

[Passed Both Houses]

[Second Reprint]

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2192

STATE OF NEW JERSEY

ADOPTED JUNE 12, 1997

Sponsored by Senator SINAGRA,
Assemblymen Felice and Cohen

1 AN ACT concerning individual, small employer and large group health
2 insurance and revising various parts of the statutory law.

3

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

6

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

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

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

11 "Carrier" means [an insurance company, health service
12 corporation, or health maintenance organization authorized to issue
13 health benefits plans in this State] any entity subject to the insurance
14 laws and regulations of this State, or subject to the jurisdiction of the
15 commissioner, that contracts or offers to contract to provide, deliver,
16 arrange for, pay for, or reimburse any of the costs of health care
17 services, including a sickness and accident insurance company, a health
18 maintenance organization, a nonprofit hospital or health service
19 corporation, or any other entity providing a plan of health insurance,
20 health benefits or health services. For purposes of this act, carriers
21 that are affiliated companies shall be treated as one carrier.

22 "Church plan" has the same meaning given that term under Title I,
23 section 3 of Pub.L.93-406, the "Employee Retirement Income Security

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate floor amendments adopted June 19, 1997.

² Assembly floor amendments adopted June 26, 1997.

1 Act of 1974" (29 U.S.C. §1002(33)).

2 "Commissioner" means the Commissioner of Banking and
3 Insurance.

4 "Community rating" means a rating system in which the premium
5 for all persons covered by a contract is the same, based on the
6 experience of all persons covered by that contract, without regard to
7 age, sex, health status, occupation and geographical location.

8 "Creditable coverage" means, with respect to an individual,
9 coverage of the individual under any of the following: a group health
10 plan; a group or individual health benefits plan; Part A or Part B of
11 Title XVIII of the federal Social Security Act (42 U.S.C. §1395 et
12 seq.); Title XIX of the federal Social Security Act (42 U.S.C. §1396
13 et seq.), other than coverage consisting solely of benefits under section
14 1928 of Title XIX of the federal Social Security Act (42
15 U.S.C. §1396s); Chapter 55 of Title 10, United States Code (10 U.S.C.
16 §1071 et seq.); a medical care program of the Indian Health Service or
17 of a tribal organization; a State health plan offered under chapter 89
18 of Title 5, United States Code (5 U.S.C. §8901 et seq.); a public
19 health plan as defined by federal regulation; and a health benefits plan
20 under section 5(e) of the "Peace Corps Act" (22 U.S.C. §2504(e)); or
21 coverage under any other type of plan as set forth by the commissioner
22 by regulation.

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

34 "Department" means the Department of Banking and Insurance.

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

37 "Eligible person" means a person who is a resident [of the State]
38 who is not eligible to be [insured] covered under a group health
39 [insurance policy] benefits plan, group health plan, governmental plan,
40 church plan, or [Medicare] Part A or Part B of Title XVIII of the
41 Social Security Act (42 U.S.C. §1395 et seq.).

42 "Federally defined eligible individual" means an eligible person: (1)
43 for whom, as of the date on which the individual seeks coverage under
44 P.L. 1992, c. 161 (C.17B:27A-2 et seq.), the aggregate of the periods
45 of creditable coverage is 18 or more months; (2) whose most recent
46 prior creditable coverage was under a group health plan, governmental

1 plan, church plan, or health insurance coverage offered in connection
2 with any such plan; (3) who is not eligible for coverage under a group
3 health plan, Part A or Part B of Title XVIII of the Social Security Act
4 (42 U.S.C.§1395 et seq.), or a State plan under Title XIX of the
5 Social Security Act (42 U.S.C.§1396 et seq.) or any successor
6 program, and who does not have another health benefits plan, or
7 hospital or medical service plan; (4) with respect to whom the most
8 recent coverage within the period of aggregate creditable coverage
9 was not terminated based on a factor relating to nonpayment of
10 premiums or fraud; (5) who, if offered the option of continuation
11 coverage under the COBRA continuation provision or a similar State
12 program, elected that coverage; and (6) who has elected continuation
13 coverage described in (5) above and has exhausted that continuation
14 coverage.

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

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

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

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

34 "Health benefits plan" means a hospital and medical expense
35 insurance policy; health service corporation contract; [or] hospital
36 service corporation contract; medical service corporation contract;
37 health maintenance organization subscriber contract; or other plan for
38 medical care delivered or issued for delivery in this State. For
39 purposes of this act, health benefits plan [does not include the
40 following plans, policies, or contracts: accident only, credit, disability,
41 long-term care, Medicare supplement coverage, CHAMPUS
42 supplement coverage, coverage for Medicare services pursuant to a
43 contract with the United States government, coverage for Medicaid
44 services pursuant to a contract with the State, coverage arising out of
45 a workers' compensation or similar law, automobile medical payment
46 insurance, personal injury protection insurance issued pursuant to

1 P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity
2 coverage] shall not include one or more, or any combination of, the
3 following: coverage only for accident, or disability income insurance,
4 or any combination thereof; coverage issued as a supplement to
5 liability insurance; liability insurance, including general liability
6 insurance and automobile liability insurance; stop loss or excess risk
7 insurance; workers' compensation or similar insurance; automobile
8 medical payment insurance; credit-only insurance; coverage for on-site
9 medical clinics; and other similar insurance coverage, as specified in
10 federal regulations, under which benefits for medical care are
11 secondary or incidental to other insurance benefits. Health benefits
12 plans shall not include the following benefits if they are provided under
13 a separate policy, certificate or contract of insurance or are otherwise
14 not an integral part of the plan: limited scope dental or vision benefits;
15 benefits for long-term care, nursing home care, home health care,
16 community-based care, or any combination thereof; and such other
17 similar, limited benefits as are specified in federal regulations. Health
18 benefits plan shall not include hospital confinement indemnity coverage
19 if the benefits are provided under a separate policy, certificate or
20 contract of insurance, there is no coordination between the provision
21 of the benefits and any exclusion of benefits under any group health
22 benefits plan maintained by the same plan sponsor, and those benefits
23 are paid with respect to an event without regard to whether benefits
24 are provided with respect to such an event under any group health plan
25 maintained by the same plan sponsor. Health benefits plan shall not
26 include the following if it is offered as a separate policy, certificate or
27 contract of insurance: Medicare supplemental health insurance as
28 defined under section 1882(g)(1) of the federal Social Security Act (42
29 U.S.C.§1395ss(g)(1)); and coverage supplemental to the coverage
30 provided under chapter 55 of Title 10, United States Code (10 U.S.C.
31 §1071 et seq.); and similar supplemental coverage provided to
32 coverage under a group health plan.

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

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

46 Individual health benefits plan shall not include a certificate issued

1 under a policy or contract issued to a trust, or to the trustees of a
2 fund, which trust or fund [is established or adopted by two or more
3 employers, by one or more labor unions or similar employee
4 organizations, or by one or more employers and one or more labor
5 unions or similar employee organizations, to insure employees of the
6 employers or members of the unions or organizations] is an employee
7 welfare benefit plan, to the extent the "Employee Retirement Income
8 Security Act of 1974" (29 U.S.C. §1001 et seq.) preempts the
9 application of P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

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

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

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

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

43 "Open enrollment" means the offering of an individual health
44 benefits plan to any eligible person on a guaranteed issue basis,
45 pursuant to procedures established by the board.

46 "Plan of operation" means the plan of operation of the program

1 adopted by the board pursuant to this act.

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

5 "Preexisting condition" means a condition that, during a specified
6 period of not more than six months immediately preceding the
7 effective date of coverage, had manifested itself in such a manner as
8 would cause an ordinarily prudent person to seek medical advice,
9 diagnosis, care or treatment, or for which medical advice, diagnosis,
10 care or treatment was recommended or received as to that condition
11 or as to a pregnancy existing on the effective date of coverage.

12 "Program" means the New Jersey Individual Health Coverage
13 Program established pursuant to this act.

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

20 "Two-year calculation period" means a two calendar year period,
21 the first of which shall begin January 1, 1997 and end December 31,
22 1998.

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

24

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

27 2. a. An individual health benefits plan issued on or after [the
28 effective date of this act] August 1, 1993 shall be subject to the
29 provisions of this act.

30 b. (1) An individual health benefits plan issued on an open
31 enrollment, modified community rated basis or community rated basis
32 prior to [the effective date of this act] August 1, 1993 shall not be
33 subject to sections 3 through 8, inclusive, of this act, unless otherwise
34 specified therein.

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

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

44 (4) Notwithstanding any other provision of law to the contrary, an
45 individual health benefits plan issued by a hospital service corporation
46 or medical service corporation prior to the effective date of P.L. . . .

1 c. , (pending before the Legislature as this bill) shall not be subject
2 to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except
3 that the plan shall guarantee renewal pursuant to subsection b. of
4 section 5 of P.L.1992, c.161 (C.17B:27A-6).

5 (5) Notwithstanding any other provision of law to the contrary, an
6 individual health benefits plan issued by a hospital service corporation
7 or medical service corporation to an eligible person or federally
8 defined eligible individual after the effective date of P.L. , c. ,
9 (pending before the Legislature as this bill) shall comply with the
10 provisions subsections c. and d. of section 2, subsection b. of section
11 3, section 5, subsection b. of section 6, and subsections c., d., and e.
12 of section 8 of P.L.1992, c.161 (C.17B:27A-3, C.17B:27A-4,
13 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall not be subject to
14 the remaining provisions of P.L.1992, c. 161.

15 c. After [the effective date of this act] August 1, 1993, an
16 individual who is eligible to participate in a group health benefits plan
17 that provides coverage for hospital or medical expenses shall not be
18 covered by an individual health benefits plan which provides benefits
19 for hospital and medical expenses that are the same or similar to
20 coverage provided in the group health benefits plan, except that an
21 individual who is eligible to participate in a group health benefits plan
22 but is currently covered by an individual health benefits plan may
23 continue to be covered by that plan until the first anniversary date of
24 the group health benefits plan occurring on or after January 1, 1994.

25 d. Except as otherwise provided in subsection c. of this section,
26 after [the effective date of this act] August 1, 1993, a person who is
27 covered by an individual health benefits plan who is a participant in, or
28 is eligible to participate in, a group health benefits plan that provides
29 the same or similar coverages as the individual health benefits plan,
30 and a person, including an employer or insurance producer, who
31 causes another person to be covered by an individual health benefits
32 plan which person is a participant in, or who is eligible to participate
33 in a group health benefits plan that provides the same or similar
34 coverages as the individual health benefits plan, shall be subject to a
35 fine by the commissioner in an amount not less than twice the annual
36 premium paid for the individual health benefits plan, together with any
37 other penalties permitted by law.

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

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

46 (2) During the period July 1, 1994 to June 30, 1995, the premium

1 rate charged by a carrier to the highest rated individual who purchased
2 an individual health benefits plan prior to the effective date of this act
3 shall not be greater than 125% of the premium rate charged to the
4 lowest rated individual purchasing that same or a similar
5 healthbenefits plan.

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

9 (4) A carrier that issues an individual health benefits plan with
10 modified community rating subject to the provisions of this subsection
11 shall make an informational filing with the board whenever it adjusts
12 or modifies its rates.] ~~(Deleted by amendment, P.L. _____, c. _____~~
13 (cf: P.L.1993, c.164, s.2)

14
15 3. Section 5 of P.L.1992, c.161 (C.17B:27A-6) is amended to read
16 as follows:

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

19 a. The health benefits plan shall guarantee coverage for an eligible
20 person and his dependents on a community rated basis.

21 b. A health benefits plan shall be renewable with respect to an
22 eligible person and his dependents at the option of the policy or
23 contract holder [except] . A carrier may terminate a health benefits
24 plan under the following circumstances:

25 (1) [nonpayment of the required premiums by] the policy or
26 contract holder has failed to pay premiums in accordance with the
27 terms of the policy or contract or the carrier has not received timely
28 premium payments;

29 (2) [fraud or misrepresentation by] the policy or contract holder [,
30 including equitable fraud, with respect to coverage of eligible
31 individuals or their dependents] has performed an act or practice that
32 constitutes fraud or made an intentional misrepresentation of material
33 fact under the terms of the coverage;

34 c. A carrier may nonrenew a health benefits plan only under the
35 following circumstances:

36 [(3)] (1) termination of eligibility of the policy or contract holder
37 if the person is no longer a resident or becomes eligible for a group
38 health benefits plan, group health plan, governmental plan or church
39 plan; [or

40 (4)] (2) cancellation or amendment by the board of the specific
41 individual health benefits plan;

42 (3) board approval of a request by the individual carrier to
43 nonrenew a particular type of health benefits plan, in accordance with
44 rules adopted by the board. After receiving board approval, a carrier
45 may nonrenew a type of health benefits plan only if the carrier: (a)
46 provides notice to each covered individual provided coverage of this

1 type of the nonrenewal at least 90 days prior to the date of the
2 nonrenewal of the coverage; (b) offers to each individual provided
3 coverage of this type the option to purchase any other individual
4 health benefits plan currently being offered by the carrier; and (c) in
5 exercising the option to nonrenew coverage of this type and in offering
6 coverage as required under (b) above, the carrier acts uniformly
7 without regard to any health status-related factor of enrolled
8 individuals or individuals who may become eligible for coverage;

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

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

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

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

30 6. The board shall establish the policy and contract forms and
31 benefit levels to be made available by all carriers for the [policies]
32 health benefits plans required to be issued pursuant to section 3 of
33 P.L.1992, c.161 (C.17B:27A-4). The board shall provide the
34 commissioner with an informational filing of the policy and contract
35 forms and benefit levels it establishes.

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

44 b. An individual health benefits plan offered pursuant to section 3
45 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
46 more than 12 months on coverage for preexisting conditions[, except

1 that the limitation shall not apply] . An individual health benefits plan
2 offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall
3 not contain a preexisting condition limitation of any period under the
4 following circumstances:

5 (1) to an individual who has, under [a prior group or individual
6 health benefits plan or Medicaid]creditable coverage, with no
7 intervening lapse in coverage of more than [30] 31 days, been treated
8 or diagnosed by a physician for a condition under that plan or satisfied
9 a 12-month preexisting condition limitation; or

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

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

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

28 e. Effective immediately for an individual health benefits plan
29 issued on or after the effective date of P.L.1995, c.316
30 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary
31 date of an individual health benefits plan in effect on the effective date
32 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health
33 benefits plans required pursuant to section 3 of P.L.1992, c.161
34 (C.17B:27A-4), including any plan offered by a federally qualified
35 health maintenance organization, shall contain benefits for expenses
36 incurred in the following:

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

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

1 to childhood immunizations and any related changes in premium. Such
2 notification shall be in a form and manner to be determined by the
3 Commissioner of Insurance.

4 The benefits shall be provided to the same extent as for any other
5 medical condition under the health benefits plan, except that no
6 deductible shall be applied for benefits provided pursuant to this
7 section. This section shall apply to all individual health benefits plans
8 in which the carrier has reserved the right to change the premium.
9 (cf: P.L.1995, c.316, s.5)

10
11 5. Section 7 of P.L.1992 c.161 (C.17B:27A-8) is amended to read
12 as follows:

13 7. a. A health maintenance organization shall not be required to
14 offer coverage to or accept an applicant pursuant to this act if [the
15 applicant is not geographically located in the health maintenance
16 organization's approved service area or if the health maintenance
17 organization does not have the capacity in its facilities to enroll
18 additional members; except that, if]:

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

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

34 b. A carrier shall not be required to offer coverage or accept
35 applications pursuant to this act if the commissioner [finds that the
36 acceptance of applications would place the carrier in a financially
37 impaired condition] determines that the carrier does not have the
38 financial reserves necessary to underwrite additional coverage. Upon
39 denying individual health benefits coverage pursuant to this subsection,
40 a carrier may not offer such coverage in the individual market for a
41 period of 180 days after the date the coverage is denied or until the
42 carrier has demonstrated to the commissioner that the carrier has
43 sufficient financial reserves to underwrite additional coverage.

1 whichever is later.

2 (cf: P.L.1992, c.161, s.7)

3

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

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

9 a. (1) By March 1, [1993] 1999, and following the close of each
10 [calendar year]two-year calculation period thereafter, or on a different
11 date established by the board:

12 (a) every carrier issuing health benefits plans in this State shall file
13 with the board its net earned premium for the preceding [calendar year
14 ending December 31] two-year calculation period; and

15 (b) every carrier issuing individual health benefits plans in the State
16 shall file with the board the net earned premium on [policies or
17 contracts] health benefits plans issued pursuant to paragraph (1) of
18 subsection b. of section 2 and section 3 of this act and the claims paid
19 [and the administrative expenses attributable to those policies or
20 contracts]. If the claims paid [and reasonable administrative expenses
21 for that calendar year] for all health benefits plans during the two-year
22 calculation period exceed 115% of the net earned premium and any
23 investment income thereon for the two-year calculation period, the
24 amount of the excess shall be the net paid loss for the carrier that shall
25 be reimbursable under this act. [For the purposes of this subsection,
26 "reasonable administrative expenses" shall be actual expenses or a
27 maximum of 25% of premium, whichever amount is less.]

28 (2) Every member shall be liable for an assessment to reimburse
29 carriers issuing individual health benefits plans in this State which
30 sustain net paid losses [for the previous year] during the two-year
31 calculation period, unless the member has received an exemption from
32 the board pursuant to subsection d. of this section and has written a
33 minimum number of non-group [persons] person life years as provided
34 for in that subsection. The assessment of each member shall be in the
35 proportion that the net earned premium of the member for the
36 [calendar year] two-year calculation period preceding the assessment
37 bears to the net earned premium of all members for the [calendar year]
38 two-year calculation period preceding the assessment.
39 Notwithstanding the provisions of this subsection to the contrary, a
40 medical service corporation or a hospital service corporation shall not
41 be liable for an assessment to reimburse carriers which sustain net paid
42 losses.

43 (3) A member that is financially impaired may seek from the
44 commissioner a deferment in whole or in part from any assessment
45 issued by the board. The commissioner may defer, in whole or in part,
46 the assessment of the member if, in the opinion of the commissioner,

1 the payment of the assessment would endanger the ability of the
2 member to fulfill its contractual obligations. If an assessment against
3 a member is deferred in whole or in part, the amount by which the
4 assessment is deferred may be assessed against the other members in
5 a manner consistent with the basis for assessment set forth in this
6 section. The member receiving the deferment shall remain liable to the
7 program for the amount deferred.

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

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

19 d. (1) Notwithstanding the provisions of this act to the contrary,
20 a carrier may apply to the board, by a date established by the board,
21 for an exemption from the assessment and reimbursement for losses
22 provided for in this section. A carrier which applies for an exemption
23 shall agree to [enroll or insure] cover a minimum number of non-group
24 [persons] person life years on an open enrollment community rated
25 basis, under a managed care or indemnity plan, as specified in this
26 subsection, provided that any indemnity plan so issued conforms with
27 sections 2 through 7, inclusive, of [this act] P.L.1992, c.161
28 (C.17B:27A-3 through 17B:27A-8). For the purposes of this
29 subsection, non-group persons include individually enrolled persons,
30 conversion policies issued pursuant to this act, Medicare cost and risk
31 lives and Medicaid [and HealthStart Plus] recipients; except that in
32 determining whether the carrier meets the minimum number of
33 non-group [persons] person life years required to be covered pursuant
34 to this subsection, the number of Medicaid recipients and Medicare
35 cost and risk lives shall not exceed 50% of the total. Pursuant to
36 regulations adopted by the board, the carrier shall determine the
37 number of non-group person life years it has covered by adding the
38 number of non-group persons covered on the last day of each calendar
39 quarter of the two-year calculation period, taking into account the
40 limitations on counting Medicaid recipients and Medicare cost and risk
41 lives, and dividing the total by eight.

42 (2) Notwithstanding the provisions of paragraph (1) of this
43 subsection to the contrary, a health maintenance organization qualified
44 pursuant to the "Health Maintenance Organization Act of 1973,"
45 Pub.L 93-222 (42 U.S.C. §300e et seq.) and tax exempt pursuant to
46 paragraph (3) of subsection (c) of section 501 of the federal Internal

1 Revenue Code of 1986, 26 U.S.C. §501, may include up to one third
2 Medicaid recipients and up to one third Medicare recipients in
3 determining whether it meets its minimum number of non-group
4 person life years.

5 (3) The minimum number of non-group [persons] person life years
6 required to be covered, as determined by the board, shall equal the
7 total number of non-group person life years of community rated [and
8 modified community rated], individually enrolled or insured persons,
9 including Medicare cost and risk lives and enrolled Medicaid [and
10 HealthStart Plus] lives, of all carriers subject to this act [as of the end
11 of the calendar year] for the two-year calculation period, multiplied by
12 the proportion that that carrier's net earned premium bears to the net
13 earned premium of all carriers for that [calendar year] two-year
14 calculation period, including those carriers that are exempt from the
15 assessment.

16 (4) [Within 180 days after the effective date of this act and on] On
17 or before March 1 of [each] the first year [thereafter] of each two-
18 year calculation period, every carrier seeking an exemption pursuant
19 to this subsection shall file with the board a statement of its net earned
20 premium for the [preceding calendar year] two-year calculation
21 period. The board shall determine each carrier's minimum number of
22 non-group [persons] person life years in accordance with this
23 subsection.

24 (5) On or before March 1 of each year immediately following the
25 close of a two-year calculation period, every carrier that was granted
26 an exemption for the preceding [calendar year] two-year calculation
27 period shall file with the board the number of non-group [persons]
28 person life years, by category, [enrolled or insured as of December 31
29 of] covered for the [preceding calendar year] two-year calculation
30 period.

31 To the extent that the carrier has failed to [enroll] cover the
32 minimum number of non-group [persons] person life years established
33 by the board, the carrier shall be assessed by the board on a pro rata
34 basis for any differential between the minimum number established by
35 the board and the actual number [enrolled or insured] covered by the
36 carrier.

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

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

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

43 (c) by the end of calendar year 1995,] it has [enrolled or insured]
44 covered 100% of the minimum number of non-group [persons] person
45 life years required.

46 (7) Any carrier that writes both managed care and indemnity

1 business that is granted an exemption pursuant to this subsection may
2 satisfy its obligation to [write] cover a minimum number of non-group
3 [persons] person life years by [writing] issuing either managed care or
4 indemnity business, or both.

5 e. [Notwithstanding the provisions of this section to the contrary,
6 no carrier shall be liable for an assessment to reimburse any carrier
7 pursuant to this section in an amount which exceeds 35% of the
8 aggregate net paid losses of all carriers filing pursuant to paragraph (1)
9 of subsection a. of this section. To the extent that this limitation
10 results in any unreimbursed paid losses to any carrier, the
11 unreimbursed net paid losses shall be distributed among carriers: (1)
12 which owe assessments pursuant to paragraph (2) of subsection a. of
13 this section; (2) whose assessments do not exceed 35% of the
14 aggregate net paid losses of all carriers; and (3) who have not received
15 an exemption pursuant to subsection d. of this section. For the
16 purposes of paragraph (3) of this subsection, a carrier shall be deemed
17 to have received an exemption notwithstanding the fact that the carrier
18 failed to enroll or insure the minimum number of non-group persons
19 required for that calendar year.] (Deleted by amendment, P.L. ____,
20 c.)(pending before the Legislature as this bill)
21 (cf: P.L.1992,c.161,s.11)
22

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

25 1. As used in this act:

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

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

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

41 "Carrier" means [any insurance company, health service
42 corporation, hospital service corporation, medical service corporation
43 or health maintenance organization authorized to issue health benefits
44 plans in this State] any entity subject to the insurance laws and
45 regulations of this State, or subject to the jurisdiction of the
46 commissioner, that contracts or offers to contract to provide, deliver,

1 arrange for, pay for, or reimburse any of the costs of health care
2 services, including an insurance company authorized to issue health
3 insurance, a health maintenance organization, a hospital service
4 corporation, medical service corporation and health service
5 corporation, or any other entity providing a plan of health insurance,
6 health benefits or health services. The term "carrier" shall not include
7 a joint insurance fund established pursuant to State law. For purposes
8 of this act, carriers that are affiliated companies shall be treated as one
9 carrier, except that any insurance company, health service corporation,
10 hospital service corporation, or medical service corporation that is an
11 affiliate of a health maintenance organization located in New Jersey or
12 any health maintenance organization located in New Jersey that is
13 affiliated with an insurance company, health service corporation,
14 hospital service corporation, or medical service corporation shall treat
15 the health maintenance organization as a separate carrier.

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

19 "Commissioner" means the Commissioner of Banking and
20 Insurance.

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

27 "Creditable coverage" means, with respect to an individual,
28 coverage of the individual under any of the following: a group health
29 plan; a group or individual health benefits plan; Part A or part B of
30 Title XVIII of the federal Social Security Act (42 U.S.C. §1395 et
31 seq.); Title XIX of the federal Social Security Act (42 U.S.C. §1396
32 et seq.), other than coverage consisting solely of benefits under section
33 1928 of Title XIX of the federal Social Security Act (42
34 U.S.C. §1396s); chapter 55 of Title 10, United States Code (10 U.S.C.
35 §1071 et seq.); a medical care program of the Indian Health Service or
36 of a tribal organization; a state health plan offered under chapter 89 of
37 Title 5, United States Code (5 U.S.C. §8901 et seq.); a public health
38 plan as defined by federal regulation; a health benefits plan under
39 section 5(e) of the "Peace Corps Act" (22 U.S.C. §2504(e)); or
40 coverage under any other type of plan as set forth by the commissioner
41 by regulation.

42 Creditable coverage shall not include coverage consisting solely of
43 the following: coverage only for accident or disability income
44 insurance, or any combination thereof; coverage issued as a
45 supplement to liability insurance; liability insurance, including general
46 liability insurance and automobile liability insurance; workers'

1 compensation or similar insurance; automobile medical payment
2 insurance; credit only insurance; coverage for on-site medical clinics;
3 coverage, as specified in federal regulation, under which benefits for
4 medical care are secondary or incidental to the insurance benefits; and
5 other coverage expressly excluded from the definition of health
6 benefits plan.

7 "Department" means the Department of Banking and Insurance.

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

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

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

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

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

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

41 "Health benefits plan" means any hospital and medical expense
42 insurance policy or certificate; health, hospital, or medical service
43 corporation contract or certificate; or health maintenance organization
44 subscriber contract or certificate delivered or issued for delivery in this
45 State by any carrier to a small employer group pursuant to section 3
46 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health

1 benefits plan" [excludes the following plans, policies, or contracts:
2 accident only, credit, disability, long-term care, coverage for Medicare
3 services pursuant to a contract with the United States government,
4 Medicare supplement, dental only, prescription only or vision only,
5 insurance issued as a supplement to liability insurance, coverage
6 arising out of a workers' compensation or similar law, hospital
7 confinement or other supplemental limited benefit insurance coverage,
8 automobile medical payment insurance, personal injury protection
9 coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.)and
10 stop loss or excess risk insurance.] shall not include one or more, or
11 any combination of, the following: coverage only for accident or
12 disability income insurance, or any combination thereof; coverage
13 issued as a supplement to liability insurance; liability insurance,
14 including general liability insurance and automobile liability insurance;
15 workers' compensation or similar insurance; automobile medical
16 payment insurance; credit-only insurance; coverage for on-site medical
17 clinics; and other similar insurance coverage, as specified in federal
18 regulations, under which benefits for medical care are secondary or
19 incidental to other insurance benefits. Health benefits plans shall not
20 include the following benefits if they are provided under a separate
21 policy, certificate or contract of insurance or are otherwise not an
22 integral part of the plan: limited scope dental or vision benefits;
23 benefits for long-term care, nursing home care, home health care,
24 community-based care, or any combination thereof; and such other
25 similar, limited benefits as are specified in federal regulations. Health
26 benefits plan shall not include hospital confinement indemnity coverage
27 if the benefits are provided under a separate policy, certificate or
28 contract of insurance, there is no coordination between the provision
29 of the benefits and any exclusion of benefits under any group health
30 benefits plan maintained by the same plan sponsor, and those benefits
31 are paid with respect to an event without regard to whether benefits
32 are provided with respect to such an event under any group health plan
33 maintained by the same plan sponsor. Health benefits plan shall not
34 include the following if it is offered as a separate policy, certificate or
35 contract of insurance: Medicare supplemental health insurance as
36 defined under section 1882(g)(1) of the federal Social Security Act (42
37 U.S.C.§1395ss(g)(1)); and coverage supplemental to the coverage
38 provided under chapter 55 of Title 10, United States Code (10 U.S.C.
39 §1071 et seq.); and similar supplemental coverage provided to
40 coverage under a group health plan.

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

46 "Late enrollee" means an eligible employee or dependent who

1 requests enrollment in a health benefits plan of a small employer
2 following the initial minimum 30-day enrollment period provided under
3 the terms of the health benefits plan. An eligible employee or
4 dependent shall not be considered a late enrollee if the individual: a.
5 was covered under another employer's health benefits plan at the time
6 he was eligible to enroll and stated at the time of the initial enrollment
7 that coverage under that other employer's health benefits plan was the
8 reason for declining enrollment, but only if the plan sponsor or carrier
9 required such a statement at that time and provided the employee with
10 notice of that requirement and the consequences of that requirement
11 at that time; b. has lost coverage under that other employer's health
12 benefits plan as a result of termination of employment or eligibility,
13 reduction in the number of hours of employment, involuntary
14 termination, the termination of the other plan's coverage, death of a
15 spouse, or divorce or legal separation; and c. requests enrollment
16 within 90 days after termination of coverage provided under another
17 employer's health benefits plan. An eligible employee or dependent
18 also shall not be considered a late enrollee if the individual is employed
19 by an employer which offers multiple health benefits plans and the
20 individual elects a different plan during an open enrollment period; the
21 individual had coverage under a COBRA continuation provision and
22 the coverage under that provision was exhausted and the employee
23 requests enrollment not later than 30 days after the date of exhaustion
24 of COBRA coverage; or if a court of competent jurisdiction has
25 ordered coverage to be provided for a spouse or minor child under a
26 covered employee's health benefits plan and request for enrollment is
27 made within 30 days after issuance of that court order.

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

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

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

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

45 "Plan sponsor" has the meaning given that term under Title I of
46 section 3 of Pub.L.93-406, the "Employee Retirement Income Security

1 Act of 1974" (29 U.S.C.§1002(16)(B)).

2 ["Preexisting condition provision" means a policy or contract
3 provision that excludes coverage under that policy or contract for
4 charges or expenses incurred during a specified period following the
5 insured's effective date of coverage, for a condition that, during a
6 specified period immediately preceding the effective date of coverage,
7 had manifested itself in such a manner as would cause an ordinarily
8 prudent person to seek medical advice, diagnosis, care or treatment,
9 or for which medical advice, diagnosis, care or treatment was
10 recommended or received as to that condition or as to pregnancy
11 existing on the effective date of coverage.]

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

19 "Program" means the New Jersey Small Employer Health Benefits
20 Program established pursuant to section 12 of P.L.1992, c.162
21 (C.17B:27A-28).

22 ["Qualifying previous coverage" means benefits or coverage
23 provided under:

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

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

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

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

43 "Small employer" means [any person, firm, corporation,
44 partnership, or association actively engaged in business which, on at
45 least 50 percent of its working days during the preceding calendar year
46 quarter, employed at least two but no more than 49 eligible employees,

1 the majority of whom are employed within the State of New Jersey.
2 In determining the number of eligible employees, companies which are
3 affiliated companies shall be considered one employer. Subsequent to
4 the issuance of a health benefits plan to a small employer pursuant to
5 the provisions of this act, and for the purpose of determining
6 eligibility, the size of a small employer shall be determined annually.
7 Except as otherwise specifically provided, provisions of this act which
8 apply to a small employer shall continue to apply until the anniversary
9 date of the health benefits plan next following the date the employer
10 no longer meets the definition of a small employer. For the purposes
11 of P.L.1992, c.162 (C.17B:27A-17 et seq.), a State, county or
12 municipal body, agency, board or department shall not be considered
13 a small employer] , in connection with a group health plan with respect
14 to a calendar year and a plan year, any person, firm, corporation,
15 partnership, or political subdivision that is actively engaged in business
16 that employed an average of at least two but not more than 50 eligible
17 employees on business days during the preceding calendar year and
18 who employs at least two employees on the first day of the plan year,
19 and the majority of the employees are employed in New Jersey. All
20 persons treated as a single employer under subsection (b), (c), (m) or
21 (o) of section 414 of the Internal Revenue Code of 1986
22 (26U.S.C.§414) shall be treated as one employer. Subsequent to the
23 issuance of a health benefits plan to a small employer and for the
24 purpose of determining continued eligibility, the size of a small
25 employer shall be determined annually. Except as otherwise
26 specifically provided, provisions of P.L.1992, c.162 (C.17B:27A-17
27 et seq.) that apply to a small employer shall continue to apply at least
28 until the plan anniversary following the date the small employer no
29 longer meets the requirements of this definition. In the case of an
30 employer that was not in existence during the preceding calendar year,
31 the determination of whether the employer is a small or large employer
32 shall be based on the average number of employees that it is
33 reasonably expected that the employer will employ on business days
34 in the current calendar year. Any reference in P.L.1992, c.162
35 (C.17B:27A-17 et seq.) to an employer shall include a reference to any
36 predecessor of such employer.

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

40 "Small employer health benefits plan" means a health benefits plan
41 for small employers approved by the commissioner pursuant to section
42 17 of P.L.1992, c.162 (C.17B:27A-33).

43 "Stop loss" or "excess risk insurance" means an insurance policy
44 designed to reimburse a self-funded arrangement of one or more small
45 employers for catastrophic, excess or unexpected expenses, wherein
46 neither the employees nor other individuals are third party beneficiaries

1 under the insurance policy. In order to be considered stop loss or
2 excess risk insurance for the purposes of P.L.1992, c.162
3 (C.17B:27A-17 et seq.), the policy shall establish a per person
4 attachment point or retention or aggregate attachment point or
5 retention, or both, which meet the following requirements:

6 a. If the policy establishes a per person attachment point or
7 retention, that specific attachment point or retention shall not be less
8 than ~~[\$25,000]~~ \$20,000 per covered person per plan year; and

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

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

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

16

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

19 2. Every health insurer, health service corporation, medical service
20 corporation, hospital service corporation, and health maintenance
21 organization licensed or authorized to provide health benefits or
22 services in this State which offers health insurance policies or
23 coverages ~~[covering two or more employees of a small employer]~~ to
24 small employers shall be subject to the provisions of this act.
25 ~~[Coverage shall be offered]~~ Carriers shall offer coverage to all eligible
26 employees of small employers and their dependents and shall not
27 exclude any employee or eligible dependent on the basis of ~~[an actual~~
28 ~~or expected health condition]~~ a health status-related factor.

29 (cf: P.L.1992, c.162, s.2)

30

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

33 6. a. No health benefits plan subject to this act shall include any
34 provision excluding coverage for a preexisting condition ~~[provision]~~
35 regardless of the cause of the condition, provided that, a preexisting
36 condition provision may apply to a late enrollee or to any group of two
37 to five persons if such provision excludes coverage for a period of no
38 more than 180 days following the effective date of coverage of such
39 enrollee, and relates only to conditions, whether physical or mental,
40 manifesting themselves during the six months immediately preceding
41 the ~~[effective date of coverage]~~ enrollment date of such enrollee ~~[in~~
42 ~~such a manner as would cause an ordinarily prudent person to seek~~
43 ~~medical advice, diagnosis, care or treatment or]~~ and for which medical
44 advice, diagnosis, care, or treatment was recommended or received
45 during the six months immediately preceding the effective date of
46 coverage], or as to a pregnancy existing on the effective date of

1 coverage]; provided that, if 10 or more late enrollees request
2 enrollment during any 30-day enrollment period, then no preexisting
3 condition provision shall apply to any such enrollee.

4 b. In determining whether a preexisting condition provision applies
5 to an eligible employee or dependent, all health benefits plans shall
6 credit the time that person was covered under [any qualifying
7 previous] creditable coverage if the [previous] creditable coverage
8 was continuous to a date not more than 90 days prior to the effective
9 date of the new coverage, exclusive of any applicable waiting period
10 under such plan. A carrier shall provide credit pursuant to this
11 provision in one of the following methods:

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

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

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

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

28 (2) A child who is adopted or placed for adoption before attaining
29 18 years of age and who, as of the last day of the 30-day period
30 beginning on the date of the adoption or placement for adoption, is
31 covered under creditable coverage. This provision shall not apply to
32 coverage before the date of the adoption or placement for adoption;
33 or

34 (3) Pregnancy as a preexisting condition.

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

36
37 10. Section 7 of P.L.1992 c.162 (C.17B:27A-23) is amended to
38 read as follows:

39 7. Every policy or contract issued to small employers in this State
40 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be
41 renewable with respect to all eligible employees or dependents at the
42 option of the policy or contract holder, or small employer except
43 [under the following circumstances] that a carrier may discontinue or
44 nonrenew a health benefits plan in accordance with the provisions of
45 this section:

46 a. [Nonpayment of the required premiums by the] A carrier may

1 discontinue such coverage only if:

2 (1) The policyholder, contract holder, or employer has failed to pay
3 premiums or contributions in accordance with the terms of the health
4 benefits plan or the carrier has not received timely premium payments
5 or

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

9 b. [Fraud or misrepresentation of the policyholder, contract holder,
10 or employer or, with respect to coverage of eligible employees or
11 dependents, the enrollees or their representatives;] (Deleted by
12 amendment, P.L. , c.).

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

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

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

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

29 (2) No later than two months following the date of the notification
30 to the commissioner that the carrier intends to cease doing business in
31 the small employer market, the carrier shall mail a notice to every
32 small business employer insured by the carrier, and all covered
33 persons, that the policy or contract of insurance will be [terminated]
34 nonrenewed. This notice shall be sent by certified mail to the small
35 business employer not less than six months in advance of the effective
36 date of the [cancellation] nonrenewal date of the policy or contract;

37 (3) Any carrier that ceases to do business pursuant to this act shall
38 be prohibited from writing new business in the small employer market
39 for a period of five years from the date [of notice to the commissioner]
40 of termination of the last health insurance coverage not so renewed²[¹,
41 except that the five-year period shall not apply to a carrier that gave
42 notice to the commissioner during the period January 1, 1997 to June
43 30, 1997 to cease doing business in the small employer market¹]²;

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

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

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

5 h. A decision by the small employer carrier to cease offering and
6 nonrenew a particular type of group health benefits plan in the small
7 employer market, if the board discontinues a standard health benefits
8 plan or as permitted or required pursuant to subsection j. of section 3
9 of P.L.1992, 162 (17B:27A-19), and pursuant to regulations adopted
10 by the commissioner:

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

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

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

22 (cf: P.L.1995, c.50, s.1)

23

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

26 9. a. (1) [Beginning on the fourth 12-month anniversary date of
27 any policy or contract issued in 1994, no small employer health
28 benefits plan shall be issued in this State unless the plan is community
29 rated.] (Deleted by amendment, P.L. , c.)

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

41 (3) [Beginning on the second 12-month anniversary after the date
42 established in paragraph (2) of this subsection of the policy or
43 contract,] For all policies or contracts providing health benefits plans
44 for small employers issued pursuant to section 3 of P.L.1992, c.162
45 (C.17B:27A-19), the premium rate charged by a carrier to the highest
46 rated small group purchasing a small employer health benefits plan

1 issued pursuant to [subsection a. of] section 3 of P.L.1992, c.162
2 (C.17B:27A-19) shall not be greater than 200% of the premium rate
3 charged for the lowest rated small group purchasing that same health
4 benefits plan; provided, however, that the only factors upon which the
5 rate differential may be based are age, gender and geography, and
6 provided further, that such factors are applied in a manner consistent
7 with regulations adopted by the board.

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

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

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

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

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

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

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

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

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

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

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

41 f. No insurance contract or policy subject to this act may be
42 entered into unless and until the carrier has made an informational
43 filing with the commissioner of a schedule of premiums, not to exceed
44 12 months in duration, to be paid pursuant to such contract or policy,
45 of the carrier's rating plan and classification system in connection with
46 such contract or policy, and of the actuarial assumptions and methods

1 used by the carrier in establishing premium rates for such contract or
2 policy.

3 g. (1) Beginning January 1, 1995, a carrier desiring to increase or
4 decrease premiums for any policy form or benefit rider offered
5 pursuant to subsection i. of section 3 of P.L.1992, c.162
6 (C.17B:27A-19) subject to this act may implement such increase or
7 decrease upon making an informational filing with the commissioner
8 of such increase or decrease, along with the actuarial assumptions and
9 methods used by the carrier in establishing such increase or decrease,
10 provided that the anticipated minimum loss ratio for [a policy form]
11 all policy forms shall not be less than 75% of the premium therefor as
12 provided in paragraph (2) of this subsection. Until December 31,
13 1996, the informational filing shall also include the carrier's rating plan
14 and classification system in connection with such increase or decrease.

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

44 (3) The loss ratio of a health benefits plan issued pursuant to
45 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be
46 calculated in accordance with the provisions of section 7 of P.L.1995,

1 c.340 (C.17B:27A-19.3), for the purposes of meeting the requirements
2 of this subsection.

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

4 i. The provisions of this act shall apply to health benefits plans
5 which are delivered, issued for delivery, renewed or continued on or
6 after January 1, 1994.

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

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

9

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

12 10. a. No health maintenance organization shall be required to
13 offer coverage or accept applications pursuant to section 3 of this act
14 to a small employer if the small employer [is not physically located in
15 the health maintenance organization's approved service area, to an
16 employee when the employee does not work or reside within a service
17 area] does not have eligible individuals who live, work, or reside in the
18 service area for such plan, or if the health maintenance organization
19 reasonably anticipates and demonstrates to the satisfaction of the
20 commissioner that it will not have the capacity in its network of
21 providers within the service area to deliver service adequately to the
22 members of such groups because of its obligations to existing group
23 contract holders and enrollees. Upon denying health insurance
24 coverage in any service area as a result of insufficient network
25 capacity in accordance with this subsection, the health maintenance
26 organization shall not offer coverage in the small employer market
27 within such service area for a period of at least 180 days after the date
28 the coverage is denied.

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

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

41 (cf: P.L.1993, c.162, s.11)

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

3 17. Subject to the approval of the commissioner, the board shall
4 formulate the five health benefits plans to be made available by small
5 employer carriers in accordance with the provisions of this act, and
6 shall promulgate five standard forms pursuant thereto. The board may
7 establish benefit levels, deductibles and co-payments, exclusions, and
8 limitations for such health benefits plans in accordance with the law.
9 The board shall ensure that the means exist for a carrier to offer high
10 deductible health benefits plan options that are consistent with section
11 301 of Title III of the "Health Insurance Portability and Accountability
12 Act of 1996," Pub.L. 104-191, regarding tax-deductible medical
13 savings accounts.

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

22 a. Utilization review of health care services, including review of
23 medical necessity of hospital and physician services;

24 b. Managed care systems, including large case management;

25 c. Provisions for selective contracting with hospitals, physicians,
26 and other [health care] participating and nonparticipating providers;

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

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

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

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

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

40

41 14. (New section) The provisions of sections 14 through 27 of
42 P.L. , c. (C.)(pending before the Legislature as this bill) shall
43 apply to group health insurance coverage that is not subject to the
44 provisions of P.L.1992, c.161 and c.162 (C.17B:27A-2 et seq. and
45 17B:27A-17 et seq.). To the extent that any provision of sections 14
46 through 27 of P.L. c. (C.)(pending before the Legislature as this

1 bill) is inconsistent with the provisions of chapter 27 of Title 17B of
2 the New Jersey Statutes and P.L.1973, c.337 (C.26:2J-1 et seq.), the
3 provisions of sections 14 through 27 shall supercede those laws.

4 As used in sections 14 through 27 of P.L. , c. (C.)(pending
5 before the Legislature as this bill):

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

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

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

30 “Excepted benefits” means:

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

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

46 c. when offered as independent, noncoordinated benefits: hospital

1 indemnity or other fixed indemnity insurance;

2 d. when offered as a separate insurance policy, certificate or
3 contract of insurance: Medicare supplemental insurance as defined
4 under section 1882(g)(1) of the federal Social Security Act (42
5 U.S.C.§1395ss(g)(1))and coverage supplemental to the coverage
6 provided under chapter 55 of Title 10, United States Code (10
7 U.S.C.§1071 et seq.) and similar supplemental coverage provided in
8 addition to coverage under a group health plan.

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

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

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

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

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

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

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

45 “Network plan” means a group health plan offered by a health
46 insurer under which the financing and delivery of medical care,

1 including items and services paid for as medical care, are provided, in
2 whole or in part, through a defined set of providers under contract
3 with the insurer. Network plan includes a health maintenance
4 organization or health insurance company with selective contracting
5 arrangements.

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

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

16

17 15. (New section) A health insurer may impose a preexisting
18 condition exclusion in its group health plan only if:

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

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

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

29

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

43

44 17. (New section) Genetic information shall not be treated as a
45 preexisting condition in the absence of a diagnosis of the condition
46 related to such information.

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

9
10 19. (New section) Except as provided in this section, a health
11 insurer which offers a group health plan shall count a period of
12 creditable coverage without regard to the specific benefits covered
13 during the period. A health insurer offering a group health plan may
14 elect to apply creditable coverage based on coverage of each of several
15 classes or categories of benefits as specified by federal regulation
16 where such election is made on a uniform basis for all participants and
17 beneficiaries and where under such election a health insurer shall count
18 a period of creditable coverage with respect to any class or category
19 of benefits if any level of benefits is covered within the class or
20 category. A health insurer who makes the election with respect to
21 group health plans offered in this State shall prominently state in any
22 disclosure statement concerning the coverage and to each employer at
23 the time of the offer or sale of the coverage, that the health insurer has
24 made that election and shall include in the disclosure statements a
25 description of the effect of the election.

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

30
31 20. (New section) a. A health insurer which offers a group health
32 plan shall provide a written certification of creditable coverage at the
33 time an individual ceases coverage or otherwise becomes covered
34 under a COBRA continuation provision; at the time an individual
35 ceases to be covered under a COBRA continuation provision; and
36 upon request, on behalf of an individual not later than 24 months after
37 the cessation of coverage under the plan or a COBRA continuation
38 provision.

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

44
45 21. (New section) A health maintenance organization which offers
46 a group health plan and which does not impose a preexisting condition

1 exclusion, may impose an affiliation period if the period is applied
2 uniformly without regard to any health status-related factors and the
3 period does not exceed two months, or three months in the case of a
4 late enrollee.

5
6 22. (New section) A health insurer which offers a group health
7 plan shall permit an employee or dependent who is eligible, but not
8 enrolled, for coverage under the terms of the plan, to enroll for
9 coverage if:

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

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

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

27
28 23. (New section) If a group health plan makes coverage available
29 with respect to a dependent of an individual who is a participant under
30 the plan or has satisfied any waiting period and is eligible to be
31 enrolled, and the dependent becomes a dependent of the individual
32 through marriage, birth, adoption or placement for adoption, the group
33 health plan shall provide for a dependent special enrollment period
34 during which the dependent and individual, if necessary, may be
35 enrolled.

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

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

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

12
13 25. (New section) A health insurer which offers a group health
14 plan may not require an individual, as a condition of enrollment or
15 continued enrollment under the plan, to pay a premium or contribution
16 which is greater than the premium or contribution for a similarly
17 situated enrollee in the plan on the basis of any health status-related
18 factor in relation to the individual or to an enrollee or a dependent of
19 the individual or enrollee. This provision shall not be construed to
20 restrict the amount that an employer may be charged for coverage
21 under a group health plan or to prevent a health insurer offering group
22 health insurance coverage from establishing premium discounts or
23 modifying otherwise applicable copayments or deductibles in return for
24 adherence to programs of health promotion and disease prevention.

25
26 26. (New section) A health insurer which offers health insurance
27 coverage in connection with a group health plan shall renew the
28 coverage under the plan at the option of the policy holder, except
29 that:

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

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

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

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

41 b. A health insurer may nonrenew the health insurance coverage
42 only if:

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

46 (2) the insurer is ceasing to offer coverage in the market in

1 accordance with State and federal law.

2 c. A health insurer may cease offering and nonrenew a particular
3 type of health insurance coverage only if :

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

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

10 (3) in exercising the option to nonrenew coverage of a particular
11 type and in offering the option to purchase all or any other health
12 insurance coverage that the insurer offers, the insurer acts uniformly
13 without regard to the claims experience of the certificate or policy
14 holder or any health status-related factor relating to any participants
15 or beneficiaries covered or new participants or beneficiaries who may
16 become eligible for the coverage.

17 d. A health insurer may cease offering and nonrenew all health
18 insurance coverage only if:

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

23 (2) the insurer ceases offering all health insurance coverage issued
24 or delivered for issuance in the State for groups under the provisions
25 of sections 14 through 27 of P.L. , c. (C.)(pending before the
26 Legislature as this bill) and coverage under the health insurance
27 coverage is nonrenewed; and

28 (3) the insurer may not provide for the issuance of any health
29 insurance coverage for groups in this State under the provisions of
30 sections 14 through 27 of P.L. , c. (C.)(pending before the
31 Legislature as this bill) , during a five-year period beginning on the
32 termination date of the last health insurance coverage that was not
33 renewed.

34
35 27. (New section) At the time of coverage renewal, a health insurer
36 may modify the health insurance coverage for a product offered to a
37 group health plan.

38
39 28. Section 6 of P.L.1995, c.340 (C.17B:27A-23.1) is repealed.

40
41 29. This act shall take effect July 1, 1997.

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45 _____
46 Makes changes to individual, small employer and large group health
insurance to comply with federal law.