[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, No. 2261

STATE OF NEW JERSEY

ADOPTED MAY 5, 1997

Sponsored 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 5 of this amendatory and supplementary act shall be known and may be cited as the "Health Benefits Coverage Availability and Affordability Act of 1997."

b. For purposes of sections 1 through 5 of this amendatory and supplementary act:

"Board" means the New Jersey Health Coverage Reform Board created pursuant to section 2 of this amendatory and supplementary act.

"Carrier" means carrier as defined in section 1 of P.L.1992, c.162 (C.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 (C.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 amendatory and supplementary act, at which

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly floor amendments adopted June 5, 1997.

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 those 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 the New Jersey Small Employer Health Benefits Program Board, the same shall mean the New Jersey Health Coverage Reform 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 subsection a. of 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 amendatory and supplementary 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 subsection b. of section 9 of P.L.1992, c.161 (C.17B:27A-10) or subsection a. of 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 amendatory and supplementary act shall cease to serve on the board. After the effective date of this amendatory and supplementary act the board shall seek recommendations, subject to the commissioner's approval, for new board members from the following organizations to replace existing board members, as the terms of comparable board members, as determined by the commissioner, expire. The new membership of the board shall be comprised of 19 members as follows:

(1) three representatives of small employers, who shall be recommended by business or trade organizations, subject to the

approval of the commissioner;

(2) one representative of a hospital, who shall be recommended by a hospital association, subject to the approval of the commissioner;

(3) one representative of organized labor who shall be recommended by a labor organization, subject to the approval of the commissioner;

(4) three licensed health insurance producers, 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 member of the public, who is covered by an individual or small employer health benefits plan who shall be nominated by the Governor and confirmed by the Senate;

(7) eight representatives of carriers: one of whom shall be a representative of authorized carriers 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 either individual or small employer health benefits plans, who shall be elected by those carriers offering small employer health benefits plans; four of whom shall be representatives of authorized carriers offering small employer health benefits plans, and one of whom shall be a representative of a mutual health insurer of this State subject to the provisions of Subtitle 3 of Title 17B of the New Jersey Statutes, all five of whom 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 or a domestic mutual insurer which converted from a health service corporation in accordance with the provisions of sections 2 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48), who shall be elected by those carriers offering small employer health benefits plans; 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 d. 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 establishing 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 amendatory and supplementary act. 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 the commissioner 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; and

(3) 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 board and approved by the commissioner, the 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), respectively.

f. The executive director of the board shall be appointed by the commissioner as a special deputy reporting to the commissioner.

3. (New section) a. The Legislature finds and declares that:

(1) Health benefits coverage, while providing important protection for individuals, is costly for individuals and businesses which insure their employees.

(2) Mandated health benefits have social, financial and medical implications for patients, providers and health benefits plans.

(3) It is therefore, in the public interest to require the review of mandated health benefits by an expert body to provide the Legislature with adequate, independent documentation defining the social and financial impact and medical efficacy of the mandate.

b. In addition to the respective powers, functions, and duties assumed by or granted to the New Jersey Health Coverage Reform Board pursuant to subsections b. and c. of section 2 of this amendatory and supplementary act, the board shall review bills introduced in either House of the Legislature which require an insurer to offer or provide a mandated health benefit and shall report their findings to the Legislature pursuant to the provisions of this section and section 4 of this amendatory and supplementary act.

c. Whenever a bill containing a mandated health benefit is introduced in the Legislature, the chairman of the standing reference

committee to which the bill or resolution has been referred in the House in which it was introduced shall request the board to prepare a written report that assesses the social and financial effects and the medical efficacy of a proposed mandated health benefit.

d. Not later than the 120th day after the request for review is received, the board shall complete its review and provide a written report to the members of the standing reference committee to which the bill has been referred. If the board requests an extension prior to the 120th day after the date of the request for review, the chairman of the standing reference committee to which the bill has been referred may grant an extension for the board to complete its review of the bill. The standing reference committee shall not consider or vote upon the bill until: the board completes its review and provides its written report to the members of the committee; the 121st day after the date the request for that review was received; or the designated day in the case of an extension.

e. If the standing reference committee of the House in which the bill was introduced determines that a bill proposing a mandated health benefit is of such an urgent nature that it would seriously impair the public health to wait for the board to issue its report, then it may vote to release the bill.

f. If the presiding officer of the House in which the bill was introduced determines that the bill is of such an urgent nature that it would seriously impair the public health to wait for the board to issue its report, the presiding officer shall so notify in writing the chairman of the standing reference committee to which the bill has been referred and the board of that determination, and the House may consider and vote upon the bill.

g. No bill requiring an insurer to offer or provide a mandated health benefit shall be reported by the standing reference committee to which it has been referred unless the written report of the board has been provided to the members of the standing reference committee, except as provided in subsections d., e. and f. of this section.

h. The board, at the request of a sponsor of the bill or any member of that standing reference committee, may amend or revise its report with respect to any bill which is amended by either House after having been reported by the standing reference committee to which it was referred in the House in which it was introduced. If a report has been issued by the board on a proposed mandated benefit within the previous three years, the board shall not be required to produce a new report on the same proposed mandated benefit unless requested to do so by the chairman of the standing reference committee to which the bill has been referred. In a case in which there are several mandated health benefits bills to be reviewed by the board, the presiding officer of the House in which the bill was introduced, or his designee, shall consult with the board to determine the order of priority for review of

the mandated health benefits bills.

i. For the purposes of this section and section 4 of this act, "mandated health benefit" or "mandate" means a benefit or coverage which is required by law to be offered or provided by an insurer including: coverage for specific health care services, treatments or practices; direct reimbursement to specific health care providers; or the offering of specific health care services, treatments or practices.

4. (New section) The review of mandated health benefits by the board shall include, at a minimum and to the extent that information is practicable and available, the following:

a. The social impact of mandating the health benefit, which shall include:

(1) The extent to which the mandated health benefit and the services it provides are needed by, available to and utilized by the population of New Jersey;

(2) The extent to which insurance coverage for the mandated health benefit already exists, or if no coverage exists, the extent to which the lack of coverage results in inadequate health care or financial hardship for the affected population of New Jersey;

(3) The demand for the mandated health benefit from the public and the source and extent of opposition to mandating the health benefit;

(4) Relevant findings bearing on the social impact of the lack of the mandated health benefit; and

(5) Such other information with respect to the social impact as the board deems appropriate.

b. The financial impact of mandating the health benefit, which shall include:

(1) The extent to which the mandated health benefit increases or decreases the cost for treatment or service;

(2) The extent to which similar mandated health benefits in other states have affected charges, costs and payments for services;

(3) The extent to which the mandated health benefit increases the appropriate use of the treatment or service;

(4) The impact of the mandated health benefit on total costs to health care insurers and on administrative costs;

(5) The impact of the mandated health benefit on total costs to purchasers of health care coverage and on benefit costs;

(6) The impact of the mandated health benefit on the total cost of health care within New Jersey; and

(7) Such other information with respect to the financial impact as the board deems appropriate.

c. The medical efficacy of mandating the health benefit, which shall include:

(1) If the mandated health benefit mandates coverage of a

particular treatment or therapy, the recommendation of a clinical study or review article in a major peer-reviewed professional journal;

(2) If the benefit mandates coverage of the services provided by an additional class of practitioners, the results of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and the practitioners already covered by benefits;

(3) The results of other research;

(4) The impact of the coverage on the general availability of health coverage in New Jersey; and

(5) Such other information with respect to the medical efficacy as the board deems appropriate.

d. The effects of balancing the social, economic and medical efficacy considerations which shall include, but not be limited to:

(1) The extent to which the need for coverage outweighs the costs of mandating the health benefit; and

(2) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option under health coverage.

e. An analysis of information collected from various sources, including but not limited to:

(1) a State data collection system;

(2) the Departments of Health and Senior Services and Banking and Insurance;

(3) health planning organizations;

(4) proponents and opponents of the proposed mandated health benefit, who shall be encouraged to provide appropriate documentation supporting their positions. The board shall examine such documentation to determine whether:

(a) the documentation is complete;

(b) the assumptions upon which the research is based are valid;

(c) the research cited in the documentation meets professional standards;

(d) all relevant research respecting the proposed mandated health benefit has been cited in the documentation; and

(e) the conclusions and interpretations in the documentation are consistent with the data submitted; and

(5) such other data sources as the board deems appropriate.

In analyzing information from the various sources, the board shall give substantial weight to the documentation provided by the proponents and opponents of the mandate to the extent that such documentation is made available to them.

5. (New section) The board shall study and report at least every 18 months to the commissioner on the effectiveness of this amendatory and supplementary act. The report shall analyze the

effectiveness of the act in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group and individual health insurance marketplace. The report shall address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers and individuals in fulfillment of the purposes of P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17B:2A-17 et seq.). The report may contain recommendations for market conduct or other regulatory standards or action.

6. 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**]** health benefits plan is the same, based on the experience of all persons covered by that **[**contract**]** health benefits plan, without regard to age, sex, health status, occupation and geographical location.

"Department" means the Department of Banking and Insurance.

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

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

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

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

"Health benefits plan" means a hospital and medical expense 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, hospital expense only offered by a hospital service corporation or a health service corporation, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity coverage.

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

Individual health benefits plan shall not include a 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 **[**contract**]** health benefits plan is formulated based on the experience of all persons covered by that **[**contract, without regard to age, sex, occupation and geographical location, but**]** health benefits plan under which rates may differ by **[**health status. The term modified community rating shall apply to contracts and policies issued prior to the effective date of this act which are subject to the provisions of subsection e. of section 2 of this act**]** age, gender and geographical location. The premium rate charged by a carrier to the highest rated individual shall not be greater than 200% of the premium rate charged to the lowest rated individual purchasing the same health benefits plan.

"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 **[**,**]**or 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.).

"Selective contracting arrangement" means an arrangement for the payment of predetermined fees or reimbursement levels for covered services under a health benefits plan by a carrier to preferred providers or preferred provider organizations.

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

7. 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, guaranteed issue, 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 section 11 of this act.

b. A carrier which offers an individual health benefits plan in this State shall offer to an eligible person a choice of five standard individual health benefits plans, which shall be offered on an open enrollment, guaranteed issue, modified community rated basis, any of which may contain provisions for managed care and managed care through selective contracting arrangements. 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 to any of the five benefit plans, 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 plans required pursuant to this subsection.

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

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

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

(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 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)

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

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

a. The health benefits plan shall guarantee coverage for an eligible person and his dependents on a community rated basis; except that a health benefits plan issued or renewed on or after April 1, 1998 shall provide that coverage 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)

9. 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) , including policy and contract forms for selective contracting arrangements within 180 days of the effective date of P.L. , c. (now before the Legislature as this bill). Within one year of the effective date of P.L. , c. (now before the Legislature as this bill), the commissioner shall report to the Legislature with regard to whether the availability of managed care products in the individual health benefits plan market is a sufficient measure to control the premium costs of individual health benefits plans. 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: (1) has, under a prior group or individual health benefits plan or Medicaid, with no 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 ; or (2) qualifies as an “eligible individual,” as defined in section 111 of the federal "Health Insurance Portability and Accountability Act of 1996," Pub. L. 104-191 (42 U.S.C. §300gg-41).

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**]** 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 and Senior Services 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 and Senior Services 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)

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**]** On or after the effective date of P.L. , c. (now before the Legislature as this bill), rates shall be formulated on **[**contracts or policies required**]** health benefits plans 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**]** block of business shall not be less than 75% **[**of the premium**]** , as determined by regulations promulgated by the commissioner and in accordance with the following requirements:

(a) **[1]**the anticipated minimum loss ratio shall be based over the entire period for which rates are computed to provide coverage, i.e., life duration; and

(b)**]**[1] the anticipated minimum loss ratio shall reflect and include in the numerator on a pro-rata basis for each block of business:

(i) **[1]**actual**]**[1] claims **[1]**paid**]** incurred[1] during the period;

(ii) the change in claims reserves, which shall be calculated in a manner consistent with and in an amount not less than claims reserves reported in connection with the annual statement required to be filed with the commissioner pursuant to subsection a. of N.J.S.17B:21-1;

(iii) expenses incurred for the development and maintenance of managed care networks, selective contracting arrangements, utilization review and precertification; assessments for any medical and hospital care losses charged to the block of business that are paid to any state or administrative board or agency; and any other similar expenses specified by the commissioner and adopted by the board pursuant to

the provisions of the "Administrative Procedure Act," P.L. 1968, c.410 (C.52:14B-1 et seq.) [1]; and

(b) any additional expenses approved by the commissioner for health maintenance organizations shall also be approved for other carriers[1].

(2) 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] individual acceptable [to the board and] to the commissioner, stating that the carrier is in compliance with the provisions of this subsection. That certification shall include supporting data and demonstrations.

[(2)] (3) Following the close of each calendar year, if the [board] [1][commissioner] board[1] determines that a carrier's [1][anticipated][1] loss ratio [was] is less than 75% [for that calendar year] [1][over the life duration of] for[1] a block of business, the carrier shall be required to reduce future premiums or 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 [1]as provided in this subparagraph (3)[1]. If the annual experience or actual loss ratio for a block of business is less than 75% for the calendar year, the carrier [1][shall] may[1] set aside, in a separate premium stabilization reserve account, funds which, if included in the numerator of the annual experience or actual loss ratio, would be sufficient to achieve a 75% anticipated loss ratio. [1]In no event shall the amount of funds held in the premium stabilization reserve account for a respective block of business exceed 20% of the annualized premium for that block of business. Once every three years each carrier shall calculate the value of the funds held in the premium stabilization account for each block of business during the preceding three-year period and, if the value of the reserve fund is determined to be more than 5% of the annualized premium for that respective block of business, the carrier shall use those funds in excess of 5% from the premium stabilization reserve to either offset premiums to new policyholders or refund premiums to policyholders during the calculation period. These refunds or offsets shall be approved by the board.[1] Funds set aside in a premium stabilization reserve account shall be expended solely to pay claims anticipated to be incurred for the block of business to which the account is attached [1], to offset premiums to new policyholders,[1] or to issue refunds to contract or policy holders for that block of business, as provided herein. The premium stabilization reserve account shall be reduced by amounts so expended.

(4) A carrier shall notify the commissioner of its initial election to define the coverages which comprise its blocks of business for all rating purposes, which may include, but not be limited to, separate blocks for standard and non-standard plans or any other aggregation

of plans. Any changes in a carrier's defined blocks of business shall be submitted to the commissioner for approval. All blocks of business shall be defined on the basis of reasonable actuarial standards.

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

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

a. (1) By March 1, 1993 and following the close of each calendar year thereafter, on a date established by the board:

(a) every carrier issuing health benefits plans in this State shall file with the board its net earned premium for the preceding calendar year ending December 31; and

(b) every carrier issuing individual health benefits plans in the State shall file with the board the net earned premium on policies or contracts issued pursuant to paragraph (1) of subsection b. of section 2 and section 3 of this act and the claims paid **[**and the administrative expenses attributable to those policies or contracts**]**. If the claims **[**paid and reasonable administrative expenses**]** incurred for that calendar year exceed the net earned premium and any investment income thereon by 15% or more, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this act. **[**For the purposes of this subsection, "reasonable administrative expenses" shall be actual expenses or a maximum of 25% of premium, whichever amount is less.**]**

(2) Every member shall be liable for an assessment to reimburse carriers issuing individual health benefits plans in this State which sustain net paid losses for the previous year, unless the member has received an exemption from the board pursuant to subsection d. of this section and has written a minimum number of non-group persons as provided for in that subsection. The assessment of each member shall be in the proportion that the net earned premium of the member for the calendar year preceding the assessment bears to the net earned

premium of all members for the calendar year preceding the assessment.

(3) A member that is financially impaired may seek from the commissioner a deferment in whole or in part from any assessment issued by the board. The commissioner may defer, in whole or in part, the assessment of the member if, in the opinion of the commissioner, the payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. If an assessment against a member is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessment set forth in this section. The member receiving the deferment shall remain liable to the program for the amount deferred.

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

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

d. (1) Notwithstanding the provisions of this act to the contrary, a carrier may apply to the board, by a date established by the board, for an exemption from the assessment and reimbursement for losses provided for in this section. A carrier which applies for an exemption shall agree to enroll or insure a minimum number of non-group persons on an open enrollment community rated basis, under a managed care or indemnity plan, as specified in this subsection, provided that any indemnity plan so issued conforms with sections 2 through 7, inclusive, of this act. For the purposes of this subsection, non-group persons include individually enrolled persons, conversion policies issued pursuant to this act, Medicare cost and risk lives and Medicaid **[**and HealthStart Plus**]** recipients; except that in determining whether the carrier meets the minimum number of non-group persons required pursuant to this subsection, the number of Medicaid recipients and Medicare cost and risk lives shall not exceed 50% of the total.

(2) Notwithstanding the provisions of paragraph (1) of this subsection to the contrary, a health maintenance organization qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub.L 93-222 (42 U.S.C. s.300e et seq.) and tax exempt pursuant to paragraph (3) of subsection (c) of section 501 of the federal Internal Revenue Code of 1986, 26 U.S.C. s.501, may include up to one third

Medicaid recipients and up to one third Medicare recipients in determining whether it meets its minimum number.

(3) The minimum number of non-group persons, as determined by the board, shall equal the total number of community rated and modified community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid and HealthStart Plus lives, of all carriers subject to this act as of the end of the calendar year, multiplied by the proportion that carrier's net earned premium bears to the net earned premium of all carriers for that calendar year, including those carriers that are exempt from the assessment.

(4) Within 180 days after the effective date of this act and on or before March 1 of each year thereafter, every carrier seeking an exemption pursuant to this subsection shall file with the board a statement of its net earned premium for the preceding calendar year. The board shall determine each carrier's minimum number of non-group persons in accordance with this subsection.

(5) On or before March 1 of each year, every carrier that was granted an exemption for the preceding calendar year shall file with the board the number of non-group persons, by category, enrolled or insured as of December 31 of the preceding calendar year.

To the extent that the carrier has failed to enroll the minimum number of non-group persons established by the board, the carrier shall be assessed by the board on a pro rata basis for any differential between the minimum number established by the board and the actual number enrolled or insured by the carrier.

(6) A carrier that applies for the exemption shall be deemed to be in compliance with the requirements of this subsection if:

(a) by the end of calendar year 1993, it has enrolled or insured at least 40% of the minimum number of non-group persons required;

(b) by the end of calendar year 1994, it has enrolled or insured at least 75% of the minimum number of non-group persons required; and

(c) by the end of calendar year 1995, it has enrolled or insured 100% of the minimum number of non-group persons required.

(7) Any carrier that writes both managed care and indemnity business that is granted an exemption pursuant to this subsection may satisfy its obligation to write a minimum number of non-group persons by writing either managed care or indemnity business, or both.

e. Notwithstanding the provisions of this section to the contrary, no carrier shall be liable for an assessment to reimburse any carrier pursuant to this section in an amount which exceeds 35% of the aggregate net paid losses of all carriers filing pursuant to paragraph (1) of subsection a. of this section. To the extent that this limitation results in any unreimbursed paid losses to any carrier, the unreimbursed net paid losses shall be distributed among carriers: (1) which owe assessments pursuant to paragraph (2) of subsection a. of

this section; (2) whose assessments do not exceed 35% of the aggregate net paid losses of all carriers; and (3) who have not received an exemption pursuant to subsection d. of this section. For the purposes of paragraph (3) of this subsection, a carrier shall be deemed to have received an exemption notwithstanding the fact that the carrier failed to enroll or insure the minimum number of non-group persons required for that calendar year.
(cf: P.L.1992, c.161, s.11)

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**]** system in which the premium for all persons covered by a **[**policy or contract form**]** health benefits plan is the same based upon the experience of the entire pool of risks covered by that **[**policy or contract form**]** health benefits plan 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, 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.

"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 offered by a hospital service corporation or a health service corporation, 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.

"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 health benefits plan is formulated based on the experience of all persons covered by that health benefits plan under which rates may differ by age, gender, and geographical location. The premium rate charged by a carrier to the highest rated small group shall not be greater than 200% of the premium rate charged to the lowest rated small group purchasing the same or a similar health benefits plan.

"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.

"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.).

"Selective contracting arrangement" means an arrangement for the payment of predetermined fees or reimbursement levels for covered services under a health benefits plan by a carrier to preferred providers or preferred provider organizations.

"Small employer", except as otherwise defined by the federal "Health Insurance Portability and Accountability Act of 1996," Pub. L. 104-191 (42 U.S.C. §300gg et al.), 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**]** $20,000 per covered person per plan year, subject to redetermination as necessary by the commissioner pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.); and

b. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than **[**125%**]** 120% of expected claims per plan year, subject to redetermination as necessary by the commissioner pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-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.340, s.1)

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

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

a linkage between the standard health benefits plans established pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19) and the plans permitted to be continued or renewed pursuant to the provisions of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) for the purpose of rating and loss ratio calculation.

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

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

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

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

6. a. **[**No**]** Except as otherwise provided by the federal "Health Insurance Portability and Accountability Act of 1996," Pub. L. 104-191, (29 U.S. §1181) 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 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, except as otherwise provided by the federal "Health Insurance Portability and Accountability Act of 1996," Pub. L. 104-191 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 7 of P.L.1992, c.162 (C.17B:27A-23) is amended to read as follows:

7. Every policy or contract issued to small employers in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be renewable with respect to all eligible employees or dependents at the option of the policy or contract holder, or small employer except under the following circumstances:

a. Nonpayment of the required premiums by the policyholder, contract holder, or employer;

b. Fraud or misrepresentation of the policyholder, contract holder, or employer or, with respect to coverage of eligible employees or dependents, the enrollees or their representatives;

c. The number of employees covered under the health benefits plan is less than the number or percentage of employees required by participation requirements under the health benefits policy or contract;

d. Noncompliance with a carrier's employment contribution requirements;

e. Any carrier doing business pursuant to the provisions of this act ceases doing business in the small employer market, if the following conditions are satisfied:

(1) The carrier gives notice to cease doing business in the small employer market to the commissioner not later than eight months prior to the date of the planned withdrawal from the small group market, during which time the carrier shall continue to be governed by this act with respect to business written pursuant to this act. For the purposes of this subsection, "date of withdrawal" means the date upon which the first notice to small employers is sent by the carrier pursuant to paragraph (2) of this subsection;

(2) No later than two months following the date of the notification to the commissioner that the carrier intends to cease doing business in the small employer market, the carrier shall mail a notice to every small business employer insured by the carrier that the policy or contract of insurance will be terminated. This notice shall be sent by certified mail to the small business employer not less than six months in advance of the effective date of the cancellation date of the policy or contract; or

(3) **[**Any carrier that ceases to do business pursuant to this act shall be prohibited from writing new business in the small employer market for a period of five years from the date of notice to the commissioner;**]** (Deleted by amendment, P.L. , c. .)

f. In the case of policies or contracts issued in connection with membership in an association or trust of employers, an employer ceases to maintain its membership in the association or trust **[**; or**]**.

g. (Deleted by amendment, P.L.1995, c.50).
(cf: P.L.1995, c.50, s.1)

16. 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 on a modified community rating basis.

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

(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**]** 1998, 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**]** block of business shall not be less than 75% **[**of the premium therefor. 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**]** ,as determined by regulations promulgated by the commissioner and in accordance with the following requirements:

(a) **[1]**[the anticipated minimum loss ratio shall be based over the entire period for which rates are computed to provide coverage, i.e., life duration; and

(b)**]**[1] the anticipated minimum loss ratio shall reflect and include in the numerator on a pro-rata basis for each block of business:

(i) **[1]**[actual]**[1]** claims **[1]**[paid] incurred[1] during the period;

(ii) the change in claims reserves, which shall be calculated in a manner consistent with and in an amount not less than claims reserves reported in connection with the annual statement required to be filed with the commissioner pursuant to subsection a. of N.J.S.17B:21-1;

(iii) expenses incurred for the development and maintenance of managed care networks, selective contracting arrangements, utilization review and precertification; assessments for any medical and hospital care losses [1][and related cost categories]1 charged to the block of business that are paid to any state or administrative board or agency; and any other [1]similar[1] expenses specified by the commissioner and adopted by the board pursuant to the provisions of the "Administrative Procedure Act," P.L. 1968, c.410 (C.52:14B-1 et seq.) [1]; and

(b) any additional expenses approved by the commissioner for health maintenance organizations shall also be approved for other carriers[1].

(2) [Each calendar year, a carrier shall return, in the form of aggregate benefits for each of the five standard policy forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19), at least 75% of the aggregate premiums collected for the policy form during that calendar year. Carriers shall annually report, no later than August 1st of each year, the loss ratio calculated pursuant to this section for each such policy form for the previous calendar year. In each case where the loss ratio for a policy fails to substantially comply with the 75% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with that policy form in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal 75% of the aggregate premiums collected for the policy form in the previous calendar year. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder.

(3)] The carrier shall submit, with its rate filing, a certification by a member of the American Academy of Actuaries, or other individual acceptable to the commissioner, stating that the carrier is in compliance with the provisions of this subsection. That certification shall include supporting data and demonstrations.

(3) Following the close of each calendar year, if the [1][commissioner] board[1] determines that a carrier's [1][anticipated]1 loss

ratio is less than 75% [1]**[**over the life duration of**]** for[1] a block of business, the carrier shall be required to reduce future premiums or refund to policy or contract holders the amount necessary to achieve the 75% loss ratio [1]as provided in this subparagraph (3)[1]. If the annual experience or actual loss ratio for a block of business is less than 75% for the calendar year, the carrier [1]**[**shall**]** may[1] set aside, in a separate premium stabilization reserve account, funds such that the funds, if included in the numerator of the annual experience or actual loss ratio, would be sufficient to achieve a 75% anticipated loss ratio. [1]In no event shall the amount of funds held in the premium stabilization reserve account for a respective block of business exceed 20% of the annualized premium for that block of business. Once every three years each carrier shall calculate the value of the funds held in the premium stabilization account for each block of business during the preceding three-year period and, if the value of the reserve fund is determined to be more than 5% of the annualized premium for that respective block of business, the carrier shall use those funds in excess of 5% from the premium stabilization reserve to either offset premiums to new policyholders or refund premiums to policyholders during the calculation period. These refunds or offsets shall be approved by the board.[1] Funds set aside in a premium stabilization reserve account shall be expended solely to pay claims anticipated to be incurred for the block of business to which the account is attached [1],to offset premiums to new policyholders,[1] or to issue refunds to contract or policy holders for that block of business, as provided herein. The premium stabilization reserve account shall be reduced by amounts so expended.

(4) A carrier shall notify the commissioner of its initial election to define the coverages which comprise its blocks of business for all rating purposes, which may include, but not be limited to, separate blocks for standard and non-standard plans or any other aggregation of plans. Any changes in a carrier's defined blocks of business shall be submitted to the commissioner for approval. All blocks of business shall be defined on the basis of reasonable actuarial standards.

(5) 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)

17. Section 5 of P.L.1982, c.95 (C.17:35C-5) is amended to read as follows:

5. The commissioner shall promulgate regulations to effectuate and enforce the provisions of P.L.1982, c.95 (C.17:35C-1 et seq.) and any regulations which are necessary to conform medicare supplement contracts and certificates with federal law. These regulations shall include, but not be limited to:

a. Establishment of minimum standards for benefits, claim payments, marketing and reporting practices and compensation arrangements;

b. Establishment of a uniform methodology for calculating **[**and**]**, reporting and certifying loss ratios, which methodology shall be established consistent with the rules governing the issuance of health benefits plans pursuant to section 8 of P.L.1992, c.161 (C.17B:27A-9); and requiring refunds or credits if the contracts or certificates do not meet loss ratio requirements;

c. (1) Establishment of a process for filing of all requests for premium increases and rate changes, which may include public hearings as determined appropriate by the commissioner prior to approval of any premium increases;

(2) Establishment of a process by which an insurer operating pursuant to the provisions of chapters 26 or 27 of Title 17B of the New Jersey Statutes, a medical service corporation operating pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.), a hospital service corporation operating pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.), a health service corporation operating pursuant to the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.),and a health maintenance organization operating pursuant to the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) may establish or amend its premium rates for Medicare supplement and Medicare complement contracts and certificates with an anticipated loss ratio of 80% or greater through a filing with the commissioner, which filing shall be approved solely on the basis of an actuarial certification that the aggregate and current loss ratios attributable to a particular contract or certificate shall not be less than 80% or, if greater, the original anticipated loss ratio.

d. Assurance of access by the public to contract, premium and loss ratio information; and

e. Establishment of standards for Medicare Select contracts and certificates at such time as this State is authorized under federal law to authorize Medicare Select contracts and certificates.

(cf: P.L.1992, c.144, s.4)

18. Section 2 of P.L.1989, c.63 (C.17:48-6e) is amended to read as follows:

2. a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a hospital service corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group if: (1) during the period immediately preceding the person's becoming a member of the group the person was enrolled as a member under another group contract issued by the corporation; and (2) the corporation paid benefits for the condition under the group contract in which the person was previously insured. Notwithstanding any other provision of law to the contrary, no small group health insurance contract issued by a hospital service corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.) shall contain any provision or be offered in a manner regarding a preexisting condition, guaranteed issue or renewability that is inconsistent with section 6 of P.L. 1992, c.162 (C.17B:27A-22), section 7 of P.L.1992, c.162 (C.17B:27A-23) or section 11 of P.L.1992, c.162 (C.17B:27A-27). Notwithstanding any other provision of law to the contrary, no individual health insurance contract issued by a hospital service corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.), shall contain any provision or be offered in a manner regarding a preexisting condition, guaranteed issue or renewability that is inconsistent with section 5 of P.L.1992, c.161 (C.17B:27A-6) or section 6 of P.L.1992, c.161 (C.17B:27A-7).

b. Nothing in this section shall be construed to operate to add any benefit, to increase the scope of any benefit, or to increase any benefit level under any group contract.

c. This section shall apply to every group or individual contract or policy in which the corporation or insurer has the right to change the premium.

(cf: P.L.1989, c.63, s.2)

19. Section 1 of P.L.1989, c.63 (C.17:48A-7d) is amended to read as follows:

1. a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a medical service corporation pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group if: (1) during the period immediately preceding the person's becoming a member of the group the person was enrolled as a member under another group contract issued by the corporation; and (2) the corporation paid benefits for the condition under the group contract in which the person was previously insured. Notwithstanding any

other provision of law to the contrary, no small group health insurance contract issued by a medical service corporation pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.) shall contain any provision or be offered in a manner regarding a preexisting condition, guaranteed issue or renewability that is inconsistent with section 6 of P.L. 1992, c.162 (C.17B:27A-22), section 7 of P.L.1992, c.162 (C.17B:27A-23) or section 11 of P.L.1992, c.162 (C.17B:27A-27). Notwithstanding any other provision of law to the contrary, no individual health insurance contract issued by a medical service corporation pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.), shall contain any provision or be offered in a manner regarding a preexisting condition, guaranteed issue or renewability that is inconsistent with section 5 of P.L.1992, c.161 (C.17B:27A-6) or section 6 of P.L.1992, c.161 (C.17B:27A-7).

b. Nothing in this section shall be construed to operate to add any benefit, to increase the scope of any benefit, or to increase any benefit level under any group contract.

c. This section shall apply to every group or individual contract or policy in which the corporation or insurer has the right to change the premium.

(cf: P.L.1989, c.63, s.1)

[1]20. (New section) Notwithstanding any State law to the contrary, all health benefit plans issued to employers with more than 50 employees shall comply with the provisions of the federal "Health Insurance Portability and Accountability Act of 1996," Pub.L. 104-191 in any instance where State law is inconsistent with that federal law.[1]

[1][20.] 21.[1] (New section) Pursuant to the “Administrative Procedure Act,” P.L. 1968, c. 410 (C. 52:14B-1 et seq), the commissioner shall promulgate regulations necessary to effectuate the provisions of this amendatory and supplementary act.

[1][21.] 22.[1] This act shall take immediately, and shall apply to policies and contracts issued or renewed on or after January 1, 1998.

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