CHAPTER 146

AN ACT concerning individual, small employer and large group 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. Section 1 of P.L.1992, c.161 (C.17B:27A-2) is amended to read as follows:

C.17B:27A-2 Definitions.

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

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier.

"Church plan" has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(33)).

"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.

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. s.1395 et seq.); Title XIX of the federal Social Security Act (42 U.S.C. s.1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (42 U.S.C.s.1396s); Chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a State health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §8901 et seq.); a public health plan as defined by federal regulation; and a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e)); or coverage under any other type of plan as set forth by the commissioner by regulation.

Creditable coverage shall not include coverage consisting solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage, as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

"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 who is not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan, or Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.).

"Federally defined eligible individual" means an eligible person: (1) for whom, as of the date on which the individual seeks coverage under P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months; (2) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan; (3) who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C.s.1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan; (4) with respect to whom the most recent coverage

within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; (5) who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and (6) who has elected continuation coverage described in (5) above and has exhausted that continuation coverage.

"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.

"Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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

"Group health plan" means an employee welfare benefit plan, as defined in Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1002(1)), to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

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

"Health status-related factor" means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

"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 an employee welfare benefit plan, to the extent the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1001 et seq.) preempts the application of P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

"Medical care" means amounts paid: (1) for the diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and (2) transportation primarily for and essential to medical care referred to in (1) above.

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

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

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, or Medicaid contracts with the State or federal government, but shall not include premiums earned from contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

"Non-group person life year" means coverage of a person for 12 months by an individual health benefits plan or conversion policy or contract subject to P.L.1992, c.161 (C.17B:27A-2 et seq.), Medicare cost or risk contract or Medicaid contract.

"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.

"Plan sponsor" shall have the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1002(16)(B)).

"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.

"Resident" means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of the calendar year.

"Two-year calculation period" means a two calendar year period, the first of which shall begin January 1, 1997 and end December 31, 1998.

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

C.17B:27A-3 Individual health benefits plans, applicability of act.

2. a. An individual health benefits plan issued on or after August 1, 1993 shall be subject to the provisions of this act.

b. (1) An individual health benefits plan issued on an open enrollment, modified community rated basis or community rated basis prior to August 1, 1993 shall not be subject to sections 3

through 8, inclusive, of this act, unless otherwise specified therein.

(2) An individual health benefits plan issued other than on an open enrollment basis prior to August 1, 1993 shall not be subject to the provisions of this act, except that the plan shall be liable for assessments made pursuant to section 11 of this act.

(3) A group conversion contract or policy issued prior to August 1, 1993 that is not issued on a modified community rated basis or community rated basis, shall not be subject to the provisions of this act, except that the contract or policy shall be liable for assessments made pursuant to section 11 of this act.

(4) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation prior to the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that the plan shall guarantee renewal pursuant to subsection b. of section 5 of P.L.1992, c.161 (C.17B:27A-6).

(5) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation to an eligible person or federally defined eligible individual after the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the provisions of subsections c. and d. of section 2, subsection b. of section 3, section 5, subsection b. of section 6, and subsections c., d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3, C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall not be subject to the remaining provisions of P.L.1992, c. 161.

c. After August 1, 1993, an individual who is eligible to participate in a group health benefits plan that provides coverage for hospital or medical expenses shall not be covered by an individual health benefits plan which provides benefits for hospital and medical expenses that are the same or similar to coverage provided in the group health benefits plan, except that an individual who is eligible to participate in a group health benefits plan but is currently covered by an individual health benefits plan may continue to be covered by that plan until the first anniversary date of the group health benefits plan occurring on or after January 1, 1994.

d. Except as otherwise provided in subsection c. of this section, after August 1, 1993, a person who is covered by an individual health benefits plan who is a participant in, or is eligible to participate in, a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, and a person, including an employer or insurance producer, who causes another person to be covered by an individual health benefits plan which person is a participant in, or who is eligible to participate in a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, shall be subject to a fine by the commissioner in an amount not less than twice the annual premium paid for the individual health benefits plan, together with any other penalties permitted by law.

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

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

C.17B:27A-6 Individual health benefits plans, requirements.

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.

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. A carrier may terminate a health benefits plan under the following circumstances:

(1) the policy or contract holder has failed to pay premiums in accordance with the terms of the policy or contract or the carrier has not received timely premium payments;

(2) the policy or contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

c. A carrier may not renew a health benefits plan only under the following circumstances:

(1) termination of eligibility of the policy or contract holder if the person is no longer a resident or becomes eligible for a group health benefits plan, group health plan, governmental

plan or church plan; (2) cancellation or amendment by the board of the specific individual health benefits plan;

(3) board approval of a request by the individual carrier to not renew a particular type of health benefits plan, in accordance with rules adopted by the board. After receiving board approval, a carrier may not renew a type of health benefits plan only if the carrier: (a) provides notice to each covered individual provided coverage of this type of the nonrenewal at least 90 days prior to the date of the nonrenewal of the coverage; (b) offers to each individual provided coverage of this type the option to purchase any other individual health benefits plan currently being offered by the carrier; and (c) in exercising the option to not renew coverage of this type and in offering coverage as required under (b) above, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for coverage;

(4) board approval of a request by the individual carrier to cease doing business in the individual health benefits market. A carrier may not renew all individual health benefits plans only if the carrier: (a) first receives approval from the board; and (b) provides notice to each individual of the nonrenewal at least 180 days prior to the date of the expiration of such coverage. A carrier ceasing to do business in the individual health benefits market may not provide for the issuance of any health benefits plan in the individual market during the five-year period beginning on the date of the termination of the last health benefits plan not so renewed; and

(5) In the case of a health benefits plan made available by a health maintenance organization carrier, the carrier shall not be required to renew coverage to an eligible individual who no longer resides, lives, or works in the service area, or in an area for which the carrier is authorized to do business, but only if coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

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

C.17B:27A-7 Establishment of policy and contract forms, benefit levels.

6. The board shall establish the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans 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. An individual health benefits plan offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting condition limitation of any period under the following circumstances:

(1) to an individual who has, under creditable coverage, with no intervening lapse in coverage of more than 31 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12-month preexisting condition limitation; or

(2) to a federally defined eligible individual who applies for an individual health benefits plan within 63 days of termination of the prior coverage.

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 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.

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

C.17B:27A-8 Offering of certain coverage not required.

7. a. A health maintenance organization shall not be required to offer coverage to or accept an applicant pursuant to this act if:

(1) the eligible individual does not live, reside, or work within the health maintenance organization's approved service area; and

(2) the carrier has demonstrated to the commissioner that the carrier will not have the capacity to deliver services adequately to additional eligible persons because of its obligations to existing group contract holders and enrollees and individual enrollees and it applies this paragraph uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible persons. Upon denying individual health benefits coverage pursuant to this paragraph, a carrier may not offer such coverage in the individual market for a period of 180 days after the date the coverage is denied. If the health maintenance organization does not have the capacity in its facilities for additional individual enrollees, it also shall not offer coverage to or accept any new group enrollees.

b. A carrier shall not be required to offer coverage or accept applications pursuant to this act if the commissioner determines that the carrier does not have the financial reserves necessary to underwrite additional coverage. Upon denying individual health benefits coverage pursuant to this subsection, a carrier may not offer such coverage in the individual market for a period of 180 days after the date the coverage is denied or until the carrier has demonstrated to the commissioner that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

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

C.17B:27A-12 Procedures for equitable sharing of program losses.

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, 1999, and following the close of each two-year calculation period thereafter, or on a different 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 two-year calculation period; and

(b) every carrier issuing individual health benefits plans in the State shall file with the board the net earned premium on health benefits plans issued pursuant to paragraph (1) of subsection b. of section 2 and section 3 of this act and the claims paid. If the claims paid for all health benefits plans during the two-year calculation period exceed 115% of the net earned premium and any investment income thereon for the two-year calculation period, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this act.

(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 during the two-year calculation period, 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 person life years 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 two-year calculation period preceding the assessment bears to the net earned premium of all members for the two-year calculation period preceding the assessment. Notwithstanding the provisions of this subsection to the contrary, a medical service corporation or a hospital service corporation shall not be liable for an assessment to reimburse carriers which sustain net paid losses.

(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 cover a minimum number of non-group person life years 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 P.L.1992, c.161 (C.17B:27A-3 through 17B:27A-8). 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 recipients; except that in determining whether the carrier meets the minimum number of non-group person life years required to be covered pursuant to this subsection, the number of Medicaid recipients and Medicare cost and risk lives shall not exceed 50% of the total. Pursuant to regulations adopted by the board, the carrier shall determine the number of non-group person life years it has covered by adding the number of non-group persons covered on the last day of each calendar quarter of the two-year calculation period, taking into account the limitations on counting Medicaid recipients and Medicare cost and risk lives, and dividing the total by eight.

(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 of non-group person life years.

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

(4) On or before March 1 of the first year of each two-year calculation period, every carrier seeking an exemption pursuant to this subsection shall file with the board a statement of its net earned premium for the two-year calculation period. The board shall determine each carrier's minimum number of non-group person life years in accordance with this subsection.

(5) On or before March 1 of each year immediately following the close of a two-year calculation period, every carrier that was granted an exemption for the preceding two-year calculation period shall file with the board the number of non-group person life years, by category, covered for the two-year calculation period.

To the extent that the carrier has failed to cover the minimum number of non-group person life years 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 covered 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 it has covered 100% of the minimum number of non-group person life years 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 cover a minimum number of non-group person life years by issuing either managed care or indemnity business, or both.

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

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

C.17B:27A-17 Definitions relative to small employer health benefits plans.

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 entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. 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.

"Church plan" has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(33)).

"Commissioner" means the Commissioner of Banking and Insurance.

"Community rating" or "community rated" means a rating methodology in which the premium charged by a carrier 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.

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or part B of Title XVIII of the federal Social Security Act (42 U.S.C. s.1395 et seq.); Title XIX of the federal Social Security Act (42 U.S.C. §1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (42 U.S.C.s.1396s); chapter 55 of Title 10, United States Code (10 U.S.C. §1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. s.8901 et seq.); a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e)); or coverage under any other type of plan as set forth by the commissioner by regulation.

Creditable coverage shall not include coverage consisting solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage, as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

"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 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.

"Enrollment date" means, with respect to a person covered under a health benefits plan, the date of enrollment of the person in the health benefits plan or, if earlier, the first day of the waiting period for such enrollment.

"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.

"Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

"Group health plan" means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

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

"Health status-related factor" means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

"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, but only if the plan sponsor or carrier required such a statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; b. has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, death of a spouse, or divorce or legal separation; 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; the individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; 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 care" means amounts paid: (1) for the diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and (2) transportation primarily for and essential to medical care referred to in (1) above.

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

"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).

"Plan sponsor" has the meaning given that term under Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(16)(B)).

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information.

"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).

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, and the majority of the employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C.s.414) shall be treated as one employer. Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L.1992, c.162 (C.17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such 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 $20,000 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.

8. Section 2 of P.L.1992, c.162 (C.17B:27A-18) is amended to read as follows:

C.17B:27A-18 Providers of health benefits, services subject to provisions of act.

2. Every health insurer, health service corporation, medical service corporation, hospital service corporation, and health maintenance organization licensed or authorized to provide health benefits or services in this State which offers health insurance policies or coverages to small employers shall be subject to the provisions of this act. Carriers shall offer coverage to all eligible employees of small employers and their dependents and shall not exclude any employee or eligible dependent on the basis of a health status-related factor.

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

C.17B:27A-22 Preexisting condition provisions.

6. a. No health benefits plan subject to this act shall include any provision excluding coverage for a preexisting condition regardless of the cause of the condition, 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, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of such enrollee and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding 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 creditable coverage if the creditable 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. A carrier shall provide credit pursuant to this provision in one of the following methods:

(1) A carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period; or

(2) A carrier shall count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits specified in federal regulation rather than the method provided in paragraph (1) of this subsection. This election shall be made on a uniform basis for all covered persons. Under this election, a carrier shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within that class or category. A carrier which elects to provide credit pursuant to this provision shall comply with all federal notice requirements.

c. A health benefits plan shall not impose a preexisting condition exclusion for the following:

(1) A newborn child who, as of the last date of the 30-day period beginning with the date of birth, is covered under creditable coverage;

(2) A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of the adoption or placement for adoption; or

(3) Pregnancy as a preexisting condition.

10. Section 7 of P.L.1992 c.162 (C.17B:27A-23) is amended to read as follows:

C.17B:27A-23 Policies, contracts renewable; exceptions.

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 that a carrier may discontinue or not renew a health benefits plan in accordance with the provisions of this section:

a. A carrier may discontinue such coverage only if:

(1) The policyholder, contract holder, or employer has failed to pay premiums or

contributions in accordance with the terms of the health benefits plan or the carrier has not received timely premium payments; or

(2) The policyholder, contract holder, or employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

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

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, and all covered persons, that the policy or contract of insurance will not be renewed. 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 nonrenewal date of the policy or contract;

(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 termination of the last health insurance coverage not so renewed;

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, but only if such coverage is terminated under this provision uniformly without regard to any health status-related factor relating to any covered individual.

g. (Deleted by amendment, P.L.1995, c.50).

h. A decision by the small employer carrier to cease offering and not renew a particular type of group health benefits plan in the small employer market, if the board discontinues a standard health benefits plan or as permitted or required pursuant to subsection j. of section 3 of P.L.1992, 162 (C.17B:27A-19), and pursuant to regulations adopted by the commissioner;

i. In the case of a health maintenance organization plan issued to a small employer:

(1) an eligible person who no longer resides, lives, or works in the carrier's approved service area, but only if coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(2) a small employer that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the carrier and the carrier would deny enrollment with respect to such plan pursuant to subsection a. of section 10 of P.L.1992, c.162 (C.17B:27A-26).

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

C.17B:27A-25 Premium rates; other plan requirements.

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

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

(3) For all policies or contracts providing health benefits plans for small employers issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19), the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19) shall not be greater than 200% of the premium rate charged for the lowest rated small group purchasing that same health benefits plan; provided, however, that the only factors upon which the rate differential may be based are age,

gender and geography, and provided further, that such factors are applied in a manner consistent with regulations adopted by the board.

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

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

(5) Any policy or contract issued after January 1, 1994 to a small employer who was not previously covered by a health benefits plan issued by the issuing small employer carrier, shall be subject to the same premium rate restrictions as provided in paragraphs (1), (2) and (3) of this subsection, which rate restrictions shall be effective on the date the policy or contract is issued.

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

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

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

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

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

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

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

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

f. No insurance contract or policy subject to this act may be entered into unless and until the carrier has made an informational filing with the commissioner of a schedule of premiums, not to exceed 12 months in duration, to be paid pursuant to such contract or policy, of the carrier's rating plan and classification system in connection with such contract or policy, and of the actuarial assumptions and methods used by the carrier in establishing premium rates for such contract or policy.

g. (1) Beginning January 1, 1995, a carrier desiring to increase or decrease premiums for any policy form or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19) subject to this act may implement such increase or decrease upon making an informational filing with the commissioner of such increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing such increase or decrease, provided that the anticipated minimum loss ratio for all policy forms shall not be less than 75% of the premium therefor as provided in paragraph (2) of this subsection. Until December 31, 1996, the informational filing shall also include the carrier's rating plan and classification system in connection with such increase or decrease.

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the 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 all of the standard policy forms and at least 75% of the aggregate premiums collected for all of the non-standard policy forms 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 all of the standard and non-standard policy forms for the previous calendar year. In each case where the loss ratio 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 the standard or nonstandard policy forms, as applicable, in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal 75% of the aggregate premiums collected for the respective policy forms 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 applicable to standard

and non-standard policy forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder.

(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).

12. Section 10 of P.L.1992, c.162 (C.17B:27A-26) is amended to read as follows:

C.17B:27A-26 Health maintenance organization coverage; exceptions.

10. a. No health maintenance organization shall be required to offer coverage or accept applications pursuant to section 3 of this act to a small employer if the small employer does not have eligible individuals who live, work, or reside in the service area for such plan, or if the health maintenance organization reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of such groups because of its obligations to existing group contract holders and enrollees. Upon denying health insurance coverage in any service area as a result of insufficient network capacity in accordance with this subsection, the health maintenance organization shall not offer coverage in the small employer market within such service area for a period of at least 180 days after the date the coverage is denied.

b. No small employer carrier shall be required to offer coverage or accept applications pursuant to this act for any period of time in which the commissioner determines that the requiring of the issuing of policies or contracts pursuant to this act would place the carrier in a financially impaired position.

c. A health maintenance organization which complies with the basic health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub.L.93-222 (42.U.S.C. s.300e et seq.), and which also provides the comprehensive health benefit plans coverage required by subsection f. of section 3 of P.L.1992, c.162 (C.17B:27A-19), shall be deemed in compliance with this act.

13. Section 17 of P.L.1992, c.162 (C.17B:27A-33) is amended to read as follows:

C.17B:27A-33 Formulation of five health benefits plans.

17. Subject to the approval of the commissioner, the board shall formulate the five health benefits plans to be made available by small employer carriers in accordance with the provisions of this act, and shall promulgate five standard forms pursuant thereto. The board may establish benefit levels, deductibles and co-payments, exclusions, and limitations for such health benefits plans in accordance with the law. The board shall ensure that the means exist for a carrier to offer high deductible health benefits plan options that are consistent with section 301 of Title III of the "Health Insurance Portability and Accountability Act of 1996," Pub.L. 104-191, regarding tax-deductible medical savings accounts.

The board shall submit the forms so established to the commissioner for approval. The commissioner shall approve the forms if the commissioner finds them to be consistent with the provisions of section 3 of P.L.1992, c. 162 (C.17B:27A-19). Any form submitted to the commissioner by the board shall be deemed approved if not expressly disapproved in writing within 60 days of its receipt by the commissioner. Such forms may contain, but shall not be limited to, the following provisions:

a. Utilization review of health care services, including review of medical necessity of hospital

and physician services;

b. Managed care systems, including large case management;

c. Provisions for selective contracting with hospitals, physicians, and other participating and nonparticipating providers;

d. Reasonable benefits differentials which are applicable to participating and nonparticipating providers;

e. Notwithstanding the provisions of section 4 of P.L.1992, c.162 (C.17B:27A-20) to the contrary, the board may, from time to time, adjust coinsurance and deductibles;

f. Such other provisions which may be quantifiably established to be cost containment devices;

g. The department shall publish annually a list of the premiums charged for each of the five small employer health benefits plans and for any rider package by all carriers writing such plans. The department shall also publish the toll free telephone number of each such carrier.

C.17B:27-54 Application of provisions; definitions.

14. The provisions of sections 14 through 27 of P.L.1997, c.146 (C.17B:27-54 through C.17B:27-67) shall apply to group health insurance coverage that is not subject to the provisions of P.L.1992, c.161 and c.162 (C.17B:27A-2 et seq. and 17B:27A-17 et seq.). To the extent that any provision of sections 14 through 27 of P.L.1997, c.146 (C.17B:27-54 through C.17B:27-67) is inconsistent with the provisions of chapter 27 of Title 17B of the New Jersey Statutes and P.L.1973, c.337 (C.26:2J-1 et seq.), the provisions of sections 14 through 27 shall supersede those laws.

As used in sections 14 through 27 of P.L.1997, c.146 (C.17B:27-54 through C.17B:27-67):

“Affiliation period” means a period which, under the terms of the group health plan offered by a health maintenance organization, begins on the enrollment date and which must expire before the health insurance becomes effective. The health maintenance organization shall not be required to provide health care services or benefits during such period and no premium shall be charged.

“Creditable coverage” means, with respect to an individual, coverage of the individual, other than coverage of excepted benefits, under any of the following: a group health plan; health insurance coverage; Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C.s.1395 et seq.); Title XIX of the federal Social Security Act (42 U.S.C.s.1396 et seq.); other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (42 U.S.C.s.1396s); chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); a medical care program of the Indian Health Service of a tribal organization; a State health benefits risk pool; a State health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. s.8901 et seq.); a public health plan; and a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C.s.2504(e)).

“Enrollment date” means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment.

“Excepted benefits” means:

a. coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers* compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified by federal regulation, under which benefits for medical care are secondary or incidental to other insurance benefits;

b. when provided under a separate policy, certificate or contract of insurance or otherwise not an integral part of the group health plan: limited scope dental or vision benefits, benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, and such other similar, limited benefits as are specified by federal regulation;

c. when offered as independent, noncoordinated benefits: hospital indemnity or other fixed indemnity insurance;

d. when offered as a separate insurance policy, certificate or contract of insurance: Medicare

supplemental insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C. s.1395ss(g)(1))and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C.s.1071 et seq.) and similar supplemental coverage provided in addition to coverage under a group health plan.

"Group health plan" means an employee welfare benefit plan, as defined in Title 1 of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974," (29 U.S.C. s.1002(1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise.

"Health insurance coverage" means benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care, under any hospital or medical expense policy or certificate or health maintenance organization contract offered by a health insurer.

"Health insurer" means an insurer licensed to sell health insurance pursuant to Title 17B of the New Jersey Statutes, a health, hospital or medical service corporation, fraternal benefit association or a health maintenance organization.

"Health status-related factor" means: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

"Health maintenance organization" means a federally qualified health maintenance organization as defined in the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.), an organization authorized under P.L.1973, c.337 (C.26:2J-1 et seq.), or a similar organization regulated under State law for solvency in the same manner and to the same extent as a health maintenance organization authorized to do business in this State.

"Late enrollee" means a participant or beneficiary who enrolls in a group health plan other than during: the first period during which the individual is eligible to enroll in the plan; or a special enrollment period.

"Medical care" means amounts paid: (1) for the diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and (2) transportation primarily for and essential to medical care referred to in (1) above.

"Network plan" means a group health plan offered by a health insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. Network plan includes a health maintenance organization or health insurance company with selective contracting arrangements.

"Preexisting condition" means with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.

"Waiting period" means with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

C.17B:27-55 Imposition of preexisting condition exclusion.

15. A health insurer may impose a preexisting condition exclusion in its group health plan only if:

a. the exclusion relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date of the participant or beneficiary;

b. the exclusion extends for a period of not more than 12 months, or 18 months for a late enrollee, after the enrollment date of the participant or beneficiary; and

c. the period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

C.17B:27-56 Incidents, certain, no imposition of preexisting condition exclusion.

16. A health insurer which offers a group health plan shall not impose a preexisting condition exclusion for the following: a. on a newborn child who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage; b. on a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage. These provisions shall not apply to a newborn child or child who is adopted or placed for adoption after the end of the first 63-day period, during all of which the newborn child or child who is adopted or placed for adoption was not covered under any creditable coverage; or c. pregnancy as a preexisting condition.

C.17B:27-57 Genetic information, not preexisting condition.

17. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

C.17B:27-58 Counting of period of creditable coverage.

18. A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage. Any period that an individual is in a waiting period for any coverage under a group health plan, or for group health insurance, or is in an affiliation period shall not be taken into account in determining whether the 63-day period is present.

C.17B:27-59 Application of creditable coverage.

19. Except as provided in this section, a health insurer which offers a group health plan shall count a period of creditable coverage without regard to the specific benefits covered during the period. A health insurer offering a group health plan may elect to apply creditable coverage based on coverage of each of several classes or categories of benefits as specified by federal regulation where such election is made or a uniform basis for all participants and beneficiaries and where under such election a health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category. A health insurer who makes the election with respect to group health plans offered in this State shall prominently state in any disclosure statement concerning the coverage and to each employer at the time of the offer or sale of the coverage, that the health insurer has made that election and shall include in the disclosure statements a description of the effect of the election.

A health insurer shall promptly disclose to a requesting plan or insurer and may charge a reasonable fee for information on, coverage of classes and categories of health benefits available under its coverage.

C.17B:27-60 Written certification of creditable coverage under COBRA.

20. a. A health insurer which offers a group health plan shall provide a written certification of creditable coverage at the time an individual ceases coverage or otherwise becomes covered under a COBRA continuation provision; at the time an individual ceases to be covered under a COBRA continuation provision; and upon request, on behalf of an individual not later than 24 months after the cessation of coverage under the plan or a COBRA continuation provision.

b. The written certification of creditable coverage shall include the period of creditable coverage of the individual under the group health plan and the coverage under any COBRA continuation provision and any waiting or affiliation period imposed with respect to the individual for coverage under the plan.

C.17B:27-61 Affiliation period imposed by HMO.

21. A health maintenance organization which offers a group health plan and which does not impose a preexisting condition exclusion, may impose an affiliation period if the period is applied uniformly without regard to any health status-related factors and the period does not exceed two

months, or three months in the case of a late enrollee.

C.17B:27-62 Permission to enroll for group coverage.

22. A health insurer which offers a group health plan shall permit an employee or dependent who is eligible, but not enrolled, for coverage under the terms of the plan, to enroll for coverage if:

a. the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent, and the employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, if the health insurer required such a statement at that time and notified the employee of the insurer*s requirements;

b. the employee*s or dependent*s other coverage described in subsection a. of this section was under a COBRA continuation provision and coverage under that provision was exhausted or the coverage was terminated due to loss of eligibility for coverage, including legal separation, divorce, death, termination of employment and reduction in hours of employment, or to the termination of employer contributions toward that coverage; and

c. the employee requests enrollment not later than 30 days after exhaustion of coverage under a COBRA continuation provision or termination of coverage pursuant to subsection b. of this section.

C.17B:27-63 Dependent special enrollment period.

23. If a group health plan makes coverage available with respect to a dependent of an individual who is a participant under the plan or has satisfied any waiting period and is eligible to be enrolled, and the dependent becomes a dependent of the individual through marriage, birth, adoption or placement for adoption, the group health plan shall provide for a dependent special enrollment period during which the dependent and individual, if necessary, may be enrolled.

The dependent special enrollment period shall be for a period of not less than 30 days and shall begin on the later of the date dependent coverage is made available or the date of marriage, birth, adoption or placement for adoption. If an individual enrolls a dependent during the first 30 days of the dependent special enrollment period, the coverage of the dependent shall become effective: in the case of a marriage, no later than the first day of the first month after the date the completed request for enrollment is received; in the case of a dependent*s birth, as of the date of birth; and in the case of a dependent*s adoption or placement for adoption, the date of the adoption or placement for adoption.

C.17B:27-64 Rules for eligibility, health status-related factors prohibited.

24. A health insurer which offers a group health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on health status-related factors in relation to the individual or a dependent of the individual.

The provisions of this section shall not be construed to require a group health plan to provide particular benefits other than those provided under the terms of its coverage or to prevent the coverage from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the coverage.

C.17B:27-65 Premiums, contributions regulated.

25. A health insurer which offers a group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution which is greater than the premium or contribution for a similarly situated enrollee in the plan on the basis of any health status-related factor in relation to the individual or to an enrollee or a dependent of the individual or enrollee. This provision shall not be construed to restrict the amount that an employer may be charged for coverage under a group health plan or to prevent a health insurer offering group health insurance coverage from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

C.17B:27-66 Renewal of coverage; exceptions.

26. A health insurer which offers health insurance coverage in connection with a group health plan shall renew the coverage under the plan at the option of the policy holder, except that:

a. A health insurer may discontinue the coverage only if:

(1) the policy holder has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the insurer has not received timely premium payments;

(2) the policy holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the health insurance coverage; and

(3) in the case of a health insurer which offers a group health plan through a network plan, there is no longer any enrollee in the plan who lives, resides or works in the service area of the insurer or in the area for which the insurer is authorized to do business; or

b. A health insurer may not renew the health insurance coverage only if:

(1) the policy holder has failed to comply with a material plan provision relating to employer contribution or group participation rules; or

(2) the insurer is ceasing to offer coverage in the market in accordance with State and federal law.

c. A health insurer may cease offering and not renew a particular type of health insurance coverage only if:

(1) the insurer provides notice to each certificate or policy holder who is provided coverage of this type, and to participants and beneficiaries covered under the coverage of the nonrenewal at least 90 days prior to the date of the nonrenewal of the coverage;

(2) the insurer offers the option to purchase all or any other health insurance coverage that the insurer offers; and

(3) in exercising the option to not renew coverage of a particular type and in offering the option to purchase all or any other health insurance coverage that the insurer offers, the insurer acts uniformly without regard to the claims experience of the certificate or policy holder or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

d. A health insurer may cease offering and not renew all health insurance coverage only if:

(1) the insurer provides notice to the Department of Banking and Insurance and each employer and participants and beneficiaries covered under the health insurance coverage, of the nonrenewal at least 180 days prior to the date of the nonrenewal;

(2) the insurer ceases offering all health insurance coverage issued or delivered for issuance in the State for groups under the provisions of sections 14 through 27 of P.L.1997, c.146 (C.17B:27-54 through C.17B:27-67) and coverage under the health insurance coverage is not renewed; and

(3) the insurer may not provide for the issuance of any health insurance coverage for groups in this State under the provisions of sections 14 through 27 of P.L.1997, c.146 (C.17B:27-54 through C.17B:27-67), during a five-year period beginning on the termination date of the last health insurance coverage that was not renewed.

C.17B:27-67 Modification of coverage.

27. At the time of coverage renewal, a health insurer may modify the health insurance coverage for a product offered to a group health plan.

Repealer.

28. Section 6 of P.L.1995, c.340 (C.17B:27A-23.1) is repealed.

29. This act shall take effect July 1, 1997.

Approved June 30, 1997.