SENATE, No. 2330

STATE OF NEW JERSEY

INTRODUCED DECEMBER 1, 1997

By Senator SINAGRA

AN ACT concerning health insurance and amending P.L.1992, c.161.

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

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

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

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

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C.s.1395 et seq.); Title XIX of the federal Social Security Act (42 U.S.C.s.1396 et seq.), other than coverage consisting solely of benefits under section

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

Matter underlined <u>thus</u> is new matter.

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

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

"Department" means the Department of Banking and Insurance.

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

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

"Federally defined eligible individual" means an eligible person: (1) for whom, as of the date on which the individual seeks coverage under P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months; (2) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan; (3) who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C.s.1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan; (4) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; (5) who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and (6) who has elected continuation coverage described in (5) above and has exhausted that continuation coverage.

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

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

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

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

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this act, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event

without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

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

Individual health benefits plan shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan, to the extent the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1001 et seq.) preempts the application of P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

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

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

"Net earned premium" means the premiums earned in this State on

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

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

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

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

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

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

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

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

"Two-year calculation period" means a two calendar year period, the first of which shall begin January 1, **[**1997**]** 1998 and end December 31, **[**1998**]** 1999.

(cf:P.L.1997, c.146, s.1)

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

11. The board shall establish procedures for the equitable sharing

of program losses among all members in accordance with their total market share as follows:

a. (1) By March 1, **[**1999**]** 2000, and following the close of each two-year calculation period thereafter, or on a different date established by the board:

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

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

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

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

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

or a member of the program either jointly or separately except as otherwise provided in this act.

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

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

(2) Notwithstanding the provisions of paragraph (1) of this subsection to the contrary, a health maintenance organization qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub.L 93-222 (42 U.S.C. s.300e et seq.) and tax exempt pursuant to paragraph (3) of subsection (c) of section 501 of the federal Internal Revenue Code of 1986, 26 U.S.C. s.501, may include up to one third Medicaid recipients and up to one third Medicare recipients in determining whether it meets its minimum number of non-group person life years.

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

that are exempt from the assessment.

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

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

To the extent that the carrier has failed to cover the minimum number of non-group person life years established by the board, the carrier shall be assessed by the board on a pro rata basis for any differential between the minimum number established by the board and the actual number covered by the carrier.

(6) A carrier that applies for the exemption shall be deemed to be in compliance with the requirements of this subsection if it has covered 100% of the minimum number of non-group person life years required.

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

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

(cf:P.L.1997, c.146, s.6)

3. This act shall take effect immediately.

STATEMENT

This bill corrects the dates for the beginning of the initial "two-year calculation period" for assessments of health insurers under the New Jersey Individual Health Coverage Program. The two-year calculation period was established in P.L.1997, c.146 and the change to a two-year calculation period was to be prospective, beginning in 1998 to allow insurers sufficient time to plan for the change. However, as enacted, the 1997 law actually made the change retroactive, beginning on January 1, 1997.

Revises date for beginning of two-year calculation period for assessments under the Individual Health Coverage Program.