or administrator so employed shall be qualified by virtue of having at least five years' experience in health benefits management or risk management or equivalent educational or professional training.

Any consultant or administrator hired by the exchange may be removed by the trustees or upon the vote of two thirds of the members of the exchange.

l. (1) The trustees shall establish procedures in the by-laws for the collection, investment and disbursement of the moneys in the exchange. The procedures shall be established in a manner which will maximize the benefits to the members with respect to investment income and cash flow. An accounting of the exchange's income and claims paid shall be sent monthly to all exchange members.

(2) No later than 60 days before the anniversary of the health benefits plan, the trustees, in consultation with an actuary, shall determine each member's assessment for the ensuing calendar year and shall notify each member thereof. Assessments may be paid on an annual, semi-annual, quarterly, bi-monthly or monthly basis, as provided in the by-laws.

m. The exchange shall hold an annual meeting, at a time and place to be established by the board of trustees. The meetings shall be held within the first quarter of each calendar year, and all members shall be notified of the meeting at least 60 days in advance. Prior to the annual meeting nominations shall be made from the membership for vacancies on the board of trustees. Voting may be done by proxy, as provided in the by-laws. Additional meetings may be held at any time, upon at least 15 days' notice to the members of the exchange. Notice of the annual meeting and any additional meetings shall be sent to the commissioner.

n. Amendments to the by-laws may be proposed by recommendation of the board of trustees or by petition of 60% of the members. Amendments shall be ratified by at least two-thirds of the membership and filed with the commissioner upon ratification.

o. The board of trustees may, from time to time, recommend modifications or additions to the health benefits plan provided by the exchange. These modifications shall become effective upon ratification by two-thirds of the members of the exchange, and shall be filed with the commissioner upon ratification.

p. The board of trustees of the exchange shall cause an annual audit to be made of the exchange's financial condition, which shall be transmitted to all members of the exchange. The board of trustees shall also cause a claims audit to be made at least biennially.

q. The members of the exchange may be assessed, from time to time, for reasonable expenses for the administration of the exchange, as provided by the by-laws of the exchange.

r. An exchange established pursuant to the provisions of this section is not an insurance company, health service corporation, hospital service corporation, medical service corporation, dental service corporation or health maintenance organization under the laws of this State, and the authorized activities of the exchange do not

constitute the transaction of insurance nor doing any insurance business.

s. Every member of the exchange, as a condition of membership, shall provide equal access to the benefits provided for herein by all of the member's full-time employees who work a normal work week of 25 or more hours.

t. (1) A health benefits plan provided by an exchange pursuant to this section shall not include any preexisting condition provision, except that, a preexisting condition provision may apply to a late enrollee or to any small employer group of less than six persons if the provision excludes coverage for a period of no more than twelve months following the effective date of coverage of the enrollee, and relates only to conditions manifesting themselves during the six months immediately preceding the effective date of coverage of the enrollee 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 during the six months immediately preceding the effective date of coverage, or as to a pregnancy existing on the effective date of coverage; except that, if 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition provision shall apply to any of those enrollees.

(2) In determining whether a preexisting condition provision applies to an eligible employee or dependent, the health benefits plan shall credit the time that person was covered under any previous health benefits plan if the previous coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

(3) For the purposes of this section, "late enrollee" means a "late enrollee" as defined in section 1 of P.L.1992, c.162 (C.17B:27A-17).

u. All of the documents or materials required to be filed with the commissioner pursuant to this section shall be available for public inspection.

v. This section shall apply to an exchange established after the effective date of this act and, in the case of an existing exchange or self-insured trust, this section shall apply upon the first anniversary date for renewal of the contract or agreement after the effective date of this act.

w. 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 are necessary to effectuate the purposes of this section.

5. 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 Banking and 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.**]** Deleted by amendment, P.L. c. (C. .)

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract or certificate; or health maintenance organization subscriber contract or certificate 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, vision only or prescription 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 or other supplemental limited benefit insurance 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 entire 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 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.

"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 policy or contract is formulated based on the experience of all persons covered by that policy or contract, **[**without regard to age, sex, occupation and geographical location, but**]** under which rates may differ by health status , age, gender and geographical location. **[**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.

"Qualifying previous coverage" means benefits or coverage

provided under:

(1) Medicare or Medicaid or any other federally funded health benefits program;

(2) a group health insurance policy or contract, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, or an employer-based, self-funded or other health benefit arrangement; or

(3) an individual health insurance policy or contract, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization.

Qualifying previous coverage shall not include the following policies, contracts or arrangements, whether issued on an individual or group basis: specified disease only, accident only, credit, disability, long-term care, Medicare supplement, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, stop loss or excess risk insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other supplemental limited benefit coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

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

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

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

3. a. No later than 180 days after the effective date of this act, a carrier shall, as a condition of issuing health benefits plans in this State, offer individual health benefits plans. The plans shall be offered on **[**an open enrollment,**]** a modified community rated basis, pursuant to the provisions of this act; except that a carrier shall be deemed to have satisfied its obligation to provide the individual health benefits plans by paying an assessment or receiving an exemption pursuant to subsection j. of section **[**11 of this act**]** 3 of P.L. , c. (C.) (pending in the Legislature as this bill).

b. A carrier shall offer to an eligible person a choice of five standard individual health benefits plans, which may be offered on a non-guaranteed issue basis, any of which may contain provisions for managed care. One plan shall be a basic health benefits plan, one plan shall be a managed care plan and three plans shall include enhanced benefits of proportionally increasing actuarial value. A carrier may elect to convert any individual contract or policy forms in force on the effective date of **[**this act**]** P.L. , c. (C.)(pending in the Legislature as this bill) of an individual eligible to participate in the Guaranteed Acceptance Plan established pursuant to section 3 of P.L.,

c. (C.)(pending in the Legislature as this bill) to any of the five health benefit plans offered under that plan, except that the carrier may not convert more than 25% of existing contracts or policies each year, and the replacement plan shall be of no less actuarial value than the policy or contract being replaced.

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

Notwithstanding the provisions of this subsection 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 a basic health benefits plan in accordance with the provisions of that law in lieu of the five standard plans required pursuant to this subsection.

Notwithstanding the provisions of this subsection to the contrary, a carrier may offer other individual health benefits plans on a non-guaranteed issue basis, in addition to the five standard health benefits plans, provided that the actuarial value of any such health benefits plan is at least equal to Plan A of the standard health benefits plans established by the board pursuant to this section; and that the policy or contract forms for any such plan are filed with the board.

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

(2) Notwithstanding the provisions of this subsection or any other law to the contrary, a carrier may, with the approval of the board, modify the coverage 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, respectively) or provide alternative benefits or services from those required by this subsection if they are within the intent of this act or if the board changes the benefits included in the basic health benefits plan.

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

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

coinsurance included in the basic health benefits plan.

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

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

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

e. If all five of the individual health benefits plans are not established by the board by the effective date of P.L.1993, c.164 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the five health benefits plans by offering each health benefits plan as it is established by the board; however, once the board establishes all five plans, the carrier shall be required to offer the five plans in accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et al.).

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

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

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

a. The health benefits plan shall **[**guarantee**]** provide coverage for an eligible person and his dependents on a modified community rated basis.

b. A health benefits plan shall be renewable with respect to an eligible person and his dependents at the option of the policy or contract holder except under the following circumstances:

(1) nonpayment of the required premiums by the policy or contract holder;

(2) fraud or misrepresentation by the policy or contract holder, including equitable fraud, with respect to coverage of eligible individuals or their dependents;

(3) termination of eligibility of the policy or contract holder; or

(4) cancellation or amendment by the board of the specific individual health benefits plan.

(cf: P.L.1992, c.161, s.5)

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

6. The board shall establish the policy and contract forms and

benefit levels to be made available by all carriers for the policies required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4). The board shall provide the commissioner with an informational filing of the policy and contract forms and benefit levels it establishes.

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

b. An individual health benefits plan offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no more than 12 months on coverage for preexisting conditions, except that the limitation shall not apply to an individual who **[**has, under a prior group or individual health benefits plan or Medicaid,**]** was covered under any qualifying previous coverage if the qualifying previous coverage was continuous with no more than 90 days intervening lapse in coverage **[**of more than 30 days, been treated or diagnosed by a physician for a condition under that plan or has satisfied a 12-month preexisting condition limitation**]** prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan.

c. In addition to the five standard individual health benefits plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board may develop up to five rider packages. Premium rates for the rider packages shall be determined in accordance with section 8 of P.L.1992, c.161 (C.17B:27A-9).

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

e. Effective immediately for an individual 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 an individual health benefits plan in effect on the effective date of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161

(C.17B:27A-4), including any plan offered by a 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 Banking and 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 individual health benefits plans in which the carrier has reserved the right to change the premium.

(cf: P.L.1995, c.316, s.5)

9. Section 8 of P.L.1992, c. 162 (C.17B:27A-24) is amended to read as follows:

8. Any small employer carrier may require a reasonable specified minimum participation of eligible employees, which shall not exceed 75%, or reasonable minimum employer contributions in determining whether to accept a small group pursuant to this act. **[**The standards so established by the carrier shall be first approved by the board and shall be applied uniformly to all small groups, except that in no event shall a**]** A small employer carrier shall not require an employer to contribute more than 10% to the annual cost of the policy or contract **[**, or an amount as otherwise provided by the board, and any minimum participation standards established by the carrier shall be reasonable**]**. In establishing the percentage of employee participation, a one-to-one credit shall be given for each employee covered by a spouse's health benefits coverage. In calculating an employer's participation, the carrier shall include all insured employees, regardless of whether the employees chose an indemnity plan or a health maintenance organization, or a combination thereof.

(cf: P.L.1995, c.298, s.3)

10. Section 8 of P.L.1992, c.161 (C.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. (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**]** P.L.1992, c.161 (C.17B:27A-4) 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**]** issued pursuant to section 3 of **[**this act**]** P.L.1992, c.161 (C.17B:27A-4) so that the anticipated minimum loss ratio for a contract or policy form shall not be less than 65% or greater than 75% of the premium ,which may vary on the basis of the level of policy benefits and premium, as determined by regulations promulgated by the board, less any assessments paid pursuant to section 3 of P.L. , c. (C.)(pending in the Legislature as this bill) and any amount paid by the carrier for first year administration costs. The loss ratio shall be based on a life duration, but refund or credit tests shall be performed not less than once in each three-year period. 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**]** a calendar year, if the board determines that a carrier's loss ratio was less than **[**75%**]**the loss ratio established by the board pursuant to paragraph (1) of this subsection 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 established by the board pursuant to paragraph (1) of this subsection.

(3) Beginning January 1, 1997 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 individual purchasing a health benefits plan issued pursuant to section 3 of P.L1992, c.161 (C.17B:27A-4) shall not be greater than 300% of the premium rate charged to the lowest rated individual purchasing that same health benefits plan.

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)

11. Section 10 of P.L.1992, c.162 (C.17B:27A-11) is amended to read as follows:

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

The board shall have the specific authority to:

a. assess members their proportionate share of program losses and administrative expenses in accordance with the provisions of section **[**11**]** 3 of **[**this act**]** P.L. , c. (C.)(pending in the Legislature as this bill), and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

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

c. review rate applications and form filings submitted by carriers in accordance with this act;

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

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

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

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

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

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

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

k. appoint from among its members appropriate legal, actuarial, and other committees as necessary to provide technical and other assistance in the operation of the program, in policy and other contract design, and any other function within the authority of the program;

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

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

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

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

1. As used in this act:

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

"Anticipated loss ratio" means the ratio of the present value of the expected benefits, not including dividends, to the present value of the expected premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. For purposes of this ratio, the present values must incorporate realistic rates of interest which are determined before federal taxes but after investment expenses.

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

"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. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, [hospital service corporation,] or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, [hospital service corporation,] or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Commissioner" means the Commissioner of Banking and Insurance.

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

"Department" means the Department of Banking and Insurance.

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

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

"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 association" includes any professional association or trade association as defined in this section or any group or exchange which makes available group health coverage under a health benefits plan to businesses with fewer than 50 eligible employees, provided that the business is a member of the association or exchange or of an association or exchange which is a member of such an association.

"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 to a small employer group pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, hospital expense only, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other supplemental limited benefit insurance coverage, automobile medical payment insurance, personal injury protection coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.)and stop loss or excess risk insurance.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: a. was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment; b. has lost coverage under that other employer's health benefits plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and c. requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order.

"Medical savings account program" means a health benefits plan that includes all of the following:

a. the purchase of qualified higher deductible hospital and medical expense insurance for the benefit of an employee and the employee's eligible dependents;

b. the payment on behalf of an employee into a medical savings account by the employee's employer of all or part of the premium differential realized by the employer based on the purchase of a higher deductible health benefits plan for the benefit of the employee and the employee's eligible dependents; and

c. an account administrator to administer the medical savings account from which payment of claims is made.

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

"Modified community rating" means a rating system in which the premium for all persons covered by a policy or contract is formulated based on the experience of all persons covered by that policy or contract under which rates may differ by health status, age, gender and geographical location.

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

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

"Preexisting condition provision" means a policy or contract provision that excludes coverage under that policy or contract for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period 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 pregnancy existing on the effective date of coverage.

"Professional association" means an association serving common professional interests that:

a. has been certified as a qualified association by the commissioner, in a form and manner to be determined by the commissioner;

b. has been actively in existence and sponsoring a health benefits plan for five years;

c. has a constitution and by-laws or other analogous governing documents;

d. has been formed in good faith for purposes other than that of obtaining insurance;

e. is not owned or controlled by a carrier;

f. does not condition membership in the association on health status or claims experience; and

g. conditions membership on a significant amount of education, training or experience, or on a license or certificate from a State authority to practice that profession.

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to section 12 of P.L.1992, c.162

(C.17B:27A-28).

"Qualifying previous coverage" means benefits or coverage provided under:

a. Medicare or Medicaid or any other federally funded health benefits program;

b. a group health insurance policy or contract, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization, or an employer-based, self-funded or other health benefit arrangement; or

c. an individual health insurance policy or contract, including coverage by an insurance company, a health, hospital or medical service corporation, or a health maintenance organization.

Qualifying previous coverage shall not include the following policies, contracts or arrangements, whether issued on an individual or group basis: specified disease only, accident only, credit, disability, long-term care, Medicare supplement, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, stop loss or excess risk insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other supplemental limited benefit coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed **[**at least two but**]** no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer. Subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of this act, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this act which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer. For the purposes of P.L.1992, c.162 (C.17B:27A-17 et seq.), a State, county or municipal body, agency, board or department shall not be considered a small employer.

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

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

"Stop loss" or "excess risk insurance" means an insurance policy

designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses, wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for the purposes of P.L.1992, c.162 (C.17B:27A-17 et seq.), the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

a. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than **[**$25,000**]** $10,000 per covered person per plan year; and

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

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

"Trade association" means an association serving common industry, business or trade interests that:

a. has been certified as a qualified association by the commissioner, in a form and manner to be determined by the commissioner;

b. has been actively in existence and sponsoring a health benefits plan for five years;

c. has a constitution and by-laws or other analogous governing documents;

d. has been formed in good faith for purposes other than that of obtaining insurance;

e. is not owned or controlled by a carrier; and

f. does not condition membership in the association on health status or claims experience.

(cf: P.L.1995, c.340, s.1)

13. 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 , which may be offered on a non-guaranteed issue basis, 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. and subsection l. 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 health benefits plan and 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, 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) 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 filing shall be amended to show any modifications in the plan that are necessary to comply with the provisions of this subsection. 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 Banking and 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**]** subsection. This **[**section**]** subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

l. Notwithstanding the provisions of this section to the contrary, a carrier may offer on a non-guaranteed issue basis to small employers, associations and trusts, health benefits plans including medical savings accounts, in addition to the five standard health benefits health plans established by the board pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19), provided that the actuarial value of the health benefits plan is at least equal to Plan A of the standard health benefits plans approved by the board and provided that the policy or contract forms for any such plans comply with the following requirements:

(1) the health benefits plan is offered to all small employer groups, associations and trusts;

(2) (a) the premium charged to the highest rated member of a group, association or trust member purchasing a health benefits plan from a carrier that covers 250 or more individuals shall not be greater than 300% of the premium charged to the lowest rated member of a group, association, or trust purchasing the same plan, and

(b) the premium charged to the highest rated group, association or trust purchasing a health benefits plan from a carrier that covers fewer than 250 individuals shall not be greater than 300% of the premium charged to the lowest rated group, association or trust purchasing the same plan;

(3) the only factors upon which the rates for the health benefits plan may be varied among participating members are the health status, age, gender and geography of the employees of those members;

(4) coverage is provided to all members that meet a reasonable specified minimum participation of eligible employee requirements, which shall not exceed 75%, but may be lower at the discretion of the carrier as to each plan it offers;

(5) coverage is required to be offered to all eligible employees and the dependents of the employees of participating groups or members of associations or trusts;

(6) the benefits offered under the health benefits plan are at least

equal in actuarial value to Plan A, without deductibles or copayments, of the standard plans established by the board pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19); and

(7) such other requirements as the board deems appropriate.

Nothing in this subsection shall be construed as preventing a carrier, trust, multiple employer arrangement or association from applying deductibles or copayments to a health benefits plan other than a standard health benefits plan.

m. Notwithstanding the provisions of this section to the contrary, a group of small employers may join together for the purpose of providing health benefits plans in accordance with the provisions of section 4 of P.L. , c. (C.)(pending in the Legislature as this bill).

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

14. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to read as follows:

6. a. No health benefits plan subject to this act shall include any preexisting condition provision, provided that, a preexisting condition provision may apply to a late enrollee or to any group of **[**two to five**]** less than six persons if such provision excludes coverage for a period of no more than 180 days following the effective date of coverage of such enrollee, and relates only to conditions manifesting themselves during the six months immediately preceding the effective date of coverage of such enrollee 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 during the six months immediately preceding the effective date of coverage, or as to a pregnancy existing on the effective date of coverage; provided that, if 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition provision shall apply to any such enrollee.

b. In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefits plans shall credit the time that person was covered under any qualifying previous coverage if the previous coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan.

(cf: P.L.1995, c.298, s.2)

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

(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 health status, 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.

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

(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.

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**]** 1997, 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 65% or more than 75% of the premium therefor , which loss ratio may vary on the basis of the level of policy benefits and premium, less any assessments paid pursuant to section 3 of P.L., c. (C.) (pending in the Legislature as this bill) and any amount paid by the carrier for first year administration costs as determined pursuant to regulations promulgated by the board. The loss ratio shall be based on a life duration, but refund or credit tests shall be performed not less than once in every three-year period. 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 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 65% but not more than 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] established by the board pursuant to paragraph (1) of this subsection, 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] the loss ratio established by the board pursuant to paragraph (1) of this subsection. 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.

(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).

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

16. Section 11 of P.L.1992, c.161 (C.17B:27A-12) is repealed.

17. This act shall take effect on the 180th day after enactment and shall apply to policies and contracts issued on or after that date.

STATEMENT

This bill consolidates the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program under the New Jersey Health Coverage Reform Board and transfers the duties, powers and authority of the governing boards of those programs to the newly consolidated board.

The bill establishes the Guaranteed Acceptance Plan to be administered by the newly consolidated board. The Guaranteed

Acceptance Plan: (1) sets forth conditions under which individuals unable to procure health insurance may purchase coverage under the Guaranteed Acceptance Plan; (2) requires all health insurers to participate in the plan; (3) requires the New Jersey Health Coverage Reform Board to select an insurer to administer the plan and establishes criteria to be used in the selection process; (4) sets forth duties of the administering insurer; (5) establishes an assessment mechanism which requires all insurers to be assessed by the board for a portion of any operating losses of the plan, based on each insurer's proportionate share of premiums collected in the State; (6) requires the plan to offer annually renewable policies that conform to the State's existing "standard health benefits plans;" (7) permits health benefits plans issued by the Guaranteed Acceptance Plan to impose a 12-month waiting period for preexisting conditions; (8) limits initial rates for coverage under the plan to 150% of the "average" standard risk rate, which is determined by the board, but permits premiums to rise to 200% of the standard rate to cover the costs associated with the program; and (9) imposes a lifetime limit on coverage of $1,000,000.

The bill reduces the retention point amount for self-insured stop loss coverage from $25,000 to $10,000.

It permits self-employed workers and small businesses to group together to reduce the cost of obtaining health insurance and also permits one-life groups to be covered under association plans. The bill modifies pure community rating standards and requires carriers to maintain a 3 to 1 premium ratio standard.

It permits the creation of medical savings accounts by employers on behalf of individuals. In order to establish a medical savings account, the purchase of a higher deductible health insurance policy is required.

The bill modifies current loss ratio requirements for individual and small employer health benefits plans by requiring premiums for all major medical and hospital expense coverages to be subject to a loss ratio requirement of at least 65% but not more than 75%, which loss ratio may vary on the basis of the level of policy benefits and premium. The loss ratio is to be based on a life duration, but refund or credit tests are required to be performed at least once in each three-year period. Certain expenses, including first-year administrative costs, are permitted to be deducted before calculating the loss ratio tests.

Finally, the bill repeals section 11 of P.L.1992, c.161 (C.17B:27A-12).

Makes various changes to the individual and small employer health benefits programs.