SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2192

STATE OF NEW JERSEY

ADOPTED JUNE 12, 1997

Sponsored by Senator SINAGRA

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
24 Act of 1974" (29 U.S.C.§1002(33)).
25 "Commissioner" means the Commissioner of Banking and
26 Insurance.
27 "Community rating" means a rating system in which the premium
28 for all persons covered by a contract is the same, based on the
29 experience of all persons covered by that contract, without regard to
30 age, sex, health status, occupation and geographical location.
31 "Creditable coverage" means, with respect to an individual,

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.

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

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

"Department" means the Department of Banking and Insurance.

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

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

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

1 was not terminated based on a factor relating to nonpayment of
2 premiums or fraud; (5) who, if offered the option of continuation
3 coverage under the COBRA continuation provision or a similar State
4 program, elected that coverage; and (6) who has elected continuation
5 coverage described in (5) above and has exhausted that continuation
6 coverage.
7 "Financially impaired" means a carrier which, after the effective
8 date of this act, is not insolvent, but is deemed by the commissioner to
9 be potentially unable to fulfill its contractual obligations, or a carrier
10 which is placed under an order of rehabilitation or conservation by a
11 court of competent jurisdiction.
12 "Governmental plan" has the meaning given that term under Title
13 I, section 3 of Pub.L.93-406, the "Employee Retirement Income
14 Security Act of 1974" (29 U.S.C.§1002(32)) and any governmental
15 plan established or maintained for its employees by the Government of
16 the United States or by any agency or instrumentality of that
17 government.
18 "Group health benefits plan" means a health benefits plan for groups
19 of two or more persons.
20 "Group health plan" means an employee welfare benefit plan, as
21 defined in Title I, section 3 of Pub.L.93-406, the "Employee
22 Retirement Income Security Act of 1974" (29 U.S.C.§1002(1)), to the
23 extent that the plan provides medical care, and including items and
24 services paid for as medical care to employees or their dependents
25 directly or through insurance, reimbursement, or otherwise.
26 "Health benefits plan" means a hospital and medical expense
27 insurance policy; health service corporation contract; [or] hospital
28 service corporation contract; medical service corporation contract;
29 health maintenance organization subscriber contract; or other plan for
30 medical care delivered or issued for delivery in this State. For
31 purposes of this act, health benefits plan [does not include the
32 following plans, policies, or contracts: accident only, credit, disability,
33 long-term care, Medicare supplement coverage, CHAMPUS
34 supplement coverage, coverage for Medicare services pursuant to a
35 contract with the United States government, coverage for Medicaid
36 services pursuant to a contract with the State, coverage arising out of
37 a workers' compensation or similar law, automobile medical payment
38 insurance, personal injury protection insurance issued pursuant to
39 P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity
40 coverage] shall not include one or more, or any combination of, the
41 following: coverage only for accident, or disability income insurance,
42 or any combination thereof; coverage issued as a supplement to
43 liability insurance; liability insurance, including general liability
44 insurance and automobile liability insurance; stop loss or excess risk
45 insurance; workers' compensation or similar insurance; automobile
46 medical payment insurance; credit-only insurance; coverage for on-site

1 medical clinics; and other similar insurance coverage, as specified in
2 federal regulations, under which benefits for medical care are
3 secondary or incidental to other insurance benefits. Health benefits
4 plans shall not include the following benefits if they are provided under
5 a separate policy, certificate or contract of insurance or are otherwise
6 not an integral part of the plan: limited scope dental or vision benefits;
7 benefits for long-term care, nursing home care, home health care,
8 community-based care, or any combination thereof; and such other
9 similar, limited benefits as are specified in federal regulations. Health
10 benefits plan shall not include hospital confinement indemnity coverage
11 if the benefits are provided under a separate policy, certificate or
12 contract of insurance, there is no coordination between the provision
13 of the benefits and any exclusion of benefits under any group health
14 benefits plan maintained by the same plan sponsor, and those benefits
15 are paid with respect to an event without regard to whether benefits
16 are provided with respect to such an event under any group health plan
17 maintained by the same plan sponsor. Health benefits plan shall not
18 include the following if it is offered as a separate policy, certificate or
19 contract of insurance: Medicare supplemental health insurance as
20 defined under section 1882(g)(1) of the federal Social Security Act (42
21 U.S.C.§1395ss(g)(1)); and coverage supplemental to the coverage
22 provided under chapter 55 of Title 10, United States Code (10 U.S.C.
23 §1071 et seq.); and similar supplemental coverage provided to
24 coverage under a group health plan.
25 "Health status-related factor" means any of the following factors:
26 health status; medical condition, including both physical and mental
27 illness; claims experience; receipt of health care; medical history;
28 genetic information; evidence of insurability, including conditions
29 arising out of acts of domestic violence; and disability.
30 "Individual health benefits plan" means: a. a health benefits plan for
31 eligible persons and their dependents; and b. a certificate issued to an
32 eligible person which evidences coverage under a policy or contract
33 issued to a trust or association, regardless of the situs of delivery of
34 the policy or contract, if the eligible person pays the premium and is
35 not being covered under the policy or contract pursuant to
36 continuation of benefits provisions applicable under federal or State
37 law.
38 Individual health benefits plan shall not include a certificate issued
39 under a policy or contract issued to a trust, or to the trustees of a
40 fund, which trust or fund [is established or adopted by two or more
41 employers, by one or more labor unions or similar employee
42 organizations, or by one or more employers and one or more labor
43 unions or similar employee organizations, to insure employees of the
44 employers or members of the unions or organizations] is an employee
45 welfare benefit plan, to the extent the "Employee Retirement Income
46 Security Act of 1974" (29 U.S.C.§1001 et seq.) preempts the

application of P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

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

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

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

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

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

"Plan of operation" means the plan of operation of the program adopted by the board pursuant to this act.

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

"Preexisting condition" means a condition that, during a specified period of not more than six months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice,

diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the effective date of coverage.

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

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

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

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

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

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

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

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

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

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

(5) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation to an eligible person or federally defined eligible individual after the effective date of P.L. , c. ,

(pending before the Legislature as this bill) shall comply with the provisions subsections c. and d. of section 2, subsection b. of section 3, section 5, subsection b. of section 6, and subsections c., d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3, C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall not be subject to the remaining provisions of P.L.1992, c. 161.

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

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

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

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

(2) During the period July 1, 1994 to June 30, 1995, the premium rate charged by a carrier to the highest rated individual who purchased an individual health benefits plan prior to the effective date of this act shall not be greater than 125% of the premium rate charged to the lowest rated individual purchasing that same or a similar health benefits plan.

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

1 (4) A carrier that issues an individual health benefits plan with
2 modified community rating subject to the provisions of this subsection
3 shall make an informational filing with the board whenever it adjusts
4 or modifies its rates.] (Deleted by amendment, P.L. , c. .
5 (cf: P.L.1993, c.164, s.2)
6
7 3. Section 5 of P.L.1992, c.161 (C.17B:27A-6) is amended to read
8 as follows:
9 5. An individual health benefits plan issued pursuant to section 3
10 of this act is subject to the following provisions:
11 a. The health benefits plan shall guarantee coverage for an eligible
12 person and his dependents on a community rated basis.
13 b. A health benefits plan shall be renewable with respect to an
14 eligible person and his dependents at the option of the policy or
15 contract holder [except] . A carrier may terminate a health benefits
16 plan under the following circumstances:
17 (1) [nonpayment of the required premiums by] the policy or
18 contract holder has failed to pay premiums in accordance with the
19 terms of the policy or contract or the carrier has not received timely
20 premium payments;
21 (2) [fraud or misrepresentation by] the policy or contract holder [,
22 including equitable fraud, with respect to coverage of eligible
23 individuals or their dependents] has performed an act or practice that
24 constitutes fraud or made an intentional misrepresentation of material
25 fact under the terms of the coverage;
26 c. A carrier may nonrenew a health benefits plan only under the
27 following circumstances:
28 [(3)] (1) termination of eligibility of the policy or contract holder
29 if the person is no longer a resident or becomes eligible for a group
30 health benefits plan, group health plan, governmental plan or church
31 plan; [or
32 (4)] (2) cancellation or amendment by the board of the specific
33 individual health benefits plan;
34 (3) board approval of a request by the individual carrier to
35 nonrenew a particular type of health benefits plan, in accordance with
36 rules adopted by the board. After receiving board approval, a carrier
37 may nonrenew a type of health benefits plan only if the carrier: (a)
38 provides notice to each covered individual provided coverage of this
39 type of the nonrenewal at least 90 days prior to the date of the
40 nonrenewal of the coverage; (b) offers to each individual provided
41 coverage of this type the option to purchase any other individual
42 health benefits plan currently being offered by the carrier; and (c) in
43 exercising the option to nonrenew coverage of this type and in offering
44 coverage as required under (b) above, the carrier acts uniformly
45 without regard to any health status-related factor of enrolled
46 individuals or individuals who may become eligible for coverage;

1 (4) board approval of a request by the individual carrier to cease
2 doing business in the individual health benefits market. A carrier may
3 nonrenew all individual health benefits plans only if the carrier: (a)
4 first receives approval from the board; and (b) provides notice to each
5 individual of the nonrenewal at least 180 days prior to the date of the
6 expiration of such coverage. A carrier ceasing to do business in the
7 individual health benefits market may not provide for the issuance of
8 any health benefits plan in the individual market during the five-year
9 period beginning on the date of the termination of the last health
10 benefits plan not so renewed; and
11 (5) In the case of a health benefits plan made available by a health
12 maintenance organization carrier, the carrier shall not be required to
13 renew coverage to an eligible individual who no longer resides, lives,
14 or works in the service area, or in an area for which the carrier is
15 authorized to do business, but only if coverage is terminated under this
16 paragraph uniformly without regard to any health status-related factor
17 of covered individuals.
18 (cf: P.L.1992, c.161, s.5)
19
20 4. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to read
21 a follows:
22 6. The board shall establish the policy and contract forms and
23 benefit levels to be made available by all carriers for the [policies]
24 health benefits plans required to be issued pursuant to section 3 of
25 P.L.1992, c.161 (C.17B:27A-4). The board shall provide the
26 commissioner with an informational filing of the policy and contract
27 forms and benefit levels it establishes.
28 a. The individual health benefits plans established by the board may
29 include cost containment measures such as, but not limited to:
30 utilization review of health care services, including review of medical
31 necessity of hospital and physician services; case management benefit
32 alternatives; selective contracting with hospitals, physicians, and other
33 health care providers; and reasonable benefit differentials applicable to
34 participating and nonparticipating providers; and other managed care
35 provisions.
36 b. An individual health benefits plan offered pursuant to section 3
37 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
38 more than 12 months on coverage for preexisting conditions[, except
39 that the limitation shall not apply] . An individual health benefits plan
40 offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall
41 not contain a preexisting condition limitation of any period under the
42 following circumstances:
43 (1) to an individual who has, under [a prior group or individual
44 health benefits plan or Medicaid]creditable coverage, with no
45 intervening lapse in coverage of more than [30] 31 days, been treated
46 or diagnosed by a physician for a condition under that plan or satisfied

1 a 12-month preexisting condition limitation; or
2 (2) to a federally defined eligible individual who applies for an
3 individual health benefits plan within 63 days of termination of the
4 prior coverage.
5 c. In addition to the five standard individual health benefits plans
6 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board
7 may develop up to five rider packages. Premium rates for the rider
8 packages shall be determined in accordance with section 8 of
9 P.L.1992, c.161 (C.17B:27A-9).
10 d. After the board's establishment of the individual health benefits
11 plans required pursuant to section 3 of P.L.1992, c.161
12 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier
13 shall file the policy or contract forms with the board and certify to the
14 board that the health benefits plans to be used by the carrier are in
15 substantial compliance with the provisions in the corresponding board
16 approved plans. The certification shall be signed by the chief
17 executive officer of the carrier. Upon receipt by the board of the
18 certification, the certified plans may be used until the board, after
19 notice and hearing, disapproves their continued use.
20 e. Effective immediately for an individual health benefits plan
21 issued on or after the effective date of P.L.1995, c.316
22 (C.17:48E-35.10 et al.) and effective on the first 12-month anniversary
23 date of an individual health benefits plan in effect on the effective date
24 of P.L.1995, c.316 (C.17:48E-35.10 et al.), the individual health
25 benefits plans required pursuant to section 3 of P.L.1992, c.161
26 (C.17B:27A-4), including any plan offered by a federally qualified
27 health maintenance organization, shall contain benefits for expenses
28 incurred in the following:
29 (1) Screening by blood lead measurement for lead poisoning for
30 children, including confirmatory blood lead testing as specified by the
31 Department of Health pursuant to section 7 of P.L.1995 , c.316
32 (C.26:2-137.1); and medical evaluation and any necessary medical
33 follow-up and treatment for lead poisoned children.
34 (2) All childhood immunizations as recommended by the Advisory
35 Committee on Immunization Practices of the United States Public
36 Health Service and the Department of Health pursuant to section 7 of
37 P.L.1995, c.316 (C.26:2-137.1). A carrier shall notify its insureds, in
38 writing, of any change in the health care services provided with respect
39 to childhood immunizations and any related changes in premium. Such
40 notification shall be in a form and manner to be determined by the
41 Commissioner of Insurance.
42 The benefits shall be provided to the same extent as for any other
43 medical condition under the health benefits plan, except that no
44 deductible shall be applied for benefits provided pursuant to this
45 section. This section shall apply to all individual health benefits plans
46 in which the carrier has reserved the right to change the premium.

1 (cf: P.L.1995, c.316, s.5)
2
3 5. Section 7 of P.L.1992 c.161 (C.17B:27A-8) is amended to read
4 as follows:
5 7. a. A health maintenance organization shall not be required to
6 offer coverage to or accept an applicant pursuant to this act if [the
7 applicant is not geographically located in the health maintenance
8 organization's approved service area or if the health maintenance
9 organization does not have the capacity in its facilities to enroll
10 additional members; except that, if]:
11 (1) the eligible individual does not live, reside, or work within the
12 health maintenance organization's approved service area; and
13 (2) the carrier has demonstrated to the commissioner that the
14 carrier will not have the capacity to deliver services adequately to
15 additional eligible persons because of its obligations to existing group
16 contract holders and enrollees and individual enrollees and it applies
17 this paragraph uniformly to individuals without regard to any health
18 status-related factor of such individuals and without regard to whether
19 the individuals are eligible persons. Upon denying individual health
20 benefits coverage pursuant to this paragraph, a carrier may not offer
21 such coverage in the individual market for a period of 180 days after
22 the date the coverage is denied. If the health maintenance organization
23 does not have the capacity in its facilities for additional individual
24 enrollees, it also shall not offer coverage to or accept any new group
25 enrollees.
26 b. A carrier shall not be required to offer coverage or accept
27 applications pursuant to this act if the commissioner [finds that the
28 acceptance of applications would place the carrier in a financially
29 impaired condition] determines that the carrier does not have the
30 financial reserves necessary to underwrite additional coverage. Upon
31 denying individual health benefits coverage pursuant to this subsection,
32 a carrier may not offer such coverage in the individual market for a
33 period of 180 days after the date the coverage is denied or until the
34 carrier has demonstrated to the commissioner that the carrier has
35 sufficient financial reserves to underwrite additional coverage,
36 whichever is later.
37 (cf: P.L.1992, c.161, s.7)
38
39 6. Section 11 of P.L.1992, c.161 (C.17B:27A-12) is amended to
40 read as follows:
41 11. The board shall establish procedures for the equitable sharing
42 of program losses among all members in accordance with their total
43 market share as follows:
44 a. (1) By March 1, [1993] 1999, and following the close of each
45 [calendar year]two-year calculation period thereafter, or on a different
46 date established by the board:

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

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

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

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

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

1 or a member of the program either jointly or separately except as
2 otherwise provided in this act.
3 c. Payment of an assessment made under this section shall be a
4 condition of issuing health benefits plans in the State for a carrier.
5 Failure to pay the assessment shall be grounds for forfeiture of a
6 carrier's authorization to issue health benefits plans of any kind in the
7 State, as well as any other penalties permitted by law.
8 d. (1) Notwithstanding the provisions of this act to the contrary,
9 a carrier may apply to the board, by a date established by the board,
10 for an exemption from the assessment and reimbursement for losses
11 provided for in this section. A carrier which applies for an exemption
12 shall agree to [enroll or insure] cover a minimum number of non-group
13 [persons] person life years on an open enrollment community rated
14 basis, under a managed care or indemnity plan, as specified in this
15 subsection, provided that any indemnity plan so issued conforms with
16 sections 2 through 7, inclusive, of [this act] P.L.1992, c.161
17 (C.17B:27A-3 through 17B:27A-8). For the purposes of this
18 subsection, non-group persons include individually enrolled persons,
19 conversion policies issued pursuant to this act, Medicare cost and risk
20 lives and Medicaid [and HealthStart Plus] recipients; except that in
21 determining whether the carrier meets the minimum number of
22 non-group [persons] person life years required to be covered pursuant
23 to this subsection, the number of Medicaid recipients and Medicare
24 cost and risk lives shall not exceed 50% of the total. Pursuant to
25 regulations adopted by the board, the carrier shall determine the
26 number of non-group person life years it has covered by adding the
27 number of non-group persons covered on the last day of each calendar
28 quarter of the two-year calculation period, taking into account the
29 limitations on counting Medicaid recipients and Medicare cost and risk
30 lives, and dividing the total by eight.
31 (2) Notwithstanding the provisions of paragraph (1) of this
32 subsection to the contrary, a health maintenance organization qualified
33 pursuant to the "Health Maintenance Organization Act of 1973,"
34 Pub.L 93-222 (42 U.S.C. §300e et seq.) and tax exempt pursuant to
35 paragraph (3) of subsection (c) of section 501 of the federal Internal
36 Revenue Code of 1986, 26 U.S.C. §501, may include up to one third
37 Medicaid recipients and up to one third Medicare recipients in
38 determining whether it meets its minimum number of non-group
39 person life years.
40 (3) The minimum number of non-group [persons] person life years
41 required to be covered, as determined by the board, shall equal the
42 total number of non-group person life years of community rated [and
43 modified community rated], individually enrolled or insured persons,
44 including Medicare cost and risk lives and enrolled Medicaid [and
45 HealthStart Plus] lives, of all carriers subject to this act [as of the end
46 of the calendar year] for the two-year calculation period, multiplied by

1 the proportion that that carrier's net earned premium bears to the net
2 earned premium of all carriers for that [calendar year] two-year
3 calculation period, including those carriers that are exempt from the
4 assessment.
5 (4) [Within 180 days after the effective date of this act and on] On
6 or before March 1 of [each] the first year [thereafter] of each two-
7 year calculation period, every carrier seeking an exemption pursuant
8 to this subsection shall file with the board a statement of its net earned
9 premium for the [preceding calendar year] two-year calculation
10 period. The board shall determine each carrier's minimum number of
11 non-group [persons] person life years in accordance with this
12 subsection.
13 (5) On or before March 1 of each year immediately following the
14 close of a two-year calculation period, every carrier that was granted
15 an exemption for the preceding [calendar year] two-year calculation
16 period shall file with the board the number of non-group [persons]
17 person life years, by category, [enrolled or insured as of December 31
18 of] covered for the [preceding calendar year] two-year calculation
19 period.
20 To the extent that the carrier has failed to [enroll] cover the
21 minimum number of non-group [persons] person life years established
22 by the board, the carrier shall be assessed by the board on a pro rata
23 basis for any differential between the minimum number established by
24 the board and the actual number [enrolled or insured] covered by the
25 carrier.
26 (6) A carrier that applies for the exemption shall be deemed to be
27 in compliance with the requirements of this subsection if[:
28 (a) by the end of calendar year 1993, it has enrolled or insured at
29 least 40% of the minimum number of non-group persons required;
30 (b) by the end of calendar year 1994, it has enrolled or insured at
31 least 75% of the minimum number of non-group persons required; and
32 (c) by the end of calendar year 1995,] it has [enrolled or insured]
33 covered 100% of the minimum number of non-group [persons] person
34 life years required.
35 (7) Any carrier that writes both managed care and indemnity
36 business that is granted an exemption pursuant to this subsection may
37 satisfy its obligation to [write] cover a minimum number of non-group
38 [persons] person life years by [writing] issuing either managed care or
39 indemnity business, or both.
40 e. [Notwithstanding the provisions of this section to the contrary,
41 no carrier shall be liable for an assessment to reimburse any carrier
42 pursuant to this section in an amount which exceeds 35% of the
43 aggregate net paid losses of all carriers filing pursuant to paragraph (1)
44 of subsection a. of this section. To the extent that this limitation
45 results in any unreimbursed paid losses to any carrier, the
46 unreimbursed net paid losses shall be distributed among carriers: (1)

1 which owe assessments pursuant to paragraph (2) of subsection a. of
2 this section; (2) whose assessments do not exceed 35% of the
3 aggregate net paid losses of all carriers; and (3) who have not received
4 an exemption pursuant to subsection d. of this section. For the
5 purposes of paragraph (3) of this subsection, a carrier shall be deemed
6 to have received an exemption notwithstanding the fact that the carrier
7 failed to enroll or insure the minimum number of non-group persons
8 required for that calendar year.] (Deleted by amendment, P.L. ,
9 c.)(pending before the Legislature as this bill)
10 (cf: P.L.1992,c.161,s.11)
11
12 7. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to
13 read as follows:
14 1. As used in this act:
15 "Actuarial certification" means a written statement by a member of
16 the American Academy of Actuaries or other individual acceptable to
17 the commissioner that a small employer carrier is in compliance with
18 the provisions of section 9 of P.L.1992, c.162 (C.17B:27A-25), based
19 upon examination, including a review of the appropriate records and
20 actuarial assumptions and methods used by the small employer carrier
21 in establishing premium rates for applicable health benefits plans.
22 "Anticipated loss ratio" means the ratio of the present value of the
23 expected benefits, not including dividends, to the present value of the
24 expected premiums, not reduced by dividends, over the entire period
25 for which rates are computed to provide coverage. For purposes of
26 this ratio, the present values must incorporate realistic rates of interest
27 which are determined before federal taxes but after investment
28 expenses.
29 "Board" means the board of directors of the program.
30 "Carrier" means [any insurance company, health service
31 corporation, hospital service corporation, medical service corporation
32 or health maintenance organization authorized to issue health benefits
33 plans in this State] any entity subject to the insurance laws and
34 regulations of this State, or subject to the jurisdiction of the
35 commissioner, that contracts or offers to contract to provide, deliver,
36 arrange for, pay for, or reimburse any of the costs of health care
37 services, including an insurance company authorized to issue health
38 insurance, a health maintenance organization, a hospital service
39 corporation, medical service corporation and health service
40 corporation, or any other entity providing a plan of health insurance,
41 health benefits or health services. The term "carrier" shall not include
42 a joint insurance fund established pursuant to State law. For purposes
43 of this act, carriers that are affiliated companies shall be treated as one
44 carrier, except that any insurance company, health service corporation,
45 hospital service corporation, or medical service corporation that is an
46 affiliate of a health maintenance organization located in New Jersey or

any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

"Department" means the Department of Banking and Insurance.

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

"Eligible employee" means a full-time employee who works a

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

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

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

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

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

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health benefits plan" [excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other supplemental limited benefit insurance coverage, automobile medical payment insurance, personal injury protection coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.)and stop loss or excess risk insurance.] shall not include one or more, or any combination of, the following: coverage only for accident or

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

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

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: a. was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such a statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; b. has lost coverage under that other employer's health

benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, death of a spouse, or divorce or legal separation; and c. requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; the individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Small employer" means [any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer. Subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of this act, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this act which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer. For the purposes of P.L.1992, c.162 (C.17B:27A-17 et seq.), a State, county or

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

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

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

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

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

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

1 "Supplemental limited benefit insurance" means insurance that is
2 provided in addition to a health benefits plan on an indemnity
3 non-expense incurred basis.
4 (cf: P.L.1995, c.340, s.1)
5
6 8. Section 2 of P.L.1992, c. 162 (C.17B:27A-18) is amended to
7 read as follows:
8 2. Every health insurer, health service corporation, medical service
9 corporation, hospital service corporation, and health maintenance
10 organization licensed or authorized to provide health benefits or
11 services in this State which offers health insurance policies or
12 coverages [covering two or more employees of a small employer] to
13 small employers shall be subject to the provisions of this act.
14 [Coverage shall be offered] Carriers shall offer coverage to all eligible
15 employees of small employers and their dependents and shall not
16 exclude any employee or eligible dependent on the basis of [an actual
17 or expected health condition] a health status-related factor.
18 (cf: P.L.1992, c.162, s.2)
19
20 9. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to
21 read as follows:
22 6. a. No health benefits plan subject to this act shall include any
23 provision excluding coverage for a preexisting condition [provision]
24 regardless of the cause of the condition, provided that, a preexisting
25 condition provision may apply to a late enrollee or to any group of two
26 to five persons if such provision excludes coverage for a period of no
27 more than 180 days following the effective date of coverage of such
28 enrollee, and relates only to conditions, whether physical or mental,
29 manifesting themselves during the six months immediately preceding
30 the [effective date of coverage] enrollment date of such enrollee [in
31 such a manner as would cause an ordinarily prudent person to seek
32 medical advice, diagnosis, care or treatment or] and for which medical
33 advice, diagnosis, care, or treatment was recommended or received
34 during the six months immediately preceding the effective date of
35 coverage[, or as to a pregnancy existing on the effective date of
36 coverage]; provided that, if 10 or more late enrollees request
37 enrollment during any 30-day enrollment period, then no preexisting
38 condition provision shall apply to any such enrollee.
39 b. In determining whether a preexisting condition provision applies
40 to an eligible employee or dependent, all health benefits plans shall
41 credit the time that person was covered under [any qualifying
42 previous] creditable coverage if the [previous] creditable coverage
43 was continuous to a date not more than 90 days prior to the effective
44 date of the new coverage, exclusive of any applicable waiting period
45 under such plan. A carrier shall provide credit pursuant to this
46 provision in one of the following methods:

1 (1) A carrier shall count a period of creditable coverage without
2 regard to the specific benefits covered during the period; or
3 (2) A carrier shall count a period of creditable coverage based on
4 coverage of benefits within each of several classes or categories of
5 benefits specified in federal regulation rather than the method
6 provided in paragraph (1) of this subsection. This election shall be
7 made on a uniform basis for all covered persons. Under this election,
8 a carrier shall count a period of creditable coverage with respect to
9 any class or category of benefits if any level of benefits is covered
10 within that class or category. A carrier which elects to provide credit
11 pursuant to this provision shall comply with all federal notice
12 requirements.
13 c. A health benefits plan shall not impose a preexisting condition
14 exclusion for the following:
15 (1) A newborn child who, as of the last date of the 30-day period
16 beginning with the date of birth, is covered under creditable coverage;
17 (2) A child who is adopted or placed for adoption before attaining
18 18 years of age and who, as of the last day of the 30-day period
19 beginning on the date of the adoption or placement for adoption, is
20 covered under creditable coverage. This provision shall not apply to
21 coverage before the date of the adoption or placement for adoption;
22 or
23 (3) Pregnancy as a preexisting condition.
24 (cf: P.L.1995, c.298, s.2)
25
26 10. Section 7 of P.L.1992 c.162 (C.17B:27A-23) is amended to
27 read as follows:
28 7. Every policy or contract issued to small employers in this State
29 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be
30 renewable with respect to all eligible employees or dependents at the
31 option of the policy or contract holder, or small employer except
32 [under the following circumstances] that a carrier may discontinue or
33 nonrenew a health benefits plan in accordance with the provisions of
34 this section:
35 a. [Nonpayment of the required premiums by the] A carrier may
36 discontinue such coverage only if:
37 (1) The policyholder, contract holder, or employer has failed to pay
38 premiums or contributions in accordance with the terms of the health
39 benefits plan or the carrier has not received timely premium payments
40 or
41 (2) The policyholder, contract holder, or employer has performed
42 an act or practice that constitutes fraud or made an intentional
43 misrepresentation of material fact under the terms of the coverage;
44 b. [Fraud or misrepresentation of the policyholder, contract holder,
45 or employer or, with respect to coverage of eligible employees or
46 dependents, the enrollees or their representatives;] (Deleted by

1 amendment, P.L. , c.).
2 c. The number of employees covered under the health benefits plan
3 is less than the number or percentage of employees required by
4 participation requirements under the health benefits policy or contract;
5 d. Noncompliance with a carrier's employment contribution
6 requirements;
7 e. Any carrier doing business pursuant to the provisions of this act
8 ceases doing business in the small employer market, if the following
9 conditions are satisfied:
10 (1) The carrier gives notice to cease doing business in the small
11 employer market to the commissioner not later than eight months prior
12 to the date of the planned withdrawal from the small group market,
13 during which time the carrier shall continue to be governed by this act
14 with respect to business written pursuant to this act. For the purposes
15 of this subsection, "date of withdrawal" means the date upon which the
16 first notice to small employers is sent by the carrier pursuant to
17 paragraph (2) of this subsection;
18 (2) No later than two months following the date of the notification
19 to the commissioner that the carrier intends to cease doing business in
20 the small employer market, the carrier shall mail a notice to every
21 small business employer insured by the carrier, and all covered
22 persons, that the policy or contract of insurance will be [terminated]
23 nonrenewed. This notice shall be sent by certified mail to the small
24 business employer not less than six months in advance of the effective
25 date of the [cancellation] nonrenewal date of the policy or contract;
26 (3) Any carrier that ceases to do business pursuant to this act shall
27 be prohibited from writing new business in the small employer market
28 for a period of five years from the date [of notice to the commissioner]
29 of termination of the last health insurance coverage not so renewed;
30 f. In the case of policies or contracts issued in connection with
31 membership in an association or trust of employers, an employer
32 ceases to maintain its membership in the association or trust [; or] ,
33 but only if such coverage is terminated under this provision uniformly
34 without regard to any health status-related factor relating to any
35 covered individual.
36 g. (Deleted by amendment, P.L.1995, c.50).
37 h. A decision by the small employer carrier to cease offering and
38 nonrenew a particular type of group health benefits plan in the small
39 employer market, if the board discontinues a standard health benefits
40 plan or as permitted or required pursuant to subsection j. of section 3
41 of P.L.1992, 162 (17B:27A-19), and pursuant to regulations adopted
42 by the commissioner;
43 i. In the case of a health maintenance organization plan issued to
44 a small employer:
45 (1) an eligible person who no longer resides, lives, or works in the
46 carrier's approved service area, but only if coverage is terminated

under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

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

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

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

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

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

(3) [Beginning on the second 12-month anniversary after the date established in paragraph (2) of this subsection of the policy or contract,] For all policies or contracts providing health benefits plans for small employers issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19), the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan issued pursuant to [subsection a. of] section 3 of P.L.1992, c.162 (C.17B:27A-19) shall not be greater than 200% of the premium rate charged for the lowest rated small group purchasing that same health benefits plan; provided, however, that the only factors upon which the rate differential may be based are age, gender and geography, and provided further, that such factors are applied in a manner consistent with regulations adopted by the board.

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

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

(5) Any policy or contract issued after January 1, 1994 to a small employer who was not previously covered by a health benefits plan

issued by the issuing small employer carrier, shall be subject to the same premium rate restrictions as provided in paragraphs (1), (2) and (3) of this subsection, which rate restrictions shall be effective on the date the policy or contract is issued.

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

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

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

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

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

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

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

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

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

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

1 (2) Each calendar year, a carrier shall return, in the form of
2 aggregate benefits for [each] all of the five standard policy forms
3 offered by the carrier pursuant to subsection a. of section 3 of
4 P.L.1992, c.162 (C.17B:27A-19), at least 75% of the aggregate
5 premiums collected for [the policy form] all of the standard policy
6 forms and at least 75% of the aggregate premiums collected for all of
7 the non-standard policy forms during that calendar year. Carriers shall
8 annually report, no later than August 1st of each year, the loss ratio
9 calculated pursuant to this section for [each such policy form] all of
10 the standard and non-standard policy forms for the previous calendar
11 year. In each case where the loss ratio [for a policy] fails to
12 substantially comply with the 75% loss ratio requirement, the carrier
13 shall issue a dividend or credit against future premiums for all
14 policyholders with [that policy form] the standard or nonstandard
15 policy forms, as applicable, in an amount sufficient to assure that the
16 aggregate benefits paid in the previous calendar year plus the amount
17 of the dividends and credits shall equal 75% of the aggregate
18 premiums collected for the respective policy [form] forms in the
19 previous calendar year. All dividends and credits must be distributed
20 by December 31 of the year following the calendar year in which the
21 loss ratio requirements were not satisfied. The annual report required
22 by this paragraph shall include a carrier's calculation of the dividends
23 and credits applicable to standard and non-standard policy forms, as
24 well as an explanation of the carrier's plan to issue dividends or
25 credits. The instructions and format for calculating and reporting loss
26 ratios and issuing dividends or credits shall be specified by the
27 commissioner by regulation. Such regulations shall include provisions
28 for the distribution of a dividend or credit in the event of cancellation
29 or termination by a policyholder.
30 (3) The loss ratio of a health benefits plan issued pursuant to
31 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be
32 calculated in accordance with the provisions of section 7 of P.L.1995,
33 c.340 (C.17B:27A-19.3), for the purposes of meeting the requirements
34 of this subsection.
35 h. (Deleted by amendment, P.L.1993, c.162).
36 i. The provisions of this act shall apply to health benefits plans
37 which are delivered, issued for delivery, renewed or continued on or
38 after January 1, 1994.
39 j. (Deleted by amendment P.L.1995, c.340).
40 (cf: P.L.1995, c.340, s.3)
41 12. Section 10 of P.L.1992 c. 162 (C.17B:27A-26) is amended to
42 read as follows.
43 10. a. No health maintenance organization shall be required to
44 offer coverage or accept applications pursuant to section 3 of this act
45 to a small employer if the small employer [is not physically located in
46 the health maintenance organization's approved service area, to an

1 employee when the employee does not work or reside within a service
2 area] <u>does not have eligible individuals who live, work, or reside in the</u>
3 <u>service area for such plan</u>, or if the health maintenance organization
4 reasonably anticipates and demonstrates to the satisfaction of the
5 commissioner that it will not have the capacity in its network of
6 providers within the service area to deliver service adequately to the
7 members of such groups because of its obligations to existing group
8 contract holders and enrollees. <u>Upon denying health insurance</u>
9 <u>coverage in any service area as a result of insufficient network</u>
10 <u>capacity in accordance with this subsection, the health maintenance</u>
11 <u>organization shall not offer coverage in the small employer market</u>
12 <u>within such service area for a period of at least 180 days after the date</u>
13 <u>the coverage is denied.</u>
14 b. No small employer carrier shall be required to offer coverage or
15 accept applications pursuant to this act for any period of time in which
16 the commissioner determines that the requiring of the issuing of
17 policies or contracts pursuant to this act would place the carrier in a
18 financially impaired position.
19 c. A health maintenance organization which complies with the basic
20 health benefits, underwriting and rating standards established by the
21 federal government pursuant to subchapter XI of Pub.L.93-222
22 (42.U.S.C. §300e et seq.), and which also provides the comprehensive
23 health benefit plans coverage required by subsection f. of section 3 of
24 P.L.1992, c.162 (C.17B:27A-19), shall be deemed in compliance with
25 this act.
26 (cf: P.L.1993, c.162, s.11)
27
28 13. Section 17 of P.L1992, c.162 (C.17B:27A-33) is amended to
29 read as follows.
30 17. Subject to the approval of the commissioner, the board shall
31 formulate the five health benefits plans to be made available by small
32 employer carriers in accordance with the provisions of this act, and
33 shall promulgate five standard forms pursuant thereto. The board may
34 establish benefit levels, deductibles and co-payments, exclusions, and
35 limitations for such health benefits plans in accordance with the law.
36 <u>The board shall ensure that the means exist for a carrier to offer high</u>
37 <u>deductible health benefits plan options that are consistent with section</u>
38 <u>301 of Title III of the "Health Insurance Portability and Accountability</u>
39 <u>Act of 1996," Pub.L. 104-191, regarding tax-deductible medical</u>
40 <u>savings accounts.</u>
41 The board shall submit the forms so established to the commissioner
42 for [his] approval . The commissioner shall approve the forms if [he]
43 <u>the commissioner</u> finds them to be consistent with the provisions of
44 section 3 of P.L.1992, c. 162 (C.17B:27A-19). Any form submitted
45 to the commissioner by the board shall be deemed approved if not
46 expressly disapproved in writing within 60 days of its receipt by the

1 commissioner. Such forms may contain, but shall not be limited to, the
2 following provisions:
3 a. Utilization review of health care services, including review of
4 medical necessity of hospital and physician services;
5 b. Managed care systems, including large case management;
6 c. Provisions for selective contracting with hospitals, physicians,
7 and other [health care] participating and nonparticipating providers;
8 d. Reasonable benefits differentials which are applicable to
9 participating and nonparticipating providers;
10 e. Notwithstanding the provisions of section 4 of P.L.1992, c.162
11 (C.17B:27A-20) to the contrary, the board may, from time to time,
12 adjust coinsurance and deductibles;
13 f. Such other provisions which may be quantifiably established to
14 be cost containment devices;
15 g. The department shall publish annually a list of the premiums
16 charged for each of the five small employer health benefits plans and
17 for any rider package by all carriers writing such plans. The
18 department shall also publish the toll free telephone number of each
19 such carrier.
20 (cf: P.L.1993, c.162, s.8)
21
22 14. (New section) The provisions of sections 14 through 27 of
23 P.L. , c. (C.)(pending before the Legislature as this bill) shall
24 apply to group health insurance coverage that is not subject to the
25 provisions of P.L.1992, c.161 and c.162 (C.17B:27A-2 et seq. and
26 17B:27A-17 et seq.). To the extent that any provision of sections 14
27 through 27 of P.L. c. (C.)(pending before the Legislature as this
28 bill) is inconsistent with the provisions of chapter 27 of Title 17B of
29 the New Jersey Statutes and P.L.1973, c.337 (C.26:2J-1 et seq.), the
30 provisions of sections 14 through 27 shall supercede those laws.
31 As used in sections 14 through 27 of P.L. , c. (C.)(pending
32 before the Legislature as this bill):
33 "Affiliation period" means a period which, under the terms of the
34 group health plan offered by a health maintenance organization, begins
35 on the enrollment date and which must expire before the health
36 insurance becomes effective. The health maintenance organization
37 shall not be required to provide health care services or benefits during
38 such period and no premium shall be charged.
39 "Creditable coverage" means, with respect to an individual,
40 coverage of the individual, other than coverage of excepted benefits,
41 under any of the following: a group health plan; health insurance
42 coverage; Part A or Part B of Title XVIII of the federal Social
43 Security Act (42U.S.C.§1395 et seq.); Title XIX of the federal Social
44 Security Act (42U.S.C.§1396 et seq.); other than coverage consisting
45 solely of benefits under section 1928 of Title XIX of the federal Social
46 Security Act (42U.S.C.§1396s); chapter 55 of Title 10, United States

1 Code (10 U.S.C.§1071 et seq.); a medical care program of the Indian
2 Health Service of a tribal organization; a State health benefits risk
3 pool; a State health plan offered under chapter 89 of Title 5, United
4 States Code (5U.S.C. 8901 et seq.); a public health plan; and a health
5 benefits plan under section 5(e) of the "Peace Corps Act" (22
6 U.S.C.§2504(e)).
7 "Enrollment date" means, with respect to an individual covered
8 under a group health plan or health insurance coverage, the date of
9 enrollment of the individual in the plan or coverage or, if earlier, the
10 first day of the waiting period for enrollment.
11 "Excepted benefits" means:
12 a. coverage only for accident or disability income insurance, or any
13 combination thereof; coverage issued as a supplement to liability
14 insurance; liability insurance, including general liability insurance and
15 automobile liability insurance; workers* compensation or similar
16 insurance; automobile medical payment insurance; credit-only
17 insurance; coverage for on-site medical clinics; and other similar
18 insurance coverage, as specified by federal regulation, under which
19 benefits for medical care are secondary or incidental to other insurance
20 benefits.
21 b. when provided under a separate policy, certificate or contract of
22 insurance or otherwise not an integral part of the group health plan:
23 limited scope dental or vision benefits, benefits for long-term care,
24 nursing home care, home health care, community-based care, or any
25 combination thereof, and such other similar, limited benefits as are
26 specified by federal regulation;
27 c. when offered as independent, noncoordinated benefits: hospital
28 indemnity or other fixed indemnity insurance;
29 d. when offered as a separate insurance policy, certificate or
30 contract of insurance: Medicare supplemental insurance as defined
31 under section 1882(g)(1) of the federal Social Security Act (42
32 U.S.C.§1395ss(g)(1))and coverage supplemental to the coverage
33 provided under chapter 55 of Title 10, United States Code (10
34 U.S.C.§1071 et seq.) and similar supplemental coverage provided in
35 addition to coverage under a group health plan.
36 "Group health plan" means an employee welfare benefit plan, as
37 defined in Title 1 of section 3 of Pub.L.93-406, the "Employee
38 Retirement Income Security Act of 1974," (29 U.S.C.§1002(1)), to
39 the extent that the plan provides medical care and including items and
40 services paid for as medical care to employees or their dependents, as
41 defined under the terms of the plan, directly or through insurance,
42 reimbursement or otherwise.
43 "Health insurance coverage" means benefits consisting of medical
44 care, provided directly, through insurance or reimbursement, or
45 otherwise, and including items and services paid for as medical care,
46 under any hospital or medical expense policy or certificate or health

maintenance organization contract offered by a health insurer.
"Health insurer" means an insurer licensed to sell health insurance pursuant to Title 17B of the New Jersey Statutes, a health, hospital or medical service corporation, fraternal benefit association or a health maintenance organization.
"Health status-related factor" means: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.
"Health maintenance organization" means a federally qualified health maintenance organization as defined in the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.§300e et seq.), an organization authorized under P.L.1973, c.337 (C.26:2J-1 et seq.), or a similar organization regulated under State law for solvency in the same manner and to the same extent as a health maintenance organization authorized to do business in this State.
"Late enrollee" means a participant or beneficiary who enrolls in a group health plan other than during: the first period during which the individual is eligible to enroll in the plan; or a special enrollment period.
"Medical care" means amounts paid: (1) for the diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and (2) transportation primarily for and essential to medical care referred to in (1) above.
"Network plan" means a group health plan offered by a health insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. Network plan includes a health maintenance organization or health insurance company with selective contracting arrangements.
"Preexisting condition" means with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.
"Waiting period" means with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

15. (New section) A health insurer may impose a preexisting condition exclusion in its group health plan only if:
a. the exclusion relates to a physical or mental condition for which

medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date of the participant or beneficiary;

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

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

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

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

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

19. (New section) Except as provided in this section, a health insurer which offers a group health plan shall count a period of creditable coverage without regard to the specific benefits covered during the period. A health insurer offering a group health plan may elect to apply creditable coverage based on coverage of each of several classes or categories of benefits as specified by federal regulation where such election is made or a uniform basis for all participants and beneficiaries and where under such election a health insurer shall count a period of creditable coverage with respect to any class or category

1 of benefits if any level of benefits is covered within the class or
2 category. A health insurer who makes the election with respect to
3 group health plans offered in this State shall prominently state in any
4 disclosure statement concerning the coverage and to each employer at
5 the time of the offer or sale of the coverage, that the health insurer has
6 made that election and shall include in the disclosure statements a
7 description of the effect of the election.
8 A health insurer shall promptly disclose to a requesting plan or
9 insurer and may charge a reasonable fee for information on, coverage
10 of classes and categories of health benefits available under its
11 coverage.
12
13 20. (New section) a. A health insurer which offers a group health
14 plan shall provide a written certification of creditable coverage at the
15 time an individual ceases coverage or otherwise becomes covered
16 under a COBRA continuation provision; at the time an individual
17 ceases to be covered under a COBRA continuation provision; and
18 upon request, on behalf of an individual not later than 24 months after
19 the cessation of coverage under the plan or a COBRA continuation
20 provision.
21 b. The written certification of creditable coverage shall include the
22 period of creditable coverage of the individual under the group health
23 plan and the coverage under any COBRA continuation provision and
24 any waiting or affiliation period imposed with respect to the individual
25 for coverage under the plan.
26
27 21. (New section) A health maintenance organization which offers
28 a group health plan and which does not impose a preexisting condition
29 exclusion, may impose an affiliation period if the period is applied
30 uniformly without regard to any health status-related factors and the
31 period does not exceed two months, or three months in the case of a
32 late enrollee.
33
34 22. (New section) A health insurer which offers a group health
35 plan shall permit an employee or dependent who is eligible, but not
36 enrolled, for coverage under the terms of the plan, to enroll for
37 coverage if:
38 a. the employee or dependent was covered under a group health
39 plan or had health insurance coverage at the time coverage was
40 previously offered to the employee or dependent, and the employee
41 stated in writing at such time that coverage under a group health plan
42 or health insurance coverage was the reason for declining enrollment,
43 if the health insurer required such a statement at that time and notified
44 the employee of the insurer*s requirements;
45 b. the employee*s or dependent*s other coverage described in
46 subsection a. of this section was under a COBRA continuation

provision and coverage under that provision was exhausted or the coverage was terminated due to loss of eligibility for coverage, including legal separation, divorce, death, termination of employment and reduction in hours of employment, or to the termination of employer contributions toward that coverage; and

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

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

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

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

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

25. (New section) A health insurer which offers a group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution which is greater than the premium or contribution for a similarly situated enrollee in the plan on the basis of any health status-related

factor in relation to the individual or to an enrollee or a dependent of the individual or enrollee. This provision shall not be construed to restrict the amount that an employer may be charged for coverage under a group health plan or to prevent a health insurer offering group health insurance coverage from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

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

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

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

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

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

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

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

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

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

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

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

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

d. A health insurer may cease offering and nonrenew all health

insurance coverage only if:

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

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

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

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

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

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

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