

17B: 27A-2

LEGISLATIVE HISTORY CHECKLIST
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(NJ Individual health Coverage Program)

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LAWS OF: 1992 CHAPTER: 161

BILL NO: A1654

SPONSOR(S): Felice and others

DATE INTRODUCED: June 20, 1992

COMMITTEE: ASSEMBLY Insurance
SENATE: ---

AMENDED DURING PASSAGE: No Assembly Committee substitute enacted

DATE OF PASSAGE: ASSEMBLY: November 16, 1992
SENATE: November 20, 1992

DATE OF APPROVAL: November 30, 1992

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT: Yes

COMMITTEE STATEMENT: ASSEMBLY: Yes
SENATE: No

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MESSAGE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

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See newspaper [REDACTED]

"Legislature approves health plan," 12-1-92, Philadelphia Inquirer.

"Strong medicine...", 12-1-92, Bergen Record.

"New Jersey bill for health care signed by Florio," 12-1-92, New York Times.

"Assembly oks health reform bill," 12-1-92, Asbury Park Press.

"Health funding bill clears the Legislature," 12-1-92, Star Ledger.

KBG:pp

P.L.1992, CHAPTER 161, *approved November 30, 1992*

Assembly Committee Substitute for

1992 Assembly No. 1654

1 **AN ACT** requiring all health insurers, health service corporations
2 and health maintenance organizations to provide individual
3 health benefits coverage on an open enrollment basis, creating
4 the New Jersey Individual Health Coverage Program, amending
5 P.L.1985, c.236, P.L.1988, c.71 and supplementing Title 17B of
6 the New Jersey Statutes.

7

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

10 1. (New section) As used in sections 1 through 15, inclusive, of
11 this act:

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

13 "Carrier" means an insurance company, health service
14 corporation or health maintenance organization authorized to
15 issue health benefits plans in this State. For purposes of this act,
16 carriers that are affiliated companies shall be treated as one
17 carrier.

18 "Commissioner" means the Commissioner of Insurance.

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

24 "Department" means the Department of Insurance.

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

27 "Eligible person" means a person who is a resident of the State
28 who is not eligible to be insured under a group health insurance
29 policy, Medicare, or Medicaid.

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

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

38 "Health benefits plan" means a hospital and medical expense
39 insurance policy; health service corporation contract; or health
40 maintenance organization subscriber contract delivered or issued
41 for delivery in this State. For purposes of this act, health
42 benefits plan does not include the following plans, policies, or

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.

1 contracts: accident only, credit, disability, long-term care,
2 Medicare supplement coverage, coverage for Medicare services
3 pursuant to a contract with the United States government,
4 coverage for Medicaid services pursuant to a contract with the
5 State, coverage arising out of a workers' compensation or similar
6 law, automobile medical payment insurance, personal injury
7 protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1
8 et seq.), or hospital confinement indemnity coverage.

9 "Individual health benefits plan" means a health benefits plan
10 for eligible persons and their dependents.

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

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

21 "Net earned premium" means the premiums earned in this
22 State on health benefits plans, less return premiums thereon and
23 dividends paid or credited to policy or contract holders on the
24 health benefits plan business. Net earned premium shall include
25 the aggregate premiums earned on the carrier's insured group
26 and individual business and health maintenance organization
27 business, including premiums from any Medicare, Medicaid or
28 HealthStart Plus contracts with the State or federal government,
29 but shall not include any excess or stop loss coverage issued by a
30 carrier in connection with any self insured health benefits plan,
31 or Medicare supplement policies or contracts.

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

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

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

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

47 2. (New section) a. An individual health benefits plan issued on
48 or after the effective date of this act shall be subject to the
49 provisions of this act.

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

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

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

12 c. After the effective date of this act, an individual who is
13 eligible to participate in a group health benefits plan that
14 provides coverage for hospital or medical expenses shall not be
15 covered by an individual health benefits plan which provides
16 benefits for hospital and medical expenses that are the same or
17 similar to coverage provided in the group health benefits plan.

18 d. After the effective date of this act, a person who is covered
19 by an individual health benefits plan who is a participant in, or is
20 eligible to participate in, a group health benefits plan that
21 provides the same or similar coverages as the individual health
22 benefits plan, and a person, including an employer or insurance
23 producer, who causes another person to be covered by an
24 individual health benefits plan which person is a participant in, or
25 who is eligible to participate in a group health benefits plan that
26 provides the same or similar coverages as the individual health
27 benefits plan, shall be subject to a fine by the commissioner in an
28 amount not less than twice the annual premium paid for the
29 individual health benefits plan, together with any other penalties
30 permitted by law.

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

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

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

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

48 (4) A carrier that issues an individual health benefits plan with
49 modified community rating subject to the provisions of this
50 subsection shall make an informational filing with the board
51 whenever it adjusts or modifies its rates.

52 3. (New section) a. No later than 180 days after the effective
53 date of this act, a carrier shall, as a condition of issuing health
54 benefits plans in this State, offer individual health benefits

1 plans. The plans shall be offered on an open enrollment,
2 community rated basis, pursuant to the provisions of this act;
3 except that, a carrier shall be deemed to have satisfied its
4 obligation to provide the individual health benefits plans by
5 paying an assessment or receiving an exemption pursuant to
6 section 11 of this act.

7 b. A carrier shall offer to an eligible person a choice of five
8 individual health benefits plans, any of which may contain
9 provisions for managed care. One plan shall be a basic health
10 benefits plan, one plan shall be a managed care plan and three
11 plans shall include enhanced benefits of proportionally increasing
12 actuarial value. A carrier may elect to convert any individual
13 health benefits plans in force on the effective date of this act to
14 any of the five benefit plans, except that the replacement plan
15 shall be of no less actuarial value than the policy or contract
16 being replaced.

17 Notwithstanding the provisions of this subsection to the
18 contrary, at any time after three years after the effective date
19 of this act, the board, by regulation, may reduce the number of
20 plans required to be offered by a carrier.

21 Notwithstanding the provisions of this subsection to the
22 contrary, a health maintenance organization which is a qualified
23 health maintenance organization pursuant to the "Health
24 Maintenance Organization Act of 1973," Pub.L.93-222 (42
25 U.S.C. §300e et seq.) shall be permitted to offer a basic health
26 benefits plan in accordance with the provisions of that law in lieu
27 of the five plans required pursuant to this subsection.

28 c. (1) A basic health benefits plan shall provide the benefits
29 set forth in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section
30 57 of P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991,
31 c.187 (C.26:2J-4.3), as the case may be.

32 (2) Notwithstanding the provisions of this subsection or any
33 other law to the contrary, a carrier may, with the approval of the
34 board, modify the coverage provided for in sections 55, 57, or 59
35 of P.L. 1991, c. 187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3,
36 respectively) or provide alternative benefits or services from
37 those required by this subsection if they are within the intent of
38 this act or if the board changes the benefits included in the basic
39 health benefits plan.

40 (3) A contract or policy for a basic health benefits plan
41 provided for in this section may contain or provide for
42 coinsurance or deductibles, or both, except that no deductible
43 shall be payable in excess of a total of \$250 by an individual or
44 \$500 by a family unit during any benefit year; no coinsurance
45 shall be payable in excess of a total of \$500 by an individual or by
46 a family unit during any benefit year; and neither coinsurance nor
47 deductibles shall apply to maternity benefits or preventative care
48 examinations.

49 (4) Notwithstanding the provisions of paragraph (3) of this
50 subsection or any other law to the contrary, a carrier may
51 provide for increased deductibles or coinsurance for a basic
52 health benefits plan if approved by the board or if the board
53 increases deductibles or coinsurance included in the basic health
54 benefits plan.

1 (5) The provisions of section 13 of P.L.1985, c.236
2 (C.17:48E-13), N.J.S.17B.26-1, and section 8 of P.L.1973, c.337
3 (C.26:2J-8) with respect to the filing of policy forms shall not
4 apply to health plans issued on or after the effective date of this
5 act.

6 (6) The provisions of section 27 of P.L.1985, c.236
7 (C.17:48E-27) and section 7 of P.L.1988, c.71 (C.17:48E-27.1)
8 with respect to rate filings shall not apply to individual health
9 plans issued on or after the effective date of this act.

10 d. Every group conversion contract or policy issued after the
11 effective date of this act shall be issued pursuant to this section;
12 except that this requirement shall not apply to any group
13 conversion contract or policy in which a portion of the premium
14 is chargeable to, or subsidized by, the group policy from which
15 the conversion is made.

16 4. (New section) The following provisions shall not apply to
17 basic health benefits plans and managed care health benefits
18 plans issued pursuant to section 3 of this act:

19 Sections 12, 32 through 35, inclusive, of P.L.1985, c.236
20 (C.17:48E-12 and C.17:48E-32 through C.17:48E-35, inclusive);
21 section 2 of P.L.1987, c.62 (C.17:48E-35.1); sections 3, 4 and 6 of
22 P.L.1991, c.279 (C.17:48E-35.4, 17B:26-2.1e and 26:2J-4.4);
23 section 1 of P. L.1977, c.118 (C.17B:26-2.1); section 1 of
24 P.L.1983, c.53 (C.17B:26-2.1a); section 1 of P.L.1987 c. 64
25 (C.17B:26-2.1c); P. L.1979, c.328 (C.17B:26-2.2 et seq.); and
26 sections 1 and 2 of P.L.1979, c.161 (C.17B:26-44.1 and 44.2).

27 5. (New section) An individual health benefits plan issued
28 pursuant to section 3 of this act is subject to the following
29 provisions:

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

32 b. A health benefits plan shall be renewable with respect to an
33 eligible person and his dependents at the option of the policy or
34 contract holder except under the following circumstances:

35 (1) nonpayment of the required premiums by the policy or
36 contract holder;

37 (2) fraud or misrepresentation by the policy or contract holder,
38 including equitable fraud, with respect to coverage of eligible
39 individuals or their dependents;

40 (3) termination of eligibility of the policy or contract holder; or

41 (4) cancellation or amendment by the board of the specific
42 individual health benefits plan.

43 6. (New section) The board shall establish the policy and
44 contract forms and benefit levels to be made available by all
45 carriers for the policies required to be issued pursuant to section
46 3 of this act. The board shall provide the commissioner with an
47 informational filing of the policy and contract forms and benefit
48 levels it establishes.

49 a. The individual health benefits plans established by the board
50 may include cost containment measures such as, but not limited
51 to: utilization review of health care services, including review of
52 medical necessity of hospital and physician services; case
53 management benefit alternatives; selective contracting with
54 hospitals, physicians, and other health care providers; and

1 reasonable benefit differentials applicable to participating and
2 nonparticipating providers; and other managed care provisions.

3 b. An individual health benefits plan offered pursuant to
4 section 3 of this act shall contain a limitation of no more than 12
5 months on coverage for pre-existing conditions, except that the
6 limitation shall not apply to an individual who satisfied a 12
7 month preexisting condition limitation under a prior group or
8 individual health benefits plan with no intervening lapse in
9 coverage.

10 c. In addition to the five standard individual health benefits
11 plans provided for in section 3 of this act, the board may develop
12 up to five rider packages. Premium rates for the rider packages
13 shall be determined in accordance with section 8 of this act.

14 d. After the board's establishment of the individual health
15 benefits plans required pursuant to section 3 of this act, and
16 notwithstanding any law to the contrary, a carrier shall file the
17 policy or contract forms with the board and certify to the board
18 that the health benefits plans to be used by the carrier are in
19 substantial compliance with the provisions in the corresponding
20 board approved plans. The certification shall be signed by the
21 chief executive officer of the carrier. Upon receipt by the board
22 of the certification, the certified plans may be used until the
23 board, after notice and hearing, disapproves their continued use.

24 7. (New section) a. A health maintenance organization shall
25 not be required to offer coverage to or accept an applicant
26 pursuant to this act if the applicant is not geographically located
27 in the health maintenance organization's approved service area
28 or if the health maintenance organization does not have the
29 capacity in its facilities to enroll additional members; except
30 that, if the health maintenance organization does not have the
31 capacity in its facilities for additional individual enrollees, it also
32 shall not offer coverage to or accept any new group enrollees.

33 b. A carrier shall not be required to offer coverage or accept
34 applications pursuant to this act if the commissioner finds that
35 the acceptance of applications would place the carrier in a
36 financially impaired condition.

37 8. (New section) a. The board shall make application to the
38 Hospital Rate Setting Commission on behalf of all carriers for
39 approval of discounted or reduced rates of payment to hospitals
40 for health care services provided under an individual health
41 benefits plan provided pursuant to this act.

42 b. In addition to discounted or reduced rates of hospital
43 payment, the board shall make application on behalf of all
44 carriers for any other subsidies, discounts, or funds that may be
45 provided for under State or federal law or regulation. A carrier
46 may include discounted or reduced rates of hospital payment and
47 other subsidies or funds granted to the board to reduce its
48 premium rates for individual health benefits plans subject to this
49 act.

50 c. A carrier shall not issue individual health benefits plans on a
51 new contract or policy form pursuant to this act until an
52 informational filing of a full schedule of rates which applies to
53 the contract or policy form has been filed with the board. The
54 board shall forward the informational filing to the commissioner
55 and the Public Advocate.

1 d. A carrier shall make an informational filing with the board
2 of any change in its rates for individual health benefits plans
3 pursuant to section 3 of this act prior to the date the rates
4 become effective. The board shall file the informational filing
5 with the commissioner and the Public Advocate. If the carrier
6 has filed all information required by the board, the filing shall be
7 deemed to be complete.

8 e. (1) Rates shall be formulated on contracts or policies
9 required pursuant to section 3 of this act so that the anticipated
10 minimum loss ratio for a contract or policy form shall not be less
11 than 75% of the premium. The carrier shall submit with its rate
12 filing supporting data, as determined by the board, and a
13 certification by a member of the American Academy of
14 Actuaries, or other individuals acceptable to the board and to the
15 commissioner, that the carrier is in compliance with the
16 provisions of this subsection.

17 (2) Following the close of each calendar year, if the board
18 determines that a carrier's loss ratio was less than 75% for that
19 calendar year, the carrier shall be required to refund to policy or
20 contract holders the difference between the amount of net
21 earned premium it received that year and the amount that would
22 have been necessary to achieve the 75% loss ratio.

23 9. (New section) a. There is created the New Jersey Individual
24 Health Coverage Program. All carriers subject to the provisions
25 of this act shall be members of the program.

26 b. Within 30 days of the effective date of this act, the
27 commissioner shall give notice to all members of the time and
28 place for the initial organizational meeting, which shall take
29 place within 60 days of the effective date. The board shall
30 consist of nine representatives. The commissioner or his designee
31 shall serve as an ex officio member on the board. Four members
32 of the board shall be appointed by the Governor, with the advice
33 and consent of the Senate: one of whom shall be a representative
34 of an employer, appointed upon the recommendation of a business
35 trade association, who is a person with experience in the
36 management or administration of an employee health benefit
37 plan; one of whom shall be a representative of organized labor,
38 appointed upon the recommendation of the A.F.L.-C.I.O., who is
39 a person with experience in the management or administration of
40 an employee health benefit plan; and two of whom shall be
41 consumers of a health benefits plan who are reflective of the
42 population in the State. Four board members who represent
43 carriers shall be elected by the members, subject to the approval
44 of the commissioner, as follows: to the extent there is one
45 licensed in this State that is willing to have a representative
46 serve on the board, a representative from each of the following
47 entities shall be elected:

- 48 (1) a health service corporation;
- 49 (2) a health maintenance organization;
- 50 (3) a mutual health insurer of this State subject to Subtitle 3
51 of Title 17B of the New Jersey Statutes; and
- 52 (4) a foreign health insurance company authorized to do
53 business in this State.

54 In approving the selection of the carrier representatives of the

1 board, the commissioner shall assure that all members of the
2 program are fairly represented.

3 Initially, two of the Governor's appointees and two of the
4 carrier representatives shall serve for a term of three years; one
5 of the Governor's appointees and one of the carrier
6 representatives shall serve for a term of two years; and one of
7 the Governor's appointees and one of the carrier representatives
8 shall serve for a term of one year. Thereafter, all board
9 members shall serve for a term of three years. Vacancies shall
10 be filled in the same manner as the original appointments.

11 c. If the initial carrier representatives to the board are not
12 elected at the organizational meeting, the commissioner shall
13 appoint those members to the initial board within 15 days of the
14 organizational meeting.

15 d. Within 90 days after the appointment of the initial board,
16 the board shall submit to the commissioner a plan of operation
17 and thereafter, any amendments to the plan necessary or suitable
18 to assure the fair, reasonable, and equitable administration of the
19 program. The commissioner may disapprove the plan of
20 operation, if the commissioner determines that it is not suitable
21 to assure the fair, reasonable, and equitable administration of the
22 program, and that it does not provide for the sharing of program
23 losses on an equitable and proportionate basis in accordance with
24 the provisions of section 11 of this act. The plan of operation or
25 amendments thereto shall become effective unless disapproved in
26 writing by the commissioner within 45 days of receipt by the
27 commissioner.

28 e. If the board fails to submit a suitable plan of operation
29 within 90 days after its appointment, the commissioner shall,
30 after notice and hearing, adopt and promulgate a temporary plan
31 of operation. The commissioner shall amend or rescind a
32 temporary plan adopted under this subsection, at the time a plan
33 of operation is submitted by the board.

34 f. The plan of operation shall establish procedures for:

35 (1) the handling and accounting of assets and monies of the
36 program, and an annual fiscal reporting to the commissioner;

37 (2) collecting assessments from members to provide for
38 sharing program losses in accordance with the provisions of
39 section 11 of this act and administrative expenses incurred or
40 estimated to be incurred during the period for which the
41 assessment is made;

42 (3) approving the coverage, benefit levels, and contract forms
43 for individual health benefits plans in accordance with the
44 provisions of section 3 of this act;

45 (4) the imposition of an interest penalty for late payment of an
46 assessment pursuant to section 11 of this act; and

47 (5) any additional matters at the discretion of the board.

48 g. The board shall appoint an insurance producer licensed to
49 sell health insurance pursuant to P.L.1987, c.293 (C.17:22A-1 et
50 seq.) to advise the board on issues related to sales of individual
51 health benefits plans issued pursuant to this act.

52 10. (New section) The program shall have the general powers
53 and authority granted under the laws of New Jersey to insurance
54 companies, health service corporations and health maintenance

- 1 organizations licensed or approved to transact business in this
2 State, except that the program shall not have the power to issue
3 health benefits plans directly to either groups or individuals.
- 4 The board shall have the specific authority to:
- 5 a. assess members their proportionate share of program losses
6 and administrative expenses in accordance with the provisions of
7 section 11 of this act, and make advance interim assessments, as
8 may be reasonable and necessary for organizational and interim
9 operating expenses and estimated losses. An interim assessment
10 shall be credited as an offset against any regular assessment due
11 following the close of the fiscal year;
- 12 b. establish rules, conditions, and procedures pertaining to the
13 sharing of program losses and administrative expenses among the
14 members of the program;
- 15 c. review rate applications and form filings submitted by
16 carriers in accordance with this act;
- 17 d. define the provisions of individual health benefits plans in
18 accordance with the requirements of this act;
- 19 e. enter into contracts which are necessary or proper to carry
20 out the provisions and purposes of this act;
- 21 f. establish a procedure for the joint distribution of
22 information on individual health benefits plans issued pursuant to
23 section 3 of this act;
- 24 g. establish, at the board's discretion, standards for the
25 application of a means test for individual health benefits plans
26 issued pursuant to section 3 of this act;
- 27 h. establish, at the board's discretion, reasonable guidelines for
28 the purchase of new individual health benefits plans by persons
29 who already are enrolled in or insured by another individual
30 health benefits plan;
- 31 i. establish minimum requirements for performance standards
32 for carriers that are reimbursed for losses submitted to the
33 program and provide for performance audits from time to time;
- 34 j. sue or be sued, including taking any legal actions necessary
35 or proper for recovery of an assessment for, on behalf of, or
36 against the program or a member;
- 37 k. appoint from among its members appropriate legal,
38 actuarial, and other committees as necessary to provide technical
39 and other assistance in the operation of the program, in policy
40 and other contract design, and any other function within the
41 authority of the program; and
- 42 l. borrow money to effect the purposes of the program. Any
43 notes or other evidence of indebtedness of the program not in
44 default shall be legal investments for carriers and may be carried
45 as admitted assets.
- 46 11. (New section) The board shall establish procedures for the
47 equitable sharing of program losses among all members in
48 accordance with their total market share as follows:
- 49 a. (1) By March 1, 1993 and following the close of each
50 calendar year thereafter, on a date established by the board:
- 51 (a) every carrier issuing health benefits plans in this State shall
52 file with the board its net earned premium for the preceding
53 calendar year ending December 31; and
- 54 (b) every carrier issuing individual health benefits plans in the

1 State shall file with the board the net earned premium on policies
2 or contracts issued pursuant to paragraph (1) of subsection b. of
3 section 2 and section 3 of this act and the claims paid and the
4 administrative expenses attributable to those policies or
5 contracts. If the claims paid and reasonable administrative
6 expenses for that calendar year exceed the net earned premium
7 and any investment income thereon, the amount of the excess
8 shall be the net paid loss for the carrier that shall be
9 reimburseable under this act. For the purposes of this subsection,
10 "reasonable administrative expenses" shall be actual expenses or
11 a maximum of 25% of premium, whichever amount is less.

12 (2) Every member shall be liable for an assessment to
13 reimburse carriers issuing individual health benefits plans in this
14 State which sustain net paid losses for the previous year, unless
15 the member has received an exemption from the board pursuant
16 to subsection d. of this section and has written a minimum
17 number of non-group persons as provided for in that subsection.
18 The assessment of each member shall be in the proportion that
19 the net earned premium of the member for the calendar year
20 preceding the assessment bears to the net earned premium of all
21 members for the calendar year preceding the assessment.

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

34 b. The participation in the program as a member, the
35 establishment of rates, forms or procedures, or any other joint or
36 collective action required by this act shall not be the basis of any
37 legal action, criminal or civil liability, or penalty against the
38 program, a member of the board or a member of the program
39 either jointly or separately except as otherwise provided in this
40 act.

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

47 d. (1) Notwithstanding the provisions of this act to the
48 contrary, a carrier may apply to the board, by a date established
49 by the board, for an exemption from the assessment and
50 reimbursement for losses provided for in this section. A carrier
51 which applies for an exemption shall agree to enroll or insure a
52 minimum number of non-group persons on an open enrollment
53 community rated basis, under a managed care or indemnity plan,
54 as specified in this subsection, provided that any indemnity plan

1 so issued conforms with sections 2 through 7, inclusive, of this
2 act. For the purposes of this subsection, non-group persons
3 include individually enrolled persons, conversion policies issued
4 pursuant to this act, Medicare cost and risk lives and Medicaid
5 and HealthStart Plus recipients; except that in determining
6 whether the carrier meets the minimum number of non-group
7 persons required pursuant to this subsection, the number of
8 Medicaid recipients and Medicare cost and risk lives shall not
9 exceed 50% of the total.

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

19 (3) The minimum number of non-group persons, as determined
20 by the board, shall equal the total number of community rated
21 and modified community rated, individually enrolled or insured
22 persons, including Medicare cost and risk lives and enrolled
23 Medicaid and HealthStart Plus lives, of all carriers subject to this
24 act as of the end of the calendar year, multiplied by the
25 proportion that that carrier's net earned premium bears to the
26 net earned premium of all carriers for that calendar year,
27 including those carriers that are exempt from the assessment.

28 (4) Within 180 days after the effective date of this act and on
29 or before March 1 of each year thereafter, every carrier seeking
30 an exemption pursuant to this subsection shall file with the board
31 a statement of its net earned premium for the preceding calendar
32 year. The board shall determine each carrier's minimum number
33 of non-group persons in accordance with this subsection.

34 (5) On or before March 1 of each year, every carrier that was
35 granted an exemption for the preceding calendar year shall file
36 with the board the number of non-group persons, by category,
37 enrolled or insured as of December 31 of the preceding calendar
38 year.

39 To the extent that the carrier has failed to enroll the minimum
40 number of non-group persons established by the board, the carrier
41 shall be assessed by the board on a pro rata basis for any
42 differential between the minimum number established by the
43 board and the actual number enrolled or insured by the carrier.

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

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

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

52 (c) by the end of calendar year 1995, it has enrolled or insured
53 100% of the minimum number of non-group persons required.

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

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

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

21 12. (New section) a. No later than March 1, 1993, any carrier
22 issuing individual health benefits plans in the State shall file with
23 the board a statement of any net paid losses for the calendar year
24 ending December 31, 1992, as calculated pursuant to subsection
25 a. of section 11 of this act, along with any supporting information
26 required by the board.

27 b. The losses filed pursuant to subsection a. of this section
28 shall be reimbursed in an amount up to \$10,000,000 or 50% of the
29 paid losses, whichever amount is less, to the carrier filing the
30 losses. The assessment shall be made as a separate assessment
31 from those required pursuant to section 11 of this act, but shall
32 be assessed in the same manner and at the same time as the first
33 assessment made after the effective date of this act as provided
34 for in section 11 of this act, except that the carrier filing for the
35 reimbursement shall not be subject to an assessment pursuant to
36 this section.

37 13. (New section) The board shall determine whether any
38 carrier has a disproportionate share of substandard risks insured
39 or enrolled under its individual health benefits plans and shall
40 make recommendations to the Governor and the Legislature for
41 remedial action to minimize the losses sustained by the carrier as
42 a result of insuring these risks.

43 14. (New section) A health benefits plan issued pursuant to
44 section 3 of this act may be sold through an insurance producer
45 licensed pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.).

46 15. (New section) Notwithstanding the provisions of P.L.1973,
47 c.337 (C.26:2J-1 et seq.) to the contrary, a health maintenance
48 organization shall not be required to submit any rate filings with
49 the commissioner for an individual health benefits plan that is
50 subject to the provisions of this act, but shall be subject to the
51 minimum loss ratio provisions of section 8 of this act.

52 16. The board shall, pursuant to the provisions of the
53 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
54 seq.), promulgate rules and regulations necessary to effectuate

1 the provisions of sections 1 through 15, inclusive, of this act.

2 17. Sections 1 through 15, inclusive, of this act shall be known
3 and may be cited as the "Individual Health Insurance Reform
4 Act."

5 18. Section 3 of P.L.1985, c.236 (C.17:48E-3) is amended to
6 read as follows:

7 3. a. No health service corporation shall be established as a
8 corporation organized for pecuniary profit. Every health service
9 corporation established pursuant to the provisions of this act shall
10 be operated for the benefit of its subscribers.

11 b. No person, firm, association or corporation, other than a
12 health service corporation or an insurance company authorized to
13 transact life or health insurance in accordance with Title 17B of
14 the New Jersey Statutes, shall establish, maintain or operate a
15 health service plan. No person, firm, association or corporation,
16 other than a hospital service corporation, a medical service
17 corporation, a dental service corporation to the extent permitted
18 by P.L.1968, c.305 (C.17:48C-1 et seq.), or an insurance company
19 authorized to transact life or health insurance business or the
20 kinds of insurance specified in subsection (d) of R.S.17:17-1, shall
21 otherwise contract in this State with persons to pay for or to
22 provide for health services on the basis of premiums or other
23 valuable considerations to be collected by the person, firm,
24 association or corporation from any persons for the issuance of
25 the contracts. This section shall not be construed as preventing
26 the exercise of any authority or privilege granted to any
27 corporation by a certificate of authority issued by the
28 commissioner pursuant to any law of this State, or as preventing
29 any person, firm, association or corporation from furnishing
30 health services required under any workers' compensation law, or
31 law pertaining to health maintenance organizations, or as
32 otherwise provided by law.

33 c. A health service corporation shall, unless prohibited by the
34 commissioner, offer as an option medical-surgical contracts and
35 dental subscriber contracts which afford subscribers prepaid or
36 postpaid benefits pursuant to which payment is made to
37 participating providers for medical-surgical and dental services
38 rendered by a participating provider network with agreements
39 granting an aggregate differential allowance or discount on
40 charges, as well as a limit on total allowances which may or may
41 not be related to the subscriber's income level, where the
42 aggregate differential or discount on charges and limit on total
43 allowances may be achieved by payment of either the individual
44 provider's actual charge or the health service corporation's
45 allowance on the charge, whichever is less.

46 d. A health service corporation shall, unless the commissioner
47 otherwise directs,] maintain [a continuous] an open enrollment
48 period[, providing] for coverage to persons who are otherwise
49 unable to obtain hospital, medical-surgical, or major medical
50 coverage in accordance with the provisions of P.L. , c. (C.)
51 (now pending before the Legislature as this bill).

52 e. No health service corporation shall have the power to
53 underwrite life insurance as defined in Title 17B of the New
54 Jersey Statutes directly, but a health service corporation may, at

1 such time as the aggregate special contingent surplus is greater
2 than 0%, own stock in, control, or otherwise become affiliated
3 with a life, health or accident insurance company organized
4 pursuant to Title 17B of the New Jersey Statutes or under the
5 laws of any other state, provided that the company is admitted in
6 this State.

7 f. No health service corporation shall solicit subscribers or
8 enter into any contract with any subscriber until it has received
9 from the commissioner a certificate of authority to do so, but if
10 a health service corporation is established by means of the
11 merger of a medical service corporation into a hospital service
12 corporation, which hospital service corporation possesses a valid
13 certificate of authority issued prior to the effective date of this
14 act, the health service corporation thus established need not
15 reapply for a new certificate of authority, but the corporation
16 shall file in the Department of Insurance any documents relating
17 to the merger which the commissioner may require.

18 g. Nothing in this act shall be deemed to prohibit a health
19 service corporation from contracting with, or paying commissions
20 to, any duly licensed affiliated or independent insurance
21 producer, to the extent permitted by the laws applicable to those
22 producers.

23 (cf: P.L. 1988, c. 71, s. 1)

24 19. Section 27 of P.L.1985, c.236 (C.17:48E-27) is amended to
25 read as follows:

26 27. No health service corporation shall issue individual
27 contracts until it has [filed] made an informational filing with the
28 commissioner, pursuant to the provisions of this act, of a full
29 schedule of rates which are to apply to those contracts. [The
30 commissioner may disapprove the rates applicable to group or
31 individual contracts at any time if he finds that the rates are
32 excessive, inadequate or unfairly discriminatory, and it shall be
33 unlawful for any corporation to effect any contract according to
34 those rates thereafter.] The rates shall be formulated so that the
35 anticipated minimum loss ratio for a contract form shall not be
36 less than 75% of the premium. The health service corporation
37 shall submit with its rate filing supporting data that the
38 corporation is in compliance with the anticipated loss ratio
39 requirement. The supporting data and certification required
40 pursuant to subsection e. of section 8 of P.L. , c. (C.) (now
41 pending before the Legislature as this bill) shall satisfy the
42 requirements of this section.

43 (cf:P.L. 1988, c. 71, s. 6)

44 20. Section 7 of P.L.1988, c.71 (C.17:48E-27.1) is amended to
45 read as follows:

46 7. A health service corporation shall [file notice] make an
47 informational filing of any change in its rates for coverage under
48 individual contracts which are not experience rated, along with
49 supporting information as [the commissioner deems necessary at
50 least 45 days] required pursuant to subsection e. of section 8 of
51 P.L. , c. (C.) (now pending before the Legislature as this
52 bill), prior to the rates becoming effective. [Unless the rates are
53 disapproved by the commissioner on or before the day the rates
54 are to become effective, they shall be deemed to be approved. In

1 his discretion, the commissioner may waive the 45 day period, or
2 any portion thereof.]

3 (cf:P.L. 1988, c. 71, s. 7)

4 21. This act shall take effect immediately.

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9 Requires all health insurers to offer individual health benefits
10 coverage on a community rated basis.

1 of three independent actuaries. The arbitration shall be in
2 accordance with, and governed by, the Commercial Arbitration
3 Rules of the American Arbitration Association.

4 8. The board shall, pursuant to the provisions of the
5 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
6 seq.), promulgate rules and regulations necessary to effectuate
7 the provisions of this act.

8 9. This act shall be known and may be cited as the "Individual
9 Health Insurance Reform Act."

10 10. This act shall take effect immediately.

11 12 13 STATEMENT 14

15 This bill reforms the individual health insurance market by
16 requiring all health insurers, including health maintenance
17 organizations, to provide individual health insurance on a
18 continuous open enrollment, guaranteed issue basis. Premiums are
19 to be based upon a community rating system, although
20 non-standard rates may be charged individuals with high risk
21 health status.

22 Under the provisions of the bill, all health insurers are
23 required, as a condition of doing business, to offer at least two
24 individual health benefits plans: a basic health benefits plan and
25 an enhanced health benefits plan. The coverage provided under
26 the basic health benefits plan is based upon the coverage required
27 in basic health care contracts or policies under the "Health Care
28 Cost Reduction Act." The coverage provided under the basic
29 health benefits plan may not exceed 80% of the actuarial value
30 provided under the enhanced health benefits plan.

31 The bill also creates the New Jersey Individual Health
32 Coverage Program governed by a nine-member board consisting
33 of the Commissioner of Insurance, the Commissioner of Health,
34 three public members, and, among others, a representative of a
35 commercial insurer, a health service corporation, and a health
36 maintenance organization. The program is authorized by the bill
37 to: establish the specific terms of basic and enhanced health
38 benefits plans; approve rates for individual health benefits plans;
39 and establish a formula for permitting increases in premiums to
40 reflect trend increases in the cost of health care. In addition, the
41 program will apportion losses in the individual health benefits
42 market among all insurers, health maintenance organizations,
43 health, hospital and medical service corporations, multiple
44 employer arrangements and third-party administrators in
45 accordance with their respective shares of the total group and
46 individual health benefits market.

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51 Requires all health insurers to have open enrollment for individual
52 health benefits coverage on a community rated basis.

ASSEMBLY INSURANCE COMMITTEE
STATEMENT TO
ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 1654

STATE OF NEW JERSEY

DATED: November 9, 1992

The Assembly Insurance Committee releases favorably the Assembly Committee Substitute for Assembly Bill No. 1654.

This Assembly Committee substitute reforms the individual health insurance market by requiring all health insurers, including health maintenance organizations, to provide individual health insurance on a open enrollment, guaranteed issue basis. All plans offered under the substitute would be community rated.

Under the provisions of the committee substitute, all health insurers are required, as a condition of issuing health benefits plans in the State, to offer five individual health benefits plans: a basic health benefits plan, a managed care plan and three enhanced health benefits plans of proportionally increasing actuarial value. The coverage provided under the basic health benefits plan is based upon the coverage required in basic health care contracts or policies under the "Health Care Cost Reduction Act."

An individual health benefits plan offered pursuant to this substitute bill shall contain a limitation of no more than 12 months on coverage for preexisting conditions, except that the limitation shall not apply to an individual who satisfied a 12 month preexisting condition limitation under a prior group or individual health benefits plan with no intervening lapse in coverage.

The committee substitute provides that a carrier may transfer to another carrier its obligation to provide individual health benefits plans. The transfer would not require any financial contribution by the transferring carrier, but the transferring carrier will continue to be liable for the assessment to cover losses of carriers that do provide the individual coverage.

The substitute bill creates the New Jersey Individual Health Coverage Program governed by a nine-member board. All carriers subject to the provisions of the substitute bill shall be members of the program. The board members shall include:

- the Commissioner of Insurance;
- four public members appointed by the Governor with the advice and consent of the Senate, including a representative of an employer and a representative of organized labor, both of whom shall have experience in the management or administration of an employee health benefits plan, and two consumers of a health benefits plan who are reflective of the population in the State; and
- four members who represent carriers, who are elected by the members subject to the approval of the commissioner, including representatives of a health service corporation, a health maintenance organization, a mutual health insurer of this State, and a foreign health insurance company authorized to do business in this State.

The program shall have the general powers and authority granted under the laws of New Jersey to insurance companies,

health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the program shall not have the power to issue health benefits plans directly to either groups or individuals.

The board shall establish procedures for the equitable sharing of program losses among all members in accordance with their total market share. The board shall assess members in the proportion that the net earned premium of the member for the calendar year preceding the assessment bears to the net earned premium of all members for the calendar year preceding the assessment. However, a carrier may apply to the board for an exemption from the assessment and reimbursement for losses provisions by agreeing to accept its market share of individual enrollees or insureds in either a managed care or indemnity plan.

The board shall have the authority to:

- review rate applications and form filings submitted by carriers in accordance with this substitute bill. Rates shall be formulated so that the anticipated minimum loss ratio for each policy or contract form is no less than 75% of the premium;
- define the provisions of individual health benefits plans in accordance with the requirements of this bill and develop up to five rider packages in addition to the five health benefits plans;
- enter into contracts which are necessary or proper to carry out the provisions and purposes of this bill;
- establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the program and provide for performance audits from time to time;
- sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the program or a member;
- appoint from among its members appropriate legal, actuarial, and other committees as necessary to provide technical and other assistance in the operation of the program, in policy and other contract design, and any other function within the authority of the program; and
- borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

Finally, the committee substitute amends section 27 of P.L.1985, c.236 (C.17:48E-27) and section 7 of P.L.1988, c.71 (C.17:48E-27.1) enabling statutes (N.J.S.A.17:48E-27 and 27.1) regarding rates of Blue Cross and Blue Shield of New Jersey's (BC/BSNJ) to eliminate the Commissioner of Insurance's authority to disapprove BC/BSNJ proposed rates. The amendments provide, instead, that BC/BSNJ shall ensure that its rates are formulated so that the anticipated minimum loss ratio is at least 75% of the premium on each contract form. This provision is consistent with the loss ratio requirement established in the substitute for all individual health benefits plans issued on and after the effective date of the committee substitute. The committee substitute also amends section 3 of P.L.1988, c.236 (C.17:48E-3) concerning BC/BSNJ's status as the insurer of "last resort" to make it consistent with the requirements of the substitute.



A1654 ✓ and A2100

OFFICE OF THE GOVERNOR NEWS RELEASE

CN-001
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TRENTON, N.J. 08625

Release:

Tuesday
Dec. 1, 1992

GOVERNOR FLORIO SIGNS SWEEPING HEALTH INSURANCE REFORMS

New Jersey today ushered in a new era of health care when Governor Jim Florio signed sweeping reforms that will help make insurance coverage and medical treatment available and affordable for virtually everyone.

"Health insurance is not a privilege, it is a fundamental right," Gov. Florio said. "These are the kinds of changes President-elect Bill Clinton is proposing on a national scale, and I am pleased New Jersey has moved ahead."

"This is a national problem, and it requires a national solution. But New Jersey isn't waiting," Gov. Florio said.

"There are nearly 1 million New Jersey residents who do not have health insurance coverage because they cannot afford it or because insurance companies won't enroll them," Gov. Florio said. "That is intolerable. These reforms will help make sure no one in our state has to lie awake at night wondering how to pay the bills if someone in the family gets sick."

"For many of our hardworking people, the health insurance bill costs more than the mortgage, forcing more and more families to drop their coverage and take their chances. And when someone in that family gets sick, they go to a hospital emergency room, the single most expensive setting to get medical treatment," Gov. Florio said.

"The changes we are making here in New Jersey will make sure more people are covered, and will shift the care they receive away from emergency rooms and toward preventive care where it belongs," Gov. Florio said.

"The reforms put an end to a system where people were routinely turned down for coverage and wound up in emergency rooms, waiting five hours to see a doctor for five minutes," Gov. Florio said. "At a time when modern medicine has given us cures for once-fatal

illnesses, too many people have seen the fear of illness replaced by the fear of financial ruin from paying the bills. Too often, you seek treatment to get well, and the bill makes you sick."

The reforms will require health insurers to provide mandatory open enrollment and community rating requiring insurers to cover all individuals seeking coverage, as well as small groups of fewer than 50 people. They also will require companies to streamline and cut wasteful administrative costs by offering five standardized policies.

Finally, companies will be required to spend at least 75 cents of every premium dollar collected on actual medical benefits, and no more than the remaining 25 cents on administrative costs, overhead and profits.

Under the current system, insurers have been free to pick and choose among applicants, and only Blue Cross has had to cover all those who seek coverage. As a result, commercial insurers only carry good risks, few companies write individual policies, Blue Cross' risk pool continues to worsen, and more and more families are forced to drop their coverage.

Community rating will require insurance companies to set one rate for everyone regardless of age, occupation or other factors, spreading the risk across a broad base of policyholders. This replaces the system where companies use age, health status, occupation, sex and geographic location in setting rates. Older people have had to pay five or more times what young people pay, people in certain occupations can pay up to twice what those in other occupations pay, and people in some geographic areas can pay up to twice what people in other areas pay.

"Right now, health insurance companies spend up to 40 cents of every dollar in small group business on administrative costs and deciding who not to insure. It has become a business of risk avoidance, rather than risk spreading," Gov. Florio said. "We're taking insurance back to what it was supposed to be. For too long insurance companies have concentrated on figuring out who not to insure. That's not fair, and it's not going to continue."

The third reform measure creates New Jersey SHIELD, which will provide coverage for those unable to afford health insurance. New Jersey SHIELD will be targeted toward the working uninsured, people who are temporarily unemployed, and part-time or seasonal workers. It will use a sliding income scale with modest co-payments so that people can receive coordinated care from practitioners in their local communities, and will direct health care dollars now spent on emergency room treatment for these families to preventive and primary care instead.

The managed care program under New Jersey SHIELD is similar to Hawaii's successful health insurance system which insures 98 percent of its residents with either employer-based insurance or its state health insurance plan.

New Jersey SHIELD, which would take effect Jan. 1, 1994, is not a replacement for Medicare, Medicaid or existing private insurance companies, but will be there for people who are not eligible, or cannot afford, existing coverage programs. New Jersey SHIELD also is not a state-run insurance system, but instead would contract with the best existing providers.

Under New Jersey SHIELD, families would receive a standard benefits package that includes:

Preventive Care
Primary Care
Emergency Room Visits
Prescription drugs
Hospitalization

The health insurance reforms were enacted at the same time that New Jersey replaced its system for funding hospital care for those who can't afford to pay for it. The prior funding system, which relied on a 19 percent tax on all hospital bills, had been ruled illegal for self-insured health plans by a federal judge. The primary users of the uncompensated care trust fund are uninsured working families, those not old enough for Medicare who do not have coverage from their employer and earn too much to qualify for Medicaid.

Under the new funding system, that tax on hospital bills will be replaced by funding from the state unemployment insurance fund. A trigger that would raise the unemployment tax on employers will take effect if the fund, now at \$2.4 billion, drops below \$1.5 billion after July, 1994.