

17B:27A-17

LEGISLATIVE HISTORY CHECKLIST
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(Health benefits plans--small business)

NJSA: 17B:27A-17

LAWS OF: 1993 **CHAPTER:** 162

BILL NO: S1686

SPONSOR(S) Bassano and Cardinale

DATE INTRODUCED: April 15, 1993

COMMITTEE: **ASSEMBLY:** ---
SENATE: Health and Human Services

AMENDED DURING PASSAGE: Yes Amendments during passage
Third reprint enacted denoted by superscript numbers

DATE OF PASSAGE: **ASSEMBLY:** June 21, 1993
SENATE: May 13, 1993

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FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT: Yes

COMMITTEE STATEMENT: **ASSEMBLY:** No
SENATE: Yes

FISCAL NOTE: No

VETO MESSAGE: No

MESSAGE ON SIGNING: No

FOLLOWING WERE PRINTED:

REPORTS: Yes

HEARINGS: Yes

974.90 New Jersey. Governor's Committee on Health Care Costs.
I59 Cost accessibility, responsibility, efficiency for New Jersey
1990 October 1, 1990. Trenton, 1990
[see especially recommendation 9]

(over)

- 974.90 New Jersey. Legislature. Assembly. Health Care Policy Study
I59 Commission.
1900a Public hearing, held 4-16-90, 5-24-90 and 7-18-90. N.J.,
Woodbridge, Edison, Kenilworth, N.J., 1990.
- 974.90 New Jersey. Legislature. Assembly. Health care Policy Study
I59 Commission.
1990b Interim report, November 28, 1990. Trenton, 1990.
- 974.90 New Jersey. Legislature. Senate. Institutions, Health and
I59 Welfare Committee.
1990c Public hearing, held 11-14-90. Trenton, 1990.

See newspaper clippings--attached:

"Shopping for individual health insurance to be easier," 7-1-93. The Record.

"Health policy changes enacted," 7-1-93. Star Ledger.

[THIRD REPRINT]

SENATE, No. 1686

STATE OF NEW JERSEY

INTRODUCED APRIL 15, 1993

By Senators BASSANO and CARDINALE

1 AN ACT concerning small group health benefits plans, amending
2 and supplementing P.L.1992, c.162¹, repealing section 30 of
3 P.L.1992, c.162¹ and amending P.L.1964, c.104.

4

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

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

9 1. As used in this act:

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

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

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

26 "Carrier" means any insurance company, health service
27 corporation, hospital service corporation, medical service
28 corporation or health maintenance organization authorized to
29 issue health benefits plans in this State. For purposes of this act,
30 carriers that are affiliated companies shall be treated as one
31 carrier, except that any insurance company, health service
32 corporation, hospital service corporation, or medical service
33 corporation that is an affiliate of a health maintenance
34 organization located in New Jersey or any health maintenance
35 organization located in New Jersey that is affiliated with an
36 insurance company, health service corporation, hospital service
37 corporation, or medical service corporation shall treat the health
38 maintenance organization as a separate carrier.

39 "Commissioner" means the Commissioner of Insurance.

40 "Community rating" means a rating methodology in which the
41 premium for all persons covered by a policy or contract form is
42 the same based upon the experience of the entire pool of risks

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

Matter underlined thus is new matter.

Matter enclosed in sub-section numerals has been adopted as follows:

¹ Senate S-H committee amendments adopted May 10, 1993.

² Assembly floor amendment adopted May 20, 1993.

³ Assembly floor amendments adopted June 10, 1993.

1 covered by that policy or contract form without regard to age,
2 gender, health status, residence or occupation.

3 "Department" means the Department of Insurance.

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

7 "Eligible employee" means a full-time employee who works a
8 normal work week of 25 or more hours. The term includes a sole
9 proprietor, a partner of a partnership, or an independent
10 contractor, if the sole proprietor, partner, or independent
11 contractor is included as an employee under a health benefits
12 plan of a small employer, but does not include employees who
13 work less than 25 hours a week or work on a temporary or
14 substitute basis.

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

21 "Health benefits plan" means any hospital and medical expense
22 [incurred] insurance policy ¹or certificate¹; health, hospital, or
23 medical service corporation contract ¹or certificate¹; or health
24 maintenance organization subscriber contract [offered] ¹or
25 certificate¹ delivered or issued for delivery in this State by any
26 carrier to a small employer group pursuant to section 3 of [this
27 act] P.L.1992, c.162 (C.17B:27A-19). For purposes of this act,
28 "health benefits plan" excludes the following plans, policies, or
29 contracts: accident only, credit, disability, long-term care,
30 coverage for Medicare services pursuant to a contract with the
31 United States government, Medicare supplement, dental only or
32 vision only, insurance issued as a supplement to liability
33 insurance, coverage arising out of a workers' compensation or
34 similar law, automobile medical payment insurance, or [insurance
35 under which benefits are payable with or without regard to fault
36 and which is statutorily required to be contained in any liability
37 insurance policy or equivalent self-insurance] personal injury
38 protection coverage issued pursuant to P.L.1972, c.70 (C.39:6A-1
39 et seq.).

40 "Late enrollee" means an eligible employee or dependent who
41 requests enrollment in a health benefits plan of a small employer
42 following the initial minimum 30-day enrollment period provided
43 under the terms of the health benefits plan. An eligible employee
44 or dependent shall not be considered a late enrollee if the
45 individual: a. was covered under another employer's health
46 benefits plan at the time he was eligible to enroll and stated at
47 the time of the initial enrollment that coverage under that other
48 employer's health benefits plan was the reason for declining
49 enrollment; b. has lost coverage under that other employer's
50 health benefits plan as a result of termination of employment,
51 the termination of the other plan's coverage, death of a spouse,
52 or divorce; and [the individual] c. requests enrollment within 90
53 days after termination of coverage provided under another
54 employer's health benefits plan. An eligible employee or

1 dependent also shall not be considered a late enrollee if the
2 individual is employed by an employer which offers multiple
3 health benefits plans and the individual elects a different plan
4 during an open enrollment period; or if a court of competent
5 jurisdiction has ordered coverage to be provided for a spouse or
6 minor child under a covered employee's health benefits plan and
7 request for enrollment is made within 30 days after issuance of
8 that court order.

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

11 ¹["MEWA" means a multiple employer welfare arrangement as
12 defined in section 3 of the federal "Employee Retirement Income
13 Security Act of 1974," Pub.L. 93-406 (29 U.S.C. §1002), except
14 that MEWA shall not include any such arrangement which is fully
15 insured within the meaning of that act.]

16 "Multiple employer arrangement" means an arrangement
17 established or maintained to provide health benefits to employees
18 and their dependents of two or more employers, whether fully
19 insured or not fully insured, and shall include, but is not limited
20 to, a multiple employer welfare arrangement, or MEWA, multiple
21 employer trust or other form of benefit trust.¹

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

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

36 "Program" means the New Jersey Small Employer Health
37 [Excess Reinsurance] Benefits Program established pursuant to
38 section 12 of [this act] P.L.1992, c.162 (C.17B:27A-28).

39 "Reinsuring carrier" means a small employer carrier electing
40 to receive reimbursement from the program in accordance with
41 section 19 of [this act] P.L.1992, c.162 (C.17B:27A-35).

42 "Risk-assuming carrier" means a small employer carrier
43 electing to assume risks pursuant to section 18 of [this act]
44 P.L.1992, c.162 (C.17B:27A-34).

45 "Small employer" means any person, firm, corporation,
46 partnership, or association actively engaged in business which, on
47 at least 50 percent of its working days during the preceding
48 calendar year quarter, employed at least two but no more than 49
49 eligible employees, the majority of whom are employed within
50 the State of New Jersey. In determining the number of eligible
51 employees, companies which are affiliated companies shall be
52 considered one employer[, subsequent]. Subsequent to the
53 issuance of a health benefits plan to a small employer pursuant to
54 the provisions of this act, and for the purpose of determining

1 eligibility, the size of a small employer shall be determined
2 annually. Except as otherwise specifically provided, provisions of
3 this act which apply to a small employer shall continue to apply
4 until the anniversary date [next] of the health benefits plan next
5 following the date the employer no longer meets the definition of
6 a small employer.

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

10 "Small employer health benefits plan" means a health benefits
11 plan for small employers approved by the commissioner pursuant
12 to section 17 of [this act] P.L.1992, c.162 (C.17B:27A-33).
13 (cf: P.L.1992, c.162, s.1)

14 2. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
15 read as follows:

16 3. a. [Every] Except as provided in subsection f. of this section,
17 every small employer carrier shall, as a condition of transacting
18 business in this State, offer to every small employer the [same]
19 five health benefit plans as provided in this section. The board
20 shall establish a standard policy form for each of the five plans,
21 which shall be the only plans offered to small groups on or after
22 January 1, 1994. One policy form shall contain the benefits
23 provided for in sections 55, 57, and 59 of P.L.1991, c.187
24 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). ¹[One] In the case of
25 indemnity carriers, one¹ policy form shall be established which
26 contains benefits and cost sharing levels which are ¹[consistent
27 with the basic method of operation and] equivalent to¹ the health
28 benefits plans of health maintenance organizations pursuant to
29 subchapter XI of Pub.L.93-222 (42 U.S.C. §300 et seq.). The
30 remaining policy forms shall contain basic hospital and
31 medical-surgical benefits, including, but not limited to:

- 32 (1) Basic inpatient and outpatient hospital care;
- 33 (2) Basic and extended medical-surgical benefits;
- 34 (3) Diagnostic tests, including x-rays;
- 35 (4) Maternity benefits, including prenatal and postnatal care;
- 36 and
- 37 (5) Preventive medicine, including periodic physical
38 examinations and inoculations.

39 At least three of the forms shall provide for major medical
40 benefits in varying lifetime aggregates, one of which shall
41 provide at least \$1,000,000 in lifetime aggregate benefits. The
42 policy forms provided pursuant to this section shall contain
43 benefits representing progressively greater actuarial values.

44 b. Initially, a carrier shall offer a plan within 90 days of the
45 approval of such plan by the commissioner. Thereafter, the plans
46 shall be available to all small employers on a continuing basis.
47 Every small employer which elects to be covered under any
48 health benefits plan who pays the premium therefor and who
49 satisfies the participation requirements of the plan shall be issued
50 a policy or contract by the carrier.

51 c. The carrier may establish a premium payment plan which
52 provides installment payments and which may contain reasonable
53 provisions to ensure payment security, provided that provisions to
54 ensure payment security are uniformly applied.

1 d. In addition to the five standard policies described in
2 subsection a. of this section, the board may develop up to five
3 rider packages. Any such package which a carrier chooses to
4 offer shall be issued to a small employer who pays the premium
5 therefor, and shall be subject to the rating methodology set forth
6 in section 9 of [this act] P.L.1992, c.162 (C.17B:27A-25).

7 e. Notwithstanding the provisions of subsection a. of this
8 section to the contrary, the board may approve a health benefits
9 plan containing only medical-surgical benefits or major medical
10 expense benefits, or a combination thereof, which is issued ¹as a
11 separate policy¹ in conjunction with a contract of insurance for
12 hospital expense benefits issued by a hospital service corporation,
13 if the health benefits plan and hospital service corporation
14 contract combined, otherwise comply with the provisions of
15 P.L.1992, c.162 (C.17B:27A-17 et seq.).

16 f. Notwithstanding the provisions of this section to the
17 contrary¹; (1)¹, a health maintenance organization which is a
18 qualified health maintenance organization pursuant to the
19 "Health Maintenance Organization Act of 1973," Pub.L.93-222
20 (42 U.S.C. §300e et seq.) shall be permitted to offer ²[a]² health
21 benefits ²[plan ¹approved by the board which is¹] plans
22 formulated by the board and approved by the commissioner which
23 are² in accordance with the provisions of that law in lieu of the
24 five plans required pursuant to this section¹; and (2) a carrier
25 which does not own or control a health maintenance organization
26 or is not otherwise affiliated with a health maintenance
27 organization, shall not be required to offer the health
28 maintenance organization type of health benefits plan required
29 pursuant to section 17 of P.L.1992, c.162 (C.17B:27A-33)].

30 Notwithstanding the provisions of this section to the contrary,
31 a health maintenance organization which is approved pursuant to
32 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer
33 ²[a]² health benefits ²[plan] plans formulated by the board and
34 approved by the commissioner which are² in accordance with the
35 provisions of that law in lieu of the five plans required pursuant
36 to this section, except that the ²[plan] plans² shall provide the
37 same level of benefits as required for a federally qualified health
38 maintenance organization, including any requirements concerning
39 copayments by enrollees.

40 g. A carrier shall not be required to own or control a health
41 maintenance organization or otherwise affiliate with a health
42 maintenance organization in order to comply with the provisions
43 of this section, but the carrier shall be required to offer the five
44 health benefits plans ²[established] which are formulated² by the
45 board ²and approved by the commissioner², including one plan
46 which contains benefits and cost sharing levels that are
47 equivalent to those required for health maintenance
48 organizations¹.

49 ²h. Notwithstanding the provisions of subsection a. of this
50 section to the contrary, the board may modify the benefits
51 provided for in sections 55, 57 and 59 of P.L.1991, c.187
52 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3).²
53 (cf: P.L.1992, c.162, s.3)

54 3. Section 4 of P.L.1992, c.162 (C.17B:27A-20) is amended to

1 read as follows:

2 4. Plans required to be offered under this act may be subject
3 to coinsurance and deductibles, which may vary by selected
4 portions of the coverage, except that no deductible applicable to
5 any portion of the coverage shall exceed \$250 for an individual or
6 family unit during any benefit year, and no coinsurance applicable
7 to any portion of the coverage shall exceed \$500 for an individual
8 or family unit during any benefit year, unless provided by the
9 board pursuant to section 17 of [this act] P.L.1992, c.162
10 (C.17B:27A-33). ²[Neither coinsurance nor deductibles shall be
11 applicable to maternity benefits.]²

12 (cf: P.L.1992, c.162, s.4)

13 4. Section 7 of P.L.1992, c.162 (C.17B:27A-23) is amended to
14 read as follows:

15 7. Every policy or contract issued to small employers in this
16 State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be
17 renewable with respect to all eligible employees or dependents at
18 the option of the policy or contract holder, or small employer
19 except under the following circumstances:

20 a. Nonpayment of the required premiums by the policyholder,
21 contract holder, or employer;

22 b. Fraud or misrepresentation of the policyholder, contract
23 holder, or employer or, with respect to coverage of eligible
24 employees or dependents, the enrollees or their representatives;

25 c. The number of employees covered under the health benefits
26 plan is less than the number or percentage of employees required
27 by participation requirements under the health benefits policy or
28 contract;

29 d. Noncompliance with a carrier's employment contribution
30 requirements;

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

34 (1) The carrier gives notice to cease doing business in the
35 small employer market to the commissioner not later than eight
36 months prior to the date of the planned withdrawal from the
37 small group market, during which time the carrier shall continue
38 to be governed by this act with respect to business written
39 pursuant to this act. For the purposes of this subsection, "date of
40 withdrawal" means the date upon which the first notice to small
41 employers is sent by the carrier pursuant to paragraph (2) of this
42 subsection;

43 (2) No later than two months following the date of the
44 notification to the commissioner that the carrier intends to cease
45 doing business in the small employer market, the carrier shall
46 mail a notice to every small business employer insured by the
47 carrier that the policy or contract of insurance will be
48 terminated. This notice shall be sent by certified mail to the
49 small business employer not less than six months in advance of
50 the effective date of the cancellation date of the policy or
51 contract;

52 (3) Any carrier that ceases to do business pursuant to this act
53 shall be prohibited from writing new business in the small
54 employer market for a period of five years from the date of

1 notice to the commissioner; ¹[or]¹

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 trust¹; or

5 g. The number of employees covered under the health benefits
6 plan is less than two¹.

7 (cf: P.L.1992, c.162, s.7)

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

10 9. a. (1) [Effective January 1, 1997] Beginning on the third
11 anniversary date of any policy or contract issued in 1994, no
12 small employer health benefits plan shall be issued in this State
13 unless the plan is community rated.

14 (2) [During the period] Beginning January 1, 1994 [to December
15 31, 1995] and upon the first anniversary date thereafter of the
16 policy or contract, the premium rate charged by a carrier to the
17 highest rated small group purchasing a small employer health
18 benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-17
19 ¹et seq.¹) shall not be greater than 300% of the premium rate
20 charged to the lowest rated small group purchasing that same
21 health benefits plan.

22 (3) [During the period January 1, 1996 to December 31, 1996]
23 Beginning on the second anniversary after the date established in
24 paragraph (2) of this subsection of the policy or contract, the
25 premium rate charged by a carrier to the highest rated small
26 group purchasing a small employer health benefits plan issued
27 pursuant to P.L.1992, c.162 (C.17B:27A-17 ¹et seq.¹) shall not be
28 greater than 200% of the premium rate charged for the lowest
29 rated small group purchasing that same health benefits plan.

30 (4) The commissioner shall study the impact on the health
31 insurance marketplace of the transition from the rating
32 methodology described in paragraph (3) of this subsection to
33 community rating. In making this study the commissioner shall
34 consult with representatives of the health insurance industry,
35 health care providers, consumer and public interest groups and
36 such other persons with expertise deemed relevant by the
37 commissioner. The commissioner shall report his findings to the
38 Governor and the Legislature on a day that the Legislature is in
39 session, on or before July 1, 1996. If the Legislature does not
40 take action within 60 days after its receipt of the commissioner's
41 report, to amend this act, community rating will become
42 effective on January 1, 1997.

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

50 b. [Notwithstanding any other provision of law to the contrary,
51 group hospital or medical coverage obtained through an
52 out-of-State trust covering a group of 49 or fewer employees or
53 participating persons who are residents of this State shall be
54 community rated regardless of the situs of delivery of the policy.]

1 (Deleted by amendment, P.L. , c.)(pending before the
2 Legislature as this bill).

3 c. Notwithstanding any other provision of law to the contrary,
4 no carrier offering any health benefits plan pursuant to the
5 provisions of this act shall act to circumvent the intent of this
6 act by acting as a third party administrator for groups of small
7 employers, any one of whom was insured as of September 1, 1992;
8 provided, however, that this provision shall not act to limit a
9 bona fide group of small employers who voluntarily act together
10 to provide health benefits to their employees.

11 d. Notwithstanding any other provision of law to the contrary,
12 this act shall apply to ¹[an] a carrier which issues a policy to an¹
13 association or trust of employers, if the group includes one or
14 more member employers or other member groups which have ¹at
15 least two but no more than¹ 49 ¹[or fewer]¹ employees or
16 members exclusive of spouses and dependents; except that, this
17 act shall not apply to ¹[an insurer] a carrier¹ which ¹[issues]
18 issued¹ a policy exclusively to the members of an association¹, on
19 or before the effective date of P.L.1992, c.162 (C.17B:27A-17 et
20 seq.),¹ if the policy ¹[is] was¹ written in the name of the
21 association, the ¹[insurer] carrier¹ writes no other group health
22 insurance policy in this State and the aggregate number of
23 insured association members exceeds 49.

24 ¹A carrier which is not exempt from the provisions of this act
25 pursuant to this subsection and which issues a policy to an
26 association or trust of employers after the effective date of
27 P.L.1992, c.162 (C.17B:27A-17 et seq.), shall be required to offer
28 small employer health benefits plans to non-association or trust
29 employers in the same manner as any other small employer
30 carrier is required pursuant to P.L.1992, c.162 (C.17B:27A-17 et
31 seq.).¹

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

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

43 g. (1) Beginning January 1, 1995, a carrier desiring to increase
44 or decrease premiums for any policy form subject to this act may
45 implement such increase or decrease upon making an
46 informational filing with the commissioner of such increase or
47 decrease, along with the actuarial assumptions and methods used
48 by the carrier in establishing such increase or decrease, provided
49 that the anticipated minimum loss ratio for a policy form shall
50 not be less than 75% of the premium therefor. Until December
51 31, 1996, the informational filing shall also include the carrier's
52 rating plan and classification system in connection with such
53 increase or decrease.

54 (2) Each calendar year, a carrier shall return, in the form of

1 aggregate benefits for each of the five standard policy forms
2 offered by the carrier pursuant to section 3 of [this act] P.L.1992,
3 c.162 (C.17B:27A-19), at least 75% of the aggregate premiums
4 collected for the policy form during that calendar year. Carriers
5 shall annually report, no later than August 1st of each year, the
6 loss ratio calculated pursuant to this section for each such policy
7 form for the previous calendar year. In each case where the loss
8 ratio for a policy fails to substantially comply with the 75% loss
9 ratio requirement, the carrier shall issue a dividend or credit
10 against future premiums for all policyholders with that policy
11 form in an amount sufficient to assure that the aggregate
12 benefits paid in the previous calendar year plus the amount of the
13 dividends and credits shall equal 75% of the aggregate premiums
14 collected for the policy form in the previous calendar year. The
15 dividend or credit shall be issued to each policy which was in
16 effect as of March 30th of the applicable year and remains in
17 effect as of the date the dividend or credit is issued. All
18 dividends and credits must be distributed by December 31 of the
19 year following the calendar year in which the loss ratio
20 requirements were not satisfied. The annual report required by
21 this paragraph shall include a carrier's calculation of the
22 dividends and credits, as well as an explanation of the carrier's
23 plan to issue dividends or credits. The instructions and format
24 for calculating and reporting loss ratios and issuing dividends or
25 credits shall be specified by the commissioner by regulation.
26 Such regulations shall include provisions for the distribution of a
27 dividend or credit in the event of cancellation or termination by a
28 policyholder.

29 h. [No carrier issuing health benefits plans covering two or
30 more employees of a small employer shall issue a plan
31 inconsistent with this act whose term extends beyond
32 December 31, 1993.] (Deleted by amendment, P.L. ,
33 c.)(pending before the Legislature as this bill).

34 i. The provisions of this act shall apply to health benefits plans
35 which are delivered, issued for delivery, renewed or continued on
36 or after January 1, 1994. [The commissioner shall withdraw
37 approval for the issuance and use of all small employer policy
38 forms, other than those approved by the board, effective January
39 1, 1994.]

40 j. A policy or contract covering two or more employees of a
41 small employer issued by a carrier prior to January 1, 1994 shall
42 remain in effect until the first anniversary date after February
43 28, 1994 of that policy or contract, but at least 60 days before
44 the first anniversary date thereof the carrier shall be required to
45 offer the small employer a policy or contract pursuant to section
46 3 of P.L.1992, c.162 (C.17B:27A 19).

47 (cf: P.L.1992, c.162, s.9)

48 6. Section 12 of P.L.1992, c.162 (C.17B:27A-28) is amended to
49 read as follows:

50 12. There is created a nonprofit entity to be known as the New
51 Jersey Small Employer Health [Excess Insurance] Benefits
52 Program. All carriers issuing health benefits plan policies and
53 contracts in this State shall be members of this program. The
54 program shall be administered by the board of directors

1 established pursuant to section 13 of [this act] P.L.1992, c.162
2 (C.17B:27A-29).

3 (cf: P.L.1992, c.162, s.12)

4 7. Section 15 of P.L.1992, c.162 (C.17B:27A-31) is amended to
5 read as follows:

6 15. The plan of operation shall constitute a public record and
7 shall include, but not be limited to, the following:

8 a. A method of handling and accounting for assets and moneys
9 of the program and an annual fiscal reporting to the
10 commissioner;

11 b. A means of providing for the filling of vacancies on the
12 board, subject to the approval of the commissioner;

13 c. [A means of selecting an administering carrier, and a
14 statement of the powers and duties of the administering carrier
15 and the compensation of the administering carrier and a
16 statement of the efficiency standards an administering carrier
17 must meet;] (Deleted by amendment, P.L. , c.)(pending before
18 the Legislature as this bill)

19 d. The method to be used to determine the extent to which a
20 carrier's payment per insured for each benefit plan provided for
21 under this act exceeds the Statewide average payment per
22 insured for each benefit plan provided for under this act;

23 e. The method for determining the extent to which a carrier
24 whose average cost of insuring individuals covered by small
25 employer health benefits plans exceeds the threshold described in
26 subsection c. of section 13 of [this act] P.L.1992, c.162
27 (C.17B:27A-29) may receive reimbursement from the program;

28 f. A statement of the efficiency and risk management
29 standards a carrier must meet before a carrier may receive
30 reimbursement from the program; and

31 g. Any additional matters which are appropriate to effectuate
32 the provisions of this act.

33 (cf: P.L.1992, c.162, s.15)

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

36 17. Subject to the approval of the commissioner, the board
37 shall formulate the five health benefits plans to be made
38 available by small employer carriers in accordance with the
39 provisions of this act, and shall promulgate five standard forms
40 pursuant thereto. The board may establish benefits levels,
41 deductibles and copayments, exclusions, and limitations for such
42 health benefits plans in accordance with the law.

43 [One health care plan shall be established which contains
44 benefits and cost sharing levels which are consistent with the
45 basic method of operation and the benefits plans of health
46 maintenance organizations, including any restrictions pursuant to
47 subchapter XI of Pub.L.93-222 (42 U.S.C. §300 et seq).] The
48 board shall submit the [plans] forms so established to the
49 commissioner for his approval [no later than 90 days after the
50 election of the board pursuant to section 13 of this act]. The
51 commissioner shall approve the [plan] forms if he finds [it] them
52 to be consistent with the provisions of section 3 of [this act]
53 P.L.1992, c.162 (C.17B:27A-19). Any [plans] form submitted to
54 the commissioner by the board shall be deemed approved if not

1 expressly disapproved in writing within 60 days of its receipt by
2 the commissioner. Such [plans] forms may contain, but shall not
3 be limited to, the following provisions:

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

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

7 c. Provision for selective contracting with hospitals,
8 physicians, and other health care providers;

9 d. Reasonable benefits differentials which are applicable to
10 participating and nonparticipating providers;

11 e. Notwithstanding the provisions of section 4 of [this act]
12 P.L.1992, c.162 (C.17B:27A-20) to the contrary, the board may,
13 from time to time, adjust coinsurance and deductibles;

14 f. Such other provisions which may be quantifiably established
15 to be cost containment devices;

16 g. The department shall publish annually a list of the premiums
17 charged for each of the five [standard] small employer health
18 benefits plans and for any rider package by all carriers writing
19 such plans. The department shall also publish the toll free
20 telephone number of each such carrier.

21 (cf: P.L.1992, c.162, s.17)

22 9. Section 21 of P.L.1992, c.162 (C.17B:27A-37) is amended to
23 read as follows:

24 21. a. Following the close of the calendar year ending
25 December 31, the [administering carrier] board shall determine
26 the total amount owed by the program in that calendar year to all
27 carriers qualifying for reimbursement by the program. Such
28 amount shall be known as the net loss of the program.

29 b. Any net loss for the year shall be recouped by assessments
30 of members. Assessments shall first be apportioned by the board
31 among all reinsuring carrier members in proportion to their
32 respective shares of the plan premiums earned in this State from
33 health benefits plans covering small employers during the
34 calendar year coinciding with or ending during the fiscal year of
35 the program, or on any other equitable basis reflecting coverage
36 of small employers as may be provided in the plan of operation. In
37 making this determination, the board may base the assessments
38 upon annual reports and other data filed by the member small
39 employer carrier.

40 c. If the net loss is not recouped before assessments totaling
41 4% of the aggregate premiums from policies or contracts
42 covering small employers have been collected from reinsuring
43 small employer carriers, additional assessments not to exceed 1%
44 of the aggregate premiums from all health benefits policies or
45 contracts shall be apportioned by the board among all members,
46 including risk-assuming carriers, in proportion to their respective
47 shares of the total health benefits plan premiums earned in this
48 State from all health benefits plans during the preceding calendar
49 year. A carrier shall receive a credit against this assessment to
50 the extent the carrier can demonstrate that its assumption of
51 high-risk small employer groups which are not reinsured is
52 proportionate to its market share of small employer health
53 benefits plans, as such groups and market shares are defined by
54 the board in the plan of operation. A carrier shall not be assessed

1 for all individual non-group contracts or policies issued on a
2 guaranteed issue basis or on any coverage issued by the carrier
3 pursuant to the Medicaid program, P.L.1968, c.413 (C.30:4D-1 et
4 seq.).

5 d. If assessments exceed actual losses and administrative
6 expenses of the program, the excess shall be held as interest and
7 used by the board to offset future losses or to reduce program
8 premiums. As used in this subsection, "future losses" includes
9 reserves for incurred but not reported claims.

10 e. Provision may be established in the plan of operation for the
11 imposition of an interest penalty for late payment of assessments.
12 (cf: P.L.1992, c.162, s.21)

13 ¹10. Section 8 of P.L.1992, c.162 (C.17B:27A-24) is amended
14 to read as follows:

15 8. Any small employer carrier may require a reasonable
16 specified minimum participation of eligible employees, which
17 shall not exceed 75%, or reasonable minimum employer
18 contributions in determining whether to accept a small group
19 pursuant to this act. The standards so established by the carrier
20 shall be first approved by the board and shall be applied uniformly
21 to all small groups, except that in no event shall a carrier require
22 an employer to contribute more than 10% to the annual cost of
23 the policy or contract, or an amount as otherwise provided by the
24 board, and any minimum participation standards established by
25 the carrier shall be reasonable. In establishing the percentage of
26 employee participation, a one-to-one credit shall be given for
27 each employee covered by a spouse's health benefits coverage.
28 In calculating an employer's participation, the carrier shall
29 include all insured employees, regardless of whether the
30 employees chose an indemnity plan or a health maintenance
31 organization, or a combination thereof.¹

32 (cf: P.L.1992, c.162, s.8)

33 ¹11. Section 10 of P.L.1992, c.162 (C.17B:27A-26) is amended
34 to read as follows:

35 10. a. No health maintenance organization shall be required to
36 offer coverage or accept applications pursuant to section 3 of
37 this act to a small employer if the small employer is not
38 physically located in the health maintenance organization's
39 approved service area, to an employee when the employee does
40 not work or reside within a service area, or if the health
41 maintenance organization reasonably anticipates and
42 demonstrates to the satisfaction of the commissioner that it will
43 not have the capacity in its network of providers within the
44 service area to deliver service adequately to the members of such
45 groups because of its obligations to existing group contract
46 holders and enrollees.

47 b. No small employer carrier shall be required to offer
48 coverage or accept applications pursuant to this act for any
49 period of time in which the commissioner determines that the
50 requiring of the issuing of policies or contracts pursuant to this
51 act would place the carrier in a financially impaired position.

52 c. A health maintenance organization which complies with the
53 basic health benefits, underwriting and rating standards
54 established by the federal government pursuant to subchapter XI

1 of Pub.L.93-222 (42.U.S.C. §300e et seq.), and which also provides
 2 the comprehensive health benefit ²[plan] plans² coverage
 3 required by subsection f. of section 3 of [this act] P.L.1992, c.162
 4 (C.17B:27A-19), shall be deemed in compliance with this act.¹

5 (cf: P.L.1992, c.162, s.10)

6 ¹[10.] 12.¹ (New section) Group hospital or medical coverage
 7 obtained through an out-of-State trust covering a group of 49 or
 8 fewer employees or participating persons who are residents of
 9 this State shall ¹[be exempt from the provisions of P.L.1992,
 10 c.162 (C.17B:27A-17 et seq.), except as provided in this section.
 11 The coverage shall comply with the provisions of subsection b. of
 12 section 3 and sections 6 and 7 of P.L.1992, c.162 (C.17B:27A-19,
 13 22 and 23)] comply with the provisions of P.L.1992, c.162
 14 (C.17B:27A-17 et seq.)¹, regardless of the situs of delivery of the
 15 policy.

16 ¹[11.] 13.¹ (New section) A ¹[MEWA] multiple employer
 17 arrangement¹ covering a group of 49 or fewer employees or
 18 participating persons of an individual employer who are residents
 19 of this State shall register with the board of directors established
 20 pursuant to section 13 of P.L.1992, c.162 (C.17B:27A-29).

21 The ¹[MEWA] multiple employer arrangement¹ shall be
 22 required to offer ¹[one or more health benefits plans in
 23 conformance with]¹ the health benefits plans established by the
 24 board. The ¹[MEWA] premium rates charged for the multiple
 25 employer arrangement¹ health benefits plan¹ ¹[shall be community
 26 rated and] shall conform to the requirements of section 9 of
 27 P.L.1992, c.162 (C.17B:27A-25) and the coverage¹ shall comply
 28 with the provisions of subsection b. of section 3 and sections 6
 29 and 7 of P.L.1992, c.162 (C.17B:27A-19, 22 and 23), regardless of
 30 the situs of delivery of the ¹[MEWA] multiple employer
 31 arrangement¹.

32 ¹14. (New section) A carrier shall notify the commissioner by
 33 December 31 of each year of any health care coverage or
 34 benefits, stop-loss coverage or administrative services only
 35 contracts it provides or enters into with a multiple employer
 36 arrangement that provides health care benefits to employees and
 37 their dependents in this State.¹

38 ¹15. (New section) a. A small employer who purchases a
 39 health benefits plan or ²[major medical benefits] rider² pursuant
 40 to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall not be permitted
 41 to purchase a health benefits plan or ²[major medical benefits]
 42 rider² with a greater actuarial value until the first anniversary
 43 date of the small employer's existing health benefits plan.

44 b. If, after the first anniversary date of a small employer's
 45 health benefits plan, the small employer purchases a health
 46 benefits plan or ²[major medical benefits] rider² of greater
 47 actuarial value than the existing health benefits plan or ²[major
 48 medical benefits] rider², the small employer shall not be
 49 permitted to change his health benefits plan or ²[major medical
 50 benefits] rider² to one of lesser actuarial value until the
 51 anniversary date of the small employer's existing health benefits
 52 plan.

53 c. Nothing in this section shall be construed to prohibit a small
 54 employer who has purchased a health benefits plan or ²[major

1 medical benefits] rider² pursuant to P.L.1992, c.162
2 (C.17B:27A-17 et seq.) from purchasing a health benefits plan or
3 ²[major medical benefits] rider² of lesser actuarial value prior to
4 the anniversary date of the existing health benefits plan or
5 ²[major medical benefits] rider², if the existing plan or ²[benefits
6 were] rider was² purchased at least 12 months prior to the latest
7 anniversary date of the plan or ²[benefits] rider².¹

8 ¹16. (New section) Upon the effective date of P.L. , c.
9 (C.)(pending before the Legislature as this bill) and through
10 December 31, 1993 and notwithstanding the provisions of
11 P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, all actions
12 adopted by the board shall be subject to the provisions of this
13 section and any action adopted by the commissioner pursuant to
14 P.L.1992, c.162 (C.17B:27A-17 et seq.), in his discretion, may be
15 subject to the provisions of this section in the same manner as
16 required for the board.

17 ²a.² For the purposes of this section, "action" includes, but is
18 not limited to: ²[the establishment and modification of health
19 benefits plans, the assessment of members and the apportionment
20 thereof, procedures and standards for the promulgation or
21 modification of policy forms, evaluation of material submitted by
22 carriers with respect to loss ratios, and the establishment of
23 procedures for refunds to policy or contract holders]

24 (1) the establishment and modification of health benefits plans;
25 (2) procedures and standards for the: (a) assessment of
26 members and the apportionment thereof; (b) filing of policy
27 forms; (c) making of rate filings; (d) evaluation of material
28 submitted by carriers with respect to loss ratios; and (e)
29 establishment of refunds to policy or contract holders; and

30 (3) the promulgation or modification of policy forms².

31 "Action" shall not include the hearing and resolution of
32 contested cases, personnel matters and applications for
33 withdrawal or exemptions.

34 ²[a.] b.² Prior to the adoption of an action of the board, the
35 board shall publish notice of its intended action in three
36 newspapers of general circulation in this State, and may publish
37 the notice of intended action in any trade or professional
38 publication which it deems necessary. The notice of intended
39 action shall include procedures for obtaining a detailed
40 description of the intended action and the time, place and manner
41 by which interested persons may present their views. The board
42 shall provide the notice of intended action and a detailed
43 description of the intended action by mail, or otherwise, to
44 affected trade and professional associations, carriers subject to
45 the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) and such
46 other interested persons or organizations which may request
47 notification. The board shall forward the notice of intended
48 action and the detailed description of the intended action
49 concurrently to the Office of Administrative Law for publication
50 in the New Jersey Register.

51 The board shall not charge any fee for placement upon the
52 mailing list of associations, carriers or other persons to be
53 notified, but the board may charge a fee to an association,
54 carrier or other person requesting a copy of the text of the

1 intended action, which fee shall not be in excess of the actual
2 cost of reproducing and mailing the copy.

3 A copy of the text of the intended action shall be available in
4 the Department of Insurance in accordance with the provisions of
5 P.L.1963, c.73 (C.47:1A-1 et seq.).

6 ²[b.] c.² The board shall hold a public hearing on the
7 establishment and modification of health benefits plans, and the
8 board may hold a public hearing on any other intended action.
9 Notice of a hearing shall be given in the notice of intended action
10 provided for in subsection ²[a.] b.² of this section.

11 ²[c.] d.² Whether or not a public hearing is held, the board
12 shall afford all interested persons an opportunity to comment in
13 writing on the intended action. Written comments shall be
14 submitted to the board within the time established by the board
15 in the notice of intended action, which time shall not be less than
16 15 calendar days from the date of notice.

17 The board shall give due consideration to all comments
18 received. Within a reasonable period of time following
19 submission of the comments pursuant to this subsection, the
20 board shall prepare for public distribution a report listing all
21 parties who provided written submissions concerning the intended
22 action, summarizing the content of the submissions and providing
23 the board's response to the data, views and arguments contained
24 in the submissions. A copy of the report shall be filed with the
25 Office of Administrative Law for publication in the New Jersey
26 Register.

27 ²[d.] e.² The board may adopt the intended action immediately
28 following the expiration of the public comment period provided in
29 subsection ²[c.] d.² of this section, or the hearing provided for in
30 subsection ²[b.] c.² of this section, whichever date is later. The
31 final action adopted by the board shall be submitted for
32 publication in the New Jersey Register to the Office of
33 Administrative Law, and shall be effective on the date of the
34 submission or such later date as the board may establish.

35 ²[e.] f.² Actions filed with the Office of Administrative Law
36 pursuant to this section shall be filed subject to the provisions of
37 subsections (a), (c), (d) and (e) of section 5 of P.L.1968, c.410
38 (C.52:14B-5).

39 ²[f.] g.² Nothing in this section shall be construed to prohibit
40 the board from adopting any action pursuant to the provisions of
41 the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1
42 et seq.).

43 ²[g.] h.² Nothing in this section shall be construed to prohibit
44 the commissioner from adopting any rule or regulation pursuant
45 to the provisions of the "Administrative Procedure Act,"
46 P.L.1968, c.410 (C.52:14B-1 et seq.), or from taking any other
47 action required or authorized by P.L.1992, c.162 (C.17B:27A-17
48 et seq.).¹

49 ¹17. (New section) a. Effective January 1, 1994, all actions
50 adopted by the board shall be subject to the provisions of this
51 section, notwithstanding the provisions of P.L.1968, c.410
52 (C.52:14B-1 et seq.) to the contrary.

53 ²a.² For the purposes of this section, "action" includes, but is
54 not limited to: ²[the establishment and modification of health

1 benefits plans, the assessment of members and the apportionment
2 thereof, procedures and standards for the promulgation or
3 modification of policy forms, evaluation of material submitted by
4 carriers with respect to loss ratios, and the establishment of
5 procedures for refunds to policy or contract holders]

6 (1) the establishment and modification of health benefits plans;

7 (2) procedures and standards for the: (a) assessment of
8 members and the apportionment thereof; (b) filing of policy
9 forms; (c) making of rate filings; (d) evaluation of material
10 submitted by carriers with respect to loss ratios; and (e)
11 establishment of refunds to policy or contract holders; and

12 (3) the promulgation or modification of policy forms².

13 "Action" shall not include the hearing and resolution of
14 contested cases, personnel matters and applications for
15 withdrawal or exemptions.

16 ²[a.] b.² Prior to the adoption of an action of the board, the
17 board shall publish notice of its intended action in three
18 newspapers of general circulation in this State, and may publish
19 the notice of intended action in any trade or professional
20 publication which it deems necessary. The notice of intended
21 action shall include procedures for obtaining a detailed
22 description of the intended action and the time, place and manner
23 by which interested persons may present their views. The board
24 shall provide the notice of intended action and a detailed
25 description of the intended action by mail, or otherwise, to
26 affected trade and professional associations, carriers subject to
27 the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) and such
28 other interested persons or organizations which may request
29 notification. The board shall forward the notice of intended
30 action and the detailed description of the intended action
31 concurrently to the Office of Administrative Law for publication
32 in the New Jersey Register.

33 The board shall not charge any fee for placement upon the
34 mailing list of associations, carriers or other persons to be
35 notified, but the board may charge a fee to an association,
36 carrier or other person requesting a copy of the text of the
37 intended action, which fee shall not be in excess of the actual
38 cost of reproducing and mailing the copy.

39 A copy of the text of the intended action shall be available in
40 the Department of Insurance in accordance with the provisions of
41 P.L.1963, c.73 (C.47:1A-1 et seq.).

42 ²[b.] c.² The board shall hold a public hearing on the
43 establishment and modification of health benefits plans, and the
44 board may hold a public hearing on any other intended action.
45 Notice of a hearing shall be given in the notice of intended action
46 provided for in subsection ²[a.] b.² of this section.

47 ²[c.] d.² Whether or not a public hearing is held, the board
48 shall afford all interested persons an opportunity to comment in
49 writing on the intended action. Written comments shall be
50 submitted to the board within the time established by the board
51 in the notice of intended action, which time shall not be less than
52 20 calendar days from the date of notice.

53 The board shall give due consideration to all comments
54 received. Within a reasonable period of time following

1 submission of the comments pursuant to this subsection, the
2 board shall prepare for public distribution a report listing all
3 parties who provided written submissions concerning the intended
4 action, summarizing the content of the submissions and providing
5 the board's response to the data, views and arguments contained
6 in the submissions. A copy of the report shall be filed with the
7 Office of Administrative Law for publication in the New Jersey
8 Register.

9 ²[d.] e.² The board may adopt the intended action immediately
10 following the expiration of the public comment period provided in
11 subsection ²[c.] d.² of this section, or the hearing provided for in
12 subsection ²[b.] c.² of this section, whichever date is later. The
13 final action adopted by the board shall be submitted for
14 publication in the New Jersey Register to the Office of
15 Administrative Law, and shall be effective on the date of the
16 submission or such later date as the board may establish.

17 ²[e.] f.² Actions filed with the Office of Administrative Law
18 pursuant to this section shall be filed subject to the provisions of
19 subsections (a), (c), (d) and (e) of section 5 of P.L.1968, c.410
20 (C.52:14B-5).

21 ²[f.] g.² Nothing in this section shall be construed to prohibit
22 the board from adopting any action pursuant to the provisions of
23 the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1
24 et seq.).

25 ²[g.] h.² Nothing in this section shall be construed to prohibit
26 the commissioner from adopting any rule or regulation pursuant
27 to the provisions of the "Administrative Procedure Act,"
28 P.L.1968, c.410 (C.52:14B-1 et seq.), or from taking any other
29 action required or authorized by P.L.1992, c.162 (C.17B:27A-17
30 et seq.).¹

31 ²[118. (New section) Notwithstanding any other law to the
32 contrary, the commissioner is authorized to approve the
33 establishment of an arrangement by a carrier which provides for
34 selective contracting with health care providers and reasonable
35 benefit differentials applicable to participating and
36 non-participating health care providers. The agreement for an
37 arrangement shall be filed and approved by the commissioner
38 before it becomes effective. The commissioner shall approve the
39 agreement if he determines, in consultation with the
40 Commissioner of Health, that the arrangement promotes health
41 care cost containment while adequately preserving quality of
42 care.]²

43 ²[119.] 18.² (New section) Notwithstanding the provisions of
44 section 16 of P.L. , c. (C.)(pending before the Legislature as
45 this bill) to the contrary, the board shall submit the health
46 benefits plans it formulates to the Legislature on a day that the
47 Legislature is in session, when it submits the plans to the
48 commissioner for approval pursuant to section 17 of P.L.1992,
49 c.162 (C.17B:27A-33). If the Legislature does not take action in
50 ²[60] 30² days to amend or otherwise change the plans, the plans
51 shall be effective upon approval by the commissioner or upon
52 such later date as the board determines.¹

53 ²19. Section 16 of P.L.1992, c.162 (C.17B:27A-32) is amended
54 to read as follows:

- 1 16. The board shall have the authority to:
- 2 a. Enter into contracts as are necessary or proper to carry out
- 3 the provisions and purposes of this act;
- 4 b. Sue or be sued, including taking any legal actions as may be
- 5 necessary for recovery of any assessments due to the program or
- 6 to avoid paying any improper claims;
- 7 c. Establish rules, conditions, and procedures pertaining to the
- 8 reimbursement and assessment of members by the program;
- 9 d. Assess members in accordance with the provisions of this
- 10 act, including such interim assessments as may be reasonable and
- 11 necessary for organizational and [interim] reasonable operating
- 12 expenses. Such interim assessments shall be credited as offsets
- 13 against any regular assessments due following the close of the
- 14 fiscal year: [and]
- 15 e. Appoint from among its members appropriate legal,
- 16 actuarial, and other committees as necessary to provide technical
- 17 assistance in the operation of the program, policy and other
- 18 contract design, and any other function within the authority of
- 19 the program; and
- 20 f. Contract for an independent actuary or any other
- 21 professional services the board deems necessary to carry out its
- 22 duties under P.L.1992, c.162 (C.17B:27A-17 et seq.).²

23 (cf: P.L.1992, c.162, s.16)

24 ²⁰20. Section 29 of P.L.1992, c.162 (C.17B:27A-45) is amended

25 to read as follows:

26 29. The board, in conjunction with the board of the New Jersey

27 Individual Health Coverage Program established pursuant to

28 section 9 of P.L.1992, c.161 (C.17B:27A-10) shall promulgate one

29 standard claim form.

30 In order to provide a standard system of payment for medical

31 services, all claim forms for any claimant's use under [any] a

32 group health insurance policy issued or delivered in this State

33 shall conform to the form adopted by the board.²

34 (cf: P.L.1992, c.162, s.29)

35 ²¹21. (New section) A carrier shall not require a small employer

36 to purchase any other insurance coverage, including, but not

37 limited to, life insurance, accident insurance or disability

38 insurance, as a condition of or in conjunction with the purchase of

39 a health benefits plan pursuant to P.L.1992, c.162 (C.17B:27A-17

40 et seq.).²

41 ²²22. (New section) Notwithstanding any other law to the

42 contrary, the commissioner is authorized to approve the

43 establishment of an arrangement by an insurance company

44 operating pursuant to Title 17B of the New Jersey Statutes and

45 authorized to issue health benefits plans in this State, that is

46 entered into on or after June 1, 1993 and which provides for

47 selective contracting with health care providers and reasonable

48 benefit differentials applicable to participating and

49 nonparticipating health care providers.

50 The agreement for an arrangement shall be filed and approved

51 by the commissioner before it becomes effective. The

52 commissioner shall approve the agreement if he determines, in

53 consultation with the Commissioner of Health, that the

54 arrangement promotes health care cost containment while

1 adequately preserving quality of care. The commissioner may
2 adopt regulations pursuant to the "Administrative Procedure
3 Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to enforce
4 and administer the arrangements.³

5 ³23. Section 11 of P.L.1992, c.162 (C.17B:27A-27) is amended
6 to read as follows:

7 11. a. Every policy or contract issued to a small employer in
8 this State, including, but not limited to, policies or contracts
9 which are subject to this act and which are delivered, issued,
10 renewed, or continued on or after [the effective date of this act]
11 January 1, 1994, shall offer continued coverage under the plan to
12 any employee whose employment was terminated for a reason
13 other than for cause and to any employee covered by such plan
14 whose hours of employment were reduced to less than 30
15 subsequent to the effective date of coverage for that employee.
16 The employee shall make a written election for continued
17 coverage within 30 days of a qualifying event. For the purposes
18 of this section, "qualifying event" shall mean the date of
19 termination of employment, or the date on which a reduction in
20 an employee's hours of employment becomes effective. For the
21 purposes of this section, the date on which a health benefits plan
22 is continued shall be the anniversary date of the issuance of the
23 plan.

24 b. Coverage continued pursuant to subsection a. of this section
25 shall consist of coverage which is identical to the coverage
26 provided under the policy or contract to similarly situated
27 beneficiaries whose coverage has not been terminated or hours of
28 employment reduced. If coverage is modified under the policy or
29 contract for any group of similarly situated beneficiaries, this
30 coverage shall also be modified in the same manner for persons
31 who are qualified beneficiaries entitled pursuant to subsection a.
32 of this section to continued coverage. Continuation of coverage
33 may not be conditioned upon, or discriminate on the basis of, lack
34 of evidence of insurability.

35 c. The health benefits plan may require payment of a premium
36 by the employee for any period of continuation coverage as
37 provided for in this section, except that the premium shall not
38 exceed 102% of the applicable premium paid for similarly
39 situated beneficiaries under the health benefits plan for a
40 specified period, and may, at the election of the payor, be made
41 in monthly installments. No premium payment shall be due
42 before the 30th day after the day on which the covered employee
43 made the initial election for continued coverage.

44 d. Coverage continued pursuant to this section shall continue
45 until the earlier of the following:

46 (1) The date upon which the employer under whose health
47 benefits plan coverage is continued ceases to provide any health
48 benefits plan to any employee or other qualified beneficiary:

49 (2) The date on which the continued coverage ceases under the
50 health benefits plan by reason of a failure to make timely
51 payment of any premium required under the plan by the former
52 employee having the continued coverage. The payment of any
53 premium shall be considered to be timely if made within 30 days
54 after the due date or within such longer period as may be

1 provided for by the policy or contract; or

2 (3) The date after the date of election on which the qualified
3 beneficiary first becomes:

4 (a) Covered under any other health benefits plan, as an
5 employee or otherwise, which does not contain a provision which
6 limits or excludes coverage with respect to any preexisting
7 condition of a covered employee or any spouse or dependent who
8 is included under the coverage provided the covered employee,
9 for such period of the limitation or exclusion; or

10 (b) Eligible for benefits under Title XVIII of the Social
11 Security Act, Pub.L.89-97 (42 U.S.C. §1395 et seq.).

12 e. Notice shall be provided to employees at the
13 commencement of coverage as to their continuation rights under
14 the plan. A qualified beneficiary may elect continuation
15 coverage offered pursuant to this section no later than 30 days
16 after the qualifying event. For the purposes of this section,
17 "qualified beneficiary" means any person covered under a small
18 employer group policy.

19 f. The provisions of this section shall not apply to any person
20 who is a qualified beneficiary for the purposes of continuation of
21 coverage as provided in accordance with section 3011(a) of Title
22 III of Pub.L.100-647 (26 U.S.C. §4980B et al.).

23 g. In no event shall any continuation of coverage provided for
24 under this section exceed 12 months from the qualifying event.
25 C.17B:27A-28 New Jersey Small Employer Health Excess
26 Insurance Program created.³

27 (cf: P.L.1992, c.162, s.11)

28 ¹[12.] ²[20.1] ³[22.2] ^{24.}³ Section 2 of P.L.1964, c.104
29 (C.17:48-6.1) is amended to read as follows:

30 2. A hospital service corporation may issue to a policyholder a
31 group contract, covering at least [10] two employees or members
32 at the date of issue, if it conforms to the following description:

33 (a) A contract issued to an employer or to the trustees of a
34 fund established by one or more employers, or issued to a labor
35 union, or issued to an association formed for purposes other than
36 obtaining such contract, or issued to the trustees of a fund
37 established by one or more labor unions, or by one or more
38 employers and one or more labor unions, covering employees and
39 members of associations or labor unions.

40 (b) A contract issued to cover any other group which the
41 Commissioner of Insurance determines may be covered in
42 accordance with sound underwriting principles.

43 Benefits may be provided for one or more members of the
44 families or one or more dependents of persons who may be
45 covered under a group contract referred to in (a) or (b) above.

46 Family type contracts shall provide that the services applicable
47 for children shall be payable with respect to a newly-born child
48 of the subscriber, or his or her spouse from the moment of birth.
49 The services for newly-born children shall consist of coverage of
50 injury or sickness including the necessary care and treatment of
51 medically diagnosed congenital defects and abnormalities. If a
52 subscription payment is required to provide services for a child,
53 the contract may require that notification of birth of a
54 newly-born child and the required payment must be furnished to

1 the service corporation within 31 days after the date of birth in
2 order to have the coverage continue beyond such 31-day period.
3 Group contracts which provide for services to the subscriber but
4 not to family members or dependents of that subscriber, other
5 than contracts which provide no dependent coverage whatsoever
6 for the subscriber's class, shall also provide services to
7 newly-born children of the subscriber which shall commence with
8 the moment of birth of each child and shall consist of coverage of
9 injury or sickness including the necessary care and treatment of
10 medically diagnosed congenital defects and abnormalities,
11 provided that application therefor and payment of the required
12 subscription amount are made to include in said contract the
13 coverage described in the preceding paragraph of this section
14 within 31 days from the date of birth of a newborn child.

15 A contract under which coverage of such a dependent
16 terminates at a specified age shall, with respect to an unmarried
17 child, covered by the contract prior to attainment of age 19, who
18 is incapable of self-sustaining employment by reason of mental
19 retardation or physical handicap and who became so incapable
20 prior to attainment of age 19 and who is chiefly dependent upon
21 the covered employee or member for support and maintenance,
22 not so terminate while the coverage of the employee or member
23 remains in force and the dependent remains in such conditions, if
24 the employee or member has within 31 days of such dependent's
25 attainment of the termination age submitted proof of such
26 dependent's incapacity as described herein. The foregoing
27 provisions of this paragraph shall not apply retrospectively or
28 prospectively to require a hospital service corporation to insure
29 as a covered dependent any mentally retarded or physically
30 handicapped child of the applicant where the contract is
31 underwritten on evidence of insurability based on health factors
32 required to be set forth in the application. In such cases any
33 contract heretofore or hereafter issued may specifically exclude
34 such mentally retarded or physically handicapped child from
35 coverage.

36 Any group contract which contains provisions for the payment
37 by the insurer of benefits for members of the family or
38 dependents of a person in the insured group shall provide that,
39 subject to payment of the appropriate premium, such family
40 members or dependents be permitted to have coverage continued
41 for at least 180 days after the death of the person in the insured
42 group.

43 The contract may provide that the term "employees" shall
44 include as employees of a single employer the employees of one
45 or more subsidiary corporations and the employees, individual
46 proprietors and partners of affiliated corporations,
47 proprietorships and partnerships if the business of the employer
48 and such corporations, proprietorships or partnerships is under
49 common control through stock ownership, contract or otherwise.
50 The contract may provide that the term "employees" shall
51 include the individual proprietor or partners of an individual
52 proprietorship or a partnership. The contract may provide that
53 the term "employees" shall include retired employees. A contract
54 issued to trustees may provide that the term "employees" shall

1 include the trustees or their employees, or both, if their duties
2 are principally connected with such trusteeship. A contract
3 issued to the trustees of a fund established by the members of an
4 association of employers may provide that the term "employees"
5 shall include the employees of the association.

6 (cf: P.L.1976, c.101, s.2)

7 ²[121.] ³[23.2] ^{25.}³ Section 30 of P.L.1992, c.162
8 (C.17B:27A-46) is repealed.¹

9 ¹[13.] ²[122.] ³[24.2] ^{26.}³ This act shall take effect
10 immediately.

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15 _____
16 Makes various changes to law governing small employer health
benefits plans.

1 The contract may provide that the term "employees" shall
2 include as employees of a single employer the employees of one
3 or more subsidiary corporations and the employees, individual
4 proprietors and partners of affiliated corporations,
5 proprietorships and partnerships if the business of the employer
6 and such corporations, proprietorships or partnerships is under
7 common control through stock ownership, contract or otherwise.
8 The contract may provide that the term "employees" shall
9 include the individual proprietor or partners of an individual
10 proprietorship or a partnership. The contract may provide that
11 the term "employees" shall include retired employees. A contract
12 issued to trustees may provide that the term "employees" shall
13 include the trustees or their employees, or both, if their duties
14 are principally connected with such trusteeship. A contract
15 issued to the trustees of a fund established by the members of an
16 association of employers may provide that the term "employees"
17 shall include the employees of the association.

18 (cf: P.L.1976, c.101, s.2)

19 13. This act shall take effect immediately.

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22 STATEMENT

23

24 This bill makes various changes to P.L.1992, c.162
25 (C.17B:27A-17 et seq.) concerning small employer health benefits
26 plans, which will ensure a more orderly implementation of the
27 law.

28 The bill provides for a phased-in implementation of the
29 requirement that all small employer health benefits plan carriers
30 offer one of five health benefits plans approved under the law,
31 effective January 1, 1994. Rather than require that all current
32 plans expire on the same date, the bill provides that a carrier will
33 have to offer one of the five new plans upon the 1994 anniversary
34 date of the current plan. This provision should ensure a smoother
35 transition from current health benefits plans to the new plans.
36 The bill continues to require, however, that any health benefits
37 plan offered to a small employer that is not currently insured by
38 a carrier shall conform to one of the five new plans, effective
39 January 1, 1994.

40 The bill also requires that certain MEWAs (multiple employer
41 welfare arrangements) register with the board of directors of the
42 New Jersey Small Employer Health Benefits Program. A MEWA,
43 while not a member of the program and, therefore, not subject to
44 any assessments under P.L.1992, c.162, will be required to offer
45 one or more health benefits plans in conformance with the health
46 benefits plans established by the board. Also, the MEWA plan
47 shall be community rated and shall comply with the guarantee
48 issue and preexisting condition requirements in the law.

49 Similarly, the bill provides that certain out-of-State trusts are
50 exempt from the provisions of P.L.1992, c.162, except that the
51 coverage provided by the trust shall be community rated and shall
52 comply with the guarantee issue and preexisting condition
53 requirements in the law.

54 The bill deletes the 90-day deadline for the board of directors

1 to submit the forms for the five health benefits plans to the
2 Commissioner of Insurance for his approval. This deadline did not
3 provide the board with adequate time to properly develop the
4 forms. The board, however, will still be required to submit the
5 forms to the commissioner in a timely manner so as to ensure
6 that the forms will be available for use by the carriers by January
7 1, 1994.

8 The bill addresses the concerns of hospital service corporations
9 which only provide hospital expense benefits and, therefore,
10 would not be able to offer the required five health benefits plans,
11 by permitting the board to approve a health benefits plan
12 containing only medical-surgical benefits or major medical
13 expense benefits, or a combination thereof, which is issued in
14 conjunction with a contract of insurance for hospital expense
15 benefits issued by a hospital service corporation, if the health
16 benefits plan and hospital service corporation contract combined,
17 otherwise comply with the provisions of P.L.1992, c.162.

18 The bill also addresses the concerns of a health maintenance
19 organization which is not affiliated with an indemnity carrier
20 and, therefore, cannot offer all five of the required health
21 benefits plans, and of a carrier which does not own or control a
22 health maintenance organization and, therefore, cannot offer the
23 required health maintenance type of health benefits plan. The
24 bill permits the health maintenance organization and indemnity
25 carrier to offer only those plans that are within their respective
26 scopes of business.

27 The bill amends section 2 of P.L.1964, c.104 (C.17:48-6.1)
28 concerning hospital service corporations, to provide that the
29 minimum number of persons in a group contract shall be two,
30 rather than 10, as the law currently provides. This change is
31 necessary in order to conform the minimum group size for a
32 hospital service corporation contract with that of P.L.1992, c.162.

33 Finally, other amendments to P.L.1992, c.162 in this bill
34 conform definitions and other health benefits plan provisions to
35 those of P.L.1992, c.161 which governs individual health benefits
36 plans, and make various technical changes to clarify the language
37 in the law.

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42 Makes various changes to law governing small employer health
43 benefits plans.

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

STATEMENT TO

SENATE, No. 1686

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 10, 1993

The Senate Health and Human Services Committee favorably reports Senate Bill No. 1686 with committee amendments.

As amended by committee, this bill makes various changes to P.L.1992, c.162 (C.17B:27A-17 et seq.) concerning small employer health benefits plans, which will ensure a more orderly implementation of the law.

The bill provides for a phased-in implementation of the requirement that all small employer health benefits plan carriers offer one of five health benefits plans approved under the law, effective January 1, 1994. Rather than require that all current plans expire on the same date, the bill provides that a carrier will have to offer one of the five new plans upon the 1994 anniversary date of the current plan. This provision should ensure a smoother transition from current health benefits plans to the new plans. The bill continues to require, however, that any health benefits plan offered to a small employer that is not currently insured by a carrier shall conform to one of the five new plans, effective January 1, 1994.

The bill also requires that multiple employer arrangements (which is defined to include MEWAs) register with the board of directors of the New Jersey Small Employer Health Benefits Program. A multiple employer arrangement, while not a member of the program and, therefore, not subject to any assessments under P.L.1992, c.162, will be required to offer one or more health benefits plans in conformance with the health benefits plans established by the board. Also, the plan shall be community rated and shall comply with the guarantee issue and preexisting condition requirements in the law.

The bill provides that out-of-State trusts are required to comply with the provisions of P.L.1992, c.162, regardless of the situs of delivery of the policy.

The bill deletes the 90-day deadline for the board of directors to submit the forms for the five health benefits plans to the Commissioner of Insurance for his approval. This deadline did not provide the board with adequate time to properly develop the forms. The board, however, will still be required to submit the forms to the commissioner in a timely manner so as to ensure that the forms will be available for use by the carriers by January 1, 1994.

The bill addresses the concerns of hospital service corporations which only provide hospital expense benefits and, therefore, would not be able to offer the required five health benefits plans, by permitting the board to approve a health benefits plan containing only medical-surgical benefits or major medical expense benefits, or a combination thereof, which is issued in conjunction with a

contract of insurance for hospital expense benefits issued by a hospital service corporation, if the health benefits plan and hospital service corporation contract combined, otherwise comply with the provisions of P.L.1992, c.162.

The bill also addresses the concerns of a health maintenance organization which is not affiliated with an indemnity carrier and, therefore, cannot offer all five of the required health benefits plans. The bill requires the health maintenance organization to offer only that plan as approved by the board, which is in accordance with the provisions of the "Health Maintenance Organization Act of 1973," Pub. L. 93-222 (42 U.S.C. §300e et seq.). With respect to a carrier which does not own or control a health maintenance organization and, therefore, cannot offer the required health maintenance organization health benefits plan, the bill clarifies that the law does not require that carrier to own or control a health maintenance organization or otherwise affiliate with one, but it requires that carrier to offer all five health benefits plans established by the board, including one plan which contains benefits and cost sharing levels that are equivalent to those required for health maintenance organizations.

The bill requires and establishes procedures for the board to give public notice for all actions adopted by the board. The bill defines actions as including, but limited to, the establishment and modification of health benefits plans, the assessment of members and the apportionment thereof, procedures and standards for the promulgation or modification of policy forms, evaluation of material submitted by carriers with respect to loss ratios, and the establishment of procedures for refunds to policy or contract holders. "Action" shall not include the hearing and resolution of contested cases, personnel matters and applications for withdrawal or exemptions.

The bill authorizes the commissioner to approve the establishment of an arrangement by a carrier which provides for selective contracting with health care providers and reasonable benefit differentials applicable to participating and non-participating health care providers. This provision would affect those small employer carriers which presently do not have the authority to enter into these arrangements.

In order to provide the Legislature with an opportunity to review the health benefits plans developed by the board to ensure that the plans comply with Legislative intent, the bill requires that the board submit the plans to the Legislature at the same time as they are submitted to the commissioner for approval. If the Legislature does not take action in 60 days to revise the plans, the plans may be adopted upon approval by the commissioner.

Also, the bill repeals section 30 of P.L.1992, c.162 (C.17B:27A-46) concerning rule making because that section is no longer necessary with the implementation of the more specific public notice requirements in this bill.

The bill amends section 2 of P.L.1964, c.104 (C.17:48-6.1) concerning hospital service corporations, to provide that the minimum number of persons in a group contract shall be two, rather than 10, as the law currently provides. This change is necessary in order to conform the minimum group size for a hospital service corporation contract with that of P.L.1992, c.162.

Finally, other amendments to P.L.1992, c.162 in this bill conform definitions and other health benefits plan provisions to those of P.L.1992, c.161 which governs individual health benefits plans, and make various technical changes to clarify the language in the law.

The committee amended the bill to:

- clarify in the definition of "health benefits plans" that the term includes certificates issued by carriers, as well as contracts and policies;
- replace the definition of "MEWA" with the broader term, multiple employer arrangement;
- clarify the responsibility of health maintenance organizations and certain indemnity carriers with respect to health benefits plans they are required to provide;
- provide that guaranteed renewal of health benefits plans shall not apply when the number of covered employees is less than two;
- provide that a non-exempt carrier which issues a policy to an association or trust of employees after November 30, 1992 shall be required to offer small employer health benefits plans to non-association or trust employers in the same manner as any other small employer carrier is required pursuant to law;
- clarify that in calculating the specified minimum participation of employers, the carrier shall include all insured employees, regardless of whether the employees chose an indemnity plan or a health maintenance organization, or a combination thereof;
- require that premium rates for group coverage provided through a multiple employer arrangement must conform to the requirements of section 9 of P.L.1992, c.162 (phasing-in of community rating);
- provide that out-of-State trusts must comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.);
- require all carriers to notify the Commissioner of Insurance by December 31 of each year of any health care coverage or benefits, stop-loss coverage or administrative services only contracts it provides or enters into with a multiple employer arrangement that provides health care benefits to employees and their dependents in this State;
- provide for certain restrictions on changing health benefits plans (increasing or decreasing coverage) prior to the annual anniversary date of the plan;
- require and establish procedures for the board to give public notice of certain actions taken by the board;
- authorize the commissioner to approve carrier arrangements which provide for selective contracting with health care providers and benefit differentials applicable to participating and non-participating providers;
- provide for Legislative oversight with respect to the adoption of health benefits plans; and
- repeal section 30 of P.L.1992, c.162 (C.17B:27A-46).