

17B: 27A-2

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(Health insurance, individual
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BILL NO: S2192

SPONSOR(S): Sinagra

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SENATE: Health

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SENATE: June 26, 1997

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FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

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[Second Reprint]

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2192

STATE OF NEW JERSEY

ADOPTED JUNE 12, 1997

Sponsored by Senator SINAGRA,
Assemblymen Felice and Cohen

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

3

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

6

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

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

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

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

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

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate floor amendments adopted June 19, 1997.

² Assembly floor amendments adopted June 26, 1997.

1 Act of 1974" (29 U.S.C.§1002(33)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46 Individual health benefits plan shall not include a certificate issued

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

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

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

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

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

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

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

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

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

1 adopted by the board pursuant to this act.

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

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

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

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

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

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

24

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

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

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

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

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

45 (4) Notwithstanding any other provision of law to the contrary, an
46 individual health benefits plan issued by a hospital service corporation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 (3) board approval of a request by the individual carrier to
44 nonrenew a particular type of health benefits plan, in accordance with
45 rules adopted by the board. After receiving board approval, a carrier

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

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

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

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

29

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

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

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

46 b. An individual health benefits plan offered pursuant to section 3

1 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no
2 more than 12 months on coverage for preexisting conditions~~], except~~
3 ~~that the limitation shall not apply]~~ . An individual health benefits plan
4 offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall
5 not contain a preexisting condition limitation of any period under the
6 following circumstances:

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

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

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

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

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

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

44 (2) All childhood immunizations as recommended by the Advisory
45 Committee on Immunization Practices of the United States Public
46 Health Service and the Department of Health pursuant to section 7 of

1 P.L.1995, c.316 (C.26:2-137.1). A carrier shall notify its insureds, in
2 writing, of any change in the health care services provided with respect
3 to childhood immunizations and any related changes in premium. Such
4 notification shall be in a form and manner to be determined by the
5 Commissioner of Insurance.

6 The benefits shall be provided to the same extent as for any other
7 medical condition under the health benefits plan, except that no
8 deductible shall be applied for benefits provided pursuant to this
9 section. This section shall apply to all individual health benefits plans
10 in which the carrier has reserved the right to change the premium.

11 (cf: P.L.1995, c.316, s.5)

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

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

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

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

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

1 whichever is later.

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

3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 life years required.

2 (7) Any carrier that writes both managed care and indemnity
3 business that is granted an exemption pursuant to this subsection may
4 satisfy its obligation to **[write]** cover a minimum number of non-group
5 **[persons]** person life years by **[writing]** issuing either managed care
6 or indemnity business, or both.

7 e. **[Notwithstanding the provisions of this section to the contrary,**
8 no carrier shall be liable for an assessment to reimburse any carrier
9 pursuant to this section in an amount which exceeds 35% of the
10 aggregate net paid losses of all carriers filing pursuant to paragraph (1)
11 of subsection a. of this section. To the extent that this limitation
12 results in any unreimbursed paid losses to any carrier, the
13 unreimbursed net paid losses shall be distributed among carriers: (1)
14 which owe assessments pursuant to paragraph (2) of subsection a. of
15 this section; (2) whose assessments do not exceed 35% of the
16 aggregate net paid losses of all carriers; and (3) who have not received
17 an exemption pursuant to subsection d. of this section. For the
18 purposes of paragraph (3) of this subsection, a carrier shall be deemed
19 to have received an exemption notwithstanding the fact that the carrier
20 failed to enroll or insure the minimum number of non-group persons
21 required for that calendar year.] (Deleted by amendment, P.L. ,
22 c.)(pending before the Legislature as this bill)
23 (cf: P.L.1992,c.161,s.11)
24

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

27 1. As used in this act:

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

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

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

43 "Carrier" means **[any insurance company, health service**
44 **corporation, hospital service corporation, medical service corporation**
45 **or health maintenance organization authorized to issue health benefits**
46 **plans in this State]** any entity subject to the insurance laws and

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

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

21 "Commissioner" means the Commissioner of Banking and
22 Insurance.

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

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

44 Creditable coverage shall not include coverage consisting solely of
45 the following: coverage only for accident or disability income
46 insurance, or any combination thereof; coverage issued as a

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

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

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

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

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

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

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

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

43 "Health benefits plan" means any hospital and medical expense
44 insurance policy or certificate; health, hospital, or medical service
45 corporation contract or certificate; or health maintenance organization
46 subscriber contract or certificate delivered or issued for delivery in this

1 State by any carrier to a small employer group pursuant to section 3
2 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health
3 benefits plan" [excludes the following plans, policies, or contracts:
4 accident only, credit, disability, long-term care, coverage for Medicare
5 services pursuant to a contract with the United States government,
6 Medicare supplement, dental only, prescription only or vision only,
7 insurance issued as a supplement to liability insurance, coverage
8 arising out of a workers' compensation or similar law, hospital
9 confinement or other supplemental limited benefit insurance coverage,
10 automobile medical payment insurance, personal injury protection
11 coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.)and
12 stop loss or excess risk insurance.] shall not include one or more, or
13 any combination of, the following: coverage only for accident or
14 disability income insurance, or any combination thereof; coverage
15 issued as a supplement to liability insurance; liability insurance,
16 including general liability insurance and automobile liability insurance;
17 workers' compensation or similar insurance; automobile medical
18 payment insurance; credit-only insurance; coverage for on-site medical
19 clinics; and other similar insurance coverage, as specified in federal
20 regulations, under which benefits for medical care are secondary or
21 incidental to other insurance benefits. Health benefits plans shall not
22 include the following benefits if they are provided under a separate
23 policy, certificate or contract of insurance or are otherwise not an
24 integral part of the plan: limited scope dental or vision benefits;
25 benefits for long-term care, nursing home care, home health care,
26 community-based care, or any combination thereof; and such other
27 similar, limited benefits as are specified in federal regulations. Health
28 benefits plan shall not include hospital confinement indemnity coverage
29 if the benefits are provided under a separate policy, certificate or
30 contract of insurance, there is no coordination between the provision
31 of the benefits and any exclusion of benefits under any group health
32 benefits plan maintained by the same plan sponsor, and those benefits
33 are paid with respect to an event without regard to whether benefits
34 are provided with respect to such an event under any group health plan
35 maintained by the same plan sponsor. Health benefits plan shall not
36 include the following if it is offered as a separate policy, certificate or
37 contract of insurance: Medicare supplemental health insurance as
38 defined under section 1882(g)(1) of the federal Social Security Act (42
39 U.S.C.§1395ss(g)(1)); and coverage supplemental to the coverage
40 provided under chapter 55 of Title 10, United States Code (10 U.S.C.
41 §1071 et seq.); and similar supplemental coverage provided to
42 coverage under a group health plan.

43 "Health status-related factor" means any of the following factors:
44 health status; medical condition, including both physical and mental
45 illness; claims experience; receipt of health care; medical history;
46 genetic information; evidence of insurability, including conditions

1 arising out of acts of domestic violence; and disability.

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

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

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

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

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

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

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

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

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

24 **["Qualifying previous coverage" means benefits or coverage**
25 **provided under:**

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

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

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

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

45 "Small employer" means **[any person, firm, corporation,**
46 **partnership, or association actively engaged in business which, on at**

1 least 50 percent of its working days during the preceding calendar year
2 quarter, employed at least two but no more than 49 eligible employees,
3 the majority of whom are employed within the State of New Jersey.
4 In determining the number of eligible employees, companies which are
5 affiliated companies shall be considered one employer. Subsequent to
6 the issuance of a health benefits plan to a small employer pursuant to
7 the provisions of this act, and for the purpose of determining
8 eligibility, the size of a small employer shall be determined annually.
9 Except as otherwise specifically provided, provisions of this act which
10 apply to a small employer shall continue to apply until the anniversary
11 date of the health benefits plan next following the date the employer
12 no longer meets the definition of a small employer. For the purposes
13 of P.L.1992, c.162 (C.17B:27A-17 et seq.), a State, county or
14 municipal body, agency, board or department shall not be considered
15 a small employer] . in connection with a group health plan with
16 respect to a calendar year and a plan year, any person, firm,
17 corporation, partnership, or political subdivision that is actively
18 engaged in business that employed an average of at least two but not
19 more than 50 eligible employees on business days during the preceding
20 calendar year and who employs at least two employees on the first day
21 of the plan year, and the majority of the employees are employed in
22 New Jersey. All persons treated as a single employer under subsection
23 (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of
24 1986 (26U.S.C. §414) shall be treated as one employer. Subsequent
25 to the issuance of a health benefits plan to a small employer and for the
26 purpose of determining continued eligibility, the size of a small
27 employer shall be determined annually. Except as otherwise
28 specifically provided, provisions of P.L.1992, c.162 (C.17B:27A-17
29 et seq.) that apply to a small employer shall continue to apply at least
30 until the plan anniversary following the date the small employer no
31 longer meets the requirements of this definition. In the case of an
32 employer that was not in existence during the preceding calendar year,
33 the determination of whether the employer is a small or large employer
34 shall be based on the average number of employees that it is
35 reasonably expected that the employer will employ on business days
36 in the current calendar year. Any reference in P.L.1992, c.162
37 (C.17B:27A-17 et seq.) to an employer shall include a reference to any
38 predecessor of such employer.

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

42 "Small employer health benefits plan" means a health benefits plan
43 for small employers approved by the commissioner pursuant to section
44 17 of P.L.1992, c.162 (C.17B:27A-33).

45 "Stop loss" or "excess risk insurance" means an insurance policy
46 designed to reimburse a self-funded arrangement of one or more small

1 employers for catastrophic, excess or unexpected expenses, wherein
2 neither the employees nor other individuals are third party beneficiaries
3 under the insurance policy. In order to be considered stop loss or
4 excess risk insurance for the purposes of P.L.1992, c.162
5 (C.17B:27A-17 et seq.), the policy shall establish a per person
6 attachment point or retention or aggregate attachment point or
7 retention, or both, which meet the following requirements:

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

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

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

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

18

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

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

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

32

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

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

1 during the six months immediately preceding the effective date of
2 coverage[, or as to a pregnancy existing on the effective date of
3 coverage]; provided that, if 10 or more late enrollees request
4 enrollment during any 30-day enrollment period, then no preexisting
5 condition provision shall apply to any such enrollee.

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

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

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

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

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

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

36 (3) Pregnancy as a preexisting condition.

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

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

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

1 this section:

2 a. ~~【Nonpayment of the required premiums by the】~~ A carrier may
3 discontinue such coverage only if:

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

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

11 b. ~~【Fraud or misrepresentation of the policyholder, contract holder,~~
12 ~~or employer or, with respect to coverage of eligible employees or~~
13 ~~dependents, the enrollees or their representatives;】~~ (Deleted by
14 amendment, P.L. , c.).

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

18 d. Noncompliance with a carrier's employment contribution
19 requirements;

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

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

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

39 (3) Any carrier that ceases to do business pursuant to this act shall
40 be prohibited from writing new business in the small employer market
41 for a period of five years from the date ~~【of notice to the~~
42 ~~commissioner】~~ of termination of the last health insurance coverage not
43 so renewed ² 【¹. except that the five-year period shall not apply to a
44 carrier that gave notice to the commissioner during the period January
45 1, 1997 to June 30, 1997 to cease doing business in the small employer

1 market¹]²;

2 f. In the case of policies or contracts issued in connection with
3 membership in an association or trust of employers, an employer
4 ceases to maintain its membership in the association or trust **【; or】** .
5 but only if such coverage is terminated under this provision uniformly
6 without regard to any health status-related factor relating to any
7 covered individual.

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

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

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

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

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

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

27

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

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

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

45 (3) **【** Beginning on the second 12-month anniversary after the date
46 established in paragraph (2) of this subsection of the policy or

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

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

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

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

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

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

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

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

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

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

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

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

45 f. No insurance contract or policy subject to this act may be
46 entered into unless and until the carrier has made an informational

1 filing with the commissioner of a schedule of premiums, not to exceed
2 12 months in duration, to be paid pursuant to such contract or policy,
3 of the carrier's rating plan and classification system in connection with
4 such contract or policy, and of the actuarial assumptions and methods
5 used by the carrier in establishing premium rates for such contract or
6 policy.

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

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

1 or termination by a policyholder.

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

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

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

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

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

13

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

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

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

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

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

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

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

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

- 22 a. Utilization review of health care services, including review of
23 medical necessity of hospital and physician services;
- 24 b. Managed care systems, including large case management;
- 25 c. Provisions for selective contracting with hospitals, physicians,
26 and other **[health care]** participating and nonparticipating providers;
- 27 d. Reasonable benefits differentials which are applicable to
28 participating and nonparticipating providers;
- 29 e. Notwithstanding the provisions of section 4 of P.L.1992, c.162
30 (C.17B:27A-20) to the contrary, the board may, from time to time,
31 adjust coinsurance and deductibles;
- 32 f. Such other provisions which may be quantifiably established to
33 be cost containment devices;
- 34 g. The department shall publish annually a list of the premiums
35 charged for each of the five small employer health benefits plans and
36 for any rider package by all carriers writing such plans. The
37 department shall also publish the toll free telephone number of each
38 such carrier.

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

40

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

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

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

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

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

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

30 “Excepted benefits” means:

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

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

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

1 indemnity or other fixed indemnity insurance;

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

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

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

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

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

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

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

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

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

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

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

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

16
17 15. (New section) A health insurer may impose a preexisting
18 condition exclusion in its group health plan only if:

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

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

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

29

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

43

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 accordance with State and federal law.

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

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

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

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

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

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

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

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

34

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

38

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

40

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

42

43

44

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

SENATE, No. 2192

STATE OF NEW JERSEY

INTRODUCED JUNE 5, 1997

By Senator SINAGRA

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

3

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

6

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

9

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

10

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

11

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

22

"Church plan" has the same meaning given that term under section
23 3(33) of the Employee Retirement Income Security Act of 1974.

24

"Commissioner" means the Commissioner of Banking and
25 Insurance.

26

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

30

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

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

Matter underlined thus is new matter.

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

9 Creditable coverage shall not include coverage consisting solely of
10 the following: (1) coverage only for accident, or disability income
11 insurance, or any combination thereof; (2) coverage issued as a
12 supplement to liability insurance; (3) liability insurance, including
13 general liability insurance and automobile liability insurance; (4)
14 workers' compensation or similar insurance; (5) automobile medical
15 payment insurance; (6) credit only insurance; (7) coverage for on-site
16 medical clinics; (8) coverage, specified in federal regulation, under
17 which benefits for medical care are secondary or incidental to the
18 insurance benefits; (9) other coverage expressly excluded from the
19 definition of health benefits plan.

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

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

23 "Eligible person" means a person who is a resident **【of the State】**
24 who is not eligible to be **【insured】** covered under a group health
25 **【insurance policy】** benefits plan, group health plan, governmental plan,
26 church plan, or 【Medicare】 Part A or Part B of Title XVIII of the
27 Social Security Act.

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

46 "Financially impaired" means a carrier which, after the effective

1 date of this act, is not insolvent, but is deemed by the commissioner to
2 be potentially unable to fulfill its contractual obligations, or a carrier
3 which is placed under an order of rehabilitation or conservation by a
4 court of competent jurisdiction.

5 "Governmental plan" has the meaning given that term under section
6 3(32) of the Employee Retirement Income Security Act of 1974 and
7 any governmental plan established or maintained for its employees by
8 the Government of the United States or by any agency or
9 instrumentality of that government.

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

12 "Group health plan" means an employee welfare benefit plan, as
13 defined in section 3(1) of the Employee Retirement Income Security
14 Act of 1974, to the extent that the plan provides medical care, as
15 defined herein, and including items and services paid for as medical
16 care to employees or their dependents directly or through insurance,
17 reimbursement, or otherwise.

18 "Health benefits plan" means a hospital and medical expense
19 insurance policy; health service corporation contract; **[or]** hospital
20 service corporation contract; medical service corporation contract;
21 health maintenance organization subscriber contract; or other plan for
22 medical care delivered or issued for delivery in this State. For
23 purposes of this act, health benefits plan**[does not include the**
24 **following plans, policies, or contracts: accident only, credit, disability,**
25 **long-term care, Medicare supplement coverage, CHAMPUS**
26 **supplement coverage, coverage for Medicare services pursuant to a**
27 **contract with the United States government, coverage for Medicaid**
28 **services pursuant to a contract with the State, coverage arising out of**
29 **a workers' compensation or similar law, automobile medical payment**
30 **insurance, personal injury protection insurance issued pursuant to**
31 **P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity**
32 **coverage]** shall not include one or more, or any combination of, the
33 following: coverage only for accident, or disability income insurance,
34 or any combination thereof; coverage issued as a supplement to
35 liability insurance; liability insurance, including general liability
36 insurance and automobile liability insurance; stop loss or excess risk
37 insurance; workers' compensation or similar insurance; automobile
38 medical payment insurance; credit-only insurance; coverage for on-site
39 medical clinics; policies or certificates of hospital confinement
40 indemnity coverage, as defined by the board; and other similar
41 insurance coverage, specified in federal regulations, under which
42 benefits for medical care are secondary or incidental to other insurance
43 benefits. Health benefits plans shall not include the following benefits
44 if they are provided under a separate policy, certificate or contract of
45 insurance or are otherwise not an integral part of the plan: limited
46 scope dental or vision benefits; benefits for long-term care, nursing

1 home care, home health care, community-based care, or any
2 combination thereof; and such other similar, limited benefits as are
3 specified in federal regulations. Health benefits plan shall not include
4 hospital confinement indemnity if the benefits are provided under a
5 separate policy, certificate or contract of insurance, there is no
6 coordination between the provision of the benefits and any exclusion
7 of benefits under any group health benefits plan maintained by the
8 same plan sponsor, and those benefits are paid with respect to an event
9 without regard to whether benefits are provided with respect to such
10 an event under any group health plan maintained by the same plan
11 sponsor. Health benefits plan shall not include the following if it is
12 offered as a separate policy, certificate or contract of insurance:
13 Medicare supplemental health insurance as defined under section
14 1882(g)(1) of the Social Security Act; and coverage supplemental to
15 the coverage provided under Chapter 55 of Title 10, United States
16 Code (10 U.S.C. §1071 et seq.); and similar supplemental coverage
17 provided to coverage under a group health plan.

18 "Health status-related factor" means any of the following factors:
19 (1) health status; (2) medical condition, including both physical and
20 mental illness; (3) claims experience; (4) receipt of health care; (5)
21 medical history; (6) genetic information; (7) evidence of insurability,
22 including conditions arising out of acts of domestic violence; and (8)
23 disability.

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

32 Individual health benefits plan shall not include a certificate issued
33 under a policy or contract issued to a trust, or to the trustees of a
34 fund, which trust or fund [is established or adopted by two or more
35 employers, by one or more labor unions or similar employee
36 organizations, or by one or more employers and one or more labor
37 unions or similar employee organizations, to insure employees of the
38 employers or members of the unions or organizations] is an employee
39 welfare benefit plan, to the extent the Employee Retirement Income
40 Security Act of 1974 preempts the application of P.L.1992, c.161
41 (C.17B:27A-2 et seq.) to that plan.

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

44 "Medical care" means amounts paid for: (1) the diagnosis, care,
45 mitigation, treatment, or prevention of disease, or amounts paid for the
46 purpose of affecting any structure or function of the body; (2)

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

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

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

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

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

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

32 "Plan sponsor" shall have the meaning given that term under section
33 3(16)(B) of the Employee Retirement Income Security Act of 1974.

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

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

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

1 coverage, who intends to be present in New Jersey for at least six
2 months of the calendar year.

3 (cf: P.L.1995, c.291, s.7)
4

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

7 1. As used in this act:

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

15 "Anticipated loss ratio" means the ratio of the present value of the
16 expected benefits, not including dividends, to the present value of the
17 expected premiums, not reduced by dividends, over the entire period
18 for which rates are computed to provide coverage. For purposes of
19 this ratio, the present values must incorporate realistic rates of interest
20 which are determined before federal taxes but after investment
21 expenses.

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

23 "Carrier" means **【**any insurance company, health service
24 corporation, hospital service corporation, medical service corporation
25 or health maintenance organization authorized to issue health benefits
26 plans in this State**】** any entity subject to the insurance laws and
27 regulations of this State, or subject to the jurisdiction of the
28 commissioner, that contracts or offers to contract to provide, deliver,
29 arrange for, pay for, or reimburse any of the costs of health care
30 services, including an insurance company authorized to issue health
31 insurance, a health maintenance organization, a hospital service
32 corporation, medical service corporation and health service
33 corporation, or any other entity providing a plan of health insurance,
34 health benefits or health services. The term "carrier" shall not include
35 a joint insurance fund established pursuant to State law. For purposes
36 of this act, carriers that are affiliated companies shall be treated as one
37 carrier, except that any insurance company, health service corporation,
38 hospital service corporation, or medical service corporation that is an
39 affiliate of a health maintenance organization located in New Jersey or
40 any health maintenance organization located in New Jersey that is
41 affiliated with an insurance company, health service corporation,
42 hospital service corporation, or medical service corporation shall treat
43 the health maintenance organization as a separate carrier.

44 "Church plan" has the meaning given that term under section 3(33)
45 of the Employee Retirement Income Security Act of 1974.

46 "Commissioner" means the Commissioner of Banking and

1 Insurance.

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

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

21 For purposes of this act, creditable coverage shall not include the
22 following policies, contracts or arrangements, whether issued on an
23 individual or group basis: accident only, credit, disability, long-term
24 care, Medicare supplement, dental only, prescription only or vision
25 only, insurance issued as a supplement to liability insurance, stop loss
26 or excess risk insurance, coverage arising out of a workers'
27 compensation or similar law, hospital confinement or other
28 supplemental limited benefit coverage, automobile medical payment
29 insurance, or personal injury protection coverage issued pursuant to
30 P.L.1972, c.70 (C.39:6A-1 et seq.).

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

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

35 "Eligible employee" means a full-time employee who works a
36 normal work week of 25 or more hours. The term includes a sole
37 proprietor, a partner of a partnership, or an independent contractor, if
38 the sole proprietor, partner, or independent contractor is included as
39 an employee under a health benefits plan of a small employer, but does
40 not include employees who work less than 25 hours a week, work on
41 a temporary or substitute basis or are participating in an employee
42 welfare arrangement established pursuant to a collective bargaining
43 agreement.

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

1 such enrollment.

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

7 "Governmental plan" has the meaning given that term under section
8 3(32) of the Employee Retirement Income Security Act of 1974 and
9 any federal governmental plan.

10 "Group health plan" means an employee welfare benefit plan, as
11 defined in section 3(1) of the Employee Retirement Income Security
12 Act of 1974, to the extent that the plan provides medical care and
13 including items and services paid for as medical care to employees or
14 their dependents (as defined under the terms of the plan) directly or
15 through insurance, reimbursement or otherwise.

16 "Health benefits plan" means any hospital and medical expense
17 insurance policy or certificate; health, hospital, or medical service
18 corporation contract or certificate; or health maintenance organization
19 subscriber contract or certificate delivered or issued for delivery in this
20 State by any carrier to a small employer group pursuant to section 3
21 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health
22 benefits plan" **【excludes the following plans, policies, or contracts:**
23 **accident only, credit, disability, long-term care, coverage for Medicare**
24 **services pursuant to a contract with the United States government,**
25 **Medicare supplement, dental only, prescription only or vision only,**
26 **insurance issued as a supplement to liability insurance, coverage**
27 **arising out of a workers' compensation or similar law, hospital**
28 **confinement or other supplemental limited benefit insurance coverage,**
29 **automobile medical payment insurance, personal injury protection**
30 **coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.)and**
31 **stop loss or excess risk insurance.】 shall not include one or more, or**
32 **any combination of, the following: coverage only for accident, or**
33 **disability income insurance, or any combination thereof; coverage**
34 **issued as a supplement to liability insurance; liability insurance,**
35 **including general liability insurance and automobile liability insurance;**
36 **workers' compensation or similar insurance; automobile medical**
37 **payment insurance; credit-only insurance; coverage for on-site medical**
38 **clinics; policies or certificates of hospital confinement indemnity; and**
39 **other similar insurance coverage, specified in federal regulations,**
40 **under which benefits for medical care are secondary or incidental to**
41 **other insurance benefits. Health benefits plans shall not include the**
42 **following benefits if they are provided under a separate policy,**
43 **certificate or contract of insurance or are otherwise not an integral**
44 **part of the plan: limited scope dental or vision benefits; benefits for**
45 **long-term care, nursing home care, home health care,**
46 **community-based care, or any combination thereof; and such other**

1 similar, limited benefits as are specified in federal regulations. Health
2 benefits plan shall not include hospital confinement indemnity if the
3 benefits are provided under a separate policy, certificate or contract of
4 insurance, there is no coordination between the provision of the
5 benefits and any exclusion of benefits under any group health benefits
6 plan maintained by the same plan sponsor, and those benefits are paid
7 with respect to an event without regard to whether benefits are
8 provided with respect to such an event under any group health plan
9 maintained by the same plan sponsor. Health benefits plan shall not
10 include the following if it is offered as a separate policy, certificate or
11 contract of insurance: Medicare supplemental health insurance as
12 defined under section 1882(g)(1) of the Social Security Act; and
13 coverage supplemental to the coverage provided under Chapter 55 of
14 Title 10, United States Code (20 U.S.C. §1071 et seq.); and similar
15 supplemental coverage provided to coverage under a group health
16 plan.

17 "Health status-related factor" means any of the following factors:
18 (1) health status; (2) medical condition, including both physical and
19 mental illness; (3) claims experience; (4) receipt of health care; (5)
20 medical history; (6) genetic information; (7) evidence of insurability,
21 including conditions arising out of acts of domestic violence; and (8)
22 disability.

23 "Late enrollee" means an eligible employee or dependent who
24 requests enrollment in a health benefits plan of a small employer
25 following the initial minimum 30-day enrollment period provided under
26 the terms of the health benefits plan. An eligible employee or
27 dependent shall not be considered a late enrollee if the individual: a.
28 was covered under another employer's health benefits plan at the time
29 he was eligible to enroll and stated at the time of the initial enrollment
30 that coverage under that other employer's health benefits plan was the
31 reason for declining enrollment, but only if the plan sponsor or carrier
32 required such a statement at that time and provided the employee with
33 notice of that requirement and the consequences of that requirement
34 at that time; b. has lost coverage under that other employer's health
35 benefits plan as a result of termination of employment or eligibility,
36 reduction in the number of hours of employment, involuntary
37 termination, the termination of the other plan's coverage, death of a
38 spouse, or divorce or legal separation; and c. requests enrollment
39 within 90 days after termination of coverage provided under another
40 employer's health benefits plan. An eligible employee or dependent
41 also shall not be considered a late enrollee if the individual is employed
42 by an employer which offers multiple health benefits plans and the
43 individual elects a different plan during an open enrollment period; the
44 individual had coverage under a COBRA continuation provision and
45 the coverage under that provision was exhausted and the employee
46 requests enrollment not later than 30 days after the date of exhaustion

1 of COBRA coverage; or if a court of competent jurisdiction has
2 ordered coverage to be provided for a spouse or minor child under a
3 covered employee's health benefits plan and request for enrollment is
4 made within 30 days after issuance of that court order.

5 "Medical care" means amounts paid for: (1) the diagnosis, care,
6 mitigation, treatment, or prevention of disease, or amounts paid for the
7 purpose of affecting any structure or function of the body; (2)
8 transportation primarily for and essential to medical care referred to
9 in (1) above; and (3) insurance covering medical care referred to in (1)
10 and (2) above.

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

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

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

24 "Plan sponsor" has the meaning given that term under section
25 3(16)(B) of the Employee Retirement Income Security Act of 1974.

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

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

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

46 **["Qualifying previous coverage" means benefits or coverage**

1 provided under:

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

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

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

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

21 "Small employer" means 【any person, firm, corporation,
22 partnership, or association actively engaged in business which, on at
23 least 50 percent of its working days during the preceding calendar year
24 quarter, employed at least two but no more than 49 eligible employees,
25 the majority of whom are employed within the State of New Jersey.
26 In determining the number of eligible employees, companies which are
27 affiliated companies shall be considered one employer. Subsequent to
28 the issuance of a health benefits plan to a small employer pursuant to
29 the provisions of this act, and for the purpose of determining
30 eligibility, the size of a small employer shall be determined annually.
31 Except as otherwise specifically provided, provisions of this act which
32 apply to a small employer shall continue to apply until the anniversary
33 date of the health benefits plan next following the date the employer
34 no longer meets the definition of a small employer. For the purposes
35 of P.L.1992, c.162 (C.17B:27A-17 et seq.), a State, county or
36 municipal body, agency, board or department shall not be considered
37 a small employer】 , in connection with a group health plan with
38 respect to a calendar year and a plan year, any person, firm,
39 corporation, partnership, or political subdivision that is actively
40 engaged in business that employed an average of at least two but not
41 more than 50 eligible employees on business days during the preceding
42 calendar year and who employs at least two employees on the first day
43 of the plan year, and the majority of the employees are employed in
44 New Jersey. All persons treated as a single employer under subsection
45 (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of
46 1986 shall be treated as one employer. Subsequent to the issuance of

1 a health benefits plan to a small employer and for the purpose of
2 determining continued eligibility, the size of a small employer shall be
3 determined annually. Except as otherwise specifically provided,
4 provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to
5 a small employer shall continue to apply at least until the plan
6 anniversary following the date the small employer no longer meets the
7 requirements of this definition. In the case of an employer which was
8 not in existence during the preceding calendar year, the determination
9 of whether the employer is a small or large employer shall be based on
10 the average number of employees that it is reasonably expected that
11 the employer will employ on business days in the current calendar
12 year. Any reference in P.L.1992, c.162 (C.17B:27A-17 et seq.) to an
13 employer shall include a reference to any predecessor of such
14 employer.

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

18 "Small employer health benefits plan" means a health benefits plan
19 for small employers approved by the commissioner pursuant to section
20 17 of P.L.1992, c.162 (C.17B:27A-33).

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

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

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

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

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

40
41 3. Section 17 of P.L.1992, c.162 (C.17B:27A-33) is amended to
42 read as follows.

43 17. Subject to the approval of the commissioner, the board shall
44 formulate the five health benefits plans to be made available by small
45 employer carriers in accordance with the provisions of this act, and
46 shall promulgate five standard forms pursuant thereto. The board may

1 establish benefit levels, deductibles and co-payments, exclusions, and
 2 limitations for such health benefits plans in accordance with the law.
 3 The board shall ensure that the means exist for a carrier to offer high
 4 deductible health benefits plan options that are consistent with Title III
 5 of the Health Insurance Portability and Accountability Act of 1996,
 6 Pub.L. 104-191, regarding tax-deductible medical savings accounts.

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

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

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

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

20 d. Reasonable benefit differentials which are applicable to
 21 participating and nonparticipating providers;

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

25 f. Such other provisions which may be quantifiably established to
 26 be cost containment devices;

27 g. The department shall publish annually a list of the premiums
 28 charged for each of the five small employer health benefits plans and
 29 for any rider package by all carriers writing such plans. The
 30 department shall also publish the toll free telephone number of each
 31 such carrier.

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

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

37 *SPONSOR'S* STATEMENT

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

1 benefits coverage.

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

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

20

21

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24

Revises the individual and small employer health benefits programs.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR **SENATE, No. 2192**

STATE OF NEW JERSEY

DATED: JUNE 12, 1997

The Senate Health Committee reports favorably a Senate Committee Substitute for Senate Bill No. 2192.

This committee substitute makes various changes to the New Jersey Individual Health Coverage Program (IHP), the Small Employer Health Benefits Program (SEP) and large group plans to conform the State's laws to the requirements of the recently enacted federal "Health Insurance Portability and Accountability Act of 1996." Changes in the laws generally concern preexisting condition exclusions, portability of health insurance and eligibility for coverage.

The substitute revises various definitions in the IHP and SEP and adds definitions for "church plan," "creditable coverage," "federally defined eligible individual," "governmental plan," "group health plan," "health status-related factor," "medical care," "plan sponsor," and "resident" as required by federal law. Comparable definitions and required provisions are added to Title 17B of the New Jersey Statutes for the large group (over 50 persons) market.

The substitute also makes the following changes in the IHP law:

- authorizes the nonrenewal of standard plans, following IHP board approval, in the case of a carrier that is withdrawing from the market in accordance with rules for orderly withdrawal adopted by the board;

- clarifies that an insurance company or health service corporation does not have to offer the health maintenance organization plan and that a hospital service corporation may offer either the standard plans, in conjunction with another carrier, or other individual health benefits plans approved by the commissioner;

- increases the allowable lapse in coverage from 30 to 31 days;

- shifts assessment and carrier reimbursement to a two-year cycle and reduces the burden of the loss assessment by allowing reimbursement only of incurred claims in excess of 115% of earned premium;

- changes the enrollment target to count "person life years," calculated as the average of quarterly enrollment over a two-year period, rather than the number of lives covered at year end, as a more accurate gauge of carrier enrollment over time.

The substitute also makes the following changes in the SEP law:

- directs the board to create high deductible options consistent with the federal law's requirements for tax-deductible medical savings accounts;

- makes permanent modified community rating, allowing the highest rates charged to small group to be no greater than 200% of the rate charged to the lowest rated small group, thus continuing the rating methodology currently in effect for the program; and

- permits carriers to aggregate their losses in all standard policy forms and in all non-standard policy forms with respect to the calculation of loss ratios, rather than require that the losses for each policy form be calculated separately.

Finally, the substitute repeals section 6 of P.L.1995, c.340 (C.17B:27A-23.1) concerning notification to small employers of ineligibility for a small employer plan. The notification provisions are provided for in the amendments that conform the law to the federal law.

STATEMENT TO

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2192

with Assembly Floor Amendments
(Proposed By Assemblyman FELICE)

ADOPTED: JUNE 26, 1997

These amendments delete the exemption for a small employer carrier that has given notice of its intent to withdraw from the small employer health benefits market, from the prohibition to write new business in that market for five years after that withdrawal.

The amendments make the substitute identical to Assembly, No. 3115.

STATEMENT TO
SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2192

with Senate Floor Amendments
(Proposed By Senator ADLER)

ADOPTED: JUNE 19, 1997

These amendments exempt a small employer carrier that has given notice during the period January 1, 1997 to June 30, 1997 to the Commissioner of Banking and Insurance of its intent to withdraw from the small employer health benefits market, from the prohibition to write new business in that market for five years after that withdrawal.