17B:27A-4.4

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 368
NJSA: 17B:27A-4.4 (Affordable health benefits plans)
BILL NO: S13 (Substituted forA3447/2791)
SPONSOR(S): Matheussen and Sinagra
DATE INTRODUCED: September 21, 2000
COMMITTEE: **ASSEMBLY:** Health; Banking and Insurance
SENATE: Health
AMENDED DURING PASSAGE: Yes
DATE OF PASSAGE: **ASSEMBLY:** December 10, 2001
SENATE: January 7, 2002
DATE OF APPROVAL: January 8 2002
FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (4th reprint enacted)
(Amendments during passage denoted by superscript numbers)

S13

SPONSORS STATEMENT: (Begins on page 6 of original bill) Yes
COMMITTEE STATEMENT: **ASSEMBLY**: Yes 5-3-2001(Health)
6-4-2001(Banking& Ins)
SENATE: Yes
FLOOR AMENDMENT STATEMENTS: Yes 12-4-2000
6-14-2001
LEGISLATIVE FISCAL ESTIMATE: No

A3447/2791

SPONSORS STATEMENT (A3447): (Begins on page 6 of original bill) Yes
SPONSORS STATEMENT (A2791): (Begins on page 6 of original bill) Yes
COMMITTEE STATEMENT: **ASSEMBLY**: Yes 5-3-2001(Health)
Identical to Assembly Health statement for S13
6-4-2001(Banking&Ins)
Identical to Assembly Banking statement to S13
SENATE: No
FLOOR AMENDMENT STATEMENTS: No
LEGISLATIVE FISCAL ESTIMATE: No
FINAL VERSION (ACS, 1ST Reprint): Yes

VETO MESSAGE: No
GOVERNOR'S PRESS RELEASE ON SIGNING: No

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or mailto:refdesk@njstatelib.org
REPORTS: No
HEARINGS: Yes
974.90 New Jersey. Legislature. Senate. Health Committee.
I59 Public meeting on the affordability and accessibility of health insurance, held
2000 February 23, 2000. Trenton, 2000
NEWSPAPER ARTICLES: No

SENATE, No. 13

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

Co-Sponsored by:
Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano and McNamara

SYNOPSIS

Requires individual and small employer group carriers to offer a new health benefits plan.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 10/24/2000)

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17:27A-17 et seq.).

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual and small group markets that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and removing most preexisting condition exclusions from policies, the plans that were established by the respective boards did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The boards of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by either board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plans provided by this act will make health insurance more accessible to many individuals and small groups that do not have the economic resources to afford the existing plans while still providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L. 1992, c. 161

(C.17B:27A-2 et seq.), every carrier shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:
90 days hospital room and board - $500 deductible per hospital stay;
Outpatient and ambulatory surgery;
Physicians' fees connected with hospital care, including general acute care and surgery;
Anesthesia and the administration of anesthesia;
Coverage for newborns;
Treatment for complications of pregnancy;
IV Solutions, blood and blood plasma;
Oxygen and the administration of oxygen;
Radiation and x-ray therapy;
Physical therapy and hydrotherapy - $20 deductible for outpatient treatment;
Dialysis - inpatient or outpatient;
Inpatient diagnostic tests and $500 annual aggregate for out-of-hospital diagnostic tests;
Laboratory fees for treatment in hospital;
Delivery room fees;
Operating room fees;
Intensive care unit;
Treatment room fees;
Emergency room services for medically necessary treatment;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for Nervous and Mental Conditions - 30 Days inpatient or outpatient - 30% copayment;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% copayment;
Wellness benefit - $600 per year, $50 deductible, 20% coinsurance per service; and
Physicians visits per year for diagnosed illness or injury - to an aggregate of $700 per year.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network or preferred provider organization; and (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with a 30% copayment in addition to whatever other copayment may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of

individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P. L. 1992, c. 162 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to guaranteed issue, calculation of loss ratio, and the liability for assessment.

f. No later than 120 days following enactment of this act, every carrier shall make an informational filing with the commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the commissioner has not disapproved the form within 30 days, the form shall be approved.

g. Every carrier and every insurance producer shall make a good faith effort to market the contract or policy established pursuant to this section. If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

3. a. Notwithstanding the provisions of P.L. 1992, c. 162 (C.17B:27A-17 et seq.), every small employer carrier shall offer a small employer health benefits plan that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 deductible per stay;
Outpatient and ambulatory surgery;
Physicians' fees connected with hospital care, including general acute care and surgery;
Anesthesia and the administration of anesthesia;
Coverage for newborns;
Treatment for complications of pregnancy;
IV Solutions, blood and blood plasma;
Oxygen and the administration of oxygen;
Radiation and x-ray therapy;
Physical therapy and hydrotherapy - $20 deductible for outpatient treatment;
Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate for out-of-hospital diagnostic tests;
Laboratory fees for treatment in hospital;
Delivery room fees;
Operating room fees;
Intensive care unit;
Treatment room fees;
Emergency room services for medically necessary treatment;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for Nervous and Mental Conditions - 30 Days inpatient or outpatient - 30% copayment;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% copayment;
Wellness benefit - $600 per year, $50 deductible, 20% coinsurance per service; and
Physicians visits per year for diagnosed illness or injury - to an aggregate of $700 per year.

b. A carrier shall offer the benefits on an indemnity basis, with an option that: (1) coverage is restricted to health care providers in the carrier's network or preferred provider organization; or (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with a 30% copayment in addition to whatever other copayment may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated small employer group shall not be greater than 350% of the premium rate charged for the lowest rated small employer group purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.

d. Carriers may offer enhanced or additional benefits for an additional premium in the form of a rider or riders, which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P. L. 1992, c. 162 (C.17B:27A-17 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to guaranteed issue, calculation of loss ratio, and the liability for assessment.

f. No later than 120 days following enactment of this act, every carrier shall make an informational filing with the commissioner, which

shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the commissioner has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier and every insurance producer shall make a good faith effort to market the contract or policy established pursuant to this section. If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

4. This act shall take effect immediately.

STATEMENT

This bill adds an additional, more affordable health insurance policy to the standard health beneftis plans offered in the individual and small employer group markets. When the respective boards of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program formulated the standard plans, they disregarded the language in the law and the legislative intent that there would be a variation in benefits among the plans, creating lower-cost policies. As a result, the standard plans are uniformly rich in benefits and for many people, increasingly unaffordable.

The plans set forth in this bill are modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This bill embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policyholders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses are administrative costs of processing claims, premium taxes, commissions, insurer profits, and provider expenses connected with the third party payer system.

This plan provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. It must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member or a member of a small employer group. It contains the same preexisting condition provisions as the standard plans.

The bill is aimed at making health insurance available for younger

families who do not have the resources to pay for coverage in the individual market, as well as small employers who cannot afford the small group policies currently offered. To this end, this policy is not to be community rated, permitting a differential of 350% from the highest-to-lowest premium, which is advantageous to the younger people without insurance coverage; the other plans in the individual market continue to be community rated and the standard plans in the small employer group market continue to be rated at a 2-1 ratio of highest-to-lowest premiums.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 13

with committee amendments

STATE OF NEW JERSEY

DATED: NOVEMBER 9, 2000

The Senate Health Committee reports favorably and with committee amendments Senate Bill No. 13.

As amended by committee, this bill adds an additional, more affordable health insurance policy to the standard health benefits plans offered in the individual and small employer markets.

The health benefits plans established in this bill are modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This bill embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policyholders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses include administrative costs of processing claims and provider expenses connected with the third party payer system.

The health benefits plans in this bill provide for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plans must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member or a member of a small employer group. The plans contain the same preexisting condition provisions as the standard plans.

The bill is aimed at making health insurance available for younger families who do not have the resources to pay for coverage in the individual market, as well as small employers who cannot afford the small group policies currently offered. To this end, this policy will not be community rated, permitting a differential of 350% from the highest-to-lowest premium, which is advantageous to younger persons without insurance coverage; the other plans in the individual market continue to be community rated and the standard plans in the small employer group market continue to be rated at a 2 to1 ratio of highest-to-lowest premiums.

The committee adopted technical amendments to the bill to clarify the intent of the bill.

[First Reprint]

SENATE, No. 13

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

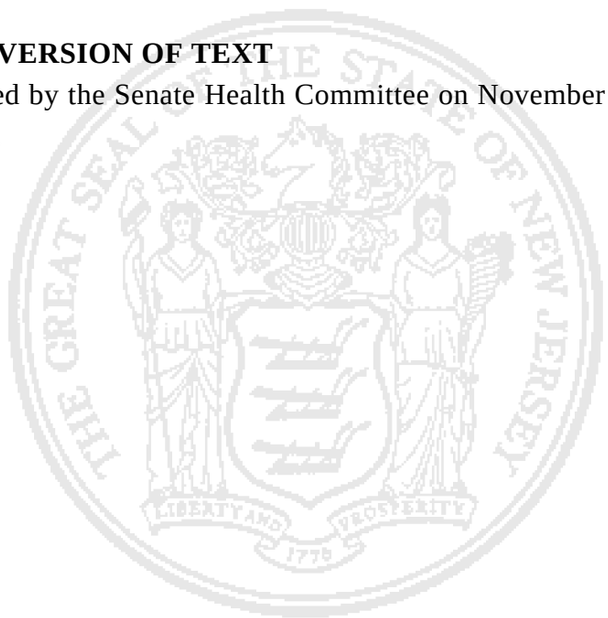
Co-Sponsored by:
Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano and McNamara

SYNOPSIS

Requires individual and small employer group carriers to offer a new health benefits plan.

CURRENT VERSION OF TEXT

As reported by the Senate Health Committee on November 9, 2000, with amendments.



(Sponsorship Updated As Of: 10/24/2000)

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17:27A-17 et seq.).

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual and small group markets that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and removing most preexisting condition exclusions from policies, the plans that were established by the respective boards did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The boards of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by either board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plans provided by this act will make health insurance more accessible to many individuals and small groups that do not have the economic resources to afford the existing plans while still providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted November 9, 2000.

providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier [1]that writes individual health benefits plans pursuant to P.L.1992, c.161[1] shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 deductible per hospital stay;

Outpatient and ambulatory surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

[1][IV Solutions] Intravenous solutions[1], blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Physical therapy and hydrotherapy - $20 deductible for outpatient treatment;

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

Intensive care unit;

Treatment room fees;

Emergency room services for medically necessary treatment;

Pharmaceuticals dispensed in hospital;

Dressings;

Splints;

Treatment for Nervous and Mental Conditions- 30 Days inpatient or outpatient - 30% copayment;

Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% copayment;

Wellness benefit - $600 per year, $50 deductible, 20% coinsurance per service; and

Physicians visits [1][per year][1] for diagnosed illness or injury - to an aggregate of $700 per year.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network [1][or preferred provider organization][1];[1][and] or[1] (2) coverage is provided through health care providers in the carrier's network [1][or preferred provider organization] [1]with an out-of-network option with a 30% copayment in addition to whatever other

copayment may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.**[1]**[162]**]** 161**[1]** (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to **[1]**preexisting conditions,**[1]** guaranteed issue, calculation of loss ratio, and the liability for assessment.

f. No later than 120 days following enactment of this act, every carrier shall make an informational filing with the commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the commissioner has not disapproved the form within 30 days, the form shall be **[1]**deemed**[1]** approved.

g. Every carrier and every insurance producer shall make a good faith effort to market the contract or policy established pursuant to this section. If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

3. a. Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.), every **[1]**[small employer]**[1]** carrier **[1]**that writes small employer health benefits plans pursuant to P.L.1992, c.162**[1]** shall offer a small employer health benefits plan that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 deductible per stay;

Outpatient and ambulatory surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

[1]⟦IV Solutions⟧ Intravenous solutions[1], blood and blood plasma;
Oxygen and the administration of oxygen;
Radiation and x-ray therapy;
Physical therapy and hydrotherapy - $20 deductible for outpatient treatment;
Dialysis - inpatient or outpatient;
Inpatient diagnostic tests and $500 annual aggregate for out-of-hospital diagnostic tests;
Laboratory fees for treatment in hospital;
Delivery room fees;
Operating room fees;
Intensive care unit;
Treatment room fees;
Emergency room services for medically necessary treatment;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for Nervous and Mental Conditions - 30 Days inpatient or outpatient - 30% copayment;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% copayment;
Wellness benefit - $600 per year, $50 deductible, 20% coinsurance per service; and
Physicians visits [1]⟦per year⟧[1] for diagnosed illness or injury - to an aggregate of $700 per year.

b. A carrier shall offer the benefits on an indemnity basis, with an option that: (1) coverage is restricted to health care providers in the carrier's network [1]⟦or preferred provider organization⟧[1]; or (2) coverage is provided through health care providers in the carrier's network [1]⟦or preferred provider organization⟧[1] with an out-of-network option with a 30% copayment in addition to whatever other copayment may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated small employer group shall not be greater than 350% of the premium rate charged for the lowest rated small employer group purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.

d. Carriers may offer enhanced or additional benefits for an additional premium in the form of a rider or riders, which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) shall

apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to[1] preexisting conditions,[1] guaranteed issue, calculation of loss ratio, and the liability for assessment.

f. No later than 120 days following enactment of this act, every carrier shall make an informational filing with the commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the commissioner has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier and every insurance producer shall make a good faith effort to market the contract or policy established pursuant to this section. If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

4. This act shall take effect immediately.

STATEMENT TO

[First Reprint]

SENATE, No. 13

with Senate Floor Amendments
(Proposed By Senator MATHEUSSEN)

ADOPTED: DECEMBER 4, 2000

These amendments:

(1) provide that the limited, new health benefits plan would apply only to individual policies and delete the provisions establishing such a plan for small employers;

(2) clarify the benefits that shall be provided under the plan by:

- establishing copayments for outpatient and ambulatory surgery ($250 per surgery) and emergency room treatment ($100 per visit);
- providing coverage for physicians' fees connected with outpatient and ambulatory surgery, outpatient physical therapy (30 visits annually with a $20 per treatment copayment, treatment for biologically-based mental illness (90 days inpatient with no coinsurance, but $500 copayment per inpatient stay, and 30 days outpatient with 30% coinsurance), rather than treatment for nervous and mental conditions, and childhood and adult immunizations; and
- replacing the terms deductible and copayment with copayment and coinsurance, respectively, to better reflect the nature of the insured's payment responsibility;

(3) restore language permitting carriers to offer the benefits with the option that coverage is restricted to health care providers in the carrier's preferred provider organization, and add language specifying that a carrier may offer coverage through an exclusive provider organization (EPO);

(4) delete language specifying that the policies issued under this bill shall be rated separately from the five standard plans in accordance with their own loss experience and specify, instead, that rates shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered;

(5) delete language that provided that carrier liability for assessment under N.J.S.A.17B:27A-11 would also apply for policies issued under this bill, and provide, instead, that the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to policies issued under this bill. The formula shall provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in

their premium, taking into account the differential in benefit levels under the health benefits plans provided for in this bill and the five standard health benefits plans;

(6) extend the effective date of the bill from immediately to nine months after enactment and require carriers to make an informational filing with the board, including the policy form, within one year of the date of enactment;

(7) delete language that requires an insurance producer to make a good faith effort to market the plan and provide, instead, that a carrier shall <u>make available</u> and make a good faith effort to market the plan. Also, amendments delete the fine for failure to make a good faith effort, and provide, instead, that a carrier that fails to comply with the marketing requirement would be subject to the provisions of the insurance trade practices act, N.J.S.A.17B:30-1 et seq.;

(8) direct the individual and small employer boards to evaluate the effectiveness of the bill and determine if the limited health benefits plan should be extended to the small employer market; and

(9) permit carriers in the small employer market to offer one or more, but not all five, of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care.

[Second Reprint]

SENATE, No. 13

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

Co-Sponsored by:
Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano and McNamara

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As amended by the Senate on December 4, 2000.

(Sponsorship Updated As Of: 10/24/2000)

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17:27A-17 et seq.).

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual [2]**[**and small group markets**]**market[2] that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and [2]**[**removing most**]** limiting[2] preexisting condition exclusions [2]**[**from**]** in[2] policies, the plans that were established by the [2]**[**respective boards**]**New Jersey Individual Health Coverage Program Board[2] did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The [2]**[**boards of the**]**[2] New Jersey Individual Health Coverage Program [2]**[**and the New Jersey Small Employer Health Benefits Program**]**Board[2] elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by [2]**[**either**]**the[2] board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit [2]**[**plans**]** plan[2] provided by this act will make health insurance more accessible to many individuals [2]**[**and small groups**]**[2] that do not have the economic resources to afford the existing plans while still

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted November 9, 2000.
[2] Senate floor amendments adopted December 4, 2000.

providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier [1]that writes individual health benefits plans pursuant to P.L.1992, c.161[1] shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 [2][deductible]copayment[2] per hospital stay;

Outpatient and ambulatory surgery [2]- $250 copayment per surgery[2];

Physicians' fees connected with hospital care, including general acute care and surgery;

[2]Physicians' fees connected with outpatient and ambulatory surgery[2]

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

[1][IV Solutions] Intravenous solutions[1], blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

[2][Physical] Inpatient physical[2] therapy and hydrotherapy

[2]Outpatient physical therapy[2] - [2]30 visits annually per covered person-[2] $20 [2][deductible for outpatient treatment] copayment per treatment[2];

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate [2]per covered person[2] for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

[2][Intensive] Special[2] care unit;

Treatment room fees;

Emergency room services for medically necessary treatment [2]- $100 copayment per visit[2];

Pharmaceuticals dispensed in hospital;

Dressings;

Splints;

[2][Treatment for Nervous and Mental Conditions- 30 Days inpatient or outpatient- 30% copayment] Treatment for biologically-based mental illness, as defined in P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance[2];

Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% [2][copayment] coinsurance[2];

[2]Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;[2]

Wellness benefit - $600 [2][per year] annual aggregate per covered person[2], $50 [2]annual[2] deductible, 20% coinsurance per service; and

Physicians visits[1][per year][1] for diagnosed illness or injury- to an [2]$700 annual[2] aggregate [2][of $700 per year] per covered person[2].

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network [1][or preferred provider organization][1] [2], including an exclusive provider organization, or the carrier's preferred provider organization[2];[1][and] or[1] (2) coverage is provided through health care providers in the carrier's network [1][or preferred provider organization][1] [2]or preferred provider organization[2] with an out-of-network option with [2][a][2] 30% [2][copayment]coinsurance[2] in addition to whatever other [2][copayment]coinsurance[2] may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. [2][Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.] Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.[2]

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.[1][162] 161[1] (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to [1]preexisting conditions,[1] guaranteed issue,

calculation of loss ratio[2][, and the liability for assessment][2]. [2] With respect to liability for assessment, the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to health benefits plans issued pursuant to this act. The formula shall provide for an equitable allocation of a carrier's assessment pursuant to section 11 of P.L. 1992, c. 161 (C.17B:27A-11), so that persons covered by the health benefits plan provided for in this act do not bear a disproportionate burden of a carrier's assessment in their premium, taking into account the differential in benefit levels under the health benefits plans provided for in this act and those health benefits plans issued pursuant to P.L. 1992, c.161 (C:17B:27A-2 et seq.). The formula may take into account the relative loss experience, relative actuarial value based on benefits offered, relative loss ratio, relative administrative expenses, and such other items as the board deems appropriate.[2]

f. No later than [2][120 days] one year[2] following enactment of this act, every carrier shall make an informational filing with the [2][commissioner] board[2], which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the [2][commissioner] board[2] has not disapproved the form within 30 days, the form shall be [1]deemed[1] approved.

g. Every carrier [2][and every insurance producer]that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and[2] shall make a good faith effort to market the contract or policy established pursuant to this section. [2][If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).] A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.[2]

[2][3. a. Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.), every [1][small employer][1] carrier [1]that writes small employer health benefits plans pursuant to P.L.1992, c.162[1] shall offer a small employer health benefits plan that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 deductible per stay;

Outpatient and ambulatory surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

[1]⟦IV Solutions⟧ Intravenous solutions[1], blood and blood plasma;
Oxygen and the administration of oxygen;
Radiation and x-ray therapy;
Physical therapy and hydrotherapy - $20 deductible for outpatient treatment;
Dialysis - inpatient or outpatient;
Inpatient diagnostic tests and $500 annual aggregate for out-of-hospital diagnostic tests;
Laboratory fees for treatment in hospital;
Delivery room fees;
Operating room fees;
Intensive care unit;
Treatment room fees;
Emergency room services for medically necessary treatment;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for Nervous and Mental Conditions - 30 Days inpatient or outpatient - 30% copayment;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% copayment;
Wellness benefit - $600 per year, $50 deductible, 20% coinsurance per service; and
Physicians visits [1]⟦per year⟧[1] for diagnosed illness or injury - to an aggregate of $700 per year.

b. A carrier shall offer the benefits on an indemnity basis, with an option that: (1) coverage is restricted to health care providers in the carrier's network [1]⟦or preferred provider organization⟧[1]; or (2) coverage is provided through health care providers in the carrier's network [1]⟦or preferred provider organization⟧[1] with an out-of-network option with a 30% copayment in addition to whatever other copayment may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated small employer group shall not be greater than 350% of the premium rate charged for the lowest rated small employer group purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.

d. Carriers may offer enhanced or additional benefits for an additional premium in the form of a rider or riders, which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) shall

apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to[1]preexisting conditions,[1] guaranteed issue, calculation of loss ratio, and the liability for assessment.

f. No later than 120 days following enactment of this act, every carrier shall make an informational filing with the commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the commissioner has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier and every insurance producer shall make a good faith effort to market the contract or policy established pursuant to this section. If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).**]**[2]

[2]3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in their report the number of policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.[2]

[2]4. A carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may offer one or more of the five health benefits plans, but shall not offer all five, as policies or contracts that require the policy holder or contract holder to receive plan benefits solely through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts

shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).[2]

[2][4.] 5.[2] This act shall take effect [2][immediately] on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act[2].

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

[Second Reprint]

SENATE, No. 13

STATE OF NEW JERSEY

DATED: MAY 3, 2001

The Assembly Health Committee reports favorably Senate Bill No. 13 (2R).

This bill adds an additional, more affordable health insurance policy to the standard health benefits plans offered in the individual market.

The health benefits plan established in this bill is modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This bill embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policyholders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses include administrative costs of processing claims and provider expenses connected with the third party payer system.

The health benefits plan in this bill provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The bill specifies that the rates applicable to policies issued under the bill shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The bill directs the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-12 that is attributable and allocated to policies issued under this bill. The formula shall provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the

differential in benefit levels under the health benefits plan provided for in this bill and the five standard health benefits plans.

In addition, the bill requires that a carrier make available, and make a good faith effort to market, the policy. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The bill directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the bill in providing affordable health care coverage and whether the health benefits plan established in this bill or a similar plan should be made available to small employers.

The bill would permit carriers in the small employer market to offer one or more, but not all five, of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care.

The bill takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The bill is aimed at making health insurance available for younger families who do not have the resources to pay for coverage in the individual market. To this end, this policy will not be community rated, permitting a differential of 350% from the highest-to-lowest premium, which is advantageous to younger persons without insurance coverage; while the other plans in the individual market will continue to be community rated.

This bill is identical to the Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791 (Vandervalk/Gregg/Guear/Greenstein), which the committee also reported on this date.

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

[Second Reprint]

SENATE, No. 13

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Banking and Insurance Committee reports favorably and with committee amendments, Senate Bill No. 13 (2R).

This bill, as amended by the committee, adds an additional health benefits plan to the five standard health benefits plans currently offered in the individual health insurance market.

With the committee amendments, the health benefits plan established under this bill provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The bill specifies that the rates applicable to policies issued under the bill shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The bill also provides that the health benefits plan established under the bill will not be community rated, permitting a differential of 350% from the highest-to-lowest premium; while the other plans in the individual market will continue to be community rated.

In addition, the bill requires that a carrier make available, and make a good faith effort to market, this health benefits plan. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the life and health insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The bill directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the bill in providing affordable health care coverage and whether the health benefits plan established in this bill or a similar plan should be made available to small employers.

The bill also permits that, in addition to the five health benefits plans, health insurance carriers that write in the small employer health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. A carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

The bill takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The committee amendments delete language from the bill which directed the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-12 that is attributable and allocated to the health benefits plan established by this bill and issued by the carriers in the individual market. The formula was to provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this bill and the five standard health benefits plans.

In addition, the amendments clarify that in addition to the five health benefits plans, health insurance carriers that write in the small employer health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. A carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

As released by the committee, this bill is identical to the Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791(1R).

[Third Reprint]

SENATE, No. 13

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

Co-Sponsored by:
Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano, McNamara, Assemblywoman Vandervalk, Assemblymen Gregg, Guear, Assemblywomen Greenstein, Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As reported by the Assembly Banking and Insurance Committee on June 4, 2001, with amendments.

(Sponsorship Updated As Of: 6/15/2001)

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 [3][(C.17:27A-17 et seq.)] (C.17B:27A-17 et seq.)[3].

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual [2][and small group markets]market[2] that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and [2][removing most] limiting[2] preexisting condition exclusions [2][from] in[2] policies, the plans that were established by the [2][respective boards]New Jersey Individual Health Coverage Program Board[2] did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The [2][boards of the][2] New Jersey Individual Health Coverage Program [2][and the New Jersey Small Employer Health Benefits Program]Board[2] elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by [2][either]the[2] board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit [2][plans] plan[2] provided by this act will make health insurance more accessible to many individuals [2][and small groups][2] that do not have the economic resources to afford the existing plans while still

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted November 9, 2000.
[2] Senate floor amendments adopted December 4, 2000.
[3] Assembly ABI committee amendments adopted June 4, 2001.

providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier [1]that writes individual health benefits plans pursuant to P.L.1992, c.161[1] shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 [2][deductible] copayment[2] per hospital stay;

Outpatient and ambulatory surgery [2]- $250 copayment per surgery[2];

Physicians' fees connected with hospital care, including general acute care and surgery;

[2]Physicians' fees connected with outpatient and ambulatory surgery[2]

[3]-[3]

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

[1][IV Solutions] Intravenous solutions[1], blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

[2][Physical] Inpatient physical[2] therapy and hydrotherapy [3]-[3]

[2]Outpatient physical therapy[2] - [2]30 visits annually per covered person-[2] $20 [2][deductible for outpatient treatment] copayment per treatment[2];

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate [2]per covered person[2] for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

[2][Intensive] Special[2] care unit;

Treatment room fees;

Emergency room services for medically necessary treatment [2]- $100 copayment per visit[2];

Pharmaceuticals dispensed in hospital;

Dressings;

Splints;

[2][Treatment for Nervous and Mental Conditions- 30 Days inpatient or outpatient- 30% copayment] Treatment for biologically-based mental illness, as defined in [3]subsection a. of section 6 of[3] P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no

coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance[2];

Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% [2][copayment] coinsurance[2];

[2]Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;[2]

Wellness benefit - $600 [2][per year] annual aggregate per covered person[2], $50 [2]annual[2] deductible, 20% coinsurance per service; and

Physicians visits[1][per year][1] for diagnosed illness or injury - to [3][an] a[3] [2]$700 annual[2] aggregate [2][of $700 per year] per covered person[2].

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network [1][or preferred provider organization][1] [2], including an exclusive provider organization, or the carrier's preferred provider organization[2];[1][and] or[1] (2) coverage is provided through health care providers in the carrier's network [1][or preferred provider organization][1] [2]or preferred provider organization[2] with an out-of-network option with [2][a][2] 30% [2][copayment] coinsurance[2] in addition to whatever other [2][copayment] coinsurance[2] may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. [2][Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.] Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.[2]

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.[1][162] 161[1] (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary

to the provisions of this section, including but not limited to, provisions relating to [1]preexisting conditions,[1] guaranteed issue, [3]and[3] calculation of loss ratio[2][, and the liability for assessment][2]. [3][[2]With respect to liability for assessment, the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to health benefits plans issued pursuant to this act. The formula shall provide for an equitable allocation of a carrier's assessment pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-11), so that persons covered by the health benefits plan provided for in this act do not bear a disproportionate burden of a carrier's assessment in their premium, taking into account the differential in benefit levels under the health benefits plans provided for in this act and those health benefits plans issued pursuant to P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into account the relative loss experience, relative actuarial value based on benefits offered, relative loss ratio, relative administrative expenses, and such other items as the board deems appropriate.[2]][3]

f. No later than [2][120 days] one year[2] following enactment of this act, every carrier shall make an informational filing with the [2][commissioner] board[2], which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the [2][commissioner] board[2] has not disapproved the form within 30 days, the form shall be [1]deemed[1] approved.

g. Every carrier [2][and every insurance producer] that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and[2] shall make a good faith effort to market the contract or policy established pursuant to this section. [2][If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).] A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.[2]

[2]3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in their report the number of policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard

health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.[2]

[2]4. [3][A][3] In addition to the five health benefits plans offered by a carrier on the effective date of this act, a[3] carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may [3]also[3] offer one or more of the [3][five health benefits][3] plans [3][, but shall not offer all five, as policies or contracts that require the policy holder or contract holder to receive plan benefits solely][3] through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. [3]A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier.[3] Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).[2]

[2][4.] 5.[2] This act shall take effect [2][immediately] on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act[2].

STATEMENT TO

[Third Reprint]

SENATE, No. 13

with Assembly Floor Amendments
(Proposed By Assemblywoman VANDERVALK)

ADOPTED: JUNE 14, 2001

This amendment permits that, in addition to the five health benefits plans, health insurance carriers that write in the individual health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. The amendments provide that a carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

[Fourth Reprint]

SENATE, No. 13

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:
Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

Co-Sponsored by:
Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano, McNamara, Assemblywoman Vandervalk, Assemblymen Gregg, Guear, Assemblywomen Greenstein, Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As amended by the General Assembly on June 14, 2001.

(Sponsorship Updated As Of: 6/15/2001)

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 [3][(C.17:27A-17 et seq.)] (C.17B:27A-17 et seq.)[3].

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual [2][and small group markets]market[2] that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and [2][removing most] limiting[2] preexisting condition exclusions [2][from] in[2] policies, the plans that were established by the [2][respective boards]New Jersey Individual Health Coverage Program Board[2] did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The [2][boards of the][2] New Jersey Individual Health Coverage Program [2][and the New Jersey Small Employer Health Benefits Program] Board[2] elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by [2][either] the[2] board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit [2][plans] plan[2] provided by this act will make health insurance more accessible to many individuals [2][and small groups][2] that do not

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted November 9, 2000.
[2] Senate floor amendments adopted December 4, 2000.
[3] Assembly ABI committee amendments adopted June 4, 2001.
[4] Assembly floor amendments adopted June 14, 2001.

have the economic resources to afford the existing plans while still providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier [1]that writes individual health benefits plans pursuant to P.L.1992, c.161[1] shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 [2][deductible] copayment[2] per hospital stay;

Outpatient and ambulatory surgery [2]- $250 copayment per surgery[2];

Physicians' fees connected with hospital care, including general acute care and surgery;

[2]Physicians' fees connected with outpatient and ambulatory surgery[2] [3].[3]

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

[1][IV Solutions] Intravenous solutions[1], blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

[2][Physical] Inpatient physical[2] therapy and hydrotherapy [3].[3]

[2]Outpatient physical therapy[2] - [2]30 visits annually per covered person-[2] $20 [2][deductible for outpatient treatment] copayment per treatment[2];

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate [2]per covered person[2] for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

[2][Intensive] Special[2] care unit;

Treatment room fees;

Emergency room services for medically necessary treatment [2]- $100 copayment per visit[2];

Pharmaceuticals dispensed in hospital;

Dressings;

Splints;

[2][Treatment for Nervous and Mental Conditions- 30 Days inpatient or outpatient- 30% copayment] Treatment for biologically-based mental illness, as defined in [3]subsection a. of section 6 of[3]

P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance[2];

Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% [2][copayment] coinsurance[2];

[2]Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;[2]

Wellness benefit - $600 [2][per year] annual aggregate per covered person[2], $50 [2]annual[2] deductible, 20% coinsurance per service; and

Physicians visits[1][per year][1] for diagnosed illness or injury - to [3][an] a[3] [2]$700 annual[2] aggregate [2][of $700 per year] per covered person[2].

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network [1][or preferred provider organization][1] [2], including an exclusive provider organization, or the carrier's preferred provider organization[2];[1][and] or[1] (2) coverage is provided through health care providers in the carrier's network [1][or preferred provider organization][1] [2]or preferred provider organization[2] with an out-of-network option with [2][a][2] 30% [2][copayment] coinsurance[2] in addition to whatever other [2][copayment] coinsurance[2] may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. [2][Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.] Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.[2]

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.[1][162] 161[1] (C.17B:27A-2 et

seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to [1]preexisting conditions,[1] guaranteed issue, [3]and[3] calculation of loss ratio[2][, and the liability for assessment][2]. [3][2]With respect to liability for assessment, the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to health benefits plans issued pursuant to this act. The formula shall provide for an equitable allocation of a carrier's assessment pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-11), so that persons covered by the health benefits plan provided for in this act do not bear a disproportionate burden of a carrier's assessment in their premium, taking into account the differential in benefit levels under the health benefits plans provided for in this act and those health benefits plans issued pursuant to P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into account the relative loss experience, relative actuarial value based on benefits offered, relative loss ratio, relative administrative expenses, and such other items as the board deems appropriate.[2]][3]

f. No later than [2][120 days] one year[2] following enactment of this act, every carrier shall make an informational filing with the [2][commissioner] board[2], which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the [2][commissioner] board[2] has not disapproved the form within 30 days, the form shall be [1]deemed[1] approved.

g. Every carrier [2][and every insurance producer] that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and[2] shall make a good faith effort to market the contract or policy established pursuant to this section. [2][If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).] A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.[2]

[2]3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in their report the number of policies or contracts sold, the premiums charged and the

effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.[2]

[4]4. In addition to the five health benefits plans offered by a carrier on the effective date of this act, a carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).[4]

[4][[2]4. [3]] 5. [4] [A] In addition to the five health benefits plans offered by a carrier on the effective date of this act, a[3] carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may [3]also[3] offer one or more of the [3][five health benefits][3] plans [3][, but shall not offer all five, as policies or contracts that require the policy holder or contract holder to receive plan benefits solely][3] through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. [3]A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier.[3] Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be

aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).[2]

[2][4.] [4][5.[2]] 6.[4] This act shall take effect [2][immediately] on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act[2].

ASSEMBLY, No. 3447

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED APRIL 19, 2001

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblyman GUY R. GREGG
District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17:27A-17 et seq.).

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual market that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and limiting preexisting condition exclusions in policies, the plans that were established by the New Jersey Individual Health Coverage Program Board did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The New Jersey Individual Health Coverage Program Board elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by the board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plan provided by this act will make health insurance more accessible to many individuals that do not have the economic resources to afford the existing plans while still providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier that writes individual health

benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 copayment per hospital stay;

Outpatient and ambulatory surgery - $250 copayment per surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Physicians' fees connected with outpatient and ambulatory surgery

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

Intravenous solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Inpatient physical therapy and hydrotherapy

Outpatient physical therapy - 30 visits annually per covered person- $20 copayment per treatment;

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate per covered person for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

Special care unit;

Treatment room fees;

Emergency room services for medically necessary treatment - $100 copayment per visit;

Pharmaceuticals dispensed in hospital;

Dressings;

Splints;

Treatment for biologically-based mental illness, as defined in P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;

Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;

Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;

Wellness benefit - $600 annual aggregate per covered person, $50 annual deductible, 20% coinsurance per service; and

Physicians visits for diagnosed illness or injury - to a $700 annual aggregate per covered person.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network, including an exclusive provider organization, or the

carrier's preferred provider organization; or (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with 30% coinsurance in addition to whatever other coinsurance may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to preexisting conditions, guaranteed issue, calculation of loss ratio. With respect to liability for assessment, the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to health benefits plans issued pursuant to this act. The formula shall provide for an equitable allocation of a carrier's assessment pursuant to section 11 of P.L. 1992, c. 161 (C.17B:27A-11), so that persons covered by the health benefits plan provided for in this act do not bear a disproportionate burden of a carrier's assessment in their premium, taking into account the differential in benefit levels under the health benefits plans provided for in this act and those health benefits plans issued pursuant to P.L. 1992, c.161 (C:17B:27A-2 et seq.). The formula may take into account the relative loss experience, relative actuarial value based on benefits offered, relative loss ratio, relative administrative expenses, and such other items as the board deems appropriate.

f. No later than one year following enactment of this act, every carrier shall make an informational filing with the board, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the board has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and shall make a good faith effort to market the contract or policy established pursuant to this section. A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.

3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in their report the number of policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.

4. A carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may offer one or more of the five health benefits plans, but shall not offer all five, as policies or contracts that require the policy holder or contract holder to receive plan benefits solely through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

5. This act shall take effect on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

STATEMENT

This bill adds an additional, more affordable health insurance policy to the standard health benefits plans offered in the individual market.

The health benefits plan established in this bill is modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This bill embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policyholders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses include administrative costs of processing claims and provider expenses connected with the third party payer system.

The health benefits plan in this bill provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The bill specifies that the rates applicable to policies issued under the bill shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The bill directs the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-11 that is attributable and allocated to policies issued under this bill. The formula shall provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this bill and the five standard health benefits plans.

In addition, the bill requires that a carrier make available, and make a good faith effort to market, the policy. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The bill directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the bill in providing affordable health care coverage and whether the health benefits plan established in this bill or a similar plan should be

made available to small employers.

The bill would permit carriers in the small employer market to offer one or more, but not all five, of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care.

The bill takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The bill is aimed at making health insurance available for younger families who do not have the resources to pay for coverage in the individual market. To this end, this policy will not be community rated, permitting a differential of 350% from the highest-to-lowest premium, which is advantageous to younger persons without insurance coverage; while the other plans in the individual market will continue to be community rated.

ASSEMBLY, No. 2791

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED OCTOBER 5, 2000

Sponsored by:
Assemblyman GARY L. GUEAR, SR.
District 14 (Mercer and Middlesex)
Assemblywoman LINDA R. GREENSTEIN
District 14 (Mercer and Middlesex)

Co-Sponsored by:
Assemblywomen Watson Coleman and Weinberg

SYNOPSIS

Requires individual and small employer group carriers to offer a new health benefits plan.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 5/4/2001)

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17:27A-17 et seq.).

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual and small group markets that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and removing most preexisting condition exclusions from policies, the plans that were established by the respective boards did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The boards of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by either board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plans provided by this act will make health insurance more accessible to many individuals and small groups that do not have the economic resources to afford the existing plans while still providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier shall offer a health benefits plan

in the individual health insurance market that includes only the coverages enumerated in this section, as follows:
90 days hospital room and board - $500 deductible per hospital stay;
Outpatient and ambulatory surgery;
Physicians' fees connected with hospital care, including general acute care and surgery;
Anesthesia and the administration of anesthesia;
Coverage for newborns;
Treatment for complications of pregnancy;
IV Solutions, blood and blood plasma;
Oxygen and the administration of oxygen;
Radiation and x-ray therapy;
Physical therapy and hydrotherapy - $20 deductible for outpatient treatment;
Dialysis - inpatient or outpatient;
Inpatient diagnostic tests and $500 annual aggregate for out-of-hospital diagnostic tests;
Laboratory fees for treatment in hospital;
Delivery room fees;
Operating room fees;
Intensive care unit;
Treatment room fees;
Emergency room services for medically necessary treatment;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for Nervous and Mental Conditions - 30 Days inpatient or outpatient - 30% copayment;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% copayment;
Wellness benefit - $600 per year, $50 deductible, 20% coinsurance per service; and
Physicians visits per year for diagnosed illness or injury - to an aggregate of $700 per year.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network or preferred provider organization; and (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with a 30% copayment in addition to whatever other copayment may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however,

that the only factors upon which the rate differential may be based are age, gender, and geography. Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.162 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to guaranteed issue, calculation of loss ratio, and the liability for assessment.

f. No later than 120 days following enactment of this act, every carrier shall make an informational filing with the commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the commissioner has not disapproved the form within 30 days, the form shall be approved.

g. Every carrier and every insurance producer shall make a good faith effort to market the contract or policy established pursuant to this section. If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

3. a. Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.), every small employer carrier shall offer a small employer health benefits plan that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 deductible per stay;

Outpatient and ambulatory surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

IV Solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Physical therapy and hydrotherapy - $20 deductible for outpatient treatment;

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;
Delivery room fees;
Operating room fees;
Intensive care unit;
Treatment room fees;
Emergency room services for medically necessary treatment;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for Nervous and Mental Conditions - 30 Days inpatient or outpatient - 30% copayment;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% copayment;
Wellness benefit - $600 per year, $50 deductible, 20% coinsurance per service; and
Physicians visits per year for diagnosed illness or injury - to an aggregate of $700 per year.

b. A carrier shall offer the benefits on an indemnity basis, with an option that: (1) coverage is restricted to health care providers in the carrier's network or preferred provider organization; or (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with a 30% copayment in addition to whatever other copayment may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated small employer group shall not be greater than 350% of the premium rate charged for the lowest rated small employer group purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.

d. Carriers may offer enhanced or additional benefits for an additional premium in the form of a rider or riders, which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to guaranteed issue, calculation of loss ratio, and the liability for assessment.

f. No later than 120 days following enactment of this act, every carrier shall make an informational filing with the commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the commissioner has not

disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier and every insurance producer shall make a good faith effort to market the contract or policy established pursuant to this section. If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

4. This act shall take effect immediately.

STATEMENT

This bill adds an additional, more affordable health insurance policy to the standard health beneftis plans offered in the individual and small employer group markets. When the respective boards of the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program formulated the standard plans, they disregarded the language in the law and the legislative intent that there would be a variation in benefits among the plans, creating lower-cost policies. As a result, the standard plans are uniformly rich in benefits and for many people, increasingly unaffordable.

The plans set forth in this bill are modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This bill embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policyholders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses are administrative costs of processing claims, premium taxes, commissions, insurer profits, and provider expenses connected with the third party payer system.

This plan provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. It must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member or a member of a small employer group. It contains the same preexisting condition provisions as the standard plans.

The bill is aimed at making health insurance available for younger families who do not have the resources to pay for coverage in the individual market, as well as small employers who cannot afford the

small group policies currently offered. To this end, this policy is not to be community rated, permitting a differential of 350% from the highest-to-lowest premium, which is advantageous to the younger people without insurance coverage; the other plans in the individual market continue to be community rated and the standard plans in the small employer group market continue to be rated at a 2-1 ratio of highest-to-lowest premiums.

ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, Nos. 3447 and 2791

STATE OF NEW JERSEY

209th LEGISLATURE

ADOPTED MAY 3, 2001

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblyman GUY R. GREGG
District 24 (Sussex, Hunterdon and Morris)
Assemblyman GARY L. GUEAR, SR.
District 14 (Mercer and Middlesex)
Assemblywoman LINDA R. GREENSTEIN
District 14 (Mercer and Middlesex)

Co-Sponsored by:
Assemblywomen Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

Substitute as adopted by the Assembly Health Committee.

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17B:27A-17 et seq.).

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual market that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and limiting preexisting condition exclusions in policies, the plans that were established by the New Jersey Individual Health Coverage Program Board did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policy holders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The New Jersey Individual Health Coverage Program Board elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by the board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plan provided by this act will make health insurance more accessible to many individuals that do not have the economic resources to afford the existing plans while still providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits

plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 copayment per hospital stay;

Outpatient and ambulatory surgery - $250 copayment per surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Physicians' fees connected with outpatient and ambulatory surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

Intravenous solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Inpatient physical therapy and hydrotherapy;

Outpatient physical therapy - 30 visits annually per covered person- $20 copayment per treatment;

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate per covered person for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

Special care unit;

Treatment room fees;

Emergency room services for medically necessary treatment - $100 copayment per visit;

Pharmaceuticals dispensed in hospital;

Dressings;

Splints;

Treatment for biologically-based mental illness, as defined in P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;

Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;

Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;

Wellness benefit - $600 annual aggregate per covered person, $50 annual deductible, 20% coinsurance per service; and

Physicians visits for diagnosed illness or injury - to a $700 annual aggregate per covered person.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network, including an exclusive provider organization, or the carrier's preferred provider organization; or (2) coverage is provided

through health care providers in the carrier's network or preferred provider organization with an out-of-network option with 30% coinsurance in addition to whatever other coinsurance may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to preexisting conditions, guaranteed issue, calculation of loss ratio. With respect to liability for assessment, the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to health benefits plans issued pursuant to this act. The formula shall provide for an equitable allocation of a carrier's assessment pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-12), so that persons covered by the health benefits plan provided for in this act do not bear a disproportionate burden of a carrier's assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this act and those health benefits plans issued pursuant to P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into account the relative loss experience, relative actuarial value based on benefits offered, relative loss ratio, relative administrative expenses, and such other items as the board deems appropriate.

f. No later than one year following enactment of this act, every carrier shall make an informational filing with the board, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the board has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier that writes individual health benefits plans

pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and shall make a good faith effort to market the contract or policy established pursuant to this section. A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.

3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in their report the number of policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.

4. A carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may offer one or more of the five health benefits plans, but shall not offer all five, as policies or contracts that require the policy holder or contract holder to receive plan benefits solely through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

5. This act shall take effect on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 3447 and 2791

STATE OF NEW JERSEY

DATED: MAY 3, 2001

The Assembly Health Committee reports favorably an Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791.

This committee substitute adds an additional, more affordable health insurance policy to the standard health benefits plans offered in the individual market.

The health benefits plan established in this substitute is modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This substitute embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policy holders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses include administrative costs of processing claims and provider expenses connected with the third-party payer system.

The health benefits plan in this substitute provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The substitute specifies that the rates applicable to policies issued under the substitute shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The substitute directs the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-12 that is attributable and allocated to policies issued under this substitute. The formula shall provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits

plan provided for in this substitute do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this substitute and the five standard health benefits plans.

In addition, the substitute requires that a carrier make available, and make a good faith effort to market, the policy. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The substitute directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the substitute in providing affordable health care coverage and whether the health benefits plan established in this substitute or a similar plan should be made available to small employers.

The substitute would permit carriers in the small employer market to offer one or more, but not all five, of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care.

The substitute takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The substitute is aimed at making health insurance available for younger families who do not have the resources to pay for coverage in the individual market. To this end, this policy will not be community rated, permitting a differential of 350% from the highest to lowest premium, which is advantageous to younger persons without insurance coverage; while the other plans in the individual market will continue to be community rated.

This substitute is identical to Senate Bill No. 13 (2R) (Matheussen/Sinagra), which the committee also reported on this date.

[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, Nos. 3447 and 2791

STATE OF NEW JERSEY

209th LEGISLATURE

ADOPTED MAY 3, 2001

Sponsored by:
Assemblywoman CHARLOTTE VANDERVALK
District 39 (Bergen)
Assemblyman GUY R. GREGG
District 24 (Sussex, Hunterdon and Morris)
Assemblyman GARY L. GUEAR, SR.
District 14 (Mercer and Middlesex)
Assemblywoman LINDA R. GREENSTEIN
District 14 (Mercer and Middlesex)

Co-Sponsored by:
Assemblywomen Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As reported by the Assembly Banking and Insurance Committee on June 4, 2001, with amendments.

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17B:27A-17 et seq.).

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual market that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and limiting preexisting condition exclusions in policies, the plans that were established by the New Jersey Individual Health Coverage Program Board did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policy holders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The New Jersey Individual Health Coverage Program Board elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by the board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plan provided by this act will make health insurance more accessible to many individuals that do not have the economic resources to afford the existing plans while still providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly ABI committee amendments adopted June 4, 2001.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 copayment per hospital stay;

Outpatient and ambulatory surgery - $250 copayment per surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Physicians' fees connected with outpatient and ambulatory surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

Intravenous solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Inpatient physical therapy and hydrotherapy;

Outpatient physical therapy - 30 visits annually per covered person- $20 copayment per treatment;

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate per covered person for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

Special care unit;

Treatment room fees;

Emergency room services for medically necessary treatment - $100 copayment per visit;

Pharmaceuticals dispensed in hospital;

Dressings;

Splints;

Treatment for biologically-based mental illness, as defined in [1]subsection a. of section 6 of[1] P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;

Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;

Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;

Wellness benefit - $600 annual aggregate per covered person, $50 annual deductible, 20% coinsurance per service; and

Physicians visits for diagnosed illness or injury - to a $700 annual aggregate per covered person.

b. A carrier shall offer the benefits on an indemnity basis, with the

option that: (1) coverage is restricted to health care providers in the carrier's network, including an exclusive provider organization, or the carrier's preferred provider organization; or (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with 30% coinsurance in addition to whatever other coinsurance may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to preexisting conditions, guaranteed issue, [1]and[1] calculation of loss ratio. [1][With respect to liability for assessment, the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to health benefits plans issued pursuant to this act. The formula shall provide for an equitable allocation of a carrier's assessment pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-12), so that persons covered by the health benefits plan provided for in this act do not bear a disproportionate burden of a carrier's assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this act and those health benefits plans issued pursuant to P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into account the relative loss experience, relative actuarial value based on benefits offered, relative loss ratio, relative administrative expenses, and such other items as the board deems appropriate.][1]

f. No later than one year following enactment of this act, every carrier shall make an informational filing with the board, which shall

include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the board has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and shall make a good faith effort to market the contract or policy established pursuant to this section. A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.

3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in their report the number of policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.

4. **1[**A**]** In addition to the five health benefits plans offered by a carrier on the effictive dat of this act, a**1** carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may **1**also**1** offer one or more of the **1[**five health benefits**]1** plans **1[**, but shall not offer all five, as policies or contracts that require the policy holder or contract holder to receive plan benefits solely**]1** through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. **1**A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier.**1** Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of

determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

5. This act shall take effect on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 3447 and 2791

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Banking and Insurance Committee reports favorably and with committee amendments, the Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791.

This bill, an Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791, as amended by the committee, adds an additional health benefits plan to the five standard health benefits plans currently offered in the individual health insurance market.

With the committee amendments, the health benefits plan established under this bill provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The bill specifies that the rates applicable to policies issued under the bill shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The bill also provides that the health benefits plan established under the bill will not be community rated, permitting a differential of 350% from the highest-to-lowest premium; while the other plans in the individual market will continue to be community rated.

In addition, the bill requires that a carrier make available, and make a good faith effort to market, this health benefits plan. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the life and health insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The bill directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the bill in providing affordable health care coverage and whether the

health benefits plan established in this bill or a similar plan should be made available to small employers.

The bill also permits that, in addition to the five health benefits plans, health insurance carriers that write in the small employer health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. A carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

The bill takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The committee amendments delete language from the bill which directed the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-12 that is attributable and allocated to the health benefits plan established by this bill and issued by the carriers in the individual market. The formula was to provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this bill and the five standard health benefits plans.

In addition, the amendments clarify that in addition to the five health benefits plans, health insurance carriers that write in the small employer health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. A carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

As released by the committee, this bill is identical to Senate Bill No.13 (3R).

§§1-4 -
C.17B:27A-4.4
to 17B:27A-4.7
§5 -
C.17B:27A-19.11
§6 - Note to §§1-5

P.L. 2001, CHAPTER 368, ***approved January 8, 2002***
Senate, No. 13 ***(Fourth Reprint)***

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 [3][(C.17:27A-17 et seq.)] (C.17B:27A-17 et seq.)[3].

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

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual [2][and small group markets]market[2] that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and [2][removing most] limiting[2] preexisting condition exclusions [2][from] in[2] policies, the plans that were established by the [2][respective boards]New Jersey Individual Health Coverage Program Board[2] did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The [2][boards of the][2] New Jersey Individual Health Coverage Program [2][and the New Jersey Small Employer Health Benefits Program] Board[2] elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted November 9, 2000.
[2] Senate floor amendments adopted December 4, 2000.
[3] Assembly ABI committee amendments adopted June 4, 2001.
[4] Assembly floor amendments adopted June 14, 2001.

d. In the absence of any affirmative action by [2][either] the[2] board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit [2][plans] plan[2] provided by this act will make health insurance more accessible to many individuals [2][and small groups][2] that do not have the economic resources to afford the existing plans while still providing essential coverage.

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier [1]that writes individual health benefits plans pursuant to P.L.1992, c.161[1] shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 [2][deductible] copayment[2] per hospital stay;

Outpatient and ambulatory surgery [2]- $250 copayment per surgery[2];

Physicians' fees connected with hospital care, including general acute care and surgery;

[2]Physicians' fees connected with outpatient and ambulatory surgery[2]

[3].[3]

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

[1][IV Solutions] Intravenous solutions[1], blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

[2][Physical] Inpatient physical[2] therapy and hydrotherapy [3].[3]

[2]Outpatient physical therapy[2] - [2]30 visits annually per covered person-[2] $20 [2][deductible for outpatient treatment] copayment per treatment[2];

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate [2]per covered person[2] for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;

[2][Intensive] Special[2] care unit;

Treatment room fees;

Emergency room services for medically necessary treatment [2]- $100 copayment per visit[2];

Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
[2][Treatment for Nervous and Mental Conditions- 30 Days inpatient or outpatient- 30% copayment] Treatment for biologically-based mental illness, as defined in [3]subsection a. of section 6 of[3] P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance[2];
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% [2][copayment] coinsurance[2];
[2]Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;[2]
Wellness benefit - $600 [2][per year] annual aggregate per covered person[2], $50 [2]annual[2] deductible, 20% coinsurance per service; and
Physicians visits[1][per year][1] for diagnosed illness or injury - to [3][an] a[3] [2]$700 annual[2] aggregate [2][of $700 per year] per covered person[2].

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network [1][or preferred provider organization][1] [2], including an exclusive provider organization, or the carrier's preferred provider organization[2];[1][and] or[1] (2) coverage is provided through health care providers in the carrier's network [1][or preferred provider organization][1] [2]or preferred provider organization[2] with an out-of-network option with [2][a][2] 30% [2][copayment] coinsurance[2] in addition to whatever other [2][copayment] coinsurance[2] may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. [2][Policies or contracts issued pursuant to this section shall be rated separately from the five standard plans, in accordance with their own loss experience.] Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.[2]

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.[1]**[**162**]** 161[1] (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to [1]preexisting conditions,[1] guaranteed issue, [3]and[3] calculation of loss ratio[2]**[**, and the liability for assessment**]**[2]. [3]**[**[2]With respect to liability for assessment, the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to health benefits plans issued pursuant to this act. The formula shall provide for an equitable allocation of a carrier's assessment pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-11), so that persons covered by the health benefits plan provided for in this act do not bear a disproportionate burden of a carrier's assessment in their premium, taking into account the differential in benefit levels under the health benefits plans provided for in this act and those health benefits plans issued pursuant to P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into account the relative loss experience, relative actuarial value based on benefits offered, relative loss ratio, relative administrative expenses, and such other items as the board deems appropriate.[2]**]**[3]

f. No later than [2]**[**120 days**]** one year[2] following enactment of this act, every carrier shall make an informational filing with the [2]**[**commissioner**]** board[2], which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the [2]**[**commissioner**]** board[2] has not disapproved the form within 30 days, the form shall be [1]deemed[1] approved.

g. Every carrier [2]**[**and every insurance producer**]** that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and[2] shall make a good faith effort to market the contract or policy established pursuant to this section. [2]**[**If the board determines that such a good faith effort has not been made, they shall recommend to the commissioner that the carrier be subject to a fine of not more than $5,000, which shall be levied by the commissioner pursuant to the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).**]** A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.[2]

[2]3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing

affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in their report the number of policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.[2]

[4]4. In addition to the five health benefits plans offered by a carrier on the effective date of this act, a carrier that writies individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).[4]

[4][[2]4. [3]] 5. [4] [A] In addition to the five health benefits plans offered by a carrier on the effective date of this act, a[3] carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may [3]also[3] offer one or more of the [3][five health benefits][3] plans [3][, but shall not offer all five, as policies or contracts that require the policy holder or contract holder to receive plan benefits solely][3] through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. [3]A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services,

pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier.[3] Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).[2]

[2][4.] [4][5.[2]] 6.[4] This act shall take effect [2][immediately] on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act[2].

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CHAPTER 368

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17B:27A-17 et seq.).

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

C.17B:27A-4.4 Findings, declarations relative to exclusive provider organization health benefit plans.

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual market that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and limiting preexisting condition exclusions in policies, the plans that were established by the New Jersey Individual Health Coverage Program Board did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The New Jersey Individual Health Coverage Program Board elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by the board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plan provided by this act will make health insurance more accessible to many individuals that do not have the economic resources to afford the existing plans while still providing essential coverage;

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

C.17B:27A-4.5 Carrier offering plans pursuant to C.17B:27A-2 et seq. to offer EPO; coverages.

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 copayment per hospital stay;
Outpatient and ambulatory surgery- $250 copayment per surgery;
Physicians' fees connected with hospital care, including general acute care and surgery;
Physicians' fees connected with outpatient and ambulatory surgery;
Anesthesia and the administration of anesthesia;
Coverage for newborns;
Treatment for complications of pregnancy;
Intravenous solutions, blood and blood plasma;
Oxygen and the administration of oxygen;
Radiation and x-ray therapy;
Inpatient physical therapy and hydrotherapy;
Outpatient physical therapy - 30 visits annually per covered person- $20 copayment per treatment;
Dialysis - inpatient or outpatient;
Inpatient diagnostic tests and $500 annual aggregate per covered person for out-of-hospital diagnostic tests;
Laboratory fees for treatment in hospital;

Delivery room fees;
Operating room fees;
Special care unit;
Treatment room fees;
Emergency room services for medically necessary treatment - $100 copayment per visit;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for biologically-based mental illness, as defined in subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;
Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;
Wellness benefit - $600 annual aggregate per covered person, $50 annual deductible, 20% coinsurance per service; and
Physicians visits for diagnosed illness or injury - to a $700 annual aggregate per covered person.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network, including an exclusive provider organization, or the carrier's preferred provider organization; or (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with 30% coinsurance in addition to whatever other coinsurance may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c. 161 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to preexisting conditions, guaranteed issue, and calculation of loss ratio.

f. No later than one year following enactment of this act, every carrier shall make an informational filing with the board, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the board has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and shall make a good faith effort to market the contract or policy established pursuant to this section. A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.

C.17B:27A-4.6 Evaluation as to effectiveness of act.

3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in

their report the number of policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.

C.17B:27A-4.7 Carrier offering plans pursuant to C.17B:27A-2 et seq. may offer additional plan with certain limited benefits.

4. In addition to the five health benefits plans offered by a carrier on the effective date of this act, a carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).

C.17B:27A-19.11 Carrier offering plans pursuant to C.17B:27A-17 et seq. may offer additional plan with certain limited benefits.

5. In addition to the five health benefits plans offered by a carrier on the effective date of this act, a carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

6. This act shall take effect on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act

Approved January 8, 2002.