SENATE, No. 2192

STATE OF NEW JERSEY

INTRODUCED JUNE 5, 1997

By Senator SINAGRA

AN ACT concerning individual and small employer 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:

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**]** 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 and 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 section 3(33) of the Employee Retirement Income Security Act of 1974.

"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 coverage of the individual under any of the following: (1) a group health plan as defined herein; (2) health benefits plan as defined herein; (3) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.); (4) Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.), other than coverage

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

Matter underlined thus is new matter.

consisting solely of benefits under section 1928; (5) Chapter 55 of Title 10, United States Code (10 U.S.C. §1071 et seq.); (6) a medical care program of the Indian Health Service or of a tribal organization; (7) a State health benefits risk pool; (8) a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §8901 et seq.); (9) a public health plan as defined by federal regulation; (10) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. §2504(e)).

Creditable coverage shall not include coverage consisting solely of the following: (1) coverage only for accident, or disability income insurance, or any combination thereof; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers' compensation or similar insurance; (5) automobile medical payment insurance; (6) credit only insurance; (7) coverage for on-site medical clinics; (8) coverage, specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; (9) 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 **[**of the State**]** who is not eligible to be **[**insured**]** covered under a group health **[**insurance policy**]** benefits plan, group health plan, governmental plan, church plan, or **[**Medicare**]** Part A or Part B of Title XVIII of the Social Security Act.

"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, a 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, or a State plan under title XIX of such Act or any successor program, and who does not have other 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 COBRA continuation provision or under a similar State program, elected that coverage; and (6) who has exhausted that continuation coverage under that provision or program, if the individual elected the continuation coverage described in (5) above.

"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 section 3(32) of the Employee Retirement Income Security Act of 1974 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 section 3(1) of the Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care, as defined herein, 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; **[**or**]** 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**[**does not include the following plans, policies, or contracts: accident only, credit, disability, long-term care, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity coverage**]** 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; policies or certificates of hospital confinement indemnity coverage, as defined by the board; and other similar insurance coverage, 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 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 Social Security Act; and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §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: (1) health status; (2) medical condition, including both physical and mental illness; (3) claims experience; (4) receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability, including conditions arising out of acts of domestic violence; and (8) 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 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**]** is an employee welfare benefit plan, to the extent the Employee Retirement Income Security Act of 1974 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 for: (1) the diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (2)

transportation primarily for and essential to medical care referred to in paragraph (1); and (3) coverage for medical care referred to in paragraphs (1) and (2).

"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 **[**or HealthStart Plus**]** 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. §§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.

"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 section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"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.

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

2. 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**]** 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 meaning given that term under section 3(33) of the Employee Retirement Income Security Act of 1974.

"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 Social Security Act (42 U.S.C. §1395 et seq.); Title XIX of the Social Security Act(42 U.S.C. §1396 et seq.), other than coverage consisting solely of benefits under section 1928; 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. §8901 et seq.); a public health plan as defined in federal regulations; a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. §2504(e)); or coverage under any other type of plan as set forth by the commissioner by regulation.

For purposes of this act, creditable coverage shall not include the following policies, contracts or arrangements, whether issued on an individual or group basis: 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.).

"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 section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

"Group health plan" means an employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 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 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, 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.**]** 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; policies or certificates of hospital confinement indemnity; and other similar insurance coverage, 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 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 Social Security Act; and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (20 U.S.C. §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: (1) health status; (2) medical condition, including both physical and mental illness; (3) claims experience; (4) receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability, including conditions arising out of acts of domestic violence; and (8) 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 for: (1) the diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (2) transportation primarily for and essential to medical care referred to in (1) above; and (3) insurance covering medical care referred to in (1) and (2) 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 section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

["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.**]**

"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. 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).

["Qualifying previous coverage" means benefits or coverage

provided under:

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

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

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

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

"Small employer" means **[**any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer. Subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of this act, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this act which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer. For the purposes of P.L.1992, c.162 (C.17B:27A-17 et seq.), a State, county or municipal body, agency, board or department shall not be considered a small employer**]** , 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 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 which 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 $25,000 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.

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

3. Section 17 of P.L1992, c.162 (C.17B:27A-33) is amended to read as follows.

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 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 **[**his**]** approval . The commissioner shall approve the forms if **[**he**]** 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 **[**health care**]** participating and nonparticipating providers;

d. Reasonable benefit 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.

(cf: P.L.1993, c.162, s.8)

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

STATEMENT

This bill makes various changes to the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program as well as changes affecting the large group health coverage markets. The vast majority of the amendments contained herein are provisions necessary to bring New Jersey state law into compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub.L.104-191, a federal law designed to provide for improved access, portability, and renewability of health

benefits coverage.

While New Jersey has already taken significant steps to address access, portability, and renewability of coverage in its individual and small employer health benefits markets, there are provisions in HIPAA which go further than New Jersey law and would have a preemptive effect on State law. This bill is intended to avoid federal preemption by modifying State law consistent with HIPAA.

With respect to changes to the Individual Health Benefits ("IHC") Program and the Small Employer Health Benefits ("SEH") Program, this bill adds and modifies definitions to conform with those terms as used under federal law. The bill also identifies a "federally defined eligible individual" who must be issued individual coverage with no applicable preexisting conditions limitations. Hospital and medical service corporations have been incorporated into the definition of "carrier" in the individual market and are made subject to the major features of reform in that market not including the loss assessment. The bill also more closely resembles the language of the federal law with respect to guaranteed issuance, guaranteed renewability and their exceptions.

Revises the individual and small employer health benefits programs.