

~~17B:27A-17 et seq.~~  
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NJSA: 17B:27A-17 et seq.

**Legislative History Checklist**  
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**Synopsis:** Requires certain insurers, service corporations and HMOs to offer standardized health insurance plans to small groups; establishes a reinsurance program.

**Bill No.:** S371

**P.L.** 1992, c. 162

*Identical to:* A757 (ACS)  
*Substituted for:* A757 (ACS)  
*Combined with:*  
*Last Session Bill No.:*

*See Above Bill(s) for Additional History*

**NJSA:** 17B:27A-17 et seq.

**Sponsor(s):** Bassano+7

**Date Introduced:** 02/13/92

**Committee Reference:**

**Statement:**

**Public Hearing:**

***Assembly:***

(Without reference)

***Senate:***

Health and Human Services

Yes

No

**Sponsor Statement:** Yes

**Fiscal Note:** No

**Dates of Passage:**

***Assembly:***

06/29/92 (56-2)  
11/30/92 (49-9)

***Senate:***

06/29/92 (38-0)  
11/30/92 (22-8)

**Amended During Passage:** Yes

**Governor's Action:**

**Veto:** Yes (Conditional)

**Date of Veto:** 09/10/92

**Date of Approval:** 11/30/92

**Message on Signing:** No

**Additional Information:**

P.L.1992, CHAPTER 162, approved November 30, 1992  
Senate Committee Substitute (First Reprint) for  
1992 Senate No. 371

1 AN ACT requiring certain health insurers, service corporations  
2 and health maintenance organizations to offer <sup>1</sup>[basic]  
3 standardized<sup>1</sup> health benefits programs to <sup>1</sup>[certain employers]  
4 small groups<sup>1</sup> and establishing a reinsurance program.

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

8 1. As used in this act:

9 "Actuarial certification" means a written statement by a  
10 member of the American Academy of Actuaries or other  
11 individual acceptable to the commissioner that a small employer  
12 carrier is in compliance with the provisions of section <sup>1</sup>[12] <sup>9</sup> of  
13 this act, based upon examination, including a review of the  
14 appropriate records and actuarial assumptions and methods used  
15 by the small employer carrier in establishing premium rates for  
16 applicable health benefits plans.

17 <sup>1</sup>"Anticipated loss ratio" means the ratio of the present value  
18 of the expected benefits, not including dividends, to the present  
19 value of the expected premiums, not reduced by dividends, over  
20 the entire period for which rates are computed to provide  
21 coverage. For purposes of this ratio, the present values must  
22 incorporate realistic rates of interest which are determined  
23 before federal taxes but after investment expenses.<sup>1</sup>

24 <sup>1</sup>"Base premium rate" means the lowest premium rate charged  
25 by the small employer carrier for the same or similar coverage,  
26 which coverage is equivalent in value to a health benefits plan  
27 covering a small employer. The term "base premium rate" refers  
28 to rates for any health benefits plan covering two or more  
29 employees of a small employer.

30 "Basic health benefits plan" means a health benefits plan for  
31 small employers which provides benefits pursuant to section 4 of  
32 this act and which is filed with the commissioner in accordance  
33 with the requirements of section 24 of this act, any portion of the  
34 premium for which is paid by a small employer or for which any  
35 covered individual is reimbursed whether through wage  
36 adjustments or otherwise, if the health benefits plan is treated by  
37 the employer or any of the covered individuals as part of a plan  
38 or program for the purposes of section 162 or section 106 of the  
39 Internal Revenue Code of 1986 (28 U.S.C. 162 or 26 U.S.C. 106).<sup>1</sup>

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

41 "Carrier" means any insurance company, health service

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

<sup>1</sup> Senate amendments adopted in accordance with Governor's  
recommendations November 30, 1992.

1 corporation, hospital service corporation, medical service  
2 corporation <sup>1</sup>[,] <sup>1</sup>or<sup>1</sup> health maintenance organization <sup>1</sup>[or  
3 MEWA]<sup>1</sup> authorized to issue health benefits plans in this State.  
4 For purposes of this act, carriers that are affiliated companies  
5 shall be treated as one carrier, except that any insurance  
6 company, health service corporation, hospital service  
7 corporation, or medical service corporation that is an affiliate of  
8 a health maintenance organization located in New Jersey or any  
9 health maintenance organization located in New Jersey that is  
10 affiliated with an insurance company, health service corporation,  
11 hospital service corporation, or medical service corporation shall  
12 treat the health maintenance organization as a separate carrier.

13 "Commissioner" means the Commissioner of Insurance.

14 <sup>1</sup>"Community rating" means a rating methodology in which the  
15 premium for all persons covered by a policy or contract form is  
16 the same based upon the experience of the entire pool of risks  
17 covered by that policy or contract form without regard to age,  
18 gender, health status, residence or occupation.<sup>1</sup>

19 "Department" means the Department of Insurance.

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

23 "Eligible employee" means a full-time employee who works a  
24 normal work week of <sup>1</sup>[30] <sup>1</sup>25<sup>1</sup> or more hours. The term includes  
25 a sole proprietor, a partner of a partnership, or an independent  
26 contractor, if the sole proprietor, partner, or independent  
27 contractor is included as an employee under a health benefits  
28 plan of a small employer, but does not include employees who  
29 work less than <sup>1</sup>[30] <sup>1</sup>25<sup>1</sup> hours a week or work on a temporary or  
30 substitute basis.

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

37 "Health benefits plan" means any hospital and medical expense  
38 incurred policy; health, hospital, or medical service corporation  
39 contract; <sup>1</sup>or<sup>1</sup> health maintenance organization subscriber  
40 contract <sup>1</sup>]; or plans provided by MEWAs<sup>1</sup> offered by <sup>1</sup>any  
41 carrier to<sup>1</sup> a small employer <sup>1</sup>group<sup>1</sup> pursuant to section <sup>1</sup>[4] <sup>1</sup>3<sup>1</sup>  
42 of this act. For purposes of this act, "health benefits plan"  
43 excludes the following plans, policies, or contracts: accident  
44 only, credit, disability, long-term care, coverage for Medicare  
45 services pursuant to a contract with the United States  
46 government, Medicare supplement, dental only or vision only  
47 issued as a supplement to liability insurance, coverage arising out  
48 of a workers' compensation or similar law, automobile medical  
49 payment insurance, or insurance under which benefits are payable  
50 with or without regard to fault and which is statutorily required  
51 to be contained in any liability insurance policy or equivalent  
52 self-insurance.

53 "Late enrollee" means an eligible employee or dependent who  
54 requests enrollment in a health benefits plan of a small employer

1 following the initial minimum 30-day enrollment period provided  
2 under the terms of the health benefits plan. An eligible employee  
3 or dependent shall not be considered a late enrollee if the  
4 individual was covered under another employer's health benefits  
5 plan at the time he was eligible to enroll and stated at the time  
6 of the initial enrollment that coverage under that other  
7 employer's health benefits plan was the reason for declining  
8 enrollment; has lost coverage under that other employer's health  
9 benefits plan as a result of termination of employment, the  
10 termination of the other plan's coverage, death of a spouse, or  
11 divorce; and the individual requests enrollment within 90 days  
12 after termination of coverage provided under another employer's  
13 health benefits plan; <sup>1</sup>or if the individual is employed by an  
14 employer under a MEWA which offers multiple health benefits  
15 plans, and the individual elects a different plan during an open  
16 enrollment period;<sup>1</sup> or if a court of competent jurisdiction has  
17 ordered coverage to be provided for a spouse or minor child under  
18 a covered employee's health benefits plan and request for  
19 enrollment is made within 30 days after issuance of that court  
20 order.

21 "Member" means all carriers issuing health benefits plans <sup>1</sup>[and  
22 MEWAs providing health benefits plans]<sup>1</sup> in this State on or after  
23 the effective date of this act.

24 <sup>1</sup>["MEWA" means any multiple employer welfare arrangement  
25 as defined in section 3 of the federal Employee Retirement and  
26 Income Security Act of 1974, Pub.L.93-406 (29 U.S.C. §1002),  
27 except for any such arrangement which is fully insured within the  
28 meaning of that act.]<sup>1</sup>

29 "Plan of operation" means the plan of operation of the program  
30 including articles, bylaws and operating rules approved pursuant  
31 to section <sup>1</sup>[20] <sup>15</sup><sup>1</sup> of this act.

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

43 "Program" means the New Jersey Small Employer Health  
44 Excess Reinsurance Program established pursuant to section <sup>1</sup>[18]  
45 <sup>12</sup><sup>1</sup> of this act.

46 "Reinsuring carrier" means a a small employer carrier electing  
47 to <sup>1</sup>[obtain excess insurance] receive reimbursement from the  
48 program<sup>1</sup> in accordance <sup>1</sup>[in] <sup>with</sup><sup>1</sup> section <sup>1</sup>[26] <sup>19</sup><sup>1</sup> of this act."

49 "Risk-assuming carrier" means a small employer carrier  
50 electing to assume risks pursuant to section <sup>1</sup>[25] <sup>18</sup><sup>1</sup> of this act."

51 "Small employer" means any person, firm, corporation,  
52 partnership, or association actively engaged in business which, on  
53 at least 50 percent of its working days during the preceding  
54 calendar year quarter, employed at least two but no more than

1 49 eligible employees, the majority of whom are employed within  
2 the State of New Jersey. In determining the number of eligible  
3 employees, companies which are affiliated companies shall be  
4 considered one employer, subsequent to the issuance of a health  
5 benefits plan to a small employer pursuant to the provisions of  
6 this act, and for the purpose of determining eligibility, the size of  
7 a small employer shall be determined annually. Except as  
8 otherwise specifically provided, provisions of this act which apply  
9 to a small employer shall continue to apply until the anniversary  
10 date next of the health benefits plan following the date the  
11 employer no longer meets the definition of a small employer.

12 "Small employer carrier" means any carrier <sup>1</sup>[or MEWA]<sup>1</sup> that  
13 offers health benefits plans covering eligible employees of one or  
14 more small employers.

15 "Small employer health benefits plan" means a health benefits  
16 plan for small employers approved by the commissioner pursuant  
17 to section <sup>1</sup>[23] <sup>17</sup><sup>1</sup> of this act.

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

27 3. <sup>1</sup>[Notwithstanding the provisions of P.L.1991, c.187, every  
28 carrier subject to the provisions of this act shall, as a condition  
29 of transacting business in this State, offer to every small  
30 employer at least two health benefits plans. One plan shall be a  
31 Basic health benefits plan, as provided in section 4 of this act,  
32 and one shall be a Basic Plus health benefits plan, as provided in  
33 section 5 of this act. Initially, the offer shall be made within 90  
34 days of the filing with the commissioner of that carrier's  
35 benefits plans. Thereafter, the plans shall be available to small  
36 employers on a continuing basis. Every small employer which  
37 elects to be covered under either of the plans provided for under  
38 this act who pays the required premium therefor and who  
39 satisfies the other requirements of the plan shall be issued a  
40 policy or contract by the carrier. The carrier may establish a  
41 premium payment plan which provides installment payments and  
42 which may contain reasonable provisions to ensure payment  
43 security, provided that provisions to ensure payment security are  
44 reasonably related to the risk and are uniformly applied. Every  
45 plan shall be in conformance with the guidelines established  
46 pursuant to section 23 of this act, and each carrier's plans shall  
47 be certified and filed with the commissioner pursuant to section  
48 24 of this act.]

49 a. Every small employer carrier shall, as a condition of  
50 transacting business in this State, offer to every small employer  
51 the same five health benefits plans as provided in section 3 of this act.

1 sections 55, 57, and 59 of P.L.1991, c.167 (C.17:48E-22.2,  
2 17B:26B-2 and 26:2]-4.3). The remaining policy forms shall  
3 contain basic hospital and medical-surgical benefits, including,  
4 but not limited to:

- 5 (1) Basic inpatient and outpatient hospital care;  
6 (2) Basic and extended medical-surgical benefits;  
7 (3) Diagnostic tests, including x-rays;  
8 (4) Maternity benefits, including prenatal and postnatal care;  
9 and  
10 (5) Preventive medicine, including periodic physical  
11 examinations and inoculations.

12 At least three of the forms shall provide for major medical  
13 benefits in varying lifetime aggregates, one of which shall  
14 provide at least \$1,000,000 in lifetime aggregate benefits. The  
15 policy forms provided pursuant to this section shall contain  
16 benefits representing progressively greater actuarial values.

17 b. Initially, a carrier shall offer a plan within 90 days of the  
18 approval of such plan by the commissioner. Thereafter, the plans  
19 shall be available to all small employers on a continuing basis.  
20 Every small employer which elects to be covered under any  
21 health benefits plan who pays the premium therefor and who  
22 satisfies the participation requirements of the plan shall be issued  
23 a policy or contract by the carrier.

24 c. The carrier may establish a premium payment plan which  
25 provides installment payments and which may contain reasonable  
26 provisions to ensure payment security, provided that provisions to  
27 ensure payment security are uniformly applied.

28 d. In addition to the five standard policies described in  
29 subsection a. of this section, the board may develop up to five  
30 rider packages. Any such package which a carrier chooses to  
31 offer shall be issued to a small employer who pays the premium  
32 therefor, and shall be subject to the rating methodology set forth  
33 in section 9 of this act.<sup>1</sup>

34 <sup>1</sup>[4. A Basic health benefits plan shall provide:

35 a. Basic hospital expense coverage for a period of 21 days in  
36 each benefit year for each covered person for expenses incurred  
37 for medically necessary treatment and services rendered as a  
38 result of injury or sickness, including:

39 (1) Daily hospital room and board, including general nursing  
40 care and special diets;

41 (2) Miscellaneous hospital services, including expenses incurred  
42 for charges made by the hospital for services and supplies which  
43 are customarily rendered by the hospital and provided for use  
44 only during any period of confinement;

45 (3) Hospital outpatient services, including surgical and other  
46 services rendered on a day stay basis, hospital services rendered  
47 within 72 hours after accidental injury, and x-ray and other  
48 laboratory and other diagnostic tests to the extent that benefits  
49 for such services would be provided if rendered to an inpatient of  
50 the hospital;

51 b. Basic medical-surgical expense coverage for each covered  
52 person for expenses incurred for medically necessary services for  
53 the treatment of sickness or injury for the following:

54 (1) Surgical services;

1 (2) Anesthesia services, including the administration of  
2 necessary general anesthesia and related procedures in  
3 connection with covered surgical services rendered by a physician  
4 other than the physician performing the surgical services;

5 (3) Inpatient hospital services rendered to a person who is  
6 confined to a hospital for treatment of sickness or injury other  
7 than that for which surgical care is required;

8 (4) Maternity benefits, including cost of delivery and pre-natal  
9 care;

10 c. Out-of-hospital physical examinations, including related  
11 x-rays, immunizations, and diagnostic tests, rendered on the  
12 following basis:

13 (1) For covered minors of less than two years of age, up to six  
14 examinations during the first two years of life;

15 (2) For covered minors of at least two years of age but not  
16 more than 18 years of age, no more than one physical  
17 examination at ages 3, 6, 9, 12, 15, and 18 years of age;

18 (3) For covered adults of at least 19 years of age but less than  
19 40 years of age, one physical examination every five years;

20 (4) For covered adults of at least 40 years of age but less than  
21 60 years of age, one examination every three years; and

22 (5) For covered adults of age 60 years or older, one  
23 examination every two years.

24 Every physical examination rendered pursuant to this  
25 subsection shall be subject to such co-payments and deductibles  
26 as are provided for in the plan.

27 d. The plan provided for herein may, subject to the approval of  
28 the commissioner, with respect to health maintenance  
29 organizations, be modified as necessary to comply with the  
30 provisions of subchapter XI of Pub.L.93-222 (42 U.S.C. §300e et  
31 seq.).<sup>1</sup>

32 <sup>1</sup>[5. a. A Basic Plus health benefits plan shall provide the  
33 same benefits as the basic policy, as well as hospital and medical  
34 expense coverage in excess of the basic policy as established and  
35 modified by the board from time to time, and approved by the  
36 commissioner, but in no case shall benefits provided for in the  
37 Basic Plus coverage exceed an actuarial value which is 20%  
38 greater than the actuarial value of the basic coverage provided  
39 pursuant to section 4 of this act.

40 b. The benefits which may be provided in excess of the  
41 benefits in the basic plan may include, but shall not be limited to,  
42 additional inpatient hospital benefits, additional diagnostic tests,  
43 benefits directed toward the prevention of disease, provided that  
44 they are quantifiably cost effective, and additional medical and  
45 surgical expense benefits.

46 c. At the discretion of the board, the Basic Plus plan may  
47 provide for a selection of not more than three alternative benefit  
48 packages which may be selected by small employers according to  
49 the needs of their work force, provided however, that no  
50 combination of alternative benefits in addition to the basic  
51 benefits shall exceed the actuarial value established in subsection  
52 a. of this section.]<sup>1</sup>

53 <sup>1</sup>[6.a.] 4.1 Plans required to be offered <sup>1</sup>[pursuant to sections  
54 4 or 5 of this act shall] under this act may<sup>1</sup> be subject to

1 coinsurance and deductibles, which may vary by selected portions  
2 of the coverage, except that no deductible applicable to any  
3 portion of the coverage shall exceed \$250 for an individual or  
4 family unit during any benefit year, and no coinsurance applicable  
5 to any portion of the coverage shall exceed \$500 for an individual  
6 or family unit during any benefit year, unless provided by the  
7 board pursuant to section <sup>1</sup>[23] <sup>17</sup> of this act. Neither  
8 coinsurance nor deductibles shall be applicable to maternity  
9 benefits.

10 <sup>1</sup>[b. Except as provided herein, no law requiring the inclusion  
11 of any specified health care service or benefit and no law  
12 requiring the reimbursement, utilization, or consideration of a  
13 specific category of licensed health care practitioner shall apply  
14 to any Basic or Basic Plus health benefits plan provided for  
15 herein.]<sup>1</sup>

16 <sup>1</sup>[7.] <sup>5</sup> <sup>1</sup> Coverage provided pursuant to this act shall be subject  
17 to standard coordination of benefits provisions for all persons  
18 covered under the policy or contract. Notwithstanding the  
19 provision of any other law to the contrary, <sup>1</sup>[coverage] the health  
20 benefits plan with the lowest actuarial value<sup>1</sup> provided under  
21 <sup>1</sup>[policies or contracts issued pursuant to sections 4 or 5 of]<sup>1</sup> this  
22 act shall not extend to any injury for which coverage is available  
23 or applicable pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4),  
24 and <sup>1</sup>[the coverage provided by a policy or contract issued  
25 pursuant to this act] that health benefits plan<sup>1</sup> shall not be used  
26 as a substitute for any insurance required to be maintained  
27 pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4).

28 <sup>1</sup>[8. a. Except as otherwise provided by this act, a preexisting  
29 condition provision shall not exclude coverage for an eligible  
30 employee or dependent for a period beyond 180 days following the  
31 effective date of coverage of an eligible employee and may only  
32 relate to conditions manifesting themselves during the six months  
33 immediately preceding the effective date of coverage in such a  
34 manner as would cause an ordinarily prudent person to seek  
35 medical advice, diagnosis, care or treatment or for which medical  
36 advice, diagnosis, care, or treatment was recommended or  
37 received during the six months immediately preceding the  
38 effective date of coverage, or as to a pregnancy existing on the  
39 effective date of coverage.]

40 8. a. No health benefits plan subject to this act shall include  
41 any preexisting condition provision, provided that, a preexisting  
42 condition provision may apply to a late enrollee or to any group  
43 of two to five persons if such provision excludes coverage for a  
44 period of no more than 180 days following the effective date of  
45 coverage of such enrollee, and relates only to conditions  
46 manifesting themselves during the six months immediately  
47 preceding the effective date of coverage of such enrollee in  
48 such a manner as would cause an ordinarily prudent person to  
49 seek medical advice, diagnosis, care or treatment or for which  
50 medical advice, diagnosis, care, or treatment was recommended  
51 or received during the six months immediately preceding the  
52 effective date of coverage, or as to a pregnancy existing on the  
53 effective date of coverage; provided that, if 10 or more late  
54 enrollees request enrollment during any 30-day enrollment

1 period, then no preexisting condition provision shall apply to any  
2 such enrollee.<sup>1</sup>

3 b. In determining whether a preexisting condition provision  
4 applies to an eligible employee or dependent, all health benefits  
5 plans shall credit the time that person was covered under <sup>1</sup>[a]  
6 any<sup>1</sup> previous <sup>1</sup>[employer based]<sup>1</sup> health benefits plan if the  
7 previous coverage was continuous to a date not more than 90 days  
8 prior to the effective date of the new coverage, exclusive of any  
9 applicable waiting period under such plan.

10 <sup>1</sup>[9.] 2.<sup>1</sup> Every policy or contract issued to small employers in  
11 this State <sup>1</sup>[including, but not limited to, policies or contracts  
12 issued pursuant to the provisions of this act]<sup>1</sup> shall be renewable  
13 with respect to all eligible employees or dependents at the option  
14 of the policy or contract holder, or small employer except under  
15 the following circumstances:

16 a. Nonpayment of the required premiums by the policyholder,  
17 contract holder, or employer;

18 b. Fraud or misrepresentation of the policyholder, contract  
19 holder, or employer or, with respect to coverage of eligible  
20 employees or dependents, the enrollees or their representatives;

21 c. The number of employees covered under the health benefits  
22 plan is less than the number or percentage of employees required  
23 by participation requirements under the health benefits policy or  
24 contract;

25 d. Noncompliance with a carrier's employment contribution  
26 requirements;

27 e. <sup>1</sup>[The carrier withdraws the policy form, with the approval  
28 of the commissioner, in which case the group shall be offered an  
29 alternative policy or contract by the carrier which offers  
30 comparable benefits;

31 f.]<sup>1</sup> Any carrier doing business pursuant to the provisions of  
32 this act ceases doing business in the small employer market, if  
33 the 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 (3) of this  
42 section;

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.

2 <sup>1</sup>[10. Late enrollees may be excluded from coverage: a. for  
3 12 months for all coverage; or b. for 12 months for a preexisting  
4 condition. No combined period of total exclusion or exclusion for  
5 a preexisting condition shall exceed 12 months.]<sup>1</sup>

6 <sup>1</sup>[11.] <sup>2</sup>g. <sup>1</sup> Any small employer carrier may require a reasonable  
7 specified minimum participation of eligible employees, which  
8 shall not exceed 75%, or reasonable minimum employer  
9 contributions in determining whether to accept a small group  
10 pursuant to this act. The standards so established by the carrier  
11 shall be first approved by the board and shall be applied uniformly  
12 to all small groups, except that in no event shall a carrier require  
13 an employer to contribute more than 10% to the annual cost of  
14 the policy or contract, or an amount as otherwise provided by the  
15 board, and any minimum participation standards established by  
16 the carrier shall be reasonable. In establishing the percentage of  
17 employee participation, a one-to-one credit shall be given for  
18 each employee covered by a spouse's health benefits coverage.

19 <sup>1</sup>[12. a. Rate differentials of any small group policies or  
20 contracts delivered, issued for delivery, or continued in this State  
21 may be based only on the factors of age, gender, and geography.  
22 No carrier shall issue any policy or contract in which the rates  
23 charged to any group exceed four times the base premium rate  
24 charged to the lowest-rated small employer group written by the  
25 carrier for a like benefits plan.

26 b. In establishing the rating classifications provided for by  
27 subsection a. of this section, no carrier shall establish an excess  
28 of six rating territories, and no rating territory shall be any  
29 smaller than a county.

30 c. No rate classifications based on age shall provide for rate  
31 changes within any period which is less than five years. Age  
32 ranges, which shall be in five-year increments, shall be  
33 established by the commissioner by regulation and shall apply to  
34 all small group policies, whether or not written pursuant to  
35 sections 4 and 5 of this act.

36 d. The premium rates charged to any small employer for  
37 policies or contracts issued before the effective date of this act  
38 by any carrier shall, within three years of the effective date of  
39 this act, conform to subsection a. of this section. The four to one  
40 ratio established by subsection a. of this section shall be applied  
41 separately to each type of benefits plan issued by the carrier.

42 e. Notwithstanding the provisions of subsection d. of this  
43 section to the contrary, the provisions of subsection a. of this  
44 section shall be applied separately to policies or contracts: (1) in  
45 the case of any small employer contracts issued by a hospital  
46 service corporation or medical service corporation or any  
47 successor corporation which constitute a closed block of business  
48 as of September 1, 1991; or (2) in the case of any small employer  
49 policies issued under an open enrollment plan by any other health  
50 insurer which have not been offered for sale as of January 1, 1989.

51 f. Any premium charged for excess coverage for policies  
52 issued pursuant to sections 4 or 5 of this act shall be subject to  
53 the limitations provided for in this section.

54 g. Rating classifications established by carriers for small

1 group policies or contracts shall not operate to produce rates for  
2 any small employer group which are excessive, inadequate, or  
3 unfairly discriminatory.

4 h. The provisions of this section shall apply to all small group  
5 business issued by any insurer in this State, whether or not  
6 written pursuant to section 4 or 5 of this act.]<sup>1</sup>

7 <sup>1</sup>[13. In connection with the offering for sale of any policy or  
8 contract to a small employer, each small employer carrier shall  
9 make a reasonable disclosure, as a part of its solicitation and  
10 sales materials, of the following:

11 a. The extent to which premium rates for a specified small  
12 employer are established or adjusted based upon the actual or  
13 expected variation in claims costs;

14 b. Any factors applicable to the policy or contract which are  
15 attributable to factors other than claim experience or duration of  
16 coverage, since issue, which affect changes in premium rates; and

17 c. Provisions relating to renewability of policies and  
18 contracts.]<sup>1</sup>

19 <sup>1</sup>[14. a. Every small employer carrier shall maintain at its  
20 principal place of business a complete and detailed description of  
21 its rating plan and underwriting practices, including renewal  
22 underwriting practices. Rating plans shall be based on commonly  
23 accepted actuarial assumptions and shall be in accordance with  
24 sound actuarial principles. This information shall be available to  
25 the commissioner upon request. Except in cases of any violation  
26 of this act, the information provided for herein shall be  
27 considered proprietary and trade secret information and shall not  
28 be subject to disclosure by the commissioner to persons outside of  
29 the department except as agreed to by the small employer carrier  
30 or as ordered by a court of competent jurisdiction.

31 b. Every small employer carrier shall file no later than March  
32 1 each year following the effective date of this act, a  
33 certification signed by an actuary and attested by an officer of  
34 the insurer that the carrier is in compliance with the act and that  
35 the rating methods of the small employer are actuarially sound.  
36 A copy of the certification shall be retained by the small  
37 employer carrier at its principal place of business.]<sup>1</sup>

38 <sup>1</sup>9. a. (1) Effective January 1, 1997, no small employer health  
39 benefits plan shall be issued in this State unless the plan is  
40 community rated.

41 (2) During the period January 1, 1994 to December 31, 1995,  
42 the premium rate charged by a carrier to the highest rated small  
43 group purchasing a small employer health benefits plan shall not  
44 be greater than 300% of the premium rate charged to the lowest  
45 rated small group purchasing that same health benefits plan.

46 (3) During the period January 1, 1996 to December 31, 1996,  
47 the premium rate charged by a carrier to the highest rated small  
48 group purchasing a small employer health benefits plan shall not  
49 be greater than 200% of the premium rate charged for the lowest  
50 rated small group purchasing that same health benefits plan.

51 (4) The commissioner shall study the impact on the health  
52 insurance marketplace of the transition from the rating  
53 methodology described in paragraph (3) of this subsection to  
54 community rating. In making this study the commissioner shall

1 consult with representatives of the health insurance industry,  
2 health care providers, consumer and public interest groups and  
3 such other persons with expertise deemed relevant by the  
4 commissioner. The commissioner shall report his findings to the  
5 Governor and the Legislature on a day that the Legislature is in  
6 session, on or before July 1, 1996. If the Legislature does not  
7 take action within 60 days after its receipt of the commissioner's  
8 report, to amend this act, community rating will become  
9 effective on January 1, 1997.

10 b. Notwithstanding any other provision of law to the contrary,  
11 group hospital or medical coverage obtained through an  
12 out-of-State trust covering a group of 49 or fewer employees or  
13 participating persons who are residents of this State shall be  
14 community rated regardless of the situs of delivery of the policy.

15 c. Notwithstanding any other provision of law to the contrary,  
16 no carrier offering any health benefits plan pursuant to the  
17 provisions of this act shall act to circumvent the intent of this  
18 act by acting as a third party administrator for groups of small  
19 employers, anyone of whom was insured as of September 1, 1992;  
20 provided, however, that this provision shall not act to limit a  
21 bona fide group of small employers who voluntarily act together  
22 to provide health benefits to their employees.

23 d. Notwithstanding any other provision of law to the contrary,  
24 this act shall apply to an association or trust of employers, if the  
25 group includes one or more member employers or other member  
26 groups which have 49 or fewer employees or members exclusive  
27 of spouses and dependents.

28 e. Nothing contained herein shall prohibit the use of premium  
29 rate structures to establish different premium rates for  
30 individuals and family units.

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

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

50 (2) Each calendar year, a carrier shall return, in the form of  
51 aggregate benefits for each of the five standard policy forms  
52 offered by the carrier pursuant to section 3 of this act, at least  
53 75% of the aggregate premiums collected for the policy form  
54 during that calendar year. Carriers shall annually report, no later

1 than August 1st of each year, the loss ratio calculated pursuant  
2 to this section for each such policy form for the previous  
3 calendar year. In each case where the loss ratio for a policy fails  
4 to substantially comply with the 75% loss ratio requirement, the  
5 carrier shall issue a dividend or credit against future premiums  
6 for all policyholders with that policy form in an amount sufficient  
7 to assure that the aggregate benefits paid in the previous  
8 calendar year plus the amount of the dividends and credits shall  
9 equal 75% of the aggregate premiums collected for the policy  
10 form in the previous calendar year. The dividend or credit shall  
11 be issued to each policy which was in effect as of March 30th of  
12 the applicable year and remains in effect as of the date the  
13 dividend or credit is issued. All dividends and credits must be  
14 distributed by December 31 of the year following the calendar  
15 year in which the loss ratio requirements were not satisfied. The  
16 annual report required by this paragraph shall include a carrier's  
17 calculation of the dividends and credits, as well as an explanation  
18 of the carrier's plan to issue dividends or credits. The  
19 instructions and format for calculating and reporting loss ratios  
20 and issuing dividends or credits shall be specified by the  
21 commissioner by regulation. Such regulations shall include  
22 provisions for the distribution of a dividend or credit in the event  
23 of cancellation or termination by a policyholder.

24 h. No carrier issuing health benefits plans covering two or  
25 more employees of a small employer shall issue a plan  
26 inconsistent with this act whose term extends beyond December  
27 31, 1993.

28 i. The provisions of this act shall apply to health benefits plans  
29 which are delivered, issued for delivery, renewed or continued on  
30 or after January 1, 1994. The commissioner shall withdraw  
31 approval for the issuance and use of all small employer policy  
32 forms, other than those approved by the board, effective January  
33 1, 1994.<sup>1</sup>

34 <sup>1</sup>[15.] 10.<sup>1</sup> a. No health maintenance organization shall be  
35 required to offer coverage or accept applications pursuant to  
36 <sup>1</sup>[sections 4 or 5] section 3<sup>1</sup> of this act to a small employer if the  
37 small employer is not physically located in the health  
38 maintenance organization's approved service area, to an  
39 employee when the employee does not work or reside within a  
40 service area, or if the health maintenance organization  
41 reasonably anticipates and demonstrates to the satisfaction of  
42 the commissioner that it will not have the capacity in its network  
43 of providers within the service area to deliver service adequately  
44 to the members of such groups because of its obligations to  
45 existing group contract holders and enrollees.

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

51 <sup>1</sup>c. A health maintenance organization which complies with  
52 the basic health benefits, underwriting and rating standards  
53 established by the federal government pursuant to subchapter XI  
54 of Pub.L.93-222 (42.U.S.C. §300e et seq.), and which also

1 provides the comprehensive health benefit plan coverage required  
2 by section 3 of this act, shall be deemed in compliance with this  
3 act.<sup>1</sup>

4 <sup>1</sup>[16. The provisions of sections 4 and 5 of this act shall apply  
5 to Basic and Basic Plus health benefits plans subject to this act  
6 which are delivered, issued for delivery, renewed or continued on  
7 or after the effective date of this act.]<sup>1</sup>

8 <sup>1</sup>[17.] 11.<sup>1</sup> a. Every policy or contract issued to a small  
9 employer in this State, including, but not limited to, policies or  
10 contracts which are subject to this act and which are delivered,  
11 issued, renewed, or continued on or after the effective date of  
12 this act, shall offer continued coverage under the plan to any  
13 employee whose employment was terminated for a reason other  
14 than for cause and to any employee covered by such plan whose  
15 hours of employment were reduced to less than 30 subsequent to  
16 the effective date of coverage for that employee. The employee  
17 shall make a written election for continued coverage within  
18 30 days of a qualifying event. For the purposes of this section,  
19 "qualifying event" shall mean the date of termination of  
20 employment, or the date on which a reduction in an employee's  
21 hours of employment becomes effective. For the purposes of this  
22 section, the date on which a health benefits plan is continued  
23 shall be the anniversary date of the issuance of the 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 <sup>1</sup>[18.] 12.<sup>1</sup> There is created a nonprofit entity to be known as  
26 the New Jersey Small Employer Health Excess Insurance  
27 Program. All carriers issuing health benefits plan policies and  
28 contracts in this State <sup>1</sup>[and any MEWA providing health  
29 benefits]<sup>1</sup> shall be members of this program. The program shall  
30 be administered by the board of directors established pursuant to  
31 section <sup>1</sup>[19] 13<sup>1</sup> of this act.

32 <sup>1</sup>[19.] 13.<sup>1</sup> a. Within 60 days of the effective date of this act,  
33 the commissioner shall give notice to all members of the time  
34 and place for the initial organizational meeting, which shall take  
35 place within 90 days of the effective date. The members shall  
36 select the initial board, subject to the approval of the  
37 commissioner. The board shall consist of 11 persons, including  
38 the Commissioner of Health and the commissioner or their  
39 designees, both of whom shall sit ex officio. Initially, three of  
40 the public members of the board shall be elected for a three year  
41 term, three shall be elected for a two year term, and three shall  
42 be elected for a one year term. Thereafter, all board members  
43 shall be elected for a term of three years. The following  
44 categories shall be represented among the public members:

45 (1) Two carriers whose principal health insurance business is in  
46 the small employer market;

47 (2) One carrier whose principal health insurance business is in  
48 the large employer market;

49 (3) A health, hospital or medical service corporation;

50 (4) A health maintenance organization;

51 (5) A risk-assuming carrier;

52 (6) A reinsuring carrier utilizing the excess coverage provided  
53 for in this act; and

54 (7) Two persons representing small employers.

1 No carrier shall have more than one representative on the  
2 board.

3 b. If the initial board is not elected at the organizational  
4 meeting, the commissioner shall appoint the public members  
5 within 15 days of the organizational meeting, in accordance with  
6 the provisions of paragraphs (1) through (7) of subsection a. of  
7 this section.

8 <sup>1</sup>c. The board shall determine the Statewide average payment  
9 per insured for each benefit plan provided for under this act.  
10 Each carrier who satisfies the efficiency and risk management  
11 standards promulgated by the board pursuant to subsection f. of  
12 section 15 of this act and whose average cost of insuring  
13 individuals covered by small employer health benefits plans  
14 exceeds the Statewide average cost of insuring such individuals  
15 by 20%, shall be reimbursed by the program for 80% of its costs  
16 in excess thereof.

17 d. All meetings of the board shall be subject to the  
18 requirements of the "Open Public Meetings Act," P.L.1975, c.231  
19 (C.10:4-6 et seq.).

20 e. At least two copies of the minutes of every meeting of the  
21 board shall be delivered forthwith to the commissioner.<sup>1</sup>

22 <sup>1</sup>[20. a.] <sup>1</sup>14. <sup>1</sup> Within 90 days after the election of the initial  
23 board, the board shall submit to the commissioner a plan of  
24 operation which shall establish the administration of the program  
25 pursuant to the provisions of this act. The plan of operation and  
26 any subsequent amendments thereto shall be submitted to the  
27 commissioner who shall, after notice and hearing, approve the  
28 plan if he finds that it is reasonable and equitable and sufficiently  
29 carries out the provisions of this act. The plan of operation shall  
30 become effective after the commissioner has approved it in  
31 writing. The plan or any subsequent amendments thereto shall be  
32 deemed approved if not expressly disapproved by the  
33 commissioner in writing within 90 days of receipt by the  
34 commissioner.

35 <sup>1</sup>[b. If the board fails to submit a suitable plan of operation  
36 within 90 days after its appointment, the commissioner shall,  
37 after notice and hearing, adopt and promulgate a temporary plan  
38 of operation. The commissioner shall amend or rescind any such  
39 plan promulgated by him upon the submission and approval of a  
40 plan submitted by the board pursuant to subsection a. of this  
41 section.]<sup>1</sup>

42 <sup>1</sup>[21.] <sup>1</sup>15. <sup>1</sup> The plan of operation shall <sup>1</sup>constitute a public  
43 record and shall <sup>1</sup>include, but not be limited to, the following:

44 a. A method of handling and accounting for assets and moneys  
45 of the program and an annual fiscal reporting to the  
46 commissioner;

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

49 c. A means of selecting an administering carrier, and a  
50 statement of the powers and duties of the administering carrier  
51 and the compensation of the administering carrier <sup>1</sup>and a  
52 statement of the efficiency standards an administering carrier  
53 must meet<sup>1</sup>;

54 d. The method to be used <sup>1</sup>[for securing excess insurance under

1 the provisions of this act] to determine the extent to which a  
2 carrier's payment per insured for each benefit plan provided for  
3 under this act, exceeds the Statewide average payment per  
4 insured for each benefit plan provided for under this act<sup>1</sup>;

5 e. The method <sup>1</sup>[to be used for establishing appropriate excess  
6 insurance premiums to be charged to carriers electing to reinsure  
7 risks in accordance with this act] for determining the extent to  
8 which a carrier whose average cost of insuring individuals  
9 covered by small employer health benefits plans exceeds the  
10 threshold described in subsection c. of section 13 of this act may  
11 receive reimbursement from the program<sup>1</sup> ;

12 f. <sup>1</sup>[The method to be used to make up any shortfall which may  
13 occur as the result of risks being reinsured under the provisions of  
14 this act.] A statement of the efficiency and risk management  
15 standards a carrier must meet before a carrier may receive  
16 reimbursement from the program; and<sup>1</sup>

17 g. <sup>1</sup>[A procedure for establishing the health benefits plans for  
18 which excess coverage is to be provided;

19 h.]<sup>1</sup> Any additional matters which are appropriate to  
20 effectuate the provisions of this act.

21 <sup>1</sup>[22.] 16.<sup>1</sup> The <sup>1</sup>[board shall have the general powers and  
22 authority granted under the laws of New Jersey to insurance  
23 companies writing health insurance pursuant to Title 17B of the  
24 New Jersey Statutes, to health maintenance organizations  
25 approved or qualified to transact business in this State, and to  
26 health service corporations, medical service corporations, and  
27 hospital service corporations, but in no case shall the program  
28 established under this act write any policy or contract of  
29 insurance directly. In addition to the aforementioned powers,  
30 the]<sup>1</sup> board shall have the authority to:

31 a. Enter into contracts as are necessary or proper to carry out  
32 the provisions and purposes of this act;

33 b. Sued or be sued, including taking any legal actions as may  
34 be necessary for recovery of any assessments due to the program  
35 or to avoid paying any improper claims;

36 c. <sup>1</sup>[Issue excess insurance policies or other documents  
37 evidencing such coverage;

38 d.]<sup>1</sup> Establish rules, conditions, and procedures pertaining to  
39 the <sup>1</sup>[reinsurance] reimbursement and assessment<sup>1</sup> of <sup>1</sup>[members'  
40 risks] members<sup>1</sup> by the program;

41 <sup>1</sup>[e. Establish appropriate rates, rate schedules, rate  
42 adjustments, rate classifications, and such other actuarial  
43 functions which may be appropriate to the operation of the  
44 program, for providing excess coverage;

45 f.] d.<sup>1</sup> Assess members in accordance with the provisions of  
46 this act, including such interim assessments as may be reasonable  
47 and necessary for organizational and interim operating expenses.  
48 Such interim assessments shall be credited as offsets against any  
49 regular assessments due following the close of the fiscal year;  
50 and<sup>1</sup>

51 <sup>1</sup>[g.] e.<sup>1</sup> Appoint from among its members appropriate legal,  
52 actuarial, and other committees as necessary to provide technical  
53 assistance in the operation of the program, policy and other  
54 contract design, and any other function within the authority of

1 the program <sup>1</sup>]; and

2 h. Borrow money to effect the purposes of the program. Any  
3 notes or other evidence of indebtedness of the program not in  
4 default shall be legal investments for carriers and may be carried  
5 as admitted assets<sup>1</sup>.

6 <sup>1</sup>[23.] 17.<sup>1</sup> Subject to the approval of the commissioner, the  
7 board shall <sup>1</sup>[establish the form and level of coverages] formulate  
8 the five health benefits plans<sup>1</sup> to be made available by small  
9 employer carriers in accordance with the provisions of this  
10 act <sup>1</sup>, and shall promulgate five standard forms pursuant thereto<sup>1</sup>

11 . The board may establish benefits levels, deductibles and  
12 copayments, exclusions, and limitations for the <sup>1</sup>[Basic and Basic  
13 Plus health care plan, consistent with sections 4 and 5 of this  
14 act. The board shall also determine what components of a small  
15 employer's health benefits plan may be reinsured] such health  
16 benefits plans in accordance with the law<sup>1</sup>.

17 One health care plan shall be established which contains  
18 benefits and cost sharing levels which are consistent with the  
19 basic method of operation and the benefits plans of health  
20 maintenance organizations, including any restrictions pursuant to  
21 subchapter XI of Pub.L.93-222 (42 U.S.C. §300 et seq.). The  
22 board shall submit the plans so established to the commissioner  
23 for his approval no later than 90 days after the election of the  
24 board pursuant to section <sup>1</sup>[19] 13<sup>1</sup> of this act. The commissioner  
25 shall approve the plan if he finds it to be consistent with the  
26 provisions of <sup>1</sup>[sections 4 and 5] section 3<sup>1</sup> of this act. Any plans  
27 submitted to the commissioner by the board shall be deemed  
28 approved if not expressly disapproved in writing within 60 days of  
29 its receipt by the commissioner. Such plans may contain, but  
30 shall not be limited to, the following provisions:

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

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

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

36 d. Reasonable benefits differentials which are applicable to  
37 participating and nonparticipating providers;

38 e. Notwithstanding the provisions of section 6 of this act to  
39 the contrary, the board may, from time to time, adjust  
40 coinsurance and deductibles; <sup>1</sup>[and]<sup>1</sup>

41 f. Such other provisions which may be quantifiably established  
42 to be cost containment devices <sup>1</sup>;

43 g. The department shall publish annually a list of the premiums  
44 charged for each of the five standard small employer health  
45 benefits plans and for any rider package by all carriers writing  
46 such plans. The department shall also publish the toll free  
47 telephone number of each such carrier<sup>1</sup> .

48 <sup>1</sup>[24. After the commissioner's approval of the health benefits  
49 plan guidelines formulated by the board pursuant to section 23 of  
50 this act, a small employer carrier shall file its policy or contract  
51 forms with the commissioner and shall certify to the  
52 commissioner, in a form required by the commissioner, that the  
53 plans filed by the carrier are in compliance with the guidelines  
54 established by the board. The certification shall be signed by the

1 chief executive officer of the carrier. Upon filing the  
2 certification with the commissioner, the carrier may use the  
3 certified plans until such time, after notice and hearing, as the  
4 commissioner disapproves their continued use.<sup>1</sup>

5 <sup>1</sup>[25.] 18.<sup>1</sup> Every small employer carrier shall elect to be  
6 either a risk-assuming carrier or a reinsuring carrier and shall  
7 file notice of such election with the board. Carriers electing to  
8 be a risk-assuming carrier shall do so only with the approval of  
9 the commissioner. Application for risk-assuming status shall be  
10 filed with the commissioner on a form approved by the  
11 commissioner, and shall be deemed approved if it is not  
12 disapproved in writing within 90 days of the commissioner's  
13 receipt of the application. In determining whether to approve an  
14 application by a small employer carrier to become a  
15 risk-assuming carrier, the commissioner shall consider the  
16 carrier's financial condition, its history of assuming and  
17 managing risk, and its experience in managing small group  
18 business. The commissioner may also seek comments from the  
19 board prior to rendering a decision on the application. Any  
20 carrier which has made application for a risk-assuming status  
21 which has been disapproved by the commissioner shall be granted  
22 a hearing within 60 days of the disapproval.

23 <sup>1</sup>[26.] 19.<sup>1</sup> a. Any member which elects to be a reinsuring  
24 carrier may <sup>1</sup>[obtain excess insurance from the program on any  
25 new small employer group policy or contract issued pursuant to  
26 sections 4 or 5 of this act, on any small employer group, or any  
27 individual beneficiary for any amount payable for eligible claims  
28 in excess of \$7,500 per covered beneficiary per year. In such  
29 case, the program shall provide the excess coverage subject to  
30 the payment by the reinsuring carrier of an appropriate  
31 reinsurance premium. Coverage may be reinsured within 60 days  
32 of the commencement of the employer's coverage with the small  
33 employer carrier. With respect to eligible employees and their  
34 dependents who are hired subsequent to the commencement of  
35 the employer's coverage and who are not late enrollees to the  
36 plan, coverage may be reinsured within 60 days of the  
37 commencement of their coverage under the plan. Excess  
38 coverage may be terminated with respect to any employee or  
39 dependent on any plan anniversary] receive reimbursement in  
40 accordance with the standards developed by the board pursuant to  
41 subsections d., e. and f. of section 15 of this act<sup>1</sup>.

42 b. Election to <sup>1</sup>[purchase excess coverage through the  
43 program] become a reinsuring carrier<sup>1</sup> shall be binding for a  
44 five-year period, except that the initial election shall be made  
45 within 30 days of the submission to the commissioner of the plan  
46 of operation provided for in section <sup>1</sup>[20] 14<sup>1</sup> of this act, and  
47 shall be effective for two years.

48 <sup>1</sup>[27.] 20.<sup>1</sup> Every member which elects to be a reinsuring  
49 carrier shall apply its case management and claims handling  
50 techniques, including, but not limited to, utilization review,  
51 individual case management, preferred provider provisions and  
52 other methods of operation, in the same manner with respect to  
53 <sup>1</sup>[both reinsured and non-reinsured] all its<sup>1</sup> business.

54 <sup>1</sup>[28. a. Premium rates charged by the program for entire

1 groups shall not exceed 1.5 times the rate established by the  
2 board for similar groups for which excess coverage has not been  
3 purchased. In computing the premium, the board shall establish a  
4 rate from which the premium shall be computed which is not less  
5 than the average rate for like risks for the small group market as  
6 a whole.

7 b. Premium rates charged by the program for individuals shall  
8 not exceed 5.0 times the rate established by the program for  
9 similar persons for which excess coverage has not been purchased.

10 c. Premium rates charged for excess insurance by the program  
11 to a health maintenance organization that is approved by the  
12 United States Secretary of Health and Human Services as a  
13 federally qualified health maintenance organization pursuant to  
14 subchapter XI of Pub.L.93-222 (42 U.S.C. §300e et seq.), and as  
15 such is subject to requirements that limit the amount of risk that  
16 may be ceded to the program, shall be reduced to reflect the  
17 portion of the risk so ceded.

18 d. Premium rates charged for excess insurance shall not be  
19 charged directly back to the group or individual for whom the  
20 excess insurance is being obtained.]<sup>1</sup>

21 <sup>1</sup>[29.] 21.<sup>1</sup> a. Following the close of <sup>1</sup>[each fiscal year of the  
22 administering carrier, the administering carrier shall determine  
23 the net premiums, the administrative expenses of the program  
24 and the incurred losses, if any, for the year, taking into account  
25 investment income and other appropriate gains and losses.  
26 Health benefits plan premiums and benefits paid by a member  
27 that are less than an amount determined by the board to justify  
28 the cost of collection shall not be considered for purposes of  
29 determining assessments. For the purposes of this section, "net  
30 premiums" means health benefits plan premiums, less  
31 administrative expense allowances, and health benefits plan  
32 premiums earned by MEWAs shall be established by adding the  
33 paid losses and administrative expenses of such associations] the  
34 calendar year ending December 31, the administering carrier  
35 shall determine the total amount owed by the program in that  
36 calendar year to all carriers qualifying for reimbursement by the  
37 program. Such amount shall be known as the net loss of the  
38 program<sup>1</sup>.

39 b. Any net loss for the year shall be recouped by assessments  
40 of members. Assessments shall first be apportioned by the board  
41 among all reinsuring carrier members in proportion to their  
42 respective shares of the plan premiums earned in this State from  
43 health benefits plans covering small employers during the  
44 calendar year coinciding with or ending during the fiscal year of  
45 the program, or on any other equitable basis reflecting coverage  
46 of small employers as may be provided in the plan of operation.  
47 In making this determination, the board may base the assessments  
48 upon annual reports and other data filed by the member small  
49 employer carrier.

50 c. If the net loss is not recouped before assessments totaling  
51 4% of the aggregate premiums from policies or contracts  
52 covering small employers have been collected from reinsuring  
53 small employer carriers, additional assessments not to exceed 1%  
54 of the aggregate premiums from all health benefits policies or

1 contracts shall be apportioned by the board among all members,  
2 including risk-assuming carriers, in proportion to their respective  
3 shares of the total health benefits plan premiums earned in this  
4 State from all health benefits plans during the preceding calendar  
5 year. A carrier shall receive a credit against this assessment to  
6 the extent the carrier can demonstrate that its assumption of  
7 high-risk small employer groups which are not reinsured is  
8 proportionate to its market share of small employer health  
9 benefits plans, as such groups and market shares are defined by  
10 the board in the plan of operation. A carrier shall not be assessed  
11 for all individual non-group contracts or policies issued on a  
12 guaranteed issue basis or on any coverage issued by the carrier  
13 pursuant to the Medicaid program, P.L.1968, c.413 (C.30:4D-1  
14 et seq.).

15 d. If assessments exceed actual losses and administrative  
16 expenses of the program, the excess shall be held at interest and  
17 used by the board to offset future losses or to reduce program  
18 premiums. As used in this subsection, "future losses" includes  
19 reserves for incurred but not reported claims.

20 e. Provision may be established in the plan of operation for the  
21 imposition of an interest penalty for late payment of assessments.

22 <sup>1</sup>[30.] 22.<sup>1</sup> A member may seek from the commissioner a  
23 deferment in whole or in part from any assessment levied by the  
24 board. The commissioner may grant the deferment if, in his  
25 opinion, the payment of the assessment would endanger the  
26 ability of the member to fulfill its contractual obligations. In the  
27 event an assessment against a member is deferred in whole or in  
28 part, the amount by which the assessment is deferred may be  
29 assessed against the other members in a manner consistent with  
30 the basis for assessment set forth in this act. The member  
31 receiving a deferment shall remain liable to the program for the  
32 amount deferred and shall be prohibited from reinsuring any  
33 individuals or groups in the program if it fails to pay assessments.

34 <sup>1</sup>[31.] 23.<sup>1</sup> A small employer carrier which elects to cease  
35 participating as a reinsuring carrier and elects to become a  
36 risk-assuming carrier shall be prohibited from <sup>1</sup>[reinsuring or  
37 continuing to reinsure any small employer health benefits plan]  
38 receiving reimbursement from the program<sup>1</sup> pursuant to this act.  
39 Any reinsuring carrier electing to become a risk-assuming carrier  
40 shall pay a prorated assessment <sup>1</sup>[based upon business issued as a  
41 reinsuring carrier for any portion of the year that the business  
42 was reinsured]<sup>1</sup>.

43 <sup>1</sup>[32. a. The board may establish a subcommittee to monitor  
44 the market conduct of risk-assuming carriers and reinsuring  
45 carriers to assure that the provisions of this act are being carried  
46 out. The subcommittee shall, from time to time, recommend for  
47 the approval by the commissioner market conduct requirements  
48 for carriers and agents. The subcommittee shall also, in  
49 conjunction with the department, publish a list of all small  
50 employer carriers, as well as a list of toll free telephone numbers  
51 which are easily accessible by small employers. In the event that  
52 the board believes that any carrier is violating any provision of  
53 this act or is conducting itself improperly in the marketing or  
54 sale of its small group business, whether issued pursuant to this

1 act or otherwise, it shall report this to the commissioner, who  
2 shall conduct an investigation of that carrier, including, but not  
3 limited to, an audit of the carrier's records.

4 b.) 24.<sup>1</sup> The board shall <sup>1</sup>[also]<sup>1</sup> establish guidelines to ensure  
5 that small employer carriers are assuming their share of high risk  
6 small employer groups in proportion to their market share of  
7 small employer health benefits plan business. In the event that  
8 any carrier does not assume its reasonable share of the high risk  
9 market, the board may adjust the assessment formula, with the  
10 approval of the commissioner, to require a proportionally higher  
11 assessment for the carrier.

12 <sup>1</sup>[33.] 25.<sup>1</sup> Any carrier which violates this act shall be subject  
13 to a penalty assessment, as determined by the commissioner,  
14 whether or not the carrier is a risk-assuming carrier or a  
15 reinsuring carrier.

16 <sup>1</sup>[34.] 26.<sup>1</sup> The excess insurance program established pursuant  
17 to this act shall be exempt from <sup>1</sup>[any taxes levied by the State,  
18 including]<sup>1</sup> premium taxes.

19 <sup>1</sup>[35. No carrier writing small employer group insurance  
20 business pursuant to this act shall insure any small group under a  
21 policy or contract of insurance provided for in sections 4 or 5 of  
22 this act, which small group is insured by any carrier as of the  
23 effective date of the act or during the calendar year immediately  
24 preceding.]<sup>1</sup>

25 <sup>1</sup>[36. No later than one year following the effective date of  
26 this act and at least annually thereafter for the subsequent four  
27 years, the board shall conduct a review of the small group  
28 insurance market to examine the effectiveness of the insurance  
29 provided for in this act in terms of its acceptance among small  
30 employers and the adequacy of the benefits provided for. The  
31 review shall determine whether an additional product or products  
32 should be made available under the program provided for by this  
33 act, including major medical coverage. In addition, the board  
34 shall analyze the effect of the four to one premium ratio  
35 established pursuant to section 12 of this act to determine  
36 whether the relationship of the high-to-low rates established  
37 pursuant to that ratio are inequitably distributed throughout the  
38 small group market, and whether the ratio so established can be  
39 further reduced without negative economic effect on any group.

40 The board shall report to the Governor and the Legislature  
41 after each review required by this section, and include any  
42 recommendations it may have with respect to the modification or  
43 augmentation of the program.]<sup>1</sup>

44 <sup>1</sup>[37.] 27.<sup>1</sup> A carrier which violates any provision of this act  
45 shall be liable to a penalty of not less than \$2,000 and not greater  
46 than \$5,000 for each violation. The penalty shall be collected by  
47 the commissioner in the name of the State in a summary  
48 proceeding in accordance with "the penalty enforcement law,"  
49 N.J.S.2A:58-1 et seq..

50 <sup>1</sup>[38.] 28.<sup>1</sup> No assessment provided for under this act shall <sup>1</sup>[,  
51 under any circumstances, be an obligation of the State] be  
52 charged, directly or indirectly, to policyholders or the public,  
53 provided that a carrier may charge such an assessment to  
54 policyholders to the extent that the charging of the assessment is

1 necessary to enable the carrier to earn a constitutionally  
2 adequate rate of return<sup>1</sup>.  
3 129. The board shall promulgate one standard claim form. In  
4 order to provide a standard system of payment for medical  
5 services, all claim forms for any claimant's use under any group  
6 health insurance policy issued or delivered in this State shall  
7 conform to the form adopted by the board.<sup>1</sup>  
8 130. Notwithstanding any other provision of law to the  
9 contrary, all regulations concerning any health benefits plan  
10 subject to this act shall be promulgated pursuant to this act.<sup>1</sup>  
11 139.] 31.<sup>1</sup> This act shall take effect immediately.

12  
13  
14  
15  
16 Requires certain insurers, service corporations and HMOs to offer  
17 standardized health insurance plans to small groups; establishes a  
18 reinsurance program.

SENATE, No. 371  
STATE OF NEW JERSEY

INTRODUCED FEBRUARY 13, 1992

By Senators BASSANO and CARDINALE

1 AN ACT requiring certain health insurers, service corporations  
2 and health maintenance organizations to offer basic health  
3 benefits programs to certain employers and establishing a  
4 reinsurance program.

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

8 1. As used in this act:

9 "Actuarial certification" means a written statement by a  
10 member of the American Academy of Actuaries or other  
11 individual acceptable to the commissioner that a small employer  
12 carrier is in compliance with the provisions of section 3 of this  
13 act, based upon examination, including a review of the  
14 appropriate records and actuarial assumptions and methods used  
15 by the small employer carrier in establishing premium rates for  
16 applicable health benefits plans.

17 "Base premium rate" means the lowest premium rate charged  
18 by the small employer carrier for the same or similar coverage,  
19 which coverage is equivalent in value to a health benefits plan  
20 covering a small employer with similar case characteristics. The  
21 term "base premium rate" refers to rates for any health benefits  
22 plan covering one or more employees of a small employer.

23 "Basic health benefits plan" means a health benefits plan for  
24 small employers which provides benefits pursuant to paragraph (2)  
25 of subsection a. of section 3 and which is approved by the  
26 commissioner in accordance with the requirements of section 8 of  
27 this act.

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

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

42 "Case characteristics" means demographic or other objective  
43 characteristics of a small employer, as determined by a small  
44 employer carrier, which are considered by the small employer  
45 carrier in the determination of premium rates for the

1 small employer. For the purposes of this act, claim experience,  
2 health status, or duration of coverage since issue are not case  
3 characteristics.

4 "Commissioner" means the Commissioner of Insurance.

5 "Department" means the Department of Insurance.

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

9 "Eligible employee" means a full-time employee who works a  
10 normal work week of 30 or more hours. The term includes a sole  
11 proprietor, a partner of a partnership, or an independent  
12 contractor, if the sole proprietor, partner, or independent  
13 contractor is included as an employee under a health benefits  
14 plan of a small employer, but does not include employees who  
15 work less than 30 hours a week or work on a temporary or  
16 substitute basis.

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

23 "Health benefits plan" means any hospital and medical expense  
24 incurred policy; health, hospital, or medical service corporation  
25 contract; health maintenance organization subscriber contract; or  
26 plans provided by MEWAs offered by an employer subject to  
27 section 2 of this act. For purposes of this act, "health benefits  
28 plan" excludes the following plans, policies, or contracts:  
29 accident only, credit, disability, long-term care, coverage for  
30 Medicare services pursuant to a contract with the United States  
31 government, Medicare supplement, dental only or vision only  
32 issued as a supplement to liability insurance, coverage arising out  
33 of a workers' compensation or similar law, automobile medical  
34 payment insurance, or insurance under which benefits are payable  
35 with or without regard to fault and which is statutorily required  
36 to be contained in any liability insurance policy or equivalent  
37 self-insurance.

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

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

6 "MEWA" means any multiple employer welfare arrangement as  
7 defined in section 3 of the federal Employee Retirement and  
8 Income Security Act of 1974, Pub.L.93-406 (29 U.S.C. §1002),  
9 except for any such arrangement which is fully insured within the  
10 meaning of that act.

11 "Midpoint rate" means, for small employers with similar case  
12 characteristics as determined by the applicable small employer  
13 carrier for a rating period, the arithmetic average of the  
14 applicable base premium rate and the corresponding highest  
15 premium rate.

16 "Plan of operation" means the plan of operation of the program  
17 including articles, bylaws and operating rules, adopted by the  
18 board pursuant to section 8 of this act.

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

30 "Program" means the New Jersey Small Employer Health  
31 Reinsurance Program established pursuant to section 8 of this act.

32 "Small employer" means any person, firm, corporation,  
33 partnership, or association actively engaged in business which, on  
34 at least 50 percent of its working days during the preceding  
35 calendar year quarter, employed no more than 25 eligible  
36 employees, the majority of whom are employed within the State  
37 of New Jersey. In determining the number of eligible employees,  
38 companies which are affiliated companies shall be considered one  
39 employer, subsequent to the issuance of a health benefits plan to  
40 a small employer pursuant to the provisions of this act, and for  
41 the purpose of determining eligibility, the size of a small  
42 employer shall be determined annually. Except as otherwise  
43 specifically provided, provisions of this act which apply to a small  
44 employer shall continue to apply until the anniversary date next  
45 of the health benefits plan following the date the employer no  
46 longer meets the definition of a small employer.

47 "Section 6 carrier" means a small employer carrier electing to  
48 comply with the requirements set forth in section 6 of this act.

49 "Section 7 carrier" means a small employer carrier electing to  
50 comply with the requirements set forth in section 7 of this act.

51 "Small employer carrier" means any carrier or MEWA that  
52 offers health benefits plans covering eligible employees of one or  
53 more small employers.

54 "Small employer health benefits plan" means a health benefits

1 plan for small employers, approved by the commissioner pursuant  
2 to subsection b. of section 8 of this act.

3 2. a. Any individual or group health benefits plan that  
4 provides health care benefits covering one or more employees of  
5 a small employer shall be subject to the provisions of this act if  
6 any one of the following conditions exist:

7 (1) any portion of the premium or benefits is paid by a small  
8 employer or any covered individual is reimbursed, whether  
9 through wage adjustments or otherwise, by a small employer for  
10 any portion of the premium; or

11 (2) the health benefits plan is treated by the employer or any  
12 of the covered individuals as part of a plan or program for the  
13 purposes of section 106 or 162 of the Internal Revenue Code of  
14 1986.

15 b. The provisions of N.J.S.17B:26-1, section 27 of P.L.1985,  
16 c.236 (C.17:48E-27) and section 3 of P.L.1973, c.337 (C.26:2J-3),  
17 shall not apply to individual health insurance policies, contracts  
18 or health maintenance organization enrollment subject to the  
19 provisions of this act.

20 c. Except as expressly provided for in this act, no law  
21 requiring the coverage of a health care service or benefit and no  
22 law requiring the reimbursement, utilization or consideration of a  
23 specific category of licensed health care practitioner shall apply  
24 to any basic health benefits plan offered or delivered to a small  
25 employer.

26 3. a. (1) Within 90 days after the commissioner's approval of  
27 the basic health benefits plans and small employer health benefits  
28 plans, pursuant to subsection b. of section 8 of this act, every  
29 small employer carrier shall, as a condition of transacting  
30 business in this State with small employers, offer to small  
31 employers at least two health benefits plans. One plan to be  
32 offered by each small employer carrier shall be a basic health  
33 benefits plan, and one plan shall be a small employer health  
34 benefits plan. Every small employer which elects to be covered  
35 under either one of these plans and agrees to make the required  
36 premium payments and to satisfy the other provisions of the  
37 elected plan shall be issued such a plan by the small employer  
38 carrier. The premium payment requirements utilized in  
39 connection with basic and small employer health benefits plans  
40 may address the potential credit risk of small employers which  
41 elect coverage in accordance with this subsection by means of  
42 payment security provisions which are reasonably related to the  
43 risk and are uniformly applied.

44 (2) A basic health benefits plan shall provide:

45 (a) Basic hospital expense coverage for a period of 21 days in a  
46 benefit year for each covered person for expenses incurred for  
47 medically necessary treatment and services rendered as a result  
48 of injury or sickness, including:

49 (i) Daily hospital room and board, including general nursing  
50 care and special diets;

51 (ii) Miscellaneous hospital services, including expenses  
52 incurred for charges made by the hospital for services and  
53 supplies which are customarily rendered by the hospital and  
54 provided for use only during any period of confinement;

1 (iii) Hospital out-patient services consisting of hospital  
2 services on the day surgery is performed; hospital services  
3 rendered within 72 hours after accidental injury; and x-ray and  
4 laboratory tests to the extent that benefits for such services  
5 would have been provided if rendered to an inpatient of the  
6 hospital;

7 (b) Basic medical-surgical expense coverage for each covered  
8 person for expenses incurred for the medically necessary services  
9 for treatment of injury or sickness for the following:

10 (i) Surgical services;

11 (ii) Anesthesia services consisting of administration of  
12 necessary general anesthesia and related procedures in  
13 connection with covered surgical services rendered by a physician  
14 other than the physician performing the surgical services;

15 (iii) In-hospital services rendered to a person who is confined  
16 to a hospital for treatment of injury or sickness other than that  
17 for which surgical care is required;

18 (c) Maternity benefits, including cost of delivery and pre-natal  
19 care;

20 (d) Out-of-hospital physical examinations, including related  
21 x-rays, immunizations and diagnostic tests, on the following basis:

22 (i) For covered minors of less than two years of age or older,  
23 up to six examinations during the first two years of life; for  
24 covered minors of two years of age or older, one examination at  
25 age 3, 6, 9, 12, 15 and 18 years;

26 (ii) For covered adults of less than 40 years of age, one  
27 examination every five years; for covered adults 40 years of age  
28 or older but less than 60 years of age, one examination every  
29 three years; and for covered adults 60 years of age or older, one  
30 examination every two years.

31 Notwithstanding the provisions of this section to the contrary,  
32 a small employer carrier may provide benefits or services  
33 alternate to those required by this subsection if they are  
34 approved by the commissioner and are within the intent of this  
35 act or if the board, subject to the approval of the commissioner,  
36 changes the benefits included in the basic health benefits plan.

37 (3) (a) No person who is eligible for coverage under Medicare  
38 pursuant to Pub. L. 89-97 (42 U.S.C. §1395 et seq.) shall be a  
39 covered person under a contract required to be offered pursuant  
40 to this section.

41 (b) A small employer carrier shall not sell a contract required  
42 to be offered pursuant to paragraph (2) of subsection a. of this  
43 section to a group which was covered by a health benefits plan  
44 any time during the 12-month period immediately preceding the  
45 effective date of coverage.

46 (4) (a) Plans required to be offered pursuant to paragraph (2)  
47 of subsection a. of this section may contain or provide for  
48 coinsurance or deductibles, or both, except that no deductible  
49 shall be payable in excess of a total of \$250 by an individual or  
50 family unit during any benefit year; no coinsurance shall be  
51 payable in excess of a total of \$500 by an individual or family  
52 unit during any benefit year; and neither coinsurance nor  
53 deductibles shall apply to maternity benefits or physical  
54 examinations covered pursuant to subparagraph (c) or (d) of

1 paragraph (2) of this subsection a.  
2 (b) Managed care systems may be utilized for coverages  
3 required to be offered pursuant to this section, subject to the  
4 review and approval of the commissioner.  
5 (5) Subject to the approval of the commissioner, any health  
6 maintenance organization which is a qualified health maintenance  
7 organization pursuant to subchapter XI of Pub.L. 93-222 (42  
8 U.S.C. §300e et seq.) shall be permitted to alter the basic health  
9 benefits plan coverage to the extent it is necessary to comply  
10 with the provisions of subchapter XI of Pub.L. 93-222 (42 U.S.C.  
11 §300e et seq.).  
12 b. Health benefits plans covering small employers shall be  
13 subject to the following provisions:  
14 (1) Except as provided in paragraph (4) of this subsection, a  
15 preexisting condition provision shall not exclude coverage for an  
16 eligible employee or dependent for a period beyond 180 days  
17 following the effective date of coverage of an eligible employee  
18 and may only relate to conditions manifesting themselves during  
19 the six months immediately preceding the effective date of  
20 coverage in such a manner as would cause an ordinarily prudent  
21 person to seek medical advice, diagnosis, care or treatment or for  
22 which medical advice, diagnosis, care, or treatment was  
23 recommended or received during the six months immediately  
24 preceding the effective date of coverage, or as to a pregnancy  
25 existing on the effective date of coverage.  
26 (2) In determining whether a preexisting condition provision  
27 applies to an eligible employee or dependent, all health benefits  
28 plans shall credit the time that person was covered under a  
29 previous employer based health benefits plan if the previous  
30 coverage was continuous to a date not more than 90 days prior to  
31 the effective date of the new coverage, exclusive of any  
32 applicable waiting period under such plan.  
33 (3) Any health benefits plan subject to this act shall be  
34 renewable with respect to all eligible employees or dependents at  
35 the option of the policyholder, contract holder or employer  
36 except under the following circumstances:  
37 (a) nonpayment of the required premiums by the policyholder,  
38 contract holder, or employer;  
39 (b) fraud or misrepresentation of the policyholder, contract  
40 holder or employer or, with respect to coverage of eligible  
41 employees or dependents, the enrollees or their representatives;  
42 (c) the number of employees covered under the health benefits  
43 plan is less than the number or percentage of employees required  
44 by participation requirements under the health benefits plan;  
45 (d) noncompliance with the carrier's employee contribution  
46 requirement; or  
47 (e) the small employer carrier ceases doing business in the  
48 small employer market, if the following conditions are satisfied:  
49 (i) a notice of the decision to cease doing business in the small  
50 employer market is provided to the commissioner and either the  
51 policyholder, contract holder, or employer;  
52 (ii) the health benefits plans subject to this act shall not be  
53 canceled for six months after the date of the required notice, and  
54 for that small employer business of a small employer carrier

1 which remains in force, the small employer carrier that ceases to  
2 write new business in the small employer market shall continue to  
3 be governed by this act with respect to business conducted under  
4 this act; and

5 (iii) a small employer carrier that ceases to do business in the  
6 small employer market in this State after the passage of this act  
7 shall be prohibited from writing new business in the small  
8 employer market for a period of five years from the date of  
9 notice to the commissioner.

10 In the case of a health maintenance organization that ceases  
11 doing business in the small employer market in one service area  
12 of the State, the rules set forth in this subsection shall apply to  
13 the health maintenance organization's operations in that service  
14 area.

15 (4) In providing coverage to late enrollees, small employer  
16 carriers may exclude a late enrollee for 18 months,  
17 notwithstanding paragraphs (1) and (2) of this subsection, or  
18 provide coverage subject to an 18-month preexisting condition  
19 exclusion, provided that if both a period of exclusion from  
20 coverage as a late enrollee and a preexisting condition exclusion  
21 are applicable to a late enrollee, the combined period shall not  
22 exceed 18 months. Except in the case of a late enrollee, the  
23 health benefits plan shall provide coverage to all eligible  
24 employees and dependents who the small employer has indicated  
25 to the small employer carrier are to be covered and may not  
26 exclude any eligible employee or dependent who would otherwise  
27 be covered under the health benefits plan on the basis of an  
28 actual or expected health condition of that person.

29 (5) In cases in which a small employer carrier requires a  
30 specified minimum participation of eligible employees, or a  
31 minimum employer contribution, in determining whether to  
32 accept a small employer group, the same participation  
33 requirement or minimum employer contribution requirement shall  
34 be applied uniformly among all small employer groups with the  
35 same number of eligible employees applying for coverage or  
36 receiving coverage from the small employer carrier and a small  
37 employer carrier shall only vary application of minimum  
38 participation or minimum employer contribution requirements by  
39 the size of the small employer group.

40 (6) (a) With respect to any health benefits plan of a small  
41 employer carrier newly issued after the effective date of this  
42 act, the premium rates charged or offered for a rating period for  
43 the same or similar coverage, which is equivalent in value to a  
44 health benefits plan covering any small employer with similar  
45 case characteristics as determined by the small employer carrier,  
46 shall not vary from the applicable midpoint rate by more than  
47 12.5% of the average midpoint rate of health benefits plans  
48 issued on or after the effective date of this act.

49 (b) No increase in premium rates for a new rating period of  
50 any health benefits plan issued or renewed to a small employer,  
51 adjusted on a pro rata basis for rating periods of more or less  
52 than one year, may exceed the sum of any percentage change in  
53 the base premium rate measured from the first day of the prior  
54 rating period to the first day of the new rating period plus 15%,

1 adjusted on a pro rata basis for rating periods greater or lesser  
2 than one year, of the base premium rate for such new rating  
3 period and any adjustment due to change in coverage of the small  
4 employer or to change in case characteristics as determined by  
5 the small employer carrier.

6 (c) In any case where a small employer carrier utilizes industry  
7 as a case characteristic in establishing premium rates, the rate  
8 factor associated with any industry classification shall not vary  
9 from the arithmetic average of the rate factors associated with  
10 all industry classifications by more than 15% of that average.

11 (d) Any adjustment in rates charged by a small employer  
12 carrier electing to be a section 7 carrier caused by reinsurance is  
13 subject to the rating limitations set forth in this section.

14 (7) In connection with the offering for sale of any health  
15 benefits plan to a small employer, each small employer carrier  
16 shall make a reasonable disclosure, as a part of its solicitation  
17 and sales materials, of the following:

18 (a) the extent to which premium rates for a specified small  
19 employer are established or adjusted based upon the actual or  
20 expected variation in claims costs or actual or expected variation  
21 in health condition of the employees and dependents of the small  
22 employer;

23 (b) the provisions concerning the small employer carrier's  
24 right to change premium rates and the factors, other than claim  
25 experience, health status, or duration of coverage, since issue,  
26 which affect changes in premium rates; and

27 (c) provisions relating to renewability of policies and contracts.

28 (8) (a) Each small employer carrier shall maintain at its  
29 principal place of business a complete and detailed description of  
30 its rating practices and renewal underwriting practices, including  
31 information and documentation which demonstrate that its rating  
32 methods and practices are based upon commonly accepted  
33 actuarial assumptions and are in accordance with sound actuarial  
34 principles.

35 (b) Each small employer carrier shall file each March 1 with  
36 the commissioner an actuarial certification that the carrier is in  
37 compliance with this act and that the rating methods of the small  
38 employer carrier are actuarially sound. A copy of such  
39 certification shall be retained by the small employer carrier at  
40 its principal place of business.

41 (c) A small employer carrier shall make the information and  
42 documentation described in subparagraph (a) of this paragraph  
43 available to the commissioner upon request. Except in cases of  
44 violations of this act, the information shall be considered  
45 proprietary and trade secret information and shall not be subject  
46 to disclosure by the commissioner to persons outside of the  
47 department except as agreed to by the small employer carrier or  
48 as ordered by a court of competent jurisdiction.

49 c. (1) No health maintenance organization, operating as either  
50 a section 6 carrier or section 7 carrier, shall be required to offer  
51 coverage or accept applications pursuant to subsection a. of this  
52 section to a small employer, if the small employer is not  
53 physically located in the health maintenance organization's  
54 approved service area, or to an employee when the employee does

1 not work or reside within a service area, or if the health  
2 maintenance organization reasonably anticipates and  
3 demonstrates to the satisfaction of the commissioner that it will  
4 not have the capacity in its network of providers within the  
5 service area to deliver service adequately to the members of such  
6 groups because of its obligations to existing group contract  
7 holders and enrollees.

8 (2) A health maintenance organization that refuses to offer  
9 coverage pursuant to paragraph (1) of this subsection may not  
10 offer coverage in the applicable service area to new employer  
11 groups with more than 25 eligible employees or small employer  
12 groups until the later of 180 days following each such refusal or  
13 the date on which the carrier notifies the commissioner that it  
14 has regained capacity to deliver services to small employer  
15 groups in the applicable service area.

16 d. A small employer carrier shall not be required to offer  
17 coverage or accept applications pursuant to subsection a. of this  
18 section where the commissioner finds that the acceptance of an  
19 application or applications would place the small employer  
20 carrier in a financially impaired condition. If, upon the  
21 determination of the commissioner that the acceptance of  
22 applications pursuant to subsection a. of this section would not  
23 place this small employer carrier in a financially impaired  
24 condition, the small employer carrier shall offer such coverage.

25 e. The provisions of paragraphs (1), (3), (5), (6), (7), and (8) of  
26 subsection b. shall apply to health benefits plans delivered, issued  
27 for delivery, renewed, or continued on or after the effective date  
28 of this act. The provisions of subsections a., c. and d., and  
29 paragraphs (2) and (4) of subsection b. of this section shall apply  
30 to all health benefits plans delivered, issued for delivery, renewed  
31 or continued in this State on or after the date the program  
32 becomes operational, as designated by the commissioner. For  
33 purposes of this subsection, the date a health benefits plan is  
34 continued shall be the anniversary date of the issuance of the  
35 health benefits plan.

36 4. a. Every health benefits plan delivered, issued, renewed, or  
37 continued on or after the effective date of this act shall offer  
38 continued coverage under the plan to any employee whose  
39 employment was terminated for a reason other than gross  
40 misconduct or to any employee whose hours of employment were  
41 reduced to less than 30. The employee shall make a written  
42 election for continued coverage within 30 days of a qualifying  
43 event. For purposes of this section, "qualifying event" means the  
44 date of termination of employment, or the date on which an  
45 employee's hours of employment are reduced to less than 30.  
46 For purposes of this section, the date on which a health benefits  
47 plan is continued shall be the anniversary date of the issuance of  
48 the plan.

49 b. The continued coverage shall consist of coverage which is  
50 identical to the coverage provided under the health benefits plan  
51 to similarly situated beneficiaries whose coverage has not been  
52 terminated. If coverage is modified under the health benefits  
53 plan for any group of similarly situated beneficiaries, this  
54 coverage shall also be modified in the same manner for all

1 individuals who are qualified beneficiaries under this section for  
2 continued coverage. Coverage may not be conditioned upon, or  
3 discriminate on the basis of, lack of evidence of insurability.

4 c. The health benefits plan may require payment of a premium  
5 by the employee for any period of continuation coverage, except  
6 that the premium shall not exceed 102 percent of the applicable  
7 premium paid for similarly situated beneficiaries under the health  
8 benefits plan for a specified period, and may, at the election of  
9 the payor, be made in monthly installments. No premium  
10 payment shall be due before the 30th day after the day on which  
11 the covered employee made the initial election for continued  
12 coverage.

13 d. Continued coverage pursuant to this section shall continue  
14 until the earlier of the following:

15 (1) The date on which the employer under whose health  
16 benefits plan coverage is continued ceases to provide any health  
17 benefits plan to any employee or other qualified beneficiary;

18 (2) The date on which the continued coverage ceases under the  
19 health benefits plan by reason of a failure to make timely  
20 payment of any premium required under the plan with respect to  
21 the qualified beneficiary. The payment of any premium shall be  
22 considered to be timely if made within 30 days after the due date  
23 or within such longer period as applies to or under the health  
24 benefits plan; or

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

27 (i) covered under any other health benefits plan, as an  
28 employee or otherwise, which does not contain a provision which  
29 limits or excludes coverage with respect to any preexisting  
30 condition of a covered employee or any spouse or dependent who  
31 is included under the coverage provided the covered employee; or

32 (ii) eligible for benefits under title XVIII of the Social Security  
33 Act, Pub.L. 89-97 (42 U.S.C. §1395 et seq.).

34 e. (1) Plan administrators shall provide written notice of  
35 health benefits continuation coverage rights to employees at the  
36 commencement of coverage under the plan. A qualified  
37 beneficiary may elect continuation coverage no later than 30  
38 days after the qualifying event. For purposes of this section,  
39 "qualified beneficiary" means any person covered under a group  
40 policy.

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

45 (3) In no event shall the continuation of coverage provided  
46 pursuant to this section exceed 12 months from the qualifying  
47 event.

48 5. a. Each small employer carrier shall elect to become either  
49 a section 6 carrier and comply with the requirements set forth in  
50 section 6 of this act, or become a section 7 carrier and comply  
51 with the requirements set forth in section 7 of this act. The  
52 election shall be effective for periods of five years, except that  
53 the initial election shall be made within 30 days of the effective  
54 date of this act and shall be made for a two-year period. The

1 commissioner may permit a carrier to modify its election during  
2 the five-year period for good cause.

3 b. A small employer carrier which elects to cease  
4 participating as a section 7 carrier and elects to become a  
5 section 6 carrier, shall be prohibited from reinsuring or  
6 continuing to reinsure any small employer health benefits plans  
7 pursuant to sections 7 and 8 of this act as soon as the carrier  
8 becomes a section 6 carrier. However, a section 7 carrier  
9 electing to become a section 6 carrier shall pay a prorated  
10 assessment based upon business issued as a section 7 carrier for  
11 any portion of the year that the business was reinsured. A small  
12 employer carrier which elects to cease participating as a section  
13 6 carrier and elects to become a section 7 carrier shall be  
14 permitted to reinsure small employer health benefits plans under  
15 the terms set forth in section 8 of this act.

16 c. In connection with the elections made in accordance with  
17 subsections a. and b. of this section, the board shall establish a  
18 committee known as the Small Group Carriers Elections  
19 Evaluation Committee, which shall be charged with assuring that  
20 the requirements of this act to provide health benefits plans for  
21 small employers without regard to the health status of employees  
22 and dependents of small employers are satisfied, and that small  
23 employer carriers are assuming a share of high risk small  
24 employer groups that is proportionate to their market share of  
25 small employer health benefits plan business, regardless of  
26 whether the carriers elect to become section 6 carriers or section  
27 7 carriers. Membership on the Small Group Carriers Elections  
28 Evaluation Committee shall be approved by the commissioner,  
29 who shall assure that section 6 carriers and section 7 carriers are  
30 fairly represented. In carrying out its responsibilities, the  
31 committee may require small employer carriers to file reports or  
32 otherwise provide information to the committee which it feels  
33 may be necessary to carry out its responsibilities under this  
34 section including, but not limited to, reports as to the number of  
35 basic and small employer health benefits plans issued or covered  
36 during designated periods in total and categorized by the number  
37 of employees, and the case characteristics and claim experience  
38 of the small employers covered under health benefits plans and  
39 may request that the commissioner establish an audit team to  
40 examine whether small employer carriers are complying with the  
41 provisions of this act. Annually, by June 30 of each year, the  
42 committee shall make findings and recommendations for action,  
43 if any, in accordance with its charge pursuant to this subsection,  
44 with respect to each prior calendar year in which elections under  
45 subsection a. of this section are in effect. The findings and  
46 recommendations for action by the committee, together with any  
47 recommendations of the board, shall be filed by the board with  
48 the commissioner within 30 days of receipt of the findings and  
49 recommendations from the committee. The findings and  
50 recommendations for action shall be subject to approval by the  
51 commissioner who may, upon request of any affected section 6  
52 carrier or section 7 carrier, call a hearing with respect to the  
53 action.

54 d. Any section 6 carrier that has violated any provision of this

1 act shall immediately cease being a section 6 carrier and shall  
2 become a section 7 carrier and shall be required to make a  
3 retroactive assessment pursuant to section 8 of this act. Any  
4 section 7 carrier found in violation of this act shall be assessed a  
5 penalty, as determined by the commissioner.

6 6. a. Any small employer carrier may become a section 6  
7 carrier if the small employer carrier notifies the board in writing  
8 and obtains approval from the commissioner to become a section  
9 6 carrier, following a hearing.

10 b. In determining whether to approve a request for election to  
11 become a section 6 carrier, the commissioner shall consider the  
12 market share of the small employer carrier seeking approval to  
13 become a section 6 carrier, the surplus of that small employer  
14 carrier, the ability of the small employer carrier to offer and  
15 maintain open enrollment, the commitment of the small employer  
16 carrier to market to all small employers in the State or its entire  
17 service area, as applicable, and the small employer carrier's  
18 ability to completely assume the risk of accepting all small  
19 employer groups that apply for coverage pursuant to section 3.

20 7. Small employer carriers electing to become section 7  
21 carriers shall comply with the requirements set forth in section 3  
22 and shall be permitted to reinsure health benefits plans sold to  
23 small employers in the manner set forth in section 8.

24 8. a. (1) There is created a nonprofit entity to be known as  
25 the New Jersey Small Employer Health Reinsurance Program.  
26 All carriers issuing health benefits plans in this State and MEWAs  
27 providing health benefits plans in this State on or after the  
28 effective date of this act shall be members of the program.

29 (2) Within 60 days of the effective date of this act, the  
30 commissioner shall give notice to all members of the time and  
31 place for the initial organizational meeting, which shall take  
32 place within 120 days of the effective date. The members shall  
33 elect the initial board, subject to approval by the commissioner.  
34 The board shall consist of at least five and not more than 11  
35 representatives who shall serve staggered terms as determined by  
36 the program's plan of operation. To the extent possible, at least  
37 two thirds of the members of the board shall be small employer  
38 carriers. At least one member of the board shall be, to the  
39 extent there is such a carrier licensed in the State that is willing  
40 to have a representative serve on the board, a representative  
41 from each of the following entities:

42 (a) two carriers whose principal health insurance business is in  
43 the small employer market;

44 (b) a carrier whose principal health insurance business is in  
45 other than the small employer market;

46 (c) a health, hospital or medical service corporation;

47 (d) a health maintenance organization;

48 (e) a section 6 carrier;

49 (f) a section 7 carrier;

50 (g) a representative of small employers;

51 (h) the commissioner or his designee;

52 (i) the Commissioner of Health or his designee; and

53 (j) the Commissioner of Labor or his designee.

54 No one carrier or MEWA, including its affiliated companies,

1 shall hold a majority of the seats on the board. In approving the  
2 selection of the board, the commissioner shall assure that all  
3 members of the program are fairly represented.

4 (3) If the initial board is not elected at the organizational  
5 meeting, the commissioner shall appoint the initial board within  
6 15 days of the organizational meeting.

7 (4) Within 180 days after the election or appointment of the  
8 initial board, the board shall submit to the commissioner a plan of  
9 operation and thereafter any amendments to the plan necessary  
10 or suitable to assure the fair, reasonable, and equitable  
11 administration of the program. The commissioner shall, after  
12 notice and hearing, approve the plan of operation, provided the  
13 commissioner determines it to be suitable to assure the fair,  
14 reasonable, and equitable administration of the program, and  
15 provides for the sharing of program gains or losses on an  
16 equitable and proportionate basis in accordance with the  
17 provisions of subsection f. of this section. The plan of operation  
18 or amendments thereto shall become effective upon approval in  
19 writing by the commissioner, consistent with the date on which  
20 the coverage under this section shall be made available. Any plan  
21 of operation or amendments thereto submitted to the  
22 commissioner by the board pursuant to this subsection shall be  
23 deemed approved by the commissioner if not expressly  
24 disapproved in writing by the commissioner within 90 days of its  
25 receipt by the commissioner.

26 (5) If the board fails to submit a suitable plan of operation  
27 within 180 days after its appointment, the commissioner shall,  
28 after notice and hearing, adopt and promulgate a temporary plan  
29 of operation. The commissioner shall amend or rescind any plan  
30 adopted by him under this paragraph, at the time a plan of  
31 operation is submitted by the board and approved by him.

32 (6) The plan of operation shall establish procedures for, among  
33 other things:

34 (a) handling and accounting of assets and moneys of the  
35 program, and for an annual fiscal reporting to the commissioner;

36 (b) setting terms of office and filling vacancies on the board,  
37 subject to the approval of the commissioner;

38 (c) selecting an administering carrier and setting forth the  
39 powers and duties of the administering carrier;

40 (d) reinsuring risks in accordance with the provisions of this  
41 act;

42 (e) collecting assessments from all members to provide for  
43 claims reinsured by the program and for administrative expenses  
44 incurred or estimated to be incurred during the period for which  
45 the assessment is made; and

46 (f) any additional matters at the discretion of the board.

47 (7) The program shall have the general powers and authority  
48 granted under the laws of New Jersey to insurance companies and  
49 health maintenance organizations licensed or certified to  
50 transact business, except the power to issue health benefits plans  
51 directly to either groups or individuals, and, in addition, the  
52 program shall have the specific authority to:

53 (a) enter into contracts as are necessary or proper to carry out  
54 the provisions and purposes of this act, including the authority,

1 with the approval of the commissioner, to enter into contracts  
2 with similar programs of other states for the joint performance  
3 of common functions or with persons or other organizations for  
4 the performance of administrative functions;

5 (b) sue or be sued, including taking any legal actions necessary  
6 or proper for recovery of any assessments for, on behalf of, or  
7 against the program or any board members;

8 (c) take any legal action necessary to avoid the payment of  
9 improper claims against the program;

10 (d) define the array of basic and small employer health  
11 benefits plans for which reinsurance will be provided, and to issue  
12 reinsurance policies, in accordance with the requirements of this  
13 act;

14 (e) establish rules, conditions, and procedures pertaining to the  
15 reinsurance of members' risks by the program;

16 (f) establish appropriate rates, rate schedules, rate  
17 adjustments, rate classifications, and any other actuarial  
18 functions appropriate to the operation of the program in  
19 accordance with this act;

20 (g) assess members in accordance with the provisions of  
21 subsection f. of this section, and to make advance interim  
22 assessments, as may be reasonable and necessary for  
23 organizational and interim operating expenses. Any interim  
24 assessments shall be credited as offsets against any regular  
25 assessments due following the close of the fiscal year;

26 (h) appoint from among members appropriate legal, actuarial,  
27 and other committees as necessary to provide technical and other  
28 assistance in the operation of the program, policy and other  
29 contract design, and any other function within the authority of  
30 the program; and

31 (i) borrow money to effect the purposes of the program. Any  
32 notes or other evidence of indebtedness of the program not in  
33 default shall be legal investments for carriers and may be carried  
34 as admitted assets.

35 b. (1) Subject to approval by the commissioner, the board shall  
36 establish the form and level of coverages to be made available by  
37 small employer carriers in accordance with the provisions of  
38 section 3 of this act. The board shall establish benefit levels,  
39 cost sharing, exclusions and limitations for the basic health  
40 benefits plans and the small employer health benefits plans. The  
41 forms and levels of coverage established by the board shall define  
42 which components of a small employer health benefits plan may  
43 be reinsured. The coverage provided under a basic health  
44 benefits plan shall not exceed 80% of the actuarial value provided  
45 under a small employer health benefits plan. One basic health  
46 benefits plan and one small employer health benefits plan shall  
47 contain benefit and cost sharing levels which are consistent with  
48 the basic method of operation and the benefit plans of health  
49 maintenance organizations, including any restrictions imposed on  
50 federally qualified health maintenance organizations pursuant to  
51 subchapter XI of Pub.L. 93-222 (42 U.S.C. §300e et seq.). The  
52 board shall submit the plans to the commissioner for his approval  
53 within 180 days after the election or appointment of the board  
54 pursuant to paragraph (2) of subsection a. of this section. Any

1 plans submitted to the commissioner by the board shall be  
2 deemed approved by the commissioner if not expressly  
3 disapproved within 90 days of receipt by the commissioner.  
4 These plans may include cost containment measures such as, but  
5 not limited to: utilization review of health care services,  
6 including review of medical necessity of hospital and physician  
7 services; case management benefit alternatives; selective  
8 contracting with hospitals, physicians, and other health care  
9 providers; reasonable benefit differentials applicable to  
10 participating and nonparticipating providers; and other managed  
11 care provisions.

12 (2) After the commissioner's approval of basic health benefits  
13 plans and small employer health benefits plans submitted by the  
14 board pursuant to paragraph (1) of this subsection, and in lieu of  
15 any contrary procedure established by law, any small employer  
16 carrier may certify to the commissioner in the form and manner  
17 the commissioner prescribes, that the basic health benefits plans  
18 and the small employer health benefits plans filed by the carrier  
19 are in substantial compliance with the provisions in the  
20 corresponding board approved plans. Upon receipt by the  
21 commissioner of the certification, the carrier may use the  
22 certified plans until the commissioner, after notice and hearing,  
23 disapproves their continued use.

24 c. Any member which elects to be a section 7 carrier may  
25 reinsure with the program coverage of an eligible employee of a  
26 small employer, or any dependent of such an employee, subject to  
27 all of the following:

28 (1) In any case in which the coverage of any eligible employee  
29 of a small employer or any dependent of such employee is  
30 reinsured or in any case in which a member reinsures all the  
31 eligible employees and dependents of the small employer, with  
32 respect to a basic health benefits plan or a small employer health  
33 benefits plan, the program shall reinsure the level of coverage  
34 provided; and with respect to other plans, the program shall  
35 reinsure the level of coverage provided in a basic or small  
36 employer health benefits plan, up to, but not exceeding, the level  
37 of coverage provided under either a basic or a small employer  
38 health benefits plan.

39 (2) With respect to eligible employees, and their dependents,  
40 who are employed by the small employer as of the date the  
41 employer's coverage by the member commences and who enroll  
42 in a manner in which they are not considered to be late enrollees  
43 to the plan, coverage may be reinsured:

44 (a) within 60 days of the commencement of the employer's  
45 coverage with the small employer carrier; or

46 (b) thereafter on any third plan anniversary of the small  
47 employer's coverage having been issued or delivered.

48 (3) With respect to eligible employees and their dependents  
49 who are hired subsequent to the commencement of the  
50 employer's coverage by the member and who are not late  
51 enrollees to the plan, coverage may be reinsured:

52 (a) within 60 days of the commencement of their coverage  
53 under the plan; or

54 (b) thereafter, on any third year plan anniversary of the small

1 employer's coverage having been issued or delivered.

2 (4) With respect to eligible employees and their dependents,  
3 when a small employer carrier reinsures the entire employer  
4 group, coverage may be reinsured within 60 days of the  
5 commencement of the group's coverage under the plan; or  
6 commencing one year following the effective date of this act,  
7 once the small employer's coverage has been in effect with the  
8 small employer carrier for a period of three consecutive years; or  
9 thereafter on any third year plan anniversary of the small  
10 employer's coverage having been issued or delivered.

11 d. Except as provided in subsection e. of this section, premium  
12 rates charged by the program for coverage reinsured by the  
13 program shall be established as follows:

14 (1) 1.5 times the rate established by the program for that  
15 classification or group with similar case characteristics and  
16 coverage, with respect to the eligible employees and their  
17 dependents of a small employer, all of whose coverage is  
18 reinsured with the program.

19 (2) 5.0 times the rate established by the program for that  
20 classification or group with similar case characteristics and  
21 coverage, with respect to an eligible employee, or his dependents.

22 e. Premium rates charged for reinsurance by the program to a  
23 health maintenance organization that is approved by the United  
24 States Secretary of Health and Human Services as a federally  
25 qualified health maintenance organization pursuant to subchapter  
26 XI of Pub.L. 93-222 (42 U.S.C. §300e. et seq.), and as such is  
27 subject to requirements that limit the amount of risk that may be  
28 ceded to the program, shall be reduced to reflect the portion of  
29 the risk that may be ceded to the program.

30 f. (1) Following the close of each fiscal year of the  
31 administering carrier, the administering carrier shall determine  
32 the net premiums, the administrative expenses of the program,  
33 and the incurred losses, if any, for the year, taking into account  
34 investment income and other appropriate gains and losses.  
35 Health benefits plan premiums and benefits paid by a member  
36 that are less than an amount determined by the board to justify  
37 the cost of collection shall not be considered for purposes of  
38 determining assessments. For purposes of this section, "net  
39 premiums" means health benefits plan premiums, less  
40 administrative expense allowances, and health benefits plan  
41 premiums earned by MEWAs shall be established by adding paid  
42 health losses and administrative expenses of the MEWA.

43 (2) Any net loss for the year shall be recouped by assessments  
44 of members.

45 (a) Assessments shall first be apportioned by the board among  
46 all section 7 carrier members in proportion to their respective  
47 shares of the total health benefits plan premiums earned in this  
48 State from health benefits plans covering small employers during  
49 the calendar year coinciding with or ending during the fiscal year  
50 of the program, or on any other equitable basis reflecting  
51 coverage of small employers as may be provided in the plan of  
52 operation.

53 (b) If the net loss is not recouped before assessments totaling  
54 4% of the premiums from health benefits plans covering small

1 employers have been collected from section 7 carriers, additional  
2 assessments shall be apportioned by the board among all members  
3 in proportion to their respective shares of the total health  
4 benefits plan premiums earned in this State from all health  
5 benefits plans during the calendar year, provided that any section  
6 6 carrier shall receive a credit against this assessment to the  
7 extent the carrier can demonstrate its assumption of high risk  
8 small employer groups. Any section 6 carrier that demonstrates  
9 it has assumed a share of high risk small employer groups  
10 proportionate to its market share of small employer health  
11 benefits plan business shall receive a full credit for the  
12 assessment.

13 (3) If assessments exceed actual losses and administrative  
14 expenses of the program, the excess shall be held in an interest  
15 bearing account and used by the board to offset future losses or  
16 to reduce program premiums. As used in this paragraph, "future  
17 losses" includes reserves for incurred but not reported claims.

18 (4) Each member's proportion of the assessment shall be  
19 determined annually by the board based on annual statements and  
20 other reports deemed necessary by the board and filed by the  
21 member with the board. MEWAs shall report to the board claims  
22 payments made and administrative expenses incurred in this State  
23 on an annual basis on a form prescribed by the commissioner.

24 (5) Provision shall be made in the plan of operation for the  
25 imposition of an interest penalty for late payment of assessments.

26 (6) A member may seek, from the commissioner, a deferment  
27 in whole or in part, from any assessment issued by the board. The  
28 commissioner may defer, in whole or in part, the assessment of a  
29 member if, in the opinion of the commissioner, the payment of  
30 the assessment would endanger the ability of the member to  
31 fulfill its contractual obligations. In the event an assessment  
32 against a member is deferred in whole or in part, the amount by  
33 which the assessment is deferred may be assessed against the  
34 other members in a manner consistent with the basis for  
35 assessment set forth in this section. The member receiving such  
36 deferment shall remain liable to the program for the amount  
37 deferred and shall be prohibited from reinsuring any individuals or  
38 groups in the program if it fails to pay such assessments.

39 g. Neither the participation in the program as members, the  
40 establishment of rates, forms or procedures, nor any other joint  
41 or collective action required by this act shall be the basis of any  
42 legal action, criminal or civil liability, or penalty against the  
43 program or any of its members either jointly or separately except  
44 as otherwise provided in this act.

45 h. The program shall be exempt from any and all taxes.

46 9. The Commissioner of Insurance shall, pursuant to the  
47 provisions of the "Administrative Procedure Act," P.L.1968,  
48 c.410 (C.52:14B-1 et seq.), promulgate rules and regulations  
49 necessary to effectuate the provisions of this act.

50 10. This act shall be known and may be cited as the "Small  
51 Business Health Insurance Reform Act."

52 11. This act shall take effect on the 180th day after  
53 enactment, but sections 9 and 11 shall take effect immediately.

STATEMENT

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This bill provides for the establishment of small employer health benefits plans and requires all small employer carriers, including health insurers, HMOs, Blue Cross/Blue Shield of New Jersey, and multiple employer welfare arrangements (MEWAs) to offer these plans to employers with fewer than 25 employees as a condition of doing business with small employers in the State of New Jersey.

Under the provisions of the bill, any employer with 25 or fewer employees may apply to any carrier doing business in the small group market and be issued a plan of basic health care coverage.

The bill provides for the establishment of the New Jersey Small Employer Health Reinsurance Program and the creation of an eleven-member board to administer the program. The board would include representatives from the various sectors of the health insurance market and at least one member who is not from the insurance industry. The cost and risk of covering high-risk groups and individuals would be shared through this reinsurance mechanism. Small employer carriers may either reinsure high-risk individuals and groups with the reinsurance facility and be subject to assessments to offset the facility's losses, or they may internalize all risks and costs. The New Jersey Small Employer Health Reinsurance Program is designed to make coverage available for any small group wishing to purchase it, and to bring greater stability to the pricing and underwriting of small group coverage.

The bill also provides that individuals who change jobs would be protected from preexisting condition exclusions, if they have satisfied an exclusion under their prior plan. The time a person was subject to a preexisting condition exclusion under a previous plan would be credited toward a subsequent plan's exclusion period if the previous coverage was continuous to within 90 days of the effective date of the new coverage. Under the provisions of the bill, an individual with a preexisting condition could not be excluded from coverage for more than 180 days.

The coverage provided under the basic health benefits plan is substantially the same as the coverage required in basic health care contracts or policies pursuant to the "Health Care Cost Reduction Act," P.L.1991, c.187 (C. 26:2H-18.24 et al). The coverage provided under the basic health benefits plan may not exceed 80% of the actuarial value provided under a small employer health benefits plan.

The bill additionally provides an option for continuation of coverage under small employer health insurance plans which is similar to the continuation of coverage option provided under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) for group health insurance plans covering group sizes over 25. The continuation coverage option is applicable for individuals covered under small employer health insurance plans whose employment is terminated for other than gross misconduct or whose hours are reduced below 30 per week.

The bill provides for the setting of rate limitations and the guaranteeing of renewability.

- 1     **Cost containment measures provided under the bill include the**
- 2     **elimination of State-mandated benefits for the basic health**
- 3     **benefits plan and the use of managed care measures.**
- 4
- 5
- 6
- 7
- 8     **Requires certain insurers, service corporations and HMOs to offer**
- 9     **basic health insurance plans to small businesses; establishes a**
- 10    **reinsurance program.**

**SENATE HEALTH AND HUMAN SERVICES COMMITTEE**

**STATEMENT TO**

**SENATE COMMITTEE SUBSTITUTE FOR**

**SENATE, No. 371**

**STATE OF NEW JERSEY**

**DATED: JUNE 15, 1992**

The Senate Health and Human Services Committee reports favorably the Senate Committee Substitute for Senate Bill No. 371.

This substitute provides for the establishment of small employer health benefits plans and requires all small employer carriers, including health insurers, HMOs, Blue Cross/Blue Shield of New Jersey, and multiple employer welfare arrangements (MEWAs) to offer these plans to employers with at least two but no more than 49 employees as a condition of doing business with small employers in the State.

Under the provisions of the substitute, an employer with 49 or fewer employees may apply to any carrier doing business in the small group market to be issued a plan of health care coverage which provides either "Basic" health benefits or "Basic Plus" health benefits.

The substitute provides for the establishment of the New Jersey Small Employer Health Excess Reinsurance Program and the creation of an 11-member board to administer the program. The board would include seven representatives from the various sectors of the health insurance market and two persons representing small employers, as well as the Commissioners of Insurance and Health as ex officio members. The cost and risk of covering high-risk groups and individuals would be shared through this reinsurance mechanism. Small employer carriers may either reinsure high-risk individuals and groups with the reinsurance facility and be subject to assessments to offset the facility's losses, or they may internalize all risks and costs. However, the risk-assuming carriers may be subject to an assessment if the net loss of the reinsurance program is not recouped before assessments totaling 4% of aggregate premiums for small business health care plans have been collected from reinsuring carriers.

The New Jersey Small Employer Health Excess Reinsurance Program is designed to make coverage available for any small group wishing to purchase it, and to bring greater stability to the pricing and underwriting of small group coverage.

The substitute also provides that individuals who change jobs would be protected from preexisting condition exclusions, if they have satisfied an exclusion under their prior plan. The time a person was subject to a preexisting condition exclusion under a previous plan would be credited toward a subsequent plan's exclusion period if the previous coverage was continuous to within 90 days of the effective date of the new coverage. Under the provisions of the substitute, an individual with a preexisting condition could not be excluded from coverage for more than 180 days.

The coverage provided under the "Basic" health benefits plan is substantially the same as the coverage required in basic health care contracts or policies pursuant to the "Health Care Cost Reduction Act," P.L.1991, c.187 (C.26:2H-18.24 et al).

The substitute additionally provides an option for continuation of coverage under small employer health insurance plans which is similar to the continuation of coverage option provided under the "Consolidated Omnibus Budget Reconciliation Act of 1985" (COBRA) for group health insurance plans covering group sizes over 25. The continuation coverage option is applicable for individuals covered under small employer health insurance plans whose employment is terminated for other than gross misconduct or whose hours are reduced below 30 per week.

The substitute provides that rate differentials for any small group carrier may be based only on the factors of age, gender and geography, and that the rate charged to any group cannot exceed four times the base premium rate charged to the lowest-rated small employer group written by the carrier for a like benefit plan.

Finally, the substitute guarantees the renewability of the group health benefits plan to any small employer who pays the required premium and satisfies the other requirements of the substitute.

SENATE COMMITTEE SUBSTITUTE FOR  
SENATE, No. 371

STATE OF NEW JERSEY

ADOPTED JUNE 15, 1992

Sponsored by Senator BASSANO

1 AN ACT requiring certain health insurers, service corporations  
2 and health maintenance organizations to offer basic health  
3 benefits programs to certain employers and establishing a  
4 reinsurance program.

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

8 1. As used in this act:

9 "Actuarial certification" means a written statement by a  
10 member of the American Academy of Actuaries or other  
11 individual acceptable to the commissioner that a small employer  
12 carrier is in compliance with the provisions of section 12 of this  
13 act, based upon examination, including a review of the  
14 appropriate records and actuarial assumptions and methods used  
15 by the small employer carrier in establishing premium rates for  
16 applicable health benefits plans.

17 "Base premium rate" means the lowest premium rate charged  
18 by the small employer carrier for the same or similar coverage,  
19 which coverage is equivalent in value to a health benefits plan  
20 covering a small employer. The term "base premium rate" refers  
21 to rates for any health benefits plan covering two or more  
22 employees of a small employer.

23 "Basic health benefits plan" means a health benefits plan for  
24 small employers which provides benefits pursuant to section 4 of  
25 this act and which is filed with the commissioner in accordance  
26 with the requirements of section 24 of this act, any portion of the  
27 premium for which is paid by a small employer or for which any  
28 covered individual is reimbursed whether through wage  
29 adjustments or otherwise, if the health benefits plan is treated by  
30 the employer or any of the covered individuals as part of a plan  
31 or program for the purposes of section 162 or section 106 of the  
32 Internal Revenue Code of 1986 (28 U.S.C. 162 or 26 U.S.C. 106).

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

34 "Carrier" means any insurance company, health service  
35 corporation, hospital service corporation, medical service  
36 corporation, health maintenance organization or MEWA  
37 authorized to issue health benefits plans in this State. For  
38 purposes of this act, carriers that are affiliated companies shall  
39 be treated as one carrier, except that any insurance company,  
40 health service corporation, hospital service corporation, or  
41 medical service corporation that is an affiliate of a health  
42 maintenance organization located in New Jersey or any health  
43 maintenance organization located in New Jersey that is affiliated  
44 with an insurance company, health service corporation, hospital  
45 service corporation, or medical service corporation shall treat

1 the health maintenance organization as a separate carrier.

2 "Commissioner" means the Commissioner of Insurance.

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 30 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 30 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 policy; health, hospital, or medical service corporation  
23 contract; health maintenance organization subscriber contract; or  
24 plans provided by MEWAs offered by a small employer pursuant  
25 to section 4 of this act. For purposes of this act, "health benefits  
26 plan" excludes the following plans, policies, or contracts:  
27 accident only, credit, disability, long-term care, coverage for  
28 Medicare services pursuant to a contract with the United States  
29 government, Medicare supplement, dental only or vision only  
30 issued as a supplement to liability insurance, coverage arising out  
31 of a workers' compensation or similar law, automobile medical  
32 payment insurance, or insurance under which benefits are payable  
33 with or without regard to fault and which is statutorily required  
34 to be contained in any liability insurance policy or equivalent  
35 self-insurance.

36 "Late enrollee" means an eligible employee or dependent who  
37 requests enrollment in a health benefits plan of a small employer  
38 following the initial minimum 30-day enrollment period provided  
39 under the terms of the health benefits plan. An eligible employee  
40 or dependent shall not be considered a late enrollee if the  
41 individual was covered under another employer's health benefits  
42 plan at the time he was eligible to enroll and stated at the time  
43 of the initial enrollment that coverage under that other  
44 employer's health benefits plan was the reason for declining  
45 enrollment; has lost coverage under that other employer's health  
46 benefits plan as a result of termination of employment, the  
47 termination of the other plan's coverage, death of a spouse, or  
48 divorce; and the individual requests enrollment within 90 days  
49 after termination of coverage provided under another employer's  
50 health benefits plan; or if the individual is employed by an  
51 employer under a MEWA which offers multiple health benefits  
52 plans, and the individual elects a different plan during an open  
53 enrollment period; or if a court of competent jurisdiction has  
54 ordered coverage to be provided for a spouse or minor child under

1 a covered employee's health benefits plan and request for  
2 enrollment is made within 30 days after issuance of that court  
3 order.

4 "Member" means all carriers issuing health benefits plans and  
5 MEWAs providing health benefits plans in this State on or after  
6 the effective date of this act.

7 "MEWA" means any multiple employer welfare arrangement as  
8 defined in section 3 of the federal Employee Retirement and  
9 Income Security Act of 1974, Pub.L.93-406 (29 U.S.C. §1002),  
10 except for any such arrangement which is fully insured within the  
11 meaning of that act.

12 "Plan of operation" means the plan of operation of the program  
13 including articles, bylaws and operating rules approved pursuant  
14 to section 20 of this act.

15 "Preexisting condition provision" means a policy or contract  
16 provision that excludes coverage under that policy or contract for  
17 charges or expenses incurred during a specified period following  
18 the insured's effective date of coverage, for a condition that,  
19 during a specified period immediately preceding the effective  
20 date of coverage, had manifested itself in such a manner as would  
21 cause an ordinarily prudent person to seek medical advice,  
22 diagnosis, care or treatment, or for which medical advice,  
23 diagnosis, care or treatment was recommended or received as to  
24 that condition or as to pregnancy existing on the effective date  
25 of coverage.

26 "Program" means the New Jersey Small Employer Health  
27 Excess Reinsurance Program established pursuant to section 18 of  
28 this act.

29 "Reinsuring carrier" means a a small employer carrier electing  
30 to obtain excess insurance in accordance in section 26 of this  
31 act."

32 "Risk-assuming carrier" means a small employer carrier  
33 electing to assume risks pursuant to section 25 of this act."

34 "Small employer" means any person, firm, corporation,  
35 partnership, or association actively engaged in business which, on  
36 at least 50 percent of its working days during the preceding  
37 calendar year quarter, employed at least two but no more than 49  
38 eligible employees, the majority of whom are employed within  
39 the State of New Jersey. In determining the number of eligible  
40 employees, companies which are affiliated companies shall be  
41 considered one employer, subsequent to the issuance of a health  
42 benefits plan to a small employer pursuant to the provisions of  
43 this act, and for the purpose of determining eligibility, the size of  
44 a small employer shall be determined annually. Except as  
45 otherwise specifically provided, provisions of this act which apply  
46 to a small employer shall continue to apply until the anniversary  
47 date next of the health benefits plan following the date the  
48 employer no longer meets the definition of a small employer.

49 "Small employer carrier" means any carrier or MEWA that  
50 offers health benefits plans covering eligible employees of one or  
51 more small employers.

52 "Small employer health benefits plan" means a health benefits  
53 plan for small employers approved by the commissioner pursuant  
54 to section 23 of this act.

1       2. Every health insurer, health service corporation, medical  
2 service corporation, hospital service corporation, and health  
3 maintenance organization licensed or authorized to provide  
4 health benefits or services in this State which offers health  
5 insurance policies or coverages covering two or more employees  
6 of a small employer shall be subject to the provisions of this act.  
7 Coverage shall be offered to all eligible employees and their  
8 dependents and shall not exclude any employee or eligible  
9 dependent on the basis of an actual or expected health condition.

10       3. Notwithstanding the provisions of P.L.1991, c.187, every  
11 carrier subject to the provisions of this act shall, as a condition  
12 of transacting business in this State, offer to every small  
13 employer at least two health benefits plans. One plan shall be a  
14 Basic health benefits plan, as provided in section 4 of this act,  
15 and one shall be a Basic Plus health benefits plan, as provided in  
16 section 5 of this act. Initially, the offer shall be made within 90  
17 days of the filing with the commissioner of that carrier's  
18 benefits plans. Thereafter, the plans shall be available to small  
19 employers on a continuing basis. Every small employer which  
20 elects to be covered under either of the plans provided for under  
21 this act who pays the required premium therefor and who  
22 satisfies the other requirements of the plan shall be issued a  
23 policy or contract by the carrier. The carrier may establish a  
24 premium payment plan which provides installment payments and  
25 which may contain reasonable provisions to ensure payment  
26 security, provided that provisions to ensure payment security are  
27 reasonably related to the risk and are uniformly applied. Every  
28 plan shall be in conformance with the guidelines established  
29 pursuant to section 23 of this act, and each carrier's plans shall  
30 be certified and filed with the commissioner pursuant to section  
31 24 of this act.

32       4. A Basic health benefits plan shall provide:

33       a. Basic hospital expense coverage for a period of 21 days in  
34 each benefit year for each covered person for expenses incurred  
35 for medically necessary treatment and services rendered as a  
36 result of injury or sickness, including:

37       (1) Daily hospital room and board, including general nursing  
38 care and special diets;

39       (2) Miscellaneous hospital services, including expenses incurred  
40 for charges made by the hospital for services and supplies which  
41 are customarily rendered by the hospital and provided for use  
42 only during any period of confinement;

43       (3) Hospital outpatient services, including surgical and other  
44 services rendered on a day stay basis, hospital services rendered  
45 within 72 hours after accidental injury, and x-ray and other  
46 laboratory and other diagnostic tests to the extent that benefits  
47 for such services would be provided if rendered to an inpatient of  
48 the hospital;

49       b. Basic medical-surgical expense coverage for each covered  
50 person for expenses incurred for medically necessary services for  
51 the treatment of sickness or injury for the following:

52       (1) Surgical services;

53       (2) Anesthesia services, including the administration of  
54 necessary general anesthesia and related procedures in

1 connection with covered surgical services rendered by a physician  
2 other than the physician performing the surgical services;

3 (3) Inpatient hospital services rendered to a person who is  
4 confined to a hospital for treatment of sickness or injury other  
5 than that for which surgical care is required;

6 (4) Maternity benefits, including cost of delivery and pre-natal  
7 care;

8 c. Out-of-hospital physical examinations, including related  
9 x-rays, immunizations, and diagnostic tests, rendered on the  
10 following basis:

11 (1) For covered minors of less than two years of age, up to six  
12 examinations during the first two years of life;

13 (2) For covered minors of at least two years of age but not  
14 more than 18 years of age, no more than one physical  
15 examination at ages 3, 6, 9, 12, 15, and 18 years of age;

16 (3) For covered adults of at least 19 years of age but less than  
17 40 years of age, one physical examination every five years;

18 (4) For covered adults of at least 40 years of age but less than  
19 60 years of age, one examination every three years; and

20 (5) For covered adults of age 60 years or older, one  
21 examination every two years.

22 Every physical examination rendered pursuant to this  
23 subsection shall be subject to such co-payments and deductibles  
24 as are provided for in the plan.

25 d. The plan provided for herein may, subject to the approval of  
26 the commissioner, with respect to health maintenance  
27 organizations, be modified as necessary to comply with the  
28 provisions of subchapter XI of Pub.L.93-222 (42 U.S.C. §300e et  
29 seq.).

30 5. a. A Basic Plus health benefits plan shall provide the same  
31 benefits as the basic policy, as well as hospital and medical  
32 expense coverage in excess of the basic policy as established and  
33 modified by the board from time to time, and approved by the  
34 commissioner, but in no case shall benefits provided for in the  
35 Basic Plus coverage exceed an actuarial value which is 20%  
36 greater than the actuarial value of the basic coverage provided  
37 pursuant to section 4 of this act.

38 b. The benefits which may be provided in excess of the  
39 benefits in the basic plan may include, but shall not be limited to,  
40 additional inpatient hospital benefits, additional diagnostic tests,  
41 benefits directed toward the prevention of disease, provided that  
42 they are quantifiably cost effective, and additional medical and  
43 surgical expense benefits.

44 c. At the discretion of the board, the Basic Plus plan may  
45 provide for a selection of not more than three alternative benefit  
46 packages which may be selected by small employers according to  
47 the needs of their work force, provided however, that no  
48 combination of alternative benefits in addition to the basic  
49 benefits shall exceed the actuarial value established in subsection  
50 a. of this section.

51 6. a. Plans required to be offered pursuant to sections 4 or 5  
52 of this act shall be subject to coinsurance and deductibles, which  
53 may vary by selected portions of the coverage, except that no  
54 deductible applicable to any portion of the coverage shall exceed

1 \$250 for an individual or family unit during any benefit year, and  
2 no coinsurance applicable to any portion of the coverage shall  
3 exceed \$500 for an individual or family unit during any benefit  
4 year, unless provided by the board pursuant to section 23 of this  
5 act. Neither coinsurance nor deductibles shall be applicable to  
6 maternity benefits.

7 b. Except as provided herein, no law requiring the inclusion of  
8 any specified health care service or benefit and no law requiring  
9 the reimbursement, utilization, or consideration of a specific  
10 category of licensed health care practitioner shall apply to any  
11 Basic or Basic Plus health benefits plan provided for herein.

12 7. Coverage provided pursuant to this act shall be subject to  
13 standard coordination of benefits provisions for all persons  
14 covered under the policy or contract. Notwithstanding the  
15 provision of any other law to the contrary, coverage provided  
16 under policies or contracts issued pursuant to sections 4 or 5 of  
17 this act shall not extend to any injury for which coverage is  
18 available or applicable pursuant to section 4 of P.L.1972, c.70  
19 (C.39:6A-4), and the coverage provided by a policy or contract  
20 issued pursuant to this act shall not be used as a substitute for  
21 any insurance required to be maintained pursuant to section 4 of  
22 P.L.1972, c.70 (C.39:6A-4).

23 8. a. Except as otherwise provided by this act, a preexisting  
24 condition provision shall not exclude coverage for an eligible  
25 employee or dependent for a period beyond 180 days following the  
26 effective date of coverage of an eligible employee and may only  
27 relate to conditions manifesting themselves during the six months  
28 immediately preceding the effective date of coverage in such a  
29 manner as would cause an ordinarily prudent person to seek  
30 medical advice, diagnosis, care or treatment or for which medical  
31 advice, diagnosis, care, or treatment was recommended or  
32 received during the six months immediately preceding the  
33 effective date of coverage, or as to a pregnancy existing on the  
34 effective date of coverage.

35 b. In determining whether a preexisting condition provision  
36 applies to an eligible employee or dependent, all health benefits  
37 plans shall credit the time that person was covered under a  
38 previous employer based health benefits plan if the previous  
39 coverage was continuous to a date not more than 90 days prior to  
40 the effective date of the new coverage, exclusive of any  
41 applicable waiting period under such plan.

42 9. Every policy or contract issued to small employers in this  
43 State including, but not limited to, policies or contracts issued  
44 pursuant to the provisions of this act shall be renewable with  
45 respect to all eligible employees or dependents at the option of  
46 the policy or contract holder, or small employer except under the  
47 following circumstances:

48 a. Nonpayment of the required premiums by the policyholder,  
49 contract holder, or employer;

50 b. Fraud or misrepresentation of the policyholder, contract  
51 holder, or employer or, with respect to coverage of eligible  
52 employees or dependents, the enrollees or their representatives;

53 c. The number of employees covered under the health benefits  
54 plan is less than the number or percentage of employees required

1 by participation requirements under the health benefits policy or  
2 contract;

3 d. Noncompliance with a carrier's employment contribution  
4 requirements;

5 e. The carrier withdraws the policy form, with the approval of  
6 the commissioner, in which case the group shall be offered an  
7 alternative policy or contract by the carrier which offers  
8 comparable benefits;

9 f. Any carrier doing business pursuant to the provisions of this  
10 act ceases doing business in the small employer market, if the  
11 following conditions are satisfied:

12 (1) The carrier gives notice to cease doing business in the  
13 small employer market to the commissioner not later than eight  
14 months prior to the date of the planned withdrawal from the  
15 small group market, during which time the carrier shall continue  
16 to be governed by this act with respect to business written  
17 pursuant to this act; For the purposes of this subsection, "date of  
18 withdrawal" means the date upon which the first notice to small  
19 employers is sent by the carrier pursuant to paragraph (3) of this  
20 section;

21 (2) No later than two months following the date of the  
22 notification to the commissioner that the carrier intends to cease  
23 doing business in the small employer market, the carrier shall  
24 mail a notice to every small business employer insured by the  
25 carrier that the policy or contract of insurance will be  
26 terminated. This notice shall be sent by certified mail to the  
27 small business employer not less than six months in advance of  
28 the effective date of the cancellation date of the policy or  
29 contract;

30 (3) Any carrier that ceases to do business pursuant to this act  
31 shall be prohibited from writing new business in the small  
32 employer market for a period of five years from the date of  
33 notice to the commissioner.

34 10. Late enrollees may be excluded from coverage: a. for  
35 12 months for all coverage; or b. for 12 months for a preexisting  
36 condition. No combined period of total exclusion or exclusion for  
37 a preexisting condition shall exceed 12 months.

38 11. Any small employer carrier may require a reasonable  
39 specified minimum participation of eligible employees, which  
40 shall not exceed 75%, or reasonable minimum employer  
41 contributions in determining whether to accept a small group  
42 pursuant to this act. The standards so established by the carrier  
43 shall be first approved by the board and shall be applied uniformly  
44 to all small groups, except that in no event shall a carrier require  
45 an employer to contribute more than 10% to the annual cost of  
46 the policy or contract, or an amount as otherwise provided by the  
47 board, and any minimum participation standards established by  
48 the carrier shall be reasonable. In establishing the percentage of  
49 employee participation, a one-to-one credit shall be given for  
50 each employee covered by a spouse's health benefits coverage.

51 12. a. Rate differentials of any small group policies or  
52 contracts delivered, issued for delivery, or continued in this State  
53 may be based only on the factors of age, gender, and geography.  
54 No carrier shall issue any policy or contract in which the rates

1 charged to any group exceed four times the base premium rate  
2 charged to the lowest-rated small employer group written by the  
3 carrier for a like benefits plan.

4 b. In establishing the rating classifications provided for by  
5 subsection a. of this section, no carrier shall establish an excess  
6 of six rating territories, and no rating territory shall be any  
7 smaller than a county.

8 c. No rate classifications based on age shall provide for rate  
9 changes within any period which is less than five years. Age  
10 ranges, which shall be in five-year increments, shall be  
11 established by the commissioner by regulation and shall apply to  
12 all small group policies, whether or not written pursuant to  
13 sections 4 and 5 of this act.

14 d. The premium rates charged to any small employer for  
15 policies or contracts issued before the effective date of this act  
16 by any carrier shall, within three years of the effective date of  
17 this act, conform to subsection a. of this section. The four to one  
18 ratio established by subsection a. of this section shall be applied  
19 separately to each type of benefits plan issued by the carrier.

20 e. Notwithstanding the provisions of subsection d. of this  
21 section to the contrary, the provisions of subsection a. of this  
22 section shall be applied separately to policies or contracts: (1) in  
23 the case of any small employer contracts issued by a hospital  
24 service corporation or medical service corporation or any  
25 successor corporation which constitute a closed block of business  
26 as of September 1, 1991; or (2) in the case of any small employer  
27 policies issued under an open enrollment plan by any other health  
28 insurer which have not been offered for sale as of January 1, 1989.

29 f. Any premium charged for excess coverage for policies  
30 issued pursuant to sections 4 or 5 of this act shall be subject to  
31 the limitations provided for in this section.

32 g. Rating classifications established by carriers for small  
33 group policies or contracts shall not operate to produce rates for  
34 any small employer group which are excessive, inadequate, or  
35 unfairly discriminatory.

36 h. The provisions of this section shall apply to all small group  
37 business issued by any insurer in this State, whether or not  
38 written pursuant to section 4 or 5 of this act.

39 13. In connection with the offering for sale of any policy or  
40 contract to a small employer, each small employer carrier shall  
41 make a reasonable disclosure, as a part of its solicitation and  
42 sales materials, of the following:

43 a. The extent to which premium rates for a specified small  
44 employer are established or adjusted based upon the actual or  
45 expected variation in claims costs;

46 b. Any factors applicable to the policy or contract which are  
47 attributable to factors other than claim experience or duration of  
48 coverage, since issue, which affect changes in premium rates; and

49 c. Provisions relating to renewability of policies and contracts.

50 14. a. Every small employer carrier shall maintain at its  
51 principal place of business a complete and detailed description of  
52 its rating plan and underwriting practices, including renewal  
53 underwriting practices. Rating plans shall be based on commonly  
54 accepted actuarial assumptions and shall be in accordance with

1 sound actuarial principles. This information shall be available to  
2 the commissioner upon request. Except in cases of any violation  
3 of this act, the information provided for herein shall be  
4 considered proprietary and trade secret information and shall not  
5 be subject to disclosure by the commissioner to persons outside of  
6 the department except as agreed to by the small employer carrier  
7 or as ordered by a court of competent jurisdiction.

8 b. Every small employer carrier shall file no later than March  
9 1 each year following the effective date of this act, a  
10 certification signed by an actuary and attested by an officer of  
11 the insurer that the carrier is in compliance with the act and that  
12 the rating methods of the small employer are actuarially sound.  
13 A copy of the certification shall be retained by the small  
14 employer carrier at its principal place of business.

15 15. a. No health maintenance organization shall be required to  
16 offer coverage or accept applications pursuant to sections 4 or 5  
17 of this act to a small employer if the small employer is not  
18 physically located in the health maintenance organization's  
19 approved service area, to an employee when the employee does  
20 not work or reside within a service area, or if the health  
21 maintenance organization reasonably anticipates and  
22 demonstrates to the satisfaction of the commissioner that it will  
23 not have the capacity in its network of providers within the  
24 service area to deliver service adequately to the members of such  
25 groups because of its obligations to existing group contract  
26 holders and enrollees.

27 b. No small employer carrier shall be required to offer  
28 coverage or accept applications pursuant to this act for any  
29 period of time in which the commissioner determines that the  
30 requiring of the issuing of policies or contracts pursuant to this  
31 act would place the carrier in a financially impaired position.

32 16. The provisions of sections 4 and 5 of this act shall apply to  
33 Basic and Basic Plus health benefits plans subject to this act  
34 which are delivered, issued for delivery, renewed or continued on  
35 or after the effective date of this act.

36 17. a. Every policy or contract issued to a small employer in  
37 this State, including, but not limited to, policies or contracts  
38 which are subject to this act and which are delivered, issued,  
39 renewed, or continued on or after the effective date of this act,  
40 shall offer continued coverage under the plan to any employee  
41 whose employment was terminated for a reason other than for  
42 cause and to any employee covered by such plan whose hours of  
43 employment were reduced to less than 30 subsequent to the  
44 effective date of coverage for that employee. The employee  
45 shall make a written election for continued coverage within  
46 30 days of a qualifying event. For the purposes of this section,  
47 "qualifying event" shall mean the date of termination of  
48 employment, or the date on which a reduction in an employee's  
49 hours of employment becomes effective. For the purposes of this  
50 section, the date on which a health benefits plan is continued  
51 shall be the anniversary date of the issuance of the plan.

52 b. Coverage continued pursuant to subsection a. of this section  
53 shall consist of coverage which is identical to the coverage  
54 provided under the policy or contract to similarly situated

1 beneficiaries whose coverage has not been terminated or hours of  
2 employment reduced. If coverage is modified under the policy or  
3 contract for any group of similarly situated beneficiaries, this  
4 coverage shall also be modified in the same manner for persons  
5 who are qualified beneficiaries entitled pursuant to subsection a.  
6 of this section to continued coverage. Continuation of coverage  
7 may not be conditioned upon, or discriminate on the basis of, lack  
8 of evidence of insurability.

9 c. The health benefits plan may require payment of a premium  
10 by the employee for any period of continuation coverage as  
11 provided for in this section, except that the premium shall not  
12 exceed 102% of the applicable premium paid for similarly  
13 situated beneficiaries under the health benefits plan for a  
14 specified period, and may, at the election of the payor, be made  
15 in monthly installments. No premium payment shall be due  
16 before the 30th day after the day on which the covered employee  
17 made the initial election for continued coverage.

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

20 (1) The date upon which the employer under whose health  
21 benefits plan coverage is continued ceases to provide any health  
22 benefits plan to any employee or other qualified beneficiary;

23 (2) The date on which the continued coverage ceases under the  
24 health benefits plan by reason of a failure to make timely  
25 payment of any premium required under the plan by the former  
26 employee having the continued coverage. The payment of any  
27 premium shall be considered to be timely if made within 30 days  
28 after the due date or within such longer period as may be  
29 provided for by the policy or contract; or

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

32 (a) Covered under any other health benefits plan, as an  
33 employee or otherwise, which does not contain a provision which  
34 limits or excludes coverage with respect to any preexisting  
35 condition of a covered employee or any spouse or dependent who  
36 is included under the coverage provided the covered employee,  
37 for such period of the limitation or exclusion; or

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

40 e. Notice shall be provided to employees at the  
41 commencement of coverage as to their continuation rights under  
42 the plan. A qualified beneficiary may elect continuation  
43 coverage offered pursuant to this section no later than 30 days  
44 after the qualifying event. For the purposes of this section,

45 "qualified beneficiary" means any person covered under a small  
46 employer group policy.

47 f. The provisions of this section shall not apply to any person

48 who is a qualified beneficiary for the purposes of continuation of  
49 coverage as provided in accordance with section 3012(a) of Title

50 III of Pub. L. 100-647 (26 U.S.C. §4980B et al.).

51 g. In no event shall any continuation of coverage provided for

52 under this section exceed 12 months from the qualifying event.

53 18. There is created a nonprofit entity to be known as the New

54 Jersey Small Employer Health Excess Insurance Program. All

1 carriers issuing health benefits plan policies and contracts in this  
2 State and any MEWA providing health benefits shall be members  
3 of this program. The program shall be administered by the board  
4 of directors established pursuant to section 19 of this act.

5 19. a. Within 80 days of the effective date of this act, the  
6 commissioner shall give notice to all members of the time and  
7 place for the initial organizational meeting, which shall take  
8 place within 90 days of the effective date. The members shall  
9 select the initial board, subject to the approval of the  
10 commissioner. The board shall consist of 11 persons, including  
11 the Commissioner of Health and the commissioner or their  
12 designees, both of whom shall sit *ex officio*. Initially, three of  
13 the public members of the board shall be elected for a three year  
14 term, three shall be elected for a two year term, and three shall  
15 be elected for a one year term. Thereafter, all board members  
16 shall be elected for a term of three years. The following  
17 categories shall be represented among the public members:

18 (1) Two carriers whose principal health insurance business is in  
19 the small employer market;

20 (2) One carrier whose principal health insurance business is in  
21 the large employer market;

22 (3) A health, hospital or medical service corporation;

23 (4) A health maintenance organization;

24 (5) A risk-assuming carrier;

25 (6) A reinsuring carrier utilizing the excess coverage provided  
26 for in this act; and

27 (7) Two persons representing small employers.

28 No carrier shall have more than one representative on the  
29 board.

30 b. If the initial board is not elected at the organizational  
31 meeting, the commissioner shall appoint the public members  
32 within 15 days of the organizational meeting, in accordance with  
33 the provisions of paragraphs (1) through (7) of subsection a. of  
34 this section.

35 20. a. Within 90 days after the election of the initial board,  
36 the board shall submit to the commissioner a plan of operation  
37 which shall establish the administration of the program pursuant  
38 to the provisions of this act. The plan of operation and any  
39 subsequent amendments thereto shall be submitted to the  
40 commissioner who shall, after notice and hearing, approve the  
41 plan if he finds that it is reasonable and equitable and sufficiently  
42 carries out the provisions of this act. The plan of operation shall  
43 become effective after the commissioner has approved it in  
44 writing. The plan or any subsequent amendments thereto shall be  
45 deemed approved if not expressly disapproved by the  
46 commissioner in writing within 90 days of receipt by the  
47 commissioner.

48 b. If the board fails to submit a suitable plan of operation  
49 within 90 days after its appointment, the commissioner shall,  
50 after notice and hearing, adopt and promulgate a temporary plan  
51 of operation. The commissioner shall amend or rescind any such  
52 plan promulgated by him upon the submission and approval of a  
53 plan submitted by the board pursuant to subsection a. of this  
54 section.

- 1     21. The plan of operation shall include, but not be limited to,  
2 the following:
- 3     a. A method of handling and accounting for assets and moneys  
4 of the program and an annual fiscal reporting to the  
5 commissioner;
- 6     b. A means of providing for the filling of vacancies on the  
7 board, subject to the approval of the commissioner;
- 8     c. A means of selecting an administering carrier, and a  
9 statement of the powers and duties of the administering carrier  
10 and the compensation of the administering carrier;
- 11     d. The method to be used for securing excess insurance under  
12 the provisions of this act;
- 13     e. The method to be used for establishing appropriate excess  
14 insurance premiums to be charged to carriers electing to reinsure  
15 risks in accordance with this act;
- 16     f. The method to be used to make up any shortfall which may  
17 occur as the result of risks being reinsured under the provisions of  
18 this act.
- 19     g. A procedure for establishing the health benefits plans for  
20 which excess coverage is to be provided;
- 21     h. Any additional matters which are appropriate to effectuate  
22 the provisions of this act.
- 23     22. The board shall have the general powers and authority  
24 granted under the laws of New Jersey to insurance companies  
25 writing health insurance pursuant to Title 17B of the New Jersey  
26 Statutes, to health maintenance organizations approved or  
27 qualified to transact business in this State, and to health service  
28 corporations, medical service corporations, and hospital service  
29 corporations, but in no case shall the program established under  
30 this act write any policy or contract of insurance directly. In  
31 addition to the aforementioned powers, the board shall have the  
32 authority to:
- 33     a. Enter into contracts as are necessary or proper to carry out  
34 the provisions and purposes of this act;
- 35     b. Sued or be sued, including taking any legal actions as may  
36 be necessary for recovery of any assessments due to the program  
37 or to avoid paying any improper claims;
- 38     c. Issue excess insurance policies or other documents  
39 evidencing such coverage;
- 40     d. Establish rules, conditions, and procedures pertaining to the  
41 reinsurance of members' risks by the program;
- 42     e. Establish appropriate rates, rate schedules, rate  
43 adjustments, rate classifications, and such other actuarial  
44 functions which may be appropriate to the operation of the  
45 program, for providing excess coverage;
- 46     f. Assess members in accordance with the provisions of this  
47 act, including such interim assessments as may be reasonable and  
48 necessary for organizational and interim operating expenses.  
49 Such interim assessments shall be credited as offsets against any  
50 regular assessments due following the close of the fiscal year;
- 51     g. Appoint from among its members appropriate legal,  
52 actuarial, and other committees as necessary to provide technical  
53 assistance in the operation of the program, policy and other  
54 contract design, and any other function within the authority of

1 the program; and

2 h. Borrow money to effect the purposes of the program. Any  
3 notes or other evidence of indebtedness of the program not in  
4 default shall be legal investments for carriers and may be carried  
5 as admitted assets.

6 23. Subject to the approval of the commissioner, the board  
7 shall establish the form and level of coverages to be made  
8 available by small employer carriers in accordance with the  
9 provisions of this act. The board may establish benefits levels,  
10 deductibles and copayments, exclusions, and limitations for the  
11 Basic and Basic Plus health care plan, consistent with sections 4  
12 and 5 of this act. The board shall also determine what  
13 components of a small employer's health benefits plan may be  
14 reinsured.

15 One health care plan shall be established which contains  
16 benefits and cost sharing levels which are consistent with the  
17 basic method of operation and the benefits plans of health  
18 maintenance organizations, including any restrictions pursuant to  
19 subchapter XI of Pub.L. 93-222 (42 U.S.C. §300 et seq.). The  
20 board shall submit the plans so established to the commissioner  
21 for his approval no later than 90 days after the election of the  
22 board pursuant to section 19 of this act. The commissioner shall  
23 approve the plan if he finds it to be consistent with the provisions  
24 of sections 4 and 5 of this act. Any plans submitted to the  
25 commissioner by the board shall be deemed approved if not  
26 expressly disapproved in writing within 60 days of its receipt by  
27 the commissioner. Such plans may contain, but shall not be  
28 limited to, the following provisions:

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

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

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

34 d. Reasonable benefits differentials which are applicable to  
35 participating and nonparticipating providers;

36 e. Notwithstanding the provisions of section 6 of this act to  
37 the contrary, the board may, from time to time, adjust  
38 coinsurance and deductibles; and

39 f. Such other provisions which may be quantifiably established  
40 to be cost containment devices.

41 24. After the commissioner's approval of the health benefits  
42 plan guidelines formulated by the board pursuant to section 23 of  
43 this act, a small employer carrier shall file its policy or contract  
44 forms with the commissioner and shall certify to the  
45 commissioner, in a form required by the commissioner, that the  
46 plans filed by the carrier are in compliance with the guidelines  
47 established by the board. The certification shall be signed by the  
48 chief executive officer of the carrier. Upon filing the  
49 certification with the commissioner, the carrier may use the  
50 certified plans until such time, after notice and hearing, as the  
51 commissioner disapproves their continued use.

52 25. Every small employer carrier shall elect to be either a  
53 risk-assuming carrier or a reinsuring carrier and shall file notice  
54 of such election with the board. Carriers electing to be a

1 risk-assuming carrier shall do so only with the approval of the  
2 commissioner. Application for risk-assuming status shall be filed  
3 with the commissioner on a form approved by the commissioner,  
4 and shall be deemed approved if it is not disapproved in writing  
5 within 90 days of the commissioner's receipt of the application.  
6 In determining whether to approve an application by a small  
7 employer carrier to become a risk-assuming carrier, the  
8 commissioner shall consider the carrier's financial condition, its  
9 history of assuming and managing risk, and its experience in  
10 managing small group business. The commissioner may also seek  
11 comments from the board prior to rendering a decision on the  
12 application. Any carrier which has made application for a  
13 risk-assuming status which has been disapproved by the  
14 commissioner shall be granted a hearing within 60 days of the  
15 disapproval.

16 26. a. Any member which elects to be a reinsuring carrier  
17 may obtain excess insurance from the program on any new small  
18 employer group policy or contract issued pursuant to sections 4 or  
19 5 of this act, on any small employer group, or any individual  
20 beneficiary for any amount payable for eligible claims in excess  
21 of \$7,500 per covered beneficiary per year. In such case, the  
22 program shall provide the excess coverage subject to the payment  
23 by the reinsuring carrier of an appropriate reinsurance premium.  
24 Coverage may be reinsured within 60 days of the commencement  
25 of the employer's coverage with the small employer carrier.  
26 With respect to eligible employees and their dependents who are  
27 hired subsequent to the commencement of the employer's  
28 coverage and who are not late enrollees to the plan, coverage  
29 may be reinsured within 60 days of the commencement of their  
30 coverage under the plan. Excess coverage may be terminated  
31 with respect to any employee or dependent on any plan  
32 anniversary.

33 b. Election to purchase excess coverage through the program  
34 shall be binding for a five-year period, except that the initial  
35 election shall be made within 30 days of the submission to the  
36 commissioner of the plan of operation provided for in section 20  
37 of this act, and shall be effective for two years.

38 27. Every member which elects to be a reinsuring carrier shall  
39 apply its case management and claims handling techniques,  
40 including, but not limited to, utilization review, individual case  
41 management, preferred provider provisions and other methods of  
42 operation, in the same manner with respect to both reinsured and  
43 non-reinsured business.

44 28. a. Premium rates charged by the program for entire  
45 groups shall not exceed 1.5 times the rate established by the  
46 board for similar groups for which excess coverage has not been  
47 purchased. In computing the premium, the board shall establish a  
48 rate from which the premium shall be computed which is not less  
49 than the average rate for like risks for the small group market as  
50 a whole.

51 b. Premium rates charged by the program for individuals shall  
52 not exceed 5.0 times the rate established by the program for  
53 similar persons for which excess coverage has not been purchased.

54 c. Premium rates charged for excess insurance by the program

1 to a health maintenance organization that is approved by the  
2 United States Secretary of Health and Human Services as a  
3 federally qualified health maintenance organization pursuant to  
4 subchapter XI of Pub. L. 93-222 (42 U.S.C. §300e et seq.), and as  
5 such is subject to requirements that limit the amount of risk that  
6 may be ceded to the program, shall be reduced to reflect the  
7 portion of the risk so ceded.

8 d. Premium rates charged for excess insurance shall not be  
9 charged directly back to the group or individual for whom the  
10 excess insurance is being obtained.

11 29. a. Following the close of each fiscal year of the  
12 administering carrier, the administering carrier shall determine  
13 the net premiums, the administrative expenses of the program  
14 and the incurred losses, if any, for the year, taking into account  
15 investment income and other appropriate gains and losses.  
16 Health benefits plan premiums and benefits paid by a member  
17 that are less than an amount determined by the board to justify  
18 the cost of collection shall not be considered for purposes of  
19 determining assessments. For the purposes of this section, "net  
20 premiums" means health benefits plan premiums, less  
21 administrative expense allowances, and health benefits plan  
22 premiums earned by MEWAs shall be established by adding the  
23 paid losses and administrative expenses of such associations.

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

35 c. If the net loss is not recouped before assessments totaling  
36 4% of the aggregate premiums from policies or contracts  
37 covering small employers have been collected from reinsuring  
38 small employer carriers, additional assessments not to exceed 1%  
39 of the aggregate premiums from all health benefits policies or  
40 contracts shall be apportioned by the board among all members,  
41 including risk-assuming carriers, in proportion to their respective  
42 shares of the total health benefits plan premiums earned in this  
43 State from all health benefits plans during the preceding calendar  
44 year. A carrier shall receive a credit against this assessment to  
45 the extent the carrier can demonstrate that its assumption of  
46 high-risk small employer groups which are not reinsured is  
47 proportionate to its market share of small employer health  
48 benefits plans, as such groups and market shares are defined by  
49 the board in the plan of operation. A carrier shall not be assessed  
50 for all individual non-group contracts or policies issued on a  
51 guaranteed issue basis or on any coverage issued by the carrier  
52 pursuant to the Medicaid program, P.L.1966, c.413 (C.30:4D-1  
53 et seq.).

54 d. If assessments exceed actual losses and administrative

1 expenses of the program, the excess shall be held at interest and  
2 used by the board to offset future losses or to reduce program  
3 premiums. As used in this subsection, "future losses" includes  
4 reserves for incurred but not reported claims.

5 e. Provision may be established in the plan of operation for the  
6 imposition of an interest penalty for late payment of assessments.

7 30. A member may seek from the commissioner a deferment in  
8 whole or in part from any assessment levied by the board. The  
9 commissioner may grant the deferment if, in his opinion, the  
10 payment of the assessment would endanger the ability of the  
11 member to fulfill its contractual obligations. In the event an  
12 assessment against a member is deferred in whole or in part, the  
13 amount by which the assessment is deferred may be assessed  
14 against the other members in a manner consistent with the basis  
15 for assessment set forth in this act. The member receiving a  
16 deferment shall remain liable to the program for the amount  
17 deferred and shall be prohibited from reinsuring any individuals or  
18 groups in the program if it fails to pay assessments.

19 31. A small employer carrier which elects to cease  
20 participating as a reinsuring carrier and elects to become a  
21 risk-assuming carrier shall be prohibited from reinsuring or  
22 continuing to reinsure any small employer health benefits plan  
23 pursuant to this act. Any reinsuring carrier electing to become a  
24 risk-assuming carrier shall pay a prorated assessment based upon  
25 business issued as a reinsuring carrier for any portion of the year  
26 that the business was reinsured.

27 32. a. The board may establish a subcommittee to monitor the  
28 market conduct of risk-assuming carriers and reinsuring carriers  
29 to assure that the provisions of this act are being carried out.  
30 The subcommittee shall, from time to time, recommend for the  
31 approval by the commissioner market conduct requirements for  
32 carriers and agents. The subcommittee shall also, in conjunction  
33 with the department, publish a list of all small employer carriers,  
34 as well as a list of toll free telephone numbers which are easily  
35 accessible by small employers. In the event that the board  
36 believes that any carrier is violating any provision of this act or  
37 is conducting itself improperly in the marketing or sale of its  
38 small group business, whether issued pursuant to this act or  
39 otherwise, it shall report this to the commissioner, who shall  
40 conduct an investigation of that carrier, including, but not  
41 limited to, an audit of the carrier's records.

42 b. The board shall also establish guidelines to ensure that small  
43 employer carriers are assuming their share of high risk small  
44 employer groups in proportion to their market share of small  
45 employer health benefits plan business. In the event that any  
46 carrier does not assume its reasonable share of the high risk  
47 market, the board may adjust the assessment formula, with the  
48 approval of the commissioner, to require a proportionally higher  
49 assessment for the carrier.

50 33. Any carrier which violates this act shall be subject to a  
51 penalty assessment, as determined by the commissioner, whether  
52 or not the carrier is a risk-assuming carrier or a reinsuring  
53 carrier.

54 34. The excess insurance program established pursuant to this

1 act shall be exempt from any taxes levied by the State, including  
2 premium taxes.

3 35. No carrier writing small employer group insurance business  
4 pursuant to this act shall insure any small group under a policy or  
5 contract of insurance provided for in sections 4 or 5 of this act,  
6 which small group is insured by any carrier as of the effective  
7 date of the act or during the calendar year immediately  
8 preceding.

9 36. No later than one year following the effective date of this  
10 act and at least annually thereafter for the subsequent four  
11 years, the board shall conduct a review of the small group  
12 insurance market to examine the effectiveness of the insurance  
13 provided for in this act in terms of its acceptance among small  
14 employers and the adequacy of the benefits provided for. The  
15 review shall determine whether an additional product or products  
16 should be made available under the program provided for by this  
17 act, including major medical coverage. In addition, the board  
18 shall analyze the effect of the four to one premium ratio  
19 established pursuant to section 12 of this act to determine  
20 whether the relationship of the high-to-low rates established  
21 pursuant to that ratio are inequitably distributed throughout the  
22 small group market, and whether the ratio so established can be  
23 further reduced without negative economic effect on any group.

24 The board shall report to the Governor and the Legislature  
25 after each review required by this section, and include any  
26 recommendations it may have with respect to the modification or  
27 augmentation of the program.

28 37. A carrier which violates any provision of this act shall be  
29 liable to a penalty of not less than \$2,000 and not greater than  
30 \$5,000 for each violation. The penalty shall be collected by the  
31 commissioner in the name of the State in a summary proceeding  
32 in accordance with "the penalty enforcement law," N.J.S.2A:58-1  
33 et seq..

34 38. No assessment provided for under this act shall, under any  
35 circumstances, be an obligation of the State.

36 39. This act shall take effect immediately.

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41 \_\_\_\_\_  
42 Requires certain insurers, service corporations and HMOs to offer  
43 basic health insurance plans to small businesses; establishes a  
reinsurance program.

SENATE COMMITTEE SUBSTITUTE FOR  
SENATE, No. 371

**ADOPTED**

STATE OF NEW JERSEY

**JUN 15 1992**

By Senator Bassano

**AN ACT** requiring certain health insurers, service corporations and health maintenance organizations to offer basic health benefits programs to certain employers and establishing a reinsurance program.

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

1. As used in this act:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 12 of this act, based upon examination, including a review of the appropriate records and actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefits plans.

"Base premium rate" means the lowest premium rate charged by the small employer carrier for the same or similar coverage, which coverage is equivalent in value to a health benefits plan covering a small employer. The term "base premium rate" refers to rates for any health benefits plan covering two or more employees of a small employer.

"Basic health benefits plan" means a health benefits plan for small employers which provides benefits pursuant to section 4 of this act and which is filed with the commissioner in accordance with the requirements of section 24 of this act, any portion of the premium for which is paid by a small employer or for which any covered individual is reimbursed whether through wage adjustments or otherwise, if the health benefits plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 162 or section 106 of the Internal Revenue Code of 1986 (28 U.S.C. 162 or 28 U.S.C. 106).

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

"Carrier" means any insurance company, health service corporation, hospital service corporation, medical service corporation, health maintenance organization or MEWA authorized to issue health benefits plans in this State. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health

maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Commissioner" means the Commissioner of Insurance.

"Department" means the Department of Insurance.

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

"Eligible employee" means a full-time employee who works a normal work week of 30 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 30 hours a week or work on a temporary or substitute basis.

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

"Health benefits plan" means any hospital and medical expense incurred policy; health, hospital, or medical service corporation contract; health maintenance organization subscriber contract; or plans provided by MEWAs offered by a small employer pursuant to section 4 of this act. For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment; has lost coverage under that other employer's health benefits plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or

divorce; and the individual requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan; or if the individual is employed by an employer under a MEWA which offers multiple health benefits plans, and the individual elects a different plan during an open enrollment period; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order.

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

"MEWA" means any multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement and Income Security Act of 1974, Pub.L.93-406 (29 U.S.C. §1002), except for any such arrangement which is fully insured within the meaning of that act.

"Plan of operation" means the plan of operation of the program including articles, bylaws and operating rules approved pursuant to section 20 of this act.

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

"Program" means the New Jersey Small Employer Health Excess Reinsurance Program established pursuant to section 18 of this act.

"Reinsuring carrier" means a small employer carrier electing to obtain excess insurance in accordance in section 26 of this act."

"Risk-assuming carrier" means a small employer carrier electing to assume risks pursuant to section 25 of this act."

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer, subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of this act, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this act which apply to a small employer shall continue to apply until the anniversary date next of the health benefits plan following the date the employer no longer meets the definition of a small employer.

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

"Small employer health benefits plan" means a health benefits plan for small employers approved by the commissioner pursuant to section 23 of this act.

2. Every health insurer, health service corporation, medical service corporation, hospital service corporation, and health maintenance organization licensed or authorized to provide health benefits or services in this State which offers health insurance policies or coverages covering two or more employees of a small employer shall be subject to the provisions of this act. Coverage shall be offered to all eligible employees and their dependents and shall not exclude any employee or eligible dependent on the basis of an actual or expected health condition.

3. Notwithstanding the provisions of P.L.1991, c.187, every carrier subject to the provisions of this act shall, as a condition of transacting business in this State, offer to every small employer at least two health benefits plans. One plan shall be a Basic health benefits plan, as provided in section 4 of this act, and one shall be a Basic Plus health benefits plan, as provided in section 5 of this act. Initially, the offer shall be made within 90 days of the filing with the commissioner of that carrier's benefits plans. Thereafter, the plans shall be available to small employers on a continuing basis. Every small employer which elects to be covered under either of the plans provided for under this act who pays the required premium therefor and who satisfies the other requirements of the plan shall be issued a policy or contract by the carrier. The carrier may establish a premium payment plan which provides installment payments and which may contain reasonable provisions to ensure payment security, provided that provisions to ensure payment security are reasonably related to the risk and are uniformly applied. Every plan shall be in conformance with the guidelines established pursuant to section 23 of this act, and each carrier's plans shall be certified and filed with the commissioner pursuant to section 24 of this act.

4. A Basic health benefits plan shall provide:

a. Basic hospital expense coverage for a period of 21 days in each benefit year for each covered person for expenses incurred for medically necessary treatment and services rendered as a result of injury or sickness, including:

(1) Daily hospital room and board, including general nursing care and special diets;

(2) Miscellaneous hospital services, including expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any period of confinement;

(3) Hospital outpatient services, including surgical and other services rendered on a day stay basis, hospital services rendered within 72 hours after accidental injury, and x-ray and other

laboratory and other diagnostic tests to the extent that benefits for such services would be provided if rendered to an inpatient of the hospital;

b. Basic medical-surgical expense coverage for each covered person for expenses incurred for medically necessary services for the treatment of sickness or injury for the following:

(1) Surgical services;

(2) Anesthesia services, including the administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician performing the surgical services;

(3) Inpatient hospital services rendered to a person who is confined to a hospital for treatment of sickness or injury other than that for which surgical care is required;

(4) Maternity benefits, including cost of delivery and pre-natal care;

c. Out-of-hospital physical examinations, including related x-rays, immunizations, and diagnostic tests, rendered on the following basis:

(1) For covered minors of less than two years of age, up to six examinations during the first two years of life;

(2) For covered minors of at least two years of age but not more than 18 years of age, no more than one physical examination at ages 3, 6, 9, 12, 15, and 18 years of age;

(3) For covered adults of at least 19 years of age but less than 40 years of age, one physical examination every five years;

(4) For covered adults of at least 40 years of age but less than 60 years of age, one examination every three years; and

(5) For covered adults of age 60 years or older, one examination every two years.

Every physical examination rendered pursuant to this subsection shall be subject to such co-payments and deductibles as are provided for in the plan.

d. The plan provided for herein may, subject to the approval of the commissioner, with respect to health maintenance organizations, be modified as necessary to comply with the provisions of subchapter XI of Pub.L.93-222 (42 U.S.C. §300e et seq.).

5. a. A Basic Plus health benefits plan shall provide the same benefits as the basic policy, as well as hospital and medical expense coverage in excess of the basic policy as established and modified by the board from time to time, and approved by the commissioner, but in no case shall benefits provided for in the Basic Plus coverage exceed an actuarial value which is 20% greater than the actuarial value of the basic coverage provided pursuant to section 4 of this act.

b. The benefits which may be provided in excess of the benefits in the basic plan may include, but shall not be limited to, additional inpatient hospital benefits, additional diagnostic tests, benefits directed toward the prevention of disease, provided that they are quantifiably cost effective, and additional medical and surgical expense benefits.

c. At the discretion of the board, the Basic Plus plan may provide for a selection of not more than three alternative benefit packages which may be selected by small employers according to the needs of their work force, provided however, that no combination of alternative benefits in addition to the basic

benefits shall exceed the actuarial value established in subsection a. of this section.

6. a. Plans required to be offered pursuant to sections 4 or 5 of this act shall be subject to coinsurance and deductibles, which may vary by selected portions of the coverage, except that no deductible applicable to any portion of the coverage shall exceed \$250 for an individual or family unit during any benefit year, and no coinsurance applicable to any portion of the coverage shall exceed \$500 for an individual or family unit during any benefit year, unless provided by the board pursuant to section 23 of this act. Neither coinsurance nor deductibles shall be applicable to maternity benefits.

b. Except as provided herein, no law requiring the inclusion of any specified health care service or benefit and no law requiring the reimbursement, utilization, or consideration of a specific category of licensed health care practitioner shall apply to any Basic or Basic Plus health benefits plan provided for herein.

7. Coverage provided pursuant to this act shall be subject to standard coordination of benefits provisions for all persons covered under the policy or contract. Notwithstanding the provision of any other law to the contrary, coverage provided under policies or contracts issued pursuant to sections 4 or 5 of this act shall not extend to any injury for which coverage is available or applicable pursuant to section 4 of P. L. 1972, c. 70 (C.39:6A-4), and the coverage provided by a policy or contract issued pursuant to this act shall not be used as a substitute for any insurance required to be maintained pursuant to section 4 of P. L. 1972, c. 70 (C.39:6A-4).

8. a. Except as otherwise provided by this act, a preexisting condition provision shall not exclude coverage for an eligible employee or dependent for a period beyond 180 days following the effective date of coverage of an eligible employee and may only relate to conditions manifesting themselves during the six months immediately preceeding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage, or as to a pregnancy existing on the effective date of coverage.

b. In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefits plans shall credit the time that person was covered under a previous employer based health benefits plan if the previous coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan.

9. Every policy or contract issued to small employers in this State including, but not limited to, policies or contracts issued pursuant to the provisions of this act shall be renewable with respect to all eligible employees or dependents at the option of the policy or contract holder, or small employer except under the following circumstances:

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

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

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

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

e. The carrier withdraws the policy form, with the approval of the commissioner, in which case the group shall be offered an alternative policy or contract by the carrier which offers comparable benefits;

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

(1) The carrier gives notice to cease doing business in the small employer market to the commissioner not later than eight months prior to the date of the planned withdrawal from the small group market, during which time the carrier shall continue to be governed by this act with respect to business written pursuant to this act; For the purposes of this subsection, "date of withdrawal" means the date upon which the first notice to small employers is sent by the carrier pursuant to paragraph (3) of this section;

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

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

10. Late enrollees may be excluded from coverage: a. for 12 months for all coverage; or b. for 12 months for a preexisting condition. No combined period of total exclusion or exclusion for a preexisting condition shall exceed 12 months.

11. Any small employer carrier may require a reasonable specified minimum participation of eligible employees, which shall not exceed 75%, or reasonable minimum employer contributions in determining whether to accept a small group pursuant to this act. The standards so established by the carrier shall be first approved by the board and shall be applied uniformly to all small groups, except that in no event shall a carrier require an employer to contribute more than 10% to the annual cost of the policy or contract, or an amount as otherwise provided by the board, and any minimum participation standards established by the carrier shall be reasonable. In establishing the percentage of employee participation, a one-to-one credit shall be given for each employee covered by a spouse's health benefits coverage.

12. a. Rate differentials of any small group policies or contracts delivered, issued for delivery, or continued in this State may be based only on the factors of age, gender, and geography. No carrier shall issue any policy or contract in which the rates charged to any group exceed four times the base premium rate charged to the lowest-rated small employer group

written by the carrier for a like benefits plan.

b. In establishing the rating classifications provided for by subsection a. of this section, no carrier shall establish an excess of six rating territories, and no rating territory shall be any smaller than a county.

c. No rate classifications based on age shall provide for rate changes within any period which is less than five years. Age ranges, which shall be in five-year increments, shall be established by the commissioner by regulation and shall apply to all small group policies, whether or not written pursuant to sections 4 and 5 of this act.

d. The premium rates charged to any small employer for policies or contracts issued before the effective date of this act by any carrier shall, within three years of the effective date of this act, conform to subsection a. of this section. The four to one ratio established by subsection a. of this section shall be applied separately to each type of benefits plan issued by the carrier.

e. Notwithstanding the provisions of subsection d. of this section to the contrary, the provisions of subsection a. of this section shall be applied separately to policies or contracts: (1) in the case of any small employer contracts issued by a hospital service corporation or medical service corporation or any successor corporation which constitute a closed block of business as of September 1, 1991; or (2) in the case of any small employer policies issued under an open enrollment plan by any other health insurer which have not been offered for sale as of January 1, 1989.

f. Any premium charged for excess coverage for policies issued pursuant to sections 4 or 5 of this act shall be subject to the limitations provided for in this section.

g. Rating classifications established by carriers for small group policies or contracts shall not operate to produce rates for any small employer group which are excessive, inadequate, or unfairly discriminatory.

h. The provisions of this section shall apply to all small group business issued by any insurer in this State, whether or not written pursuant to section 4 or 5 of this act.

13. In connection with the offering for sale of any policy or contract to a small employer, each small employer carrier shall make a reasonable disclosure, as a part of its solicitation and sales materials, of the following:

a. The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs;

b. Any factors applicable to the policy or contract which are attributable to factors other than claim experience or duration of coverage, since issue, which affect changes in premium rates; and

c. Provisions relating to renewability of policies and contracts.

14. a. Every small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating plan and underwriting practices, including renewal underwriting practices. Rating plans shall be based on commonly accepted actuarial assumptions and shall be in accordance with sound actuarial principles. This information shall be available to

the commissioner upon request. Except in cases of any violation of this act, the information provided for herein shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

b. Every small employer carrier shall file no later than March 1 each year following the effective date of this act, a certification signed by an actuary and attested by an officer of the insurer that the carrier is in compliance with the act and that the rating methods of the small employer are actuarially sound. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

15. a. No health maintenance organization shall be required to offer coverage or accept applications pursuant to sections 4 or 5 of this act to a small employer if the small employer is not physically located in the health maintenance organization's approved service area, to an employee when the employee does not work or reside within a service area, or if the health maintenance organization reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of such groups because of its obligations to existing group contract holders and enrollees.

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

16. The provisions of sections 4 and 5 of this act shall apply to Basic and Basic Plus health benefits plans subject to this act which are delivered, issued for delivery, renewed or continued on or after the effective date of this act.

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

b. Coverage continued pursuant to subsection a. of this section shall consist of coverage which is identical to the coverage provided under the policy or contract to similarly situated beneficiaries whose coverage has not been terminated or hours of

employment reduced. If coverage is modified under the policy or contract for any group of similarly situated beneficiaries, this coverage shall also be modified in the same manner for persons who are qualified beneficiaries entitled pursuant to subsection a. of this section to continued coverage. Continuation of coverage may not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

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

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

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

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

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

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

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

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

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

g. In no event shall any continuation of coverage provided for under this section exceed 12 months from the qualifying event.

18. There is created a nonprofit entity to be known as the New Jersey Small Employer Health Excess Insurance Program. All carriers issuing health benefits plan policies and contracts in this

State and any MEWA providing health benefits shall be members of this program. The program shall be administered by the board of directors established pursuant to section 19 of this act.

19. a. Within 60 days of the effective date of this act, the commissioner shall give notice to all members of the time and place for the initial organizational meeting, which shall take place within 90 days of the effective date. The members shall select the initial board, subject to the approval of the commissioner. The board shall consist of 11 persons, including the Commissioner of Health and the commissioner or their designees, both of whom shall sit ex officio. Initially, three of the public members of the board shall be elected for a three year term, three shall be elected for a two year term, and three shall be elected for a one year term. Thereafter, all board members shall be elected for a term of three years. The following categories shall be represented among the public members:

- (1) Two carriers whose principal health insurance business is in the small employer market;
- (2) One carrier whose principal health insurance business is in the large employer market;
- (3) A health, hospital or medical service corporation;
- (4) A health maintenance organization;
- (5) A risk-assuming carrier;
- (6) A reinsuring carrier utilizing the excess coverage provided for in this act; and
- (7) Two persons representing small employers.

No carrier shall have more than one representative on the board.

b. If the initial board is not elected at the organizational meeting, the commissioner shall appoint the public members within 15 days of the organizational meeting, in accordance with the provisions of paragraphs (1) through (7) of subsection a. of this section.

20. a. Within 90 days after the election of the initial board, the board shall submit to the commissioner a plan of operation which shall establish the administration of the program pursuant to the provisions of this act. The plan of operation and any subsequent amendments thereto shall be submitted to the commissioner who shall, after notice and hearing, approve the plan if he finds that it is reasonable and equitable and sufficiently carries out the provisions of this act. The plan of operation shall become effective after the commissioner has approved it in writing. The plan or any subsequent amendments thereto shall be deemed approved if not expressly disapproved by the commissioner in writing within 90 days of receipt by the commissioner.

b. If the board fails to submit a suitable plan of operation within 90 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any such plan promulgated by him upon the submission and approval of a plan submitted by the board pursuant to subsection a. of this section.

21. The plan of operation shall include, but not be limited to, the following:

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

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

c. A means of selecting an administering carrier, and a statement of the powers and duties of the administering carrier and the compensation of the administering carrier;

d. The method to be used for securing excess insurance under the provisions of this act;

e. The method to be used for establishing appropriate excess insurance premiums to be charged to carriers electing to reinsure risks in accordance with this act;

f. The method to be used to make up any shortfall which may occur as the result of risks being reinsured under the provisions of this act.

g. A procedure for establishing the health benefits plans for which excess coverage is to be provided;

h. Any additional matters which are appropriate to effectuate the provisions of this act.

22. The board shall have the general powers and authority granted under the laws of New Jersey to insurance companies writing health insurance pursuant to Title 17B of the New Jersey Statutes, to health maintenance organizations approved or qualified to transact business in this State, and to health service corporations, medical service corporations, and hospital service corporations, but in no case shall the program established under this act write any policy or contract of insurance directly. In addition to the aforementioned powers, the board shall have the authority to:

a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act;

b. Sued or be sued, including taking any legal actions as may be necessary for recovery of any assessments due to the program or to avoid paying any improper claims;

c. Issue excess insurance policies or other documents evidencing such coverage;

d. Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the program;

e. Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and such other actuarial functions which may be appropriate to the operation of the program, for providing excess coverage;

f. Assess members in accordance with the provisions of this act, including such interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

g. Appoint from among its members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and

h. 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.

23. Subject to the approval of the commissioner, the board shall establish the form and level of coverages to be made available by small employer carriers in accordance with the provisions of this act. The board may establish benefits levels, deductibles and copayments, exclusions, and limitations for the Basic and Basic Plus health care plan, consistent with sections 4 and 5 of this act. The board shall also determine what components of a small employer's health benefits plan may be reinsured.

One health care plan shall be established which contains benefits and cost sharing levels which are consistent with the basic method of operation and the benefits plans of health maintenance organizations, including any restrictions pursuant to subchapter XI of Pub.L. 93-222 (42 U.S.C. §300 et seq.). The board shall submit the plans so established to the commissioner for his approval no later than 90 days after the election of the board pursuant to section 19 of this act. The commissioner shall approve the plan if he finds it to be consistent with the provisions of sections 4 and 5 of this act. Any plans submitted to the commissioner by the board shall be deemed approved if not expressly disapproved in writing within 60 days of its receipt by the commissioner. Such plans may contain, but shall not be limited to, the following provisions:

- a. Utilization review of health care services, including review of medical necessity of hospital and physician services;
- b. Managed care systems, including large case management;
- c. Provision for selective contracting with hospitals, physicians, and other health care providers;
- d. Reasonable benefits differentials which are applicable to participating and nonparticipating providers;
- e. Notwithstanding the provisions of section 6 of this act to the contrary, the board may, from time to time, adjust coinsurance and deductibles; and
- f. Such other provisions which may be quantifiably established to be cost containment devices.

24. After the commissioner's approval of the health benefits plan guidelines formulated by the board pursuant to section 23 of this act, a small employer carrier shall file its policy or contract forms with the commissioner and shall certify to the commissioner, in a form required by the commissioner, that the plans filed by the carrier are in compliance with the guidelines established by the board. The certification shall be signed by the chief executive officer of the carrier. Upon filing the certification with the commissioner, the carrier may use the certified plans until such time, after notice and hearing, as the commissioner disapproves their continued use.

25. Every small employer carrier shall elect to be either a risk-assuming carrier or a reinsuring carrier and shall file notice of such election with the board. Carriers electing to be a risk-assuming carrier shall do so only with the approval of the commissioner. Application for risk-assuming status shall be filed with the commissioner on a form approved by the commissioner, and shall be deemed approved if it is not disapproved in writing

within 90 days of the commissioner's receipt of the application. In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the commissioner shall consider the carrier's financial condition, its history of assuming and managing risk, and its experience in managing small group business. The commissioner may also seek comments from the board prior to rendering a decision on the application. Any carrier which has made application for a risk-assuming status which has been disapproved by the commissioner shall be granted a hearing within 60 days of the disapproval.

26. a. Any member which elects to be a reinsuring carrier may obtain excess insurance from the program on any new small employer group policy or contract issued pursuant to sections 4 or 5 of this act, on any small employer group, or any individual beneficiary for any amount payable for eligible claims in excess of \$7,500 per covered beneficiary per year. In such case, the program shall provide the excess coverage subject to the payment by the reinsuring carrier of an appropriate reinsurance premium. Coverage may be reinsured within 60 days of the commencement of the employer's coverage with the small employer carrier. With respect to eligible employees and their dependents who are hired subsequent to the commencement of the employer's coverage and who are not late enrollees to the plan, coverage may be reinsured within 60 days of the commencement of their coverage under the plan. Excess coverage may be terminated with respect to any employee or dependent on any plan anniversary.

b. Election to purchase excess coverage through the program shall be binding for a five-year period, except that the initial election shall be made within 30 days of the submission to the commissioner of the plan of operation provided for in section 20 of this act, and shall be effective for two years.

27. Every member which elects to be a reinsuring carrier shall apply its case management and claims handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions and other methods of operation, in the same manner with respect to both reinsured and non-reinsured business.

28. a. Premium rates charged by the program for entire groups shall not exceed 1.5 times the rate established by the board for similar groups for which excess coverage has not been purchased. In computing the premium, the board shall establish a rate from which the premium shall be computed which is not less than the average rate for like risks for the small group market as a whole.

b. Premium rates charged by the program for individuals shall not exceed 5.0 times the rate established by the program for similar persons for which excess coverage has not been purchased.

c. Premium rates charged for excess insurance by the program to a health maintenance organization that is approved by the United States Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to subchapter XI of Pub. L. 93-222 (42 U.S.C. §300e et seq.), and as such is subject to requirements that limit the amount of risk that may be ceded to the program, shall be reduced to reflect the portion of the risk so ceded.

d. Premium rates charged for excess insurance shall not be charged directly back to the group or individual for whom the excess insurance is being obtained.

29. a. Following the close of each fiscal year of the administering carrier, the administering carrier shall determine the net premiums, the administrative expenses of the program and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses. Health benefits plan premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. For the purposes of this section, "net premiums" means health benefits plan premiums, less administrative expense allowances, and health benefits plan premiums earned by MEWAs shall be established by adding the paid losses and administrative expenses of such associations.

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

c. If the net loss is not recouped before assessments totaling 4% of the aggregate premiums from policies or contracts covering small employers have been collected from reinsuring small employer carriers, additional assessments not to exceed 1% of the aggregate premiums from all health benefits policies or contracts shall be apportioned by the board among all members, including risk-assuming carriers, in proportion to their respective shares of the total health benefits plan premiums earned in this State from all health benefits plans during the preceding calendar year. A carrier shall receive a credit against this assessment to the extent the carrier can demonstrate that its assumption of high-risk small employer groups which are not reinsured is proportionate to its market share of small employer health benefits plans, as such groups and market shares are defined by the board in the plan of operation. A carrier shall not be assessed for all individual non-group contracts or policies issued on a guaranteed issue basis or on any coverage issued by the carrier pursuant to the Medicaid program, P.L.1968, c.413 (C.30:4D-1 et seq.).

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

e. Provision may be established in the plan of operation for the imposition of an interest penalty for late payment of assessments.

30. A member may seek from the commissioner a deferment in whole or in part from any assessment levied by the board. The commissioner may grant the deferment if, in his opinion, the payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessment set forth in this act. The member receiving a deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

31. A small employer carrier which elects to cease participating as a reinsuring carrier and elects to become a risk-assuming carrier shall be prohibited from reinsuring or continuing to reinsure any small employer health benefits plan pursuant to this act. Any reinsuring carrier electing to become a risk-assuming carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

32. a. The board may establish a subcommittee to monitor the market conduct of risk-assuming carriers and reinsuring carriers to assure that the provisions of this act are being carried out. The subcommittee shall, from time to time, recommend for the approval by the commissioner market conduct requirements for carriers and agents. The subcommittee shall also, in conjunction with the department, publish a list of all small employer carriers, as well as a list of toll free telephone numbers which are easily accessible by small employers. In the event that the board believes that any carrier is violating any provision of this act or is conducting itself improperly in the marketing or sale of its small group business, whether issued pursuant to this act or otherwise, it shall report this to the commissioner, who shall conduct an investigation of that carrier, including, but not limited to, an audit of the carrier's records.

b. The board shall also establish guidelines to ensure that small employer carriers are assuming their share of high risk small employer groups in proportion to their market share of small employer health benefits plan business. In the event that any carrier does not assume its reasonable share of the high risk market, the board may adjust the assessment formula, with the approval of the commissioner, to require a proportionally higher assessment for the carrier.

33. Any carrier which violates this act shall be subject to a penalty assessment, as determined by the commissioner, whether or not the carrier is a risk-assuming carrier or a reinsuring carrier.

34. The excess insurance program established pursuant to this act shall be exempt from any taxes levied by the State, including premium taxes.

35. No carrier writing small employer group insurance business pursuant to this act shall insure any small group under a policy or contract of insurance provided for in sections 4 or 5 of this act, which small group is insured by any carrier as of the effective date of the act or during the calendar year immediately preceding.

36. No later than one year following the effective date of this act and at least annually thereafter for the subsequent four years, the board shall conduct a review of the small group insurance market to examine the effectiveness of the insurance provided for in this act in terms of its acceptance among small employers and the adequacy of the benefits provided for. The review shall determine whether an additional product or products should be made available under the program provided for by this act, including major medical coverage. In addition, the board shall analyze the effect of the four to one premium ratio established pursuant to section 12 of this act to determine whether the relationship of the high-to-low rates established pursuant to that ratio are inequitably distributed throughout the small group market, and whether the ratio so established can be further reduced without negative economic effect on any group.

The board shall report to the Governor and the Legislature after each review required by this section, and include any recommendations it may have with respect to the modification or augmentation of the program.

37. A carrier which violates any provision of this act shall be liable to a penalty of not less than \$2,000 and not greater than \$5,000 for each violation. The penalty shall be collected by the commissioner in the name of the State in a summary proceeding in accordance with "the penalty enforcement law," N.J.S.2A:58-1 et seq..

38. No assessment provided for under this act shall, under any circumstances, be an obligation of the State.

39. This act shall take effect immediately.

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Requires certain insurers, service corporations and HMOs to offer basic health insurance plans to small businesses; establishes a reinsurance program.

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September 10, 1992

SENATE COMMITTEE SUBSTITUTE FOR  
SENATE BILL NO. 371

To the Senate:

Pursuant to Article V, Section I, Paragraph 14, of the New Jersey Constitution, I herewith return Senate Committee Substitute for Senate Bill No. 371 with my objections for reconsideration.

This nation is currently undergoing a health care crisis of truly massive proportions. We continue to make stunning progress in the face of profound medical challenges, with amazing scientific discoveries that ease our pain and save us from terrible diseases. And yet we have failed miserably at solving the political problems that keep the doors of quality and affordable health care closed to millions of Americans. In New Jersey alone, 800,000 citizens wake up every morning without any health insurance coverage. These hard working men and women live every day of their lives not knowing how they would possibly pay for their medical bills if they were to become sick, or to get seriously hurt in an accident.

In this country, more and more of our citizens are finding it impossible to pay health insurance premiums that have spiralled upward as their paychecks have shrunk. These citizens are forced to choose between getting medical insurance and putting food on the table. And those who can afford to pay these premiums know that they are supporting a health care industry that is totally out of control. They know that the inflated premiums they pay are a reflection of a system plagued by massive inefficiency. In this system, up to 40 cents out of every premium dollar goes to feed the insurance bureaucracy, which is more interested in spending its resources deciding who not to cover, than paying people's medical bills. Premiums are rising uncontrollably because none of the participants in the process -- doctors, hospitals, attorneys, insurance companies, and, yes, even patients themselves -- have any

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incentive to behave in a way that keeps costs down. The inefficiency and the waste multiplies every step of the way, and then gets passed on to the premiums we all must pay.

That is why I am pleased that, at the national level as well as here in New Jersey, our citizens have placed health care reform at the top of our social agenda. Our citizens will no longer tolerate delay. They demand effective reform, and they demand it now.

I accept this challenge, because I believe the citizens of this State deserve much better. That is why, as Governor, I have consistently advanced policies that widen access to health care. I have vigorously advocated policies that make health insurance more affordable.

In April of this year, in a speech to the New Jersey Hospital Association, I laid out a comprehensive plan for health insurance reform that, I believe, would make New Jersey a national leader in health care policy. The health care problem, of course, is a terribly complicated one, and admits of no easy solution. No single piece of legislation will ever fix the system entirely. Indeed, our ability to succeed will ultimately depend on the courage of our elected officials in Washington, D.C., at the level of government that is best equipped to grapple with a problem that does not respect state boundaries.

However, as I indicated in April, I believe we can achieve real progress right here in New Jersey, right now in 1992. I believe we have the opportunity to make New Jersey a national leader in health insurance reform, by enacting legislation that contains two essential components: open enrollment and community rating.

Unlike many of our counterparts in Europe and Asia, this country does not guarantee its citizens access to affordable health care. In this country, one's ability to obtain affordable health care is at the mercy of a market that is more flawed than free. Health insurance corporations are currently allowed to pick and choose their customers. They are not required to make insurance available to small groups or to individuals, and they are free to deny health insurance to anyone they conclude is too much of a health risk.

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This laissez-faire attitude leaves enormous gaps in the market that swallow hundreds of thousands of this State's citizens. In this system, access to health care coverage depends upon whether you are lucky enough to work for an employer that is large enough to command the attention of insurance corporations. Absent any restrictions, insurance companies naturally prefer to deal with larger employers, which generally offer bigger pools of employees and thus larger margins of profit.

This is why we see so many stories in the news of families without insurance who are forced to reach out to their neighbors and friends for financial support in order to pay for life-saving treatment. I recently met with Roslyn Schwartz, whose personal courage and determination are a model to everyone. After surviving a series of surgeries to remove tumors from throughout her body, Roslyn is now in remission from cancer. But rather than spend her days cherishing a life she very nearly lost, Roslyn suffers every day from the anguish of not knowing how she will pay \$9,000 in medical bills that hang over her head, with a yearly income of less than \$6,000. She continues to live without health insurance, because no health insurance company will offer her coverage, and because she would not even be able to afford it if one did. Worst of all, Roslyn cannot pay for critical follow-up tests that would catch a recurrence of her cancer early on, when it can be treated.

Convinced that government had abandoned her, and the thousands like her who have fallen through the cracks, Roslyn set out to march 61 miles from Ridgefield to Trenton, to carry her message to our elected officials that the time has come for reform. On August 12, on the third day of her march, I met with her in a diner in Elizabeth. I told her that I had heard her cries. I asked her to end her march, because her message had been heard not only in Trenton, but across this State. I vowed to fight for Roslyn, and for the hundreds of thousands of citizens like her who have the right to be treated with dignity and respect at the most critical time of their lives.

Because of people like Roslyn Schwartz, I strongly support a policy of universal access to health insurance, coupled with a

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policy of open enrollment. In this State, we must require health insurance companies to offer coverage to all, and to deny coverage to none. We need to require insurance companies to exercise greater responsibility. In New Jersey, the privilege of selling insurance to some should carry with it a duty to provide the same coverage to all. And we need a policy of open enrollment -- that is, a policy that requires insurance companies to accept all who apply, not just those who are young, but those who are elderly, not just those who are healthy, but those who are ill.

I realize, moreover, that forcing insurance companies to extend coverage to small groups means nothing if that coverage is inadequate, discriminatory, or prohibitively expensive. We need to extend coverage to all of our citizens, but we cannot make the critical mistake of doing so only in form. That is why, when requiring insurance companies to extend health care coverage to everyone, we must make certain to lay down some fundamental ground rules.

Along with states such as Vermont and New York, this State should embrace community rating, which would prohibit insurance companies from discriminating on the basis of demographic factors such as age, gender, and occupation. The whole point of insurance is that it provides us with an opportunity to share equally in the health risks we all face as individuals. It makes no sense to have a system in which insurance companies spend an enormous amount of resources trying to discriminate between individuals. Whatever benefit we might get from a system that imposes higher costs upon the most unfortunate is more than outweighed by the enormous administrative cost this system passes along to everyone. We should simply eliminate this administrative red tape from the system, bring the overall cost down, and charge everyone an equitable rate. Not only will the overall cost of insurance go down, but the system will become more competitive: with every company forced to charge a single rate per plan, it will be easier for consumers to compare the products offered by these insurance companies.

In order to permit an orderly transaction to the new system, the reforms described herein would be phased in over a four-year

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period. Over this period, the use of rating factors, such as age, gender, geographic location and occupation, would be completely eliminated. This planned, phasing-in process would minimize any precipitous rate increases to young, healthy groups and permit both the public and the insurance industry the opportunity to adapt to the new system.

These are the components of health care reform that I believe are essential. With these changes, we can make New Jersey a national leader in health care reform. But we must have the courage -- inspired by people like Roslyn Schwartz -- to follow through with these changes, however unpopular to certain interest groups. Health care reform is far too important to the citizens of this State for us to settle for half-measures, or empty promises.

The bill that I am returning to the Legislature today represents a welcome nod in the direction of health care reform. This bill would require insurance companies doing business in this State to make minimal coverage available to small businesses. I commend the Legislature for presenting me with a bill that contains the rough outlines of one essential component of health care reform.

I am returning this bill to the Legislature, however, because it lacks certain components of reform that are essential to real change. This bill would require insurance companies to offer insurance policies to small businesses, but it would allow these companies to fulfill this obligation with skeleton policies that carry stiff pricetags, discriminate against certain policyholders, and exclude individuals with the greatest need for coverage. This bill does not require community rating, which would allow insurance companies to continue to waste enormous amounts of resources in making fine statistical discriminations between their policyholders, so that they can charge higher premiums on the basis of factors such as age, gender, and occupation. This bill would only require insurance companies to offer minimal, bare-bones policies, which would deny policyholders the option of comprehensive coverage.

Furthermore, this bill would do for health insurance what the JUA (the Joint Underwriting Association) did for car insurance. This bill would establish the "New Jersey Small Employer Health

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Excess Reinsurance Program," which would be administered by an 11-member board composed primarily of representatives of the insurance industry. Insurance companies would be authorized to dump so-called "bad risks" into this State-sanctioned program. Given our recent experience with the JUA, I am surprised that the Legislature would want to take a similar chance in the area of health care. With the JUA, the State was ultimately held responsible for bailing out a system that ran itself into deep deficit. We cannot expose our taxpayers to a similar obligation with health insurance. Although the Legislature proposes to solve this problem with a provision that would technically absolve the State from financial responsibility, the political pressure to bail out the system would be intense were the program ever to run into deficit. I simply cannot sanction the creation of a health insurance counterpart to the failed JUA.

For all of these reasons, I am returning this bill to the Legislature with recommendations that it adopt amendments that would turn this bill into legislation of which we can be proud. I am recommending that this bill be modified to provide for open enrollment, so that no one will be denied access to health care coverage. I am recommending that the Legislature adopt community rating, to eliminate red tape from the system and to ensure equity in the setting of premiums. I am recommending that the Legislature require insurance companies to sell the same five standard policies to be determined by the industry, which will both reduce administrative costs for insurers and providers and which will help to make this process more intelligible to consumers. The requirement that insurance companies offer five standard policies to be determined by the industry will also ensure that the small business community is able to compare like products. To facilitate this cost-shopping, I will require that the Department of Insurance annually publish the prices charged by insurance companies for each of these five policies.

I am also recommending that the Legislature eliminate the health insurance version of the JUA that this bill proposes. In its place, I am recommending that the Legislature establish a mechanism that

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allows risk to be spread across as wide a base as possible but at the same time maximizes the incentive of each carrier to manage risk and control costs.

With these changes, this legislation could represent an historic moment for New Jersey. For the first time in this State's history, citizens working for small businesses would be guaranteed access to health care. Insurance companies would no longer be free to deny those who are in the greatest need of coverage. Coverage would be comprehensive. Premiums would be fairer. And the system would run more efficiently.

I realize that the action I am taking today may not be very popular with certain interest groups. Even though my proposals enjoy the endorsement of a number of segments of the health care industry, it is no secret that the health insurance industry as a whole opposes the kinds of changes I have been fighting for. I am confident, however, that the Legislature will consider my proposals, and act upon them, in a manner that reflects an understanding of our obligations to the people of this State, and the needs of people like Roslyn Schwartz. Inspired by her courage, we must strive to make a difference. Along the way, we must resist the political temptation to placate certain powerful groups, and to cover our tracks with actions that look like "change" but which are mere shadows of reform. Our citizens are tired of elected officials who talk loudly of "change," but are unwilling to translate political rhetoric into real and effective action. I encourage the Legislature to join me in answering the people's call to solve the health care crisis in a way that they deserve. This bill only addresses small group health insurance reform. A separate piece of legislation is pending which would address individual insurance reform and I am anxious to work with the Legislature on that matter.

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Therefore, I herewith return Senate Committee Substitute for Senate Bill No. 371 and recommend that it be amended as follows:

Page 1, Title, Line 2: After "offer" delete "basic" insert "standardized"

Page 1, Title, Lines 3-4: After "to" delete "certain employers" insert "small groups"

Page 1, Section 1, After Line 16: Insert new definition as follows: "Anticipated loss ratio" means the ratio of the present value of the expected benefits, not including dividends, to the present value of the expected premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. For purposes of this ratio, the present values must incorporate realistic rates of interest which are determined before federal taxes but after investment expenses.

Page 1, Section 1, Lines 17-32: Delete in entirety

Page 1, Section 1, Line 36: After "organization" delete "or MEWA"

Page 2, Section 1, After Line 2: Insert new definition as follows: "Community rating" means a rating methodology in which the premium for all persons covered by a policy or contract form is the same based upon the experience of the entire pool of risks covered by that policy or contract form without regard to age, gender, health status, residence or occupation."

Page 2, Section 1, Line 8: After "of" delete "30" insert "25"

Page 2, Section 1, Line 13: After "than" delete "30" insert "25"

Page 2, Section 1, Line 23: After "contract" insert "or" after second "contract" delete "or"

Page 2, Section 1, Line 24: Delete "plans provided by MEWAs"; after "by" insert "any carrier to a"; after "employer" insert "group"

Page 2, Section 1, Lines 50-51: After "plan;" delete "or if the individual is employed by an employer under a MEWA"

Page 3, Section 1, Line 4-5: After "plans" delete "and MEWAs providing health benefits plans"

Page 3, Section 1, Lines 7-11: Delete in entirety

Page 3, Section 1, Line 14: After "section" delete "20" insert "15"

Page 3, Section 1, Line 27: After "section" delete "18" insert "12"

Page 3, Section 1, Line 30: After "to" delete "obtain excess insurance" insert "receive reimbursement from the Program"; after "accordance" delete "in" insert "with"; after "section" delete "26" insert "12"

Page 3, Section 1, Line 33: Delete "25" insert "18"

Page 3, Section 1, Line 49 After "carrier" delete "or MEWA"

Page 3, Section 1, Line 54: After "section" delete "23" and insert "17"

Page 4, Sections 3 and 4, Lines 10-54: Delete in entirety and insert new section as follows:

"3. a. Every small employer carrier shall, as a condition of transacting business in this State, offer to every small employer the same five health benefit plans. The board shall establish a standard policy form for each of the five plans, which shall be the only plans offered to small groups on or after January 1, 1994. One policy form shall contain the benefits provided for in sections 55,

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57, and 59 of P.L. 1991, c.187 (C. ). The remaining policy forms shall contain basic hospital and medical-surgical benefits, including, but not limited to:

1. Basic inpatient and outpatient hospital care;
2. Basic and extended medical-surgical benefits;
3. Diagnostic tests, including x-rays;
4. Maternity benefits, including pre-natal and post-natal care;
5. Preventive medicine, including periodic physical examinations and inoculations..

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

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

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

d. In addition to the five standard policies described in subsection 3.a., the board may develop up to five rider packages. Any such package which a carrier chooses to offer shall be issued to an small employer who pays the premium therefor, and shall be subject to the rating methodology set forth in section 9 of this act."

Page 5, Sections 4 and 5, Lines 1-50: Delete in entirety

Page 5, Section 6, Line 51: Delete "6." and insert "4." after "offered" delete "pursuant to sections 4 and 5" and insert "under this act may"

Page 5, Section 6, Line 52: Delete "of this act shall"

Page 6, Section 6, Line 4: After "section" delete "23" and insert "17"

Page 6, Section 6, Line 7-11: Delete in entirety

Page 6, Section 7, Line 12: Delete "7" and insert "5"

Page 6, Section 7, Line 15: After "contrary," delete "coverage provided" and insert "the health benefits plan with the lowest actuarial value provided under"

Page 6, Section 7, Line 16: Delete in entirety

Page 6, Section 7, Lines 19-20: After "and" delete "the coverage provided by a policy or contract issued pursuant to this act" and insert "that health benefits plan"

Page 6, Section 8, Lines 23-34: Delete in entirety and insert new subsection as follows:

"6. a. No health benefits plan subject to this act shall include any pre-existing condition provision, provided, that a pre-existing condition provision may apply to a late enrollee or to any group of two-to-five persons if such provision excludes coverage for a period of no more than 180 days following the effective date of coverage of such enrollee, and relates only to conditions manifesting themselves

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during the six months immediately preceding the effective date of coverage of such enrollee in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage, or as to a pregnancy existing on the effective date of coverage; provided, that if 10 or more late enrollees request enrollment during any 30 day enrollment period, then no pre-existing condition provision shall apply to any such enrollee."

Page 6, Section 8, Line 37: After "under" delete "a" and insert "any"

Page 6, Section 8, Line 38: After "previous" delete "employer based"

Page 6, Section 9, Line 42: Delete "9." insert "7."

Page 6, Section 9, Lines 43-44: After "State" delete "including, but not limited to, policies or contracts issued pursuant to the provisions of this act"

Page 7, Section 9, Lines 5-8: After "e." delete in entirety

Page 7, Section 9, Line 9: Delete "f."

Page 7, Section 10, Lines 34-37: Delete in entirety

Page 7, Section 11, Line 38: Delete "11." and insert "8."

Page 7, Section 12, Lines 51-54: After "12. a." delete in entirety and insert new section 9 as follows:

"9. a. (1) Effective January 1, 1997, no small employer health benefits plan shall be issued in this State unless the plan is community rated.

(2) During the period beginning on January 1, 1994 and ending December 31, 1995, the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan shall not be greater than 300% of the premium rate charged to the lowest rated small group purchasing that same health benefits plan.

(3) During the period January 1, 1996 to December 31, 1996, the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan shall not be greater than 200% of the premium rate charged for the lowest rated small group purchasing that same health benefits plan.

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

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

c. Notwithstanding any other provision of law to the contrary, no carrier offering any health benefits plan pursuant to the

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provisions of this act shall act to circumvent the intent of this act by acting as a third party administrator for groups of small employers, anyone of whom was insured as of September 1, 1992; provided, however, that this provision shall not act to limit a bona fide group of small employers who voluntarily act together to provide health benefits to their employees.

d. Notwithstanding any other provision of law to the contrary, this act shall apply to an association or trust of employers, if the group includes one or more member employers or other member groups which have 49 or fewer employees or members exclusive of spouses and dependents.

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

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

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

g. (2) Each calendar year, a carrier shall return, in the form of aggregate benefits for each of the five standard policy forms offered by the carrier pursuant to section 3 of this act at least seventy-five percent of the aggregate premiums collected for the policy form during that fiscal year. Carriers shall annually report, no later than August first of each year, the loss ratio calculated pursuant to this section for each such policy form for the previous calendar year. In each case where the loss ratio for a policy fails to substantially comply with the seventy-five percent loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policy holders with that policy form in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal seventy-five percent of the aggregate premiums collected for the policy form in the previous calendar year. The dividend or credit shall be issued to each policy which was in effect as of March thirtieth of the applicable year and remains in effect as of the date the dividend or credit is issued. All dividends and credits must be distributed by December thirty-first of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policy holder.

h. No carrier issuing health benefits plans covering two or more employees of a small employer shall issue a plan inconsistent with this act whose term extends beyond December 31, 1993.

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i. The provisions of this act shall apply to health benefits plans which are delivered, issued for delivery, renewed or continued on or after January 1, 1994. The Commissioner shall withdraw approval for the issuance and use of all small group policy forms, other than those approved by the board, effective January 1, 1994."

Page 8, Section 12, Lines 1-38: Delete in entirety

Page 8, Sections 13 and 14, Lines 39-54: Delete in entirety

Page 9, Section 14, Lines 1-14: Delete in entirety

Page 9, Section 15, Line 15: Delete "15." insert "10."

Page 9, Section 15, Line 16: After "to" delete "section 4 or 5" insert "section 3"

Page 9, Section 15, After Line 31: Insert new subsection as follows:

"c. A health maintenance organization which complies with the basic health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub. L. 93-222 (42 U.S.C. § 300e et seq.), and which also provides the comprehensive health benefit plan coverage required by Section 3 of this act, shall be deemed in compliance with this act."

Page 9, Section 16, Lines 32-35: Delete in entirety

Page 9, Section 17, Line 36: Delete "17." insert "11."

Page 10, Section 18, Line 53: Delete "18." insert "12."

Page 11, Section 18, Line 2: After "State" delete "and any MEWA providing health benefits"

Page 11, Section 18, After Line 4: Insert new subsection as follows:

"c. The board shall determine the statewide average payment per insured for each benefit plan provided for under this act. Each carrier who satisfies the efficiency and risk management standards promulgated by the board pursuant to section 15f, and whose average cost of insuring individuals covered by small employer health benefits plans exceeds the statewide average cost of insuring such individuals by 20 percent, shall be reimbursed by the program for 80 percent of its costs in excess thereof."

Page 11, Section 19, Line 5: Delete "19." and insert "13."

Page 11, Section 19, After Line 34: Insert new subsections as follows:

"c. All meetings of the board shall be subject to the requirements of the Open Public Meetings Act, N.J.S.A. 10:4-6 et seq."

"d. At least two copies of the minutes of every meeting of the board shall be delivered forthwith to the commissioner."

Page 11, Section 20, Line 35: Delete "20." and insert "14."

Page 11, Section 20, Lines 48-54: Delete in entirety

Page 12, Section 21, Line 1: Delete "21." and insert "15."; after "shall" insert "constitute a public record and shall"

Page 12, Section 21, Line 10: After "carrier" insert "and a statement of the efficiency standards an administering carrier must meet"

Page 12, Section 21, Lines 11-20: Delete in entirety and insert new subsections as follows:

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"d. The method to be used to determine the extent to which a carrier's payment per insured for each benefit plan provided for under this act, exceeds the statewide average payment per insured for each benefit plan provided for under this act;

e. The method for determining the extent to which a carrier whose average cost of insuring individuals covered by small employer health benefits plans exceeds the threshold described in section 12c may receive reimbursement from the program;

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

Page 12, Section 21, Line 21: Delete "h." insert "g."

Page 12, Section 22, Line 23: Delete "22." and insert "16."

Page 12, Section 22, Lines 23-30: After "The" delete in entirety

Page 12, Section 22, Line 31: Delete "addition to the aforementioned powers, the"

Page 12, Section 22, Lines 38-39: After "c." delete in entirety

Page 12, Section 22, Line 40: Delete "d."; after "the" insert "reimbursement and assessment"

Page 12, Section 22, Line 41: Delete "reinsurance"; after "members" delete "risks"

Page 12, Section 22, Lines 42-45: Delete in entirety

Page 12, Section 22, Line 46: Delete "f." insert "d."

Page 12, Section 22, Line 50: After "year;" insert "and"

Page 12, Section 22, Line 51: Delete "g." insert "e."

Page 13, Section 22, Lines 1-5: After "program" delete in entirety

Page 13, Section 23, Line 6: Delete "23." and insert "17."

Page 13, Section 23, Line 7: After "shall" delete "establish the form and level of coverages" and insert "formulate the five health benefits plans"

Page 13, Section 23, Line 9: After "act" insert ", and shall promulgate five standard forms pursuant thereto"

Page 13, Section 23, Line 10: Delete "the" and insert "such health benefits plans in accordance with law"

Page 13, Section 23, Line 11-14: Delete in entirety

Page 13, Section 23, Line 24: After "of" delete "sections 4 and 5" and insert "section 3"

Page 13, Section 23, After Line 40: Insert new subsection as follows:

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

Page 13, Section 24, Lines 41-51: Delete in entirety

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Page 13, Section 25, Line 52: Delete "25." and insert "18."

Page 14, Section 26, Line 16: Delete "26." and insert "19."

Page 14, Section 26, Lines 17-32: After "may" delete in entirety insert "receive reimbursement in accordance with the standards developed by the board pursuant to subparagraphs d, e, and f of section 15 of this act."

Page 14, Section 27, Line 33: After "to" delete in entirety insert "become a reinsuring carrier"

Page 14, Section 27, Line 38: Delete "27." and insert "20."

Page 14, Section 27, Lines 42-43: After "to" delete "both reinsured and non-reinsured" and insert "all its"

Page 14, Section 28, Lines 44-54: Delete "in entirety"

Page 15, Section 28, Lines 1-10: Delete in entirety

Page 15, Section 29, Line 11: Delete "29." and insert "21."

Page 15, Section 29, Lines 11-23: After "a." delete in entirety and insert "Following the close of the calendar year ending December 31, the administering carrier, the administering carrier shall determine the total amount owed by the program in that calendar year to all carriers qualifying for reimbursement by the program. Such amount shall be known as the net loss of the program."

Page 16, Section 30, Line 7: Delete "30." and insert "22."

Page 16, Section 31, Line 19: Delete "31." and insert "23."

Page 16, Section 31, Lines 21-22: After "from" delete in entirety; insert "receiving reimbursement from the program"

Page 16, Section 31, Lines 24-26: After "assessment" delete in entirety insert "."

Page 16, Section 32, Lines 27-41: Delete "32." and insert "24."; after "a." delete in entirety

Page 16, Section 32, Line 42: Delete "b."; after "shall" delete "also"

Page 16, Section 33, Line 50: Delete "33." and insert "25."

Page 16, Section 34, Line 54: Delete "34." and insert "26."

Page 17, Section 34, Line 1: After "from" delete "any taxes levied by the State, including"

Page 17, Sections 35 and 36, Lines 3-27: Delete in entirety

Page 17, Section 37, Line 28: Delete "37." and insert "27."

Page 17, Section 38, Line 34: Delete "38." and insert "28."; after "shall" delete "under any" and insert "be charged, directly or indirectly, to policyholders or the public, provided that a carrier may charge such an assessment to policy holders to the extent that the charging of the assessment is necessary to enable the carrier to earn a constitutionally adequate rate of return."

Page 17, Section 38, Line 35: Delete in entirety and insert new sections as follows:

"29. The board shall promulgate one standard claim form. In order to provide a standard system of payment for medical services, all claim forms for any claimant's use under any group health insurance policy issued or delivered in this State shall conform to the form adopted by the board."

CONDITIONAL VETO

to

**ADOPTED**  
**NOV 30 1992**

**SENATE COMMITTEE SUBSTITUTE FOR SENATE No. 371**

REPLACE TITLE TO READ:

AN ACT requiring certain health insurers, service corporations and health maintenance organizations to offer <sup>1</sup>[basic] standardized<sup>1</sup> health benefits programs to <sup>1</sup>[certain employers] small groups<sup>1</sup> and establishing a reinsurance program.

REPLACE SECTION 1 TO READ:

1. As used in this act:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section <sup>1</sup>[12] <sup>9</sup><sup>1</sup> of this act, based upon examination, including a review of the appropriate records and actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefits plans.

<sup>1</sup>"Anticipated loss ratio" means the ratio of the present value of the expected benefits, not including dividends, to the present value of the expected premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. For purposes of this ratio, the present values must incorporate realistic rates of interest which are determined before federal taxes but after investment expenses.<sup>1</sup>

<sup>1</sup>"Base premium rate" means the lowest premium rate charged by the small employer carrier for the same or similar coverage, which coverage is equivalent in value to a health benefits plan covering a small employer. The term "base premium rate" refers to rates for any health benefits plan covering two or more employees of a small employer.

"Basic health benefits plan" means a health benefits plan for small employers which provides benefits pursuant to section 4 of this act and which is filed with the commissioner in accordance with the requirements of section 24 of this act, any portion of the premium for which is paid by a small employer or for which any covered individual is reimbursed whether through wage adjustments or otherwise, if the health benefits plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 162 or section 106 of the Internal Revenue Code of 1986 (28 U.S.C. 162 or 26 U.S.C. 106).<sup>1</sup>

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

"Carrier" means any insurance company, health service corporation, hospital service corporation, medical service corporation <sup>1</sup>[,] or<sup>1</sup> health maintenance organization <sup>1</sup>[or MEWA]<sup>1</sup> authorized to issue health benefits plans in this State. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company,

health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Commissioner" means the Commissioner of Insurance.

<sup>1</sup>"Community rating" means a rating methodology in which the premium for all persons covered by a policy or contract form is the same based upon the experience of the entire pool of risks covered by that policy or contract form without regard to age, gender, health status, residence or occupation.<sup>1</sup>

"Department" means the Department of Insurance.

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

"Eligible employee" means a full-time employee who works a normal work week of <sup>1</sup>[30] 25<sup>1</sup> or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than <sup>1</sup>[30] 25<sup>1</sup> hours a week or work on a temporary or substitute basis.

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

"Health benefits plan" means any hospital and medical expense incurred policy; health, hospital, or medical service corporation contract; <sup>1</sup>or<sup>1</sup> health maintenance organization subscriber contract <sup>1</sup>or<sup>1</sup> plans provided by MEWAs<sup>1</sup> offered by <sup>1</sup>any carrier to<sup>1</sup> a small employer <sup>1</sup>group<sup>1</sup> pursuant to section <sup>1</sup>[4] 3<sup>1</sup> of this act. For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment; has lost coverage under that other employer's health benefits plan as a result of termination of employment, the

termination of the other plan's coverage, death of a spouse, or divorce; and the individual requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan; <sup>1</sup>[or if the individual is employed by an employer under a MEWA which offers multiple health benefits plans, and the individual elects a different plan during an open enrollment period;]<sup>1</sup> or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order.

"Member" means all carriers issuing health benefits plans <sup>1</sup>[and MEWAs providing health benefits plans]<sup>1</sup> in this State on or after the effective date of this act.

<sup>1</sup>["MEWA" means any multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement and Income Security Act of 1974, Pub.L.93-406 (29 U.S.C. §1002), except for any such arrangement which is fully insured within the meaning of that act.]<sup>1</sup>

"Plan of operation" means the plan of operation of the program including articles, bylaws and operating rules approved pursuant to section <sup>1</sup>[20] 15<sup>1</sup> of this act.

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

"Program" means the New Jersey Small Employer Health Excess Reinsurance Program established pursuant to section <sup>1</sup>[18] 12<sup>1</sup> of this act.

"Reinsuring carrier" means a a small employer carrier electing to <sup>1</sup>[obtain excess insurance] receive reimbursement from the program<sup>1</sup> in accordance <sup>1</sup>[in] with<sup>1</sup> section <sup>1</sup>[26] 19<sup>1</sup> of this act."

"Risk-assuming carrier" means a small employer carrier electing to assume risks pursuant to section <sup>1</sup>[25] 18<sup>1</sup> of this act."

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer, subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of this act, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this act which apply to a small employer shall continue to apply until the anniversary date next of the health benefits plan following the date the employer no longer meets the definition of a small employer.

"Small employer carrier" means any carrier <sup>1</sup>[or MEWA]<sup>1</sup> that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan for small employers approved by the commissioner pursuant to section <sup>1</sup>[23] <sup>17</sup> of this act.

REPLACE SECTION 3 TO READ:

3. <sup>1</sup>[Notwithstanding the provisions of P.L.1991, c.187, every carrier subject to the provisions of this act shall, as a condition of transacting business in this State, offer to every small employer at least two health benefits plans. One plan shall be a Basic health benefits plan, as provided in section 4 of this act, and one shall be a Basic Plus health benefits plan, as provided in section 5 of this act. Initially, the offer shall be made within 90 days of the filing with the commissioner of that carrier's benefits plans. Thereafter, the plans shall be available to small employers on a continuing basis. Every small employer which elects to be covered under either of the plans provided for under this act who pays the required premium therefor and who satisfies the other requirements of the plan shall be issued a policy or contract by the carrier. The carrier may establish a premium payment plan which provides installment payments and which may contain reasonable provisions to ensure payment security, provided that provisions to ensure payment security are reasonably related to the risk and are uniformly applied. Every plan shall be in conformance with the guidelines established pursuant to section 23 of this act, and each carrier's plans shall be certified and filed with the commissioner pursuant to section 24 of this act.]

a. Every small employer carrier shall, as a condition of transacting business in this State, offer to every small employer the same five health benefit plans. The board shall establish a standard policy form for each of the five plans, which shall be the only plans offered to small groups on or after January 1, 1994. One policy form shall contain the benefits provided for in sections 55, 57, and 59 of P.L. 1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). The remaining policy forms shall contain basic hospital and medical-surgical benefits, including, but not limited to:

- (1) Basic inpatient and outpatient hospital care;
- (2) Basic and extended medical-surgical benefits;
- (3) Diagnostic tests, including x-rays;
- (4) Maternity benefits, including prenatal and postnatal care;

and

(5) Preventive medicine, including periodic physical examinations and inoculations.

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

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

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

d. In addition to the five standard policies described in subsection a. of this section, the board may develop up to five rider packages. Any such package which a carrier chooses to offer shall be issued to a small employer who pays the premium therefor, and shall be subject to the rating methodology set forth in section 9 of this act.<sup>1</sup>

OMIT SECTIONS 4 AND 5 IN THEIR ENTIRETY

REPLACE SECTION 6 TO READ:

<sup>1</sup>[6.a.] 4.<sup>1</sup> Plans required to be offered <sup>1</sup>[pursuant to sections 4 or 5 of this act shall] under this act may<sup>1</sup> be subject to coinsurance and deductibles, which may vary by selected portions of the coverage, except that no deductible applicable to any portion of the coverage shall exceed \$250 for an individual or family unit during any benefit year, and no coinsurance applicable to any portion of the coverage shall exceed \$500 for an individual or family unit during any benefit year, unless provided by the board pursuant to section <sup>1</sup>[23] 17<sup>1</sup> of this act. Neither coinsurance nor deductibles shall be applicable to maternity benefits.

<sup>1</sup>[b. Except as provided herein, no law requiring the inclusion of any specified health care service or benefit and no law requiring the reimbursement, utilization, or consideration of a specific category of licensed health care practitioner shall apply to any Basic or Basic Plus health benefits plan provided for herein.]<sup>1</sup>

REPLACE SECTION 7 TO READ:

<sup>1</sup>[7.] 5.<sup>1</sup> Coverage provided pursuant to this act shall be subject to standard coordination of benefits provisions for all persons covered under the policy or contract. Notwithstanding the provision of any other law to the contrary, <sup>1</sup>[coverage] the health benefits plan with the lowest actuarial value<sup>1</sup> provided under <sup>1</sup>[policies or contracts issued pursuant to sections 4 or 5 of] this act shall not extend to any injury for which coverage is available or applicable pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), and <sup>1</sup>[the coverage provided by a policy or contract issued pursuant to this act] that health benefits plan<sup>1</sup> shall not be used as a substitute for any insurance required to be maintained pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4).

REPLACE SECTION 8 TO READ:

<sup>1</sup>[8. a. Except as otherwise provided by this act, a preexisting condition provision shall not exclude coverage for an eligible employee or dependent for a period beyond 180 days following the effective date of coverage of an eligible employee and may only relate to conditions manifesting themselves during the six months immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage, or as to a pregnancy existing on the effective date of coverage.]

6. a. No health benefits plan subject to this act shall include any preexisting condition provision, provided that, a preexisting condition provision may apply to a late enrollee or to any group of two to five persons if such provision excludes coverage for a period of no more than 180 days following the effective date of coverage of such enrollee, and relates only to conditions manifesting themselves during the six months immediately preceding the effective date of coverage of such enrollee in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage, or as to a pregnancy existing on the effective date of coverage; provided that, if 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition provision shall apply to any such enrollee.<sup>1</sup>

b. In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefits plans shall credit the time that person was covered under <sup>1</sup>[a] any<sup>1</sup> previous <sup>1</sup>[employer based]<sup>1</sup> health benefits plan if the previous coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan.

REPLACE SECTION 9 TO READ:

<sup>1</sup>[9.] 7.<sup>1</sup> Every policy or contract issued to small employers in this State <sup>1</sup>[including, but not limited to, policies or contracts issued pursuant to the provisions of this act]<sup>1</sup> shall be renewable with respect to all eligible employees or dependents at the option of the policy or contract holder, or small employer except under the following circumstances:

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

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

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

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

e. <sup>1</sup>[The carrier withdraws the policy form, with the approval of the commissioner, in which case the group shall be offered an alternative policy or contract by the carrier which offers comparable benefits;

f.]<sup>1</sup> Any carrier doing business pursuant to the provisions of this act ceases doing business in the small employer market, if the following conditions are satisfied:

(1) The carrier gives notice to cease doing business in the small employer market to the commissioner not later than eight months prior to the date of the planned withdrawal from the small group market, during which time the carrier shall continue to be governed by this act with respect to business written pursuant to this act; For the purposes of this subsection, "date of withdrawal" means the date upon which the first notice to small employers is sent by the carrier pursuant to paragraph (3) of this section;

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

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

OMIT SECTION 10 IN ITS ENTIRETY

RENUMBER SECTION 11 AS SECTION 8

OMIT SECTIONS 12, 13 AND 14 IN THEIR ENTIRETY

INSERT NEW SECTION 9 TO READ:

19. a. (1) Effective January 1, 1997, no small employer health benefits plan shall be issued in this State unless the plan is community rated.

(2) During the period January 1, 1994 to December 31, 1995, the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan shall not be greater than 300% of the premium rate charged to the lowest rated small group purchasing that same health benefits plan.

(3) During the period January 1, 1996 to December 31, 1996, the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan shall not be greater than 200% of the premium rate charged for the lowest rated small group purchasing that same health benefits plan.

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

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

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

d. Notwithstanding any other provision of law to the contrary, this act shall apply to an association or trust of employers, if the group includes one or more member employers or other member groups which have 49 or fewer employees or members exclusive of spouses and dependents.

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

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

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

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for each of the five standard policy forms offered by the carrier pursuant to section 3 of this act, at least 75% of the aggregate premiums collected for the policy form during that calendar year. Carriers shall annually report, no later than August 1st of each year, the loss ratio calculated pursuant to this section for each such policy form for the previous calendar year. In each case where the loss ratio for a policy fails to substantially comply with the 75% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with that policy form in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal 75% of the aggregate premiums collected for the policy form in the previous calendar year. The dividend or credit shall be issued to each policy which was in effect as of March 30th of the applicable year and remains in effect as of the date the dividend or credit is issued. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits, as well as an explanation

of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder.

h. No carrier issuing health benefits plans covering two or more employees of a small employer shall issue a plan inconsistent with this act whose term extends beyond December 31, 1993.

i. The provisions of this act shall apply to health benefits plans which are delivered, issued for delivery, renewed or continued on or after January 1, 1994. The commissioner shall withdraw approval for the issuance and use of all small employer policy forms, other than those approved by the board, effective January 1, 1994.<sup>1</sup>

REPLACE SECTION 15 TO READ:

<sup>1</sup>[15.] 10.<sup>1</sup> a. No health maintenance organization shall be required to offer coverage or accept applications pursuant to <sup>1</sup>[sections 4 or 5] section 3<sup>1</sup> of this act to a small employer if the small employer is not physically located in the health maintenance organization's approved service area, to an employee when the employee does not work or reside within a service area, or if the health maintenance organization reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of such groups because of its obligations to existing group contract holders and enrollees.

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

<sup>1</sup>c. A health maintenance organization which complies with the basic health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub.L. 93-222 (42.U.S.C. §300e et seq.), and which also provides the comprehensive health benefit plan coverage required by section 3 of this act, shall be deemed in compliance with this act.<sup>1</sup>

OMIT SECTION 16 IN ITS ENTIRETY

RENUMBER SECTION 17 AS SECTION 11

REPLACE SECTION 18 TO READ:

<sup>1</sup>[18.] 12.<sup>1</sup> There is created a nonprofit entity to be known as the New Jersey Small Employer Health Excess Insurance Program. All carriers issuing health benefits plan policies and contracts in this State <sup>1</sup>[and any MEWA providing health benefits]<sup>1</sup> shall be members of this program. The program shall be administered by the board of directors established pursuant to section <sup>1</sup>[19] 13<sup>1</sup> of this act.

**REPLACE SECTION 19 TO READ:**

<sup>1</sup>[19.] 13.<sup>1</sup> a. Within 60 days of the effective date of this act, the commissioner shall give notice to all members of the time and place for the initial organizational meeting, which shall take place within 90 days of the effective date. The members shall select the initial board, subject to the approval of the commissioner. The board shall consist of 11 persons, including the Commissioner of Health and the commissioner or their designees, ooth of whom shall sit ex officio. Initially, three of the public members of the board shall be elected for a three year term, three shall be elected for a two year term, and three shall be elected for a one year term. Thereafter, all board members shall be elected for a term of three years. The following categories shall be represented among the public members:

- (1) Two carriers whose principal health insurance business is in the small employer market;
- (2) One carrier whose principal health insurance business is in the large employer market;
- (3) A health, hospital or medical service corporation;
- (4) A health maintenance organization;
- (5) A risk-assuming carrier;
- (6) A reinsuring carrier utilizing the excess coverage provided for in this act; and
- (7) Two persons representing small employers.

No carrier shall have more than one representative on the board.

b. If the initial board is not elected at the organizational meeting, the commissioner shall appoint the public members within 15 days of the organizational meeting, in accordance with the provisions of paragraphs (1) through (7) of subsection a. of this section.

<sup>1</sup>c. The board shall determine the Statewide average payment per insured for each benefit plan provided for under this act. Each carrier who satisfies the efficiency and risk management standards promulgated by the board pursuant to subsection f. of section 15 of this act and whose average cost of insuring individuals covered by small employer health benefits plans exceeds the Statewide average cost of insuring such individuals by 20%, shall be reimbursed by the program for 80% of its costs in excess thereof.

d. All meetings of the board shall be subject to the requirements of the "Open Public Meetings Act." P.L.1975, c.231 (C.10:4-6 et seq.).

e. At least two copies of the minutes of every meeting of the board shall be delivered forthwith to the commissioner.<sup>1</sup>

**REPLACE SECTION 20 TO READ:**

<sup>1</sup>[20. a.] 14.<sup>1</sup> Within 90 days after the election of the initial board, the board shall submit to the commissioner a plan of operation which shall establish the administration of the program pursuant to the provisions of this act. The plan of operation and any subsequent amendments thereto shall be submitted to the commissioner who shall, after notice and hearing, approve the plan if he finds that it is reasonable and equitable and sufficiently carries out the provisions of this act. The plan of operation shall become effective after the commissioner has approved it in writing. The plan or any subsequent amendments thereto shall be deemed approved if not expressly disapproved by the

commissioner in writing within 90 days of receipt by the commissioner.

<sup>1</sup>[b. If the board fails to submit a suitable plan of operation within 90 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any such plan promulgated by him upon the submission and approval of a plan submitted by the board pursuant to subsection a. of this section.]<sup>1</sup>

**REPLACE SECTION 21 TO READ:**

<sup>1</sup>[21.] 15.<sup>1</sup> The plan of operation shall <sup>1</sup>constitute a public record and shall<sup>1</sup> include, but not be limited to, the following:

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

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

c. A means of selecting an administering carrier, and a statement of the powers and duties of the administering carrier and the compensation of the administering carrier <sup>1</sup>and a statement of the efficiency standards an administering carrier must meet<sup>1</sup> ;

d. The method to be used <sup>1</sup>[for securing excess insurance under the provisions of this act] to determine the extent to which a carrier's payment per insured for each benefit plan provided for under this act, exceeds the Statewide average payment per insured for each benefit plan provided for under this act<sup>1</sup>;

e. The method <sup>1</sup>[to be used for establishing appropriate excess insurance premiums to be charged to carriers electing to reinsure risks in accordance with this act] for determining the extent to which a carrier whose average cost of insuring individuals covered by small employer health benefits plans exceeds the threshold described in subsection c. of section 13 of this act may receive reimbursement from the program<sup>1</sup> ;

f. <sup>1</sup>[The method to be used to make up any shortfall which may occur as the result of risks being reinsured under the provisions of this act.] A statement of the efficiency and risk management standards a carrier must meet before a carrier may receive reimbursement from the program; and<sup>1</sup>

g. <sup>1</sup>[A procedure for establishing the health benefits plans for which excess coverage is to be provided;

h.]<sup>1</sup> Any additional matters which are appropriate to effectuate the provisions of this act.

**REPLACE SECTION 22 TO READ:**

<sup>1</sup>[22.] 16.<sup>1</sup> The <sup>1</sup>[board shall have the general powers and authority granted under the laws of New Jersey to insurance companies writing health insurance pursuant to Title 17B of the New Jersey Statutes, to health maintenance organizations approved or qualified to transact business in this State, and to health service corporations, medical service corporations, and hospital service corporations, but in no case shall the program established under this act write any policy or contract of insurance directly. In addition to the aforementioned powers, the]<sup>1</sup> board shall have the authority to:

a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act;

commissioner in writing within 90 days of receipt by the commissioner.

<sup>1</sup>[b. If the board fails to submit a suitable plan of operation within 90 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any such plan promulgated by him upon the submission and approval of a plan submitted by the board pursuant to subsection a. of this section.]<sup>1</sup>

**REPLACE SECTION 21 TO READ:**

<sup>1</sup>[21.] 15.<sup>1</sup> The plan of operation shall <sup>1</sup>constitute a public record and shall<sup>1</sup> include, but not be limited to, the following:

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

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

c. A means of selecting an administering carrier, and a statement of the powers and duties of the administering carrier and the compensation of the administering carrier <sup>1</sup>and a statement of the efficiency standards an administering carrier must meet<sup>1</sup> ;

d. The method to be used <sup>1</sup>[for securing excess insurance under the provisions of this act] to determine the extent to which a carrier's payment per insured for each benefit plan provided for under this act, exceeds the Statewide average payment per insured for each benefit plan provided for under this act<sup>1</sup>;

e. The method <sup>1</sup>[to be used for establishing appropriate excess insurance premiums to be charged to carriers electing to reinsure risks in accordance with this act] for determining the extent to which a carrier whose average cost of insuring individuals covered by small employer health benefits plans exceeds the threshold described in subsection c. of section 13 of this act may receive reimbursement from the program<sup>1</sup> ;

f. <sup>1</sup>[The method to be used to make up any shortfall which may occur as the result of risks being reinsured under the provisions of this act.] A statement of the efficiency and risk management standards a carrier must meet before a carrier may receive reimbursement from the program; and<sup>1</sup>

g. <sup>1</sup>[A procedure for establishing the health benefits plans for which excess coverage is to be provided;

h.]<sup>1</sup> Any additional matters which are appropriate to effectuate the provisions of this act.

**REPLACE SECTION 22 TO READ:**

<sup>1</sup>[22.] 16.<sup>1</sup> The <sup>1</sup>[board shall have the general powers and authority granted under the laws of New Jersey to insurance companies writing health insurance pursuant to Title 17B of the New Jersey Statutes, to health maintenance organizations approved or qualified to transact business in this State, and to health service corporations, medical service corporations, and hospital service corporations, but in no case shall the program established under this act write any policy or contract of insurance directly. In addition to the aforementioned powers, the]<sup>1</sup> board shall have the authority to:

a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act;

b. Sued or be sued, including taking any legal actions as may be necessary for recovery of any assessments due to the program or to avoid paying any improper claims;

c. <sup>1</sup>[Issue excess insurance policies or other documents evidencing such coverage;

d.]<sup>1</sup> Establish rules, conditions, and procedures pertaining to the <sup>1</sup>[reinsurance] reimbursement and assessment<sup>1</sup> of <sup>1</sup>[members' risks] members<sup>1</sup> by the program;

<sup>1</sup>[e. Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and such other actuarial functions which may be appropriate to the operation of the program, for providing excess coverage;

f.] d.<sup>1</sup> Assess members in accordance with the provisions of this act, including such interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year; and<sup>1</sup>

<sup>1</sup>[g.] e.<sup>1</sup> Appoint from among its members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program <sup>1</sup>[: and

h. 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]<sup>1</sup>.

**REPLACE SECTION 23 TO READ:**

<sup>1</sup>[23.] 17.<sup>1</sup> Subject to the approval of the commissioner, the board shall <sup>1</sup>[establish the form and level of coverages] formulate the five health benefits plans<sup>1</sup> to be made available by small employer carriers in accordance with the provisions of this act <sup>1</sup>, and shall promulgate five standard forms pursuant thereto<sup>1</sup>. The board may establish benefits levels, deductibles and copayments, exclusions, and limitations for the <sup>1</sup>[Basic and Basic Plus health care plan, consistent with sections 4 and 5 of this act. The board shall also determine what components of a small employer's health benefits plan may be reinsured] such health benefits plans in accordance with the law<sup>1</sup>.

One health care plan shall be established which contains benefits and cost sharing levels which are consistent with the basic method of operation and the benefits plans of health maintenance organizations, including any restrictions pursuant to subchapter XI of Pub.L. 93-222 (42 U.S.C. §300 et seq.). The board shall submit the plans so established to the commissioner for his approval no later than 90 days after the election of the board pursuant to section <sup>1</sup>[19] 13<sup>1</sup> of this act. The commissioner shall approve the plan if he finds it to be consistent with the provisions of <sup>1</sup>[sections 4 and 5] section 3<sup>1</sup> of this act. Any plans submitted to the commissioner by the board shall be deemed approved if not expressly disapproved in writing within 60 days of its receipt by the commissioner. Such plans may contain, but shall not be limited to, the following provisions:

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

b. Managed care systems, including large case management;

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

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

e. Notwithstanding the provisions of section 6 of this act to the contrary, the board may, from time to time, adjust coinsurance and deductibles; <sup>1</sup>[and]<sup>1</sup>

f. Such other provisions which may be quantifiably established to be cost containment devices <sup>1</sup>;

g. The department shall publish annually a list of the premiums charged for each of the five standard small employer health benefits plans and for any rider package by all carriers writing such plans. The department shall also publish the toll free telephone number of each such carrier<sup>1</sup>.

OMIT SECTION 24 IN ITS ENTIRETY

RENUMBER SECTION 25 AS SECTION 18

REPLACE SECTION 26 TO READ:

<sup>1</sup>[26.] 19.<sup>1</sup> a. Any member which elects to be a reinsuring carrier may <sup>1</sup>[obtain excess insurance from the program on any new small employer group policy or contract issued pursuant to sections 4 or 5 of this act, on any small employer group, or any individual beneficiary for any amount payable for eligible claims in excess of \$7,500 per covered beneficiary per year. In such case, the program shall provide the excess coverage subject to the payment by the reinsuring carrier of an appropriate reinsurance premium. Coverage may be reinsured within 60 days of the commencement of the employer's coverage with the small employer carrier. With respect to eligible employees and their dependents who are hired subsequent to the commencement of the employer's coverage and who are not late enrollees to the plan, coverage may be reinsured within 60 days of the commencement of their coverage under the plan. Excess coverage may be terminated with respect to any employee or dependent on any plan anniversary] receive reimbursement in accordance with the standards developed by the board pursuant to subsections d., e. and f. of section 15 of this act<sup>1</sup>.

b. Election to <sup>1</sup>[purchase excess coverage through the program] become a reinsuring carrier<sup>1</sup> shall be binding for a five-year period, except that the initial election shall be made within 30 days of the submission to the commissioner of the plan of operation provided for in section <sup>1</sup>[20] 14<sup>1</sup> of this act, and shall be effective for two years.

REPLACE SECTION 27 TO READ:

<sup>1</sup>[27.] 20.<sup>1</sup> Every member which elects to be a reinsuring carrier shall apply its case management and claims handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions and other methods of operation, in the same manner with respect to <sup>1</sup>[both reinsured and non-reinsured] all its<sup>1</sup> business.

OMIT SECTION 28 IN ITS ENTIRETY

REPLACE SECTION 29 TO READ:

<sup>1</sup>[29.] 21.<sup>1</sup> a. Following the close of <sup>1</sup>[each fiscal year of the administering carrier, the administering carrier shall determine the net premiums, the administrative expenses of the program and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses. Health benefits plan premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. For the purposes of this section, "net premiums" means health benefits plan premiums, less administrative expense allowances, and health benefits plan premiums earned by MEWAs shall be established by adding the paid losses and administrative expenses of such associations] the calendar year ending December 31, the administering carrier shall determine the total amount owed by the program in that calendar year to all carriers qualifying for reimbursement by the program. Such amount shall be known as the net loss of the program<sup>1</sup>.

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

c. If the net loss is not recouped before assessments totaling 4% of the aggregate premiums from policies or contracts covering small employers have been collected from reinsuring small employer carriers, additional assessments not to exceed 1% of the aggregate premiums from all health benefits policies or contracts shall be apportioned by the board among all members, including risk-assuming carriers, in proportion to their respective shares of the total health benefits plan premiums earned in this State from all health benefits plans during the preceding calendar year. A carrier shall receive a credit against this assessment to the extent the carrier can demonstrate that its assumption of high-risk small employer groups which are not reinsured is proportionate to its market share of small employer health benefits plans, as such groups and market shares are defined by the board in the plan of operation. A carrier shall not be assessed for all individual non-group contracts or policies issued on a guaranteed issue basis or on any coverage issued by the carrier pursuant to the Medicaid program, P.L.1968, c.413 (C.30:4D-1 et seq.).

d. If assessments exceed actual losses and administrative

expenses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

e. Provision may be established in the plan of operation for the imposition of an interest penalty for late payment of assessments.

RENUMBER SECTION 30 AS SECTION 22

REPLACE SECTION 31 TO READ:

<sup>1</sup>[31.] 23.<sup>1</sup> A small employer carrier which elects to cease participating as a reinsuring carrier and elects to become a risk-assuming carrier shall be prohibited from <sup>1</sup>[reinsuring or continuing to reinsure any small employer health benefits plan] receiving reimbursement from the program<sup>1</sup> pursuant to this act. Any reinsuring carrier electing to become a risk-assuming carrier shall pay a prorated assessment <sup>1</sup>[based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured]<sup>1</sup>.

REPLACE SECTION 32 TO READ:

<sup>1</sup>[32. a. The board may establish a subcommittee to monitor the market conduct of risk-assuming carriers and reinsuring carriers to assure that the provisions of this act are being carried out. The subcommittee shall, from time to time, recommend for the approval by the commissioner market conduct requirements for carriers and agents. The subcommittee shall also, in conjunction with the department, publish a list of all small employer carriers, as well as a list of toll free telephone numbers which are easily accessible by small employers. In the event that the board believes that any carrier is violating any provision of this act or is conducting itself improperly in the marketing or sale of its small group business, whether issued pursuant to this act or otherwise, it shall report this to the commissioner, who shall conduct an investigation of that carrier, including, but not limited to, an audit of the carrier's records.

b.) 24.<sup>1</sup> The board shall <sup>1</sup>[also]<sup>1</sup> establish guidelines to ensure that small employer carriers are assuming their share of high risk small employer groups in proportion to their market share of small employer health benefits plan business. In the event that any carrier does not assume its reasonable share of the high risk market, the board may adjust the assessment formula, with the approval of the commissioner, to require a proportionally higher assessment for the carrier.

RENUMBER SECTION 33 AS 25

REPLACE SECTION 34 TO READ:

<sup>1</sup>[34.] 28.<sup>1</sup> The excess insurance program established pursuant to this act shall be exempt from <sup>1</sup>[any taxes levied by the State, including]<sup>1</sup> premium taxes.

OMIT SECTIONS 35 AND 36 IN THEIR ENTIRETY

RENUMBER SECTION 37 AS SECTION 27

REPLACE SECTION 38 TO READ:

<sup>1</sup>[38.] 28.<sup>1</sup> No assessment provided for under this act shall <sup>1</sup>[, under any circumstances, be an obligation of the State] be charged, directly or indirectly, to policyholders or the public, provided that a carrier may charge such an assessment to policyholders to the extent that the charging of the assessment is necessary to enable the carrier to earn a constitutionally adequate rate of return<sup>1</sup> .

INSERT NEW SECTION 29 TO READ:

29. The board shall promulgate one standard claim form. In order to provide a standard system of payment for medical services, all claim forms for any claimant's use under any group health insurance policy issued or delivered in this State shall conform to the form adopted by the board.<sup>1</sup>

INSERT NEW SECTION 30 TO READ:

30. Notwithstanding any other provision of law to the contrary, all regulations concerning any health benefits plan subject to this act shall be promulgated pursuant to this act.<sup>1</sup>

RENUMBER SECTION 39 AS SECTION 31

REPLACE SYNOPSIS TO READ:

Requires certain insurers, service corporations and HMOs to offer standardized health insurance plans to small groups; establishes a reinsurance program.

SENATE COMMITTEE SUBSTITUTE FOR  
SENATE, No. 371

STATE OF NEW JERSEY

ADOPTED JUNE 15, 1992

Sponsored by Senators BASSANO, Adler and Ciesla

1 AN ACT requiring certain health insurers, service corporations  
2 and health maintenance organizations to offer <sup>1</sup>[basic]  
3 standardized<sup>1</sup> health benefits programs to <sup>1</sup>[certain employers]  
4 small groups<sup>1</sup> and establishing a reinsurance program.

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

8 1. As used in this act:

9 "Actuarial certification" means a written statement by a  
10 member of the American Academy of Actuaries or other  
11 individual acceptable to the commissioner that a small employer  
12 carrier is in compliance with the provisions of section <sup>1</sup>[12] g<sup>1</sup> of  
13 this act, based upon examination, including a review of the  
14 appropriate records and actuarial assumptions and methods used  
15 by the small employer carrier in establishing premium rates for  
16 applicable health benefits plans.

17 <sup>1</sup>"Anticipated loss ratio" means the ratio of the present value  
18 of the expected benefits, not including dividends, to the present  
19 value of the expected premiums, not reduced by dividends, over  
20 the entire period for which rates are computed to provide  
21 coverage. For purposes of this ratio, the present values must  
22 incorporate realistic rates of interest which are determined  
23 before federal taxes but after investment expenses.<sup>1</sup>

24 <sup>1</sup>"Base premium rate" means the lowest premium rate charged  
25 by the small employer carrier for the same or similar coverage,  
26 which coverage is equivalent in value to a health benefits plan  
27 covering a small employer. The term "base premium rate" refers  
28 to rates for any health benefits plan covering two or more  
29 employees of a small employer.

30 "Basic health benefits plan" means a health benefits plan for  
31 small employers which provides benefits pursuant to section 4 of  
32 this act and which is filed with the commissioner in accordance  
33 with the requirements of section 24 of this act, any portion of the  
34 premium for which is paid by a small employer or for which any  
35 covered individual is reimbursed whether through wage  
36 adjustments or otherwise, if the health benefits plan is treated by  
37 the employer or any of the covered individuals as part of a plan  
38 or program for the purposes of section 162 or section 106 of the  
39 Internal Revenue Code of 1986 (28 U.S.C. 162 or 26 U.S.C. 106).<sup>1</sup>

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

41 "Carrier" means any insurance company, health service

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

<sup>1</sup> Senate amendments adopted in accordance with Governor's  
recommendations November 30, 1992.

1 corporation, hospital service corporation, medical service  
2 corporation <sup>1</sup>[,] <sup>1</sup>or<sup>1</sup> health maintenance organization <sup>1</sup>[or  
3 MEWA]<sup>1</sup> authorized to issue health benefits plans in this State.  
4 For purposes of this act, carriers that are affiliated companies  
5 shall be treated as one carrier, except that any insurance  
6 company, health service corporation, hospital service  
7 corporation, or medical service corporation that is an affiliate of  
8 a health maintenance organization located in New Jersey or any  
9 health maintenance organization located in New Jersey that is  
10 affiliated with an insurance company, health service corporation,  
11 hospital service corporation, or medical service corporation shall  
12 treat the health maintenance organization as a separate carrier.

13 "Commissioner" means the Commissioner of Insurance.

14 <sup>1</sup>"Community rating" means a rating methodology in which the  
15 premium for all persons covered by a policy or contract form is  
16 the same based upon the experience of the entire pool of risks  
17 covered by that policy or contract form without regard to age,  
18 gender, health status, residence or occupation.<sup>1</sup>

19 "Department" means the Department of Insurance.

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

23 "Eligible employee" means a full-time employee who works a  
24 normal work week of <sup>1</sup>[30] <sup>1</sup>25<sup>1</sup> or more hours. The term includes  
25 a sole proprietor, a partner of a partnership, or an independent  
26 contractor, if the sole proprietor, partner, or independent  
27 contractor is included as an employee under a health benefits  
28 plan of a small employer, but does not include employees who  
29 work less than <sup>1</sup>[30] <sup>1</sup>25<sup>1</sup> hours a week or work on a temporary or  
30 substitute basis.

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

37 "Health benefits plan" means any hospital and medical expense  
38 incurred policy; health, hospital, or medical service corporation  
39 contract; <sup>1</sup>or<sup>1</sup> health maintenance organization subscriber  
40 contract <sup>1</sup>[(; or plans provided by MEWAs]<sup>1</sup> offered by <sup>1</sup>any  
41 carrier to<sup>1</sup> a small employer <sup>1</sup>group<sup>1</sup> pursuant to section <sup>1</sup>[4] <sup>1</sup>3<sup>1</sup>  
42 of this act. For purposes of this act, "health benefits plan"  
43 excludes the following plans, policies, or contracts: accident  
44 only, credit, disability, long-term care, coverage for Medicare  
45 services pursuant to a contract with the United States  
46 government, Medicare supplement, dental only or vision only  
47 issued as a supplement to liability insurance, coverage arising out  
48 of a workers' compensation or similar law, automobile medical  
49 payment insurance, or insurance under which benefits are payable  
50 with or without regard to fault and which is statutorily required  
51 to be contained in any liability insurance policy or equivalent  
52 self-insurance.

53 "Late enrollee" means an eligible employee or dependent who  
54 requests enrollment in a health benefits plan of a small employer

1 following the initial minimum 30-day enrollment period provided  
2 under the terms of the health benefits plan. An eligible employee  
3 or dependent shall not be considered a late enrollee if the  
4 individual was covered under another employer's health benefits  
5 plan at the time he was eligible to enroll and stated at the time  
6 of the initial enrollment that coverage under that other  
7 employer's health benefits plan was the reason for declining  
8 enrollment; has lost coverage under that other employer's health  
9 benefits plan as a result of termination of employment, the  
10 termination of the other plan's coverage, death of a spouse, or  
11 divorce; and the individual requests enrollment within 90 days  
12 after termination of coverage provided under another employer's  
13 health benefits plan; <sup>1</sup>[or if the individual is employed by an  
14 employer under a MEWA which offers multiple health benefits  
15 plans, and the individual elects a different plan during an open  
16 enrollment period;]<sup>1</sup> or if a court of competent jurisdiction has  
17 ordered coverage to be provided for a spouse or minor child under  
18 a covered employee's health benefits plan and request for  
19 enrollment is made within 30 days after issuance of that court  
20 order.

21 "Member" means all carriers issuing health benefits plans <sup>1</sup>[and  
22 MEWAs providing health benefits plans]<sup>1</sup> in this State on or after  
23 the effective date of this act.

24 <sup>1</sup>["MEWA" means any multiple employer welfare arrangement  
25 as defined in section 3 of the federal Employee Retirement and  
26 Income Security Act of 1974, Pub.L.93-406 (29 U.S.C. §1002),  
27 except for any such arrangement which is fully insured within the  
28 meaning of that act.]<sup>1</sup>

29 "Plan of operation" means the plan of operation of the program  
30 including articles, bylaws and operating rules approved pursuant  
31 to section <sup>1</sup>[20] 15<sup>1</sup> of this act.

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

43 "Program" means the New Jersey Small Employer Health  
44 Excess Reinsurance Program established pursuant to section <sup>1</sup>[18]  
45 12<sup>1</sup> of this act.

46 "Reinsuring carrier" means a a small employer carrier electing  
47 to <sup>1</sup>[obtain excess insurance] receive reimbursement from the  
48 program<sup>1</sup> in accordance <sup>1</sup>[in] with<sup>1</sup> section <sup>1</sup>[26] 19<sup>1</sup> of this act."

49 "Risk-assuming carrier" means a small employer carrier  
50 electing to assume risks pursuant to section <sup>1</sup>[25] 18<sup>1</sup> of this act."

51 "Small employer" means any person, firm, corporation,  
52 partnership, or association actively engaged in business which, on  
53 at least 50 percent of its working days during the preceding  
54 calendar year quarter, employed at least two but no more than

1 49 eligible employees, the majority of whom are employed within  
2 the State of New Jersey. In determining the number of eligible  
3 employees, companies which are affiliated companies shall be  
4 considered one employer, subsequent to the issuance of a health  
5 benefits plan to a small employer pursuant to the provisions of  
6 this act, and for the purpose of determining eligibility, the size of  
7 a small employer shall be determined annually. Except as  
8 otherwise specifically provided, provisions of this act which apply  
9 to a small employer shall continue to apply until the anniversary  
10 date next of the health benefits plan following the date the  
11 employer no longer meets the definition of a small employer.

12 "Small employer carrier" means any carrier <sup>1</sup>[or MEWA]<sup>1</sup> that  
13 offers health benefits plans covering eligible employees of one or  
14 more small employers.

15 "Small employer health benefits plan" means a health benefits  
16 plan for small employers approved by the commissioner pursuant  
17 to section <sup>1</sup>[23] <sup>17</sup><sup>1</sup> of this act.

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

27 3. <sup>1</sup>[Notwithstanding the provisions of P.L.1991, c.187, every  
28 carrier subject to the provisions of this act shall, as a condition  
29 of transacting business in this State, offer to every small  
30 employer at least two health benefits plans. One plan shall be a  
31 Basic health benefits plan, as provided in section 4 of this act,  
32 and one shall be a Basic Plus health benefits plan, as provided in  
33 section 5 of this act. Initially, the offer shall be made within 90  
34 days of the filing with the commissioner of that carrier's  
35 benefits plans. Thereafter, the plans shall be available to small  
36 employers on a continuing basis. Every small employer which  
37 elects to be covered under either of the plans provided for under  
38 this act who pays the required premium therefor and who  
39 satisfies the other requirements of the plan shall be issued a  
40 policy or contract by the carrier. The carrier may establish a  
41 premium payment plan which provides installment payments and  
42 which may contain reasonable provisions to ensure payment  
43 security, provided that provisions to ensure payment security are  
44 reasonably related to the risk and are uniformly applied. Every  
45 plan shall be in conformance with the guidelines established  
46 pursuant to section 23 of this act, and each carrier's plans shall  
47 be certified and filed with the commissioner pursuant to section  
48 24 of this act.]

49 a. Every small employer carrier shall, as a condition of  
50 transacting business in this State, offer to every small employer  
51 the same five health benefit plans. The board shall establish a  
52 standard policy form for each of the five plans, which shall be the  
53 only plans offered to small groups on or after January 1, 1994.  
54 One policy form shall contain the benefits provided for in

1 sections 55, 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2,  
2 17B:26B-2 and 26:2J-4.3). The remaining policy forms shall  
3 contain basic hospital and medical-surgical benefits, including,  
4 but not limited to:

- 5 (1) Basic inpatient and outpatient hospital care;
- 6 (2) Basic and extended medical-surgical benefits;
- 7 (3) Diagnostic tests, including x-rays;
- 8 (4) Maternity benefits, including prenatal and postnatal care;

9 and

10 (5) Preventive medicine, including periodic physical  
11 examinations and inoculations.

12 At least three of the forms shall provide for major medical  
13 benefits in varying lifetime aggregates, one of which shall  
14 provide at least \$1,000,000 in lifetime aggregate benefits. The  
15 policy forms provided pursuant to this section shall contain  
16 benefits representing progressively greater actuarial values.

17 b. Initially, a carrier shall offer a plan within 90 days of the  
18 approval of such plan by the commissioner. Thereafter, the plans  
19 shall be available to all small employers on a continuing basis.  
20 Every small employer which elects to be covered under any  
21 health benefits plan who pays the premium therefor and who  
22 satisfies the participation requirements of the plan shall be issued  
23 a policy or contract by the carrier.

24 c. The carrier may establish a premium payment plan which  
25 provides installment payments and which may contain reasonable  
26 provisions to ensure payment security, provided that provisions to  
27 ensure payment security are uniformly applied.

28 d. In addition to the five standard policies described in  
29 subsection a. of this section, the board may develop up to five  
30 rider packages. Any such package which a carrier chooses to  
31 offer shall be issued to a small employer who pays the premium  
32 therefor, and shall be subject to the rating methodology set forth  
33 in section 9 of this act.<sup>1</sup>

34 <sup>1</sup>[4. A Basic health benefits plan shall provide:

35 a. Basic hospital expense coverage for a period of 21 days in  
36 each benefit year for each covered person for expenses incurred  
37 for medically necessary treatment and services rendered as a  
38 result of injury or sickness, including:

- 39 (1) Daily hospital room and board, including general nursing  
40 care and special diets;
- 41 (2) Miscellaneous hospital services, including expenses incurred  
42 for charges made by the hospital for services and supplies which  
43 are customarily rendered by the hospital and provided for use  
44 only during any period of confinement;
- 45 (3) Hospital outpatient services, including surgical and other  
46 services rendered on a day stay basis, hospital services rendered  
47 within 72 hours after accidental injury, and x-ray and other  
48 laboratory and other diagnostic tests to the extent that benefits  
49 for such services would be provided if rendered to an inpatient of  
50 the hospital;

51 b. Basic medical-surgical expense coverage for each covered  
52 person for expenses incurred for medically necessary services for  
53 the treatment of sickness or injury for the following:

- 54 (1) Surgical services;

1 (2) Anesthesia services, including the administration of  
2 necessary general anesthesia and related procedures in  
3 connection with covered surgical services rendered by a physician  
4 other than the physician performing the surgical services;

5 (3) Inpatient hospital services rendered to a person who is  
6 confined to a hospital for treatment of sickness or injury other  
7 than that for which surgical care is required;

8 (4) Maternity benefits, including cost of delivery and pre-natal  
9 care;

10 c. Out-of-hospital physical examinations, including related  
11 x-rays, immunizations, and diagnostic tests, rendered on the  
12 following basis:

13 (1) For covered minors of less than two years of age, up to six  
14 examinations during the first two years of life;

15 (2) For covered minors of at least two years of age but not  
16 more than 18 years of age, no more than one physical  
17 examination at ages 3, 6, 9, 12, 15, and 18 years of age;

18 (3) For covered adults of at least 19 years of age but less than  
19 40 years of age, one physical examination every five years;

20 (4) For covered adults of at least 40 years of age but less than  
21 60 years of age, one examination every three years; and

22 (5) For covered adults of age 60 years or older, one  
23 examination every two years.

24 Every physical examination rendered pursuant to this  
25 subsection shall be subject to such co-payments and deductibles  
26 as are provided for in the plan.

27 d. The plan provided for herein may, subject to the approval of  
28 the commissioner, with respect to health maintenance  
29 organizations, be modified as necessary to comply with the  
30 provisions of subchapter XI of Pub.L.93-222 (42 U.S.C. §300e et  
31 seq.).<sup>1</sup>

32 <sup>1</sup>[5. a. A Basic Plus health benefits plan shall provide the  
33 same benefits as the basic policy, as well as hospital and medical  
34 expense coverage in excess of the basic policy as established and  
35 modified by the board from time to time, and approved by the  
36 commissioner, but in no case shall benefits provided for in the  
37 Basic Plus coverage exceed an actuarial value which is 20%  
38 greater than the actuarial value of the basic coverage provided  
39 pursuant to section 4 of this act.

40 b. The benefits which may be provided in excess of the  
41 benefits in the basic plan may include, but shall not be limited to,  
42 additional inpatient hospital benefits, additional diagnostic tests,  
43 benefits directed toward the prevention of disease, provided that  
44 they are quantifiably cost effective, and additional medical and  
45 surgical expense benefits.

46 c. At the discretion of the board, the Basic Plus plan may  
47 provide for a selection of not more than three alternative benefit  
48 packages which may be selected by small employers according to  
49 the needs of their work force, provided however, that no  
50 combination of alternative benefits in addition to the basic  
51 benefits shall exceed the actuarial value established in subsection  
52 a. of this section.]<sup>1</sup>

53 <sup>1</sup>[6.a.] 4.<sup>1</sup> Plans required to be offered <sup>1</sup>[pursuant to sections  
54 4 or 5 of this act shall] under this act may<sup>1</sup> be subject to

1 coinsurance and deductibles, which may vary by selected portions  
2 of the coverage, except that no deductible applicable to any  
3 portion of the coverage shall exceed \$250 for an individual or  
4 family unit during any benefit year, and no coinsurance applicable  
5 to any portion of the coverage shall exceed \$500 for an individual  
6 or family unit during any benefit year, unless provided by the  
7 board pursuant to section ~~1[23]~~ 17<sup>1</sup> of this act. Neither  
8 coinsurance nor deductibles shall be applicable to maternity  
9 benefits.

10 <sup>1</sup>[b. Except as provided herein, no law requiring the inclusion  
11 of any specified health care service or benefit and no law  
12 requiring the reimbursement, utilization, or consideration of a  
13 specific category of licensed health care practitioner shall apply  
14 to any Basic or Basic Plus health benefits plan provided for  
15 herein.]<sup>1</sup>

16 <sup>1</sup>[7.] 5.<sup>1</sup> Coverage provided pursuant to this act shall be subject  
17 to standard coordination of benefits provisions for all persons  
18 covered under the policy or contract. Notwithstanding the  
19 provision of any other law to the contrary, <sup>1</sup>[coverage] the health  
20 benefits plan with the lowest actuarial value<sup>1</sup> provided under  
21 <sup>1</sup>[policies or contracts issued pursuant to sections 4 or 5 of]<sup>1</sup> this  
22 act shall not extend to any injury for which coverage is available  
23 or applicable pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4),  
24 and <sup>1</sup>[the coverage provided by a policy or contract issued  
25 pursuant to this act] that health benefits plan<sup>1</sup> shall not be used  
26 as a substitute for any insurance required to be maintained  
27 pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4).

28 <sup>1</sup>[8. a. Except as otherwise provided by this act, a preexisting  
29 condition provision shall not exclude coverage for an eligible  
30 employee or dependent for a period beyond 180 days following the  
31 effective date of coverage of an eligible employee and may only  
32 relate to conditions manifesting themselves during the six months  
33 immediately preceeding the effective date of coverage in such a  
34 manner as would cause an ordinarily prudent person to seek  
35 medical advice, diagnosis, care or treatment or for which medical  
36 advice, diagnosis, care, or treatment was recommended or  
37 received during the six months immediately preceding the  
38 effective date of coverage, or as to a pregnancy existing on the  
39 effective date of coverage.]

40 6. a. No health benefits plan subject to this act shall include  
41 any preexisting condition provision, provided that, a preexisting  
42 condition provision may apply to a late enrollee or to any group  
43 of two to five persons if such provision excludes coverage for a  
44 period of no more than 180 days following the effective date of  
45 coverage of such enrollee, and relates only to conditions  
46 manifesting themselves during the six months immediately  
47 preceeding the effective date of coverage of such enrollee in  
48 such a manner as would cause an ordinarily prudent person to  
49 seek medical advice, diagnosis, care or treatment or for which  
50 medical advice, diagnosis, care, or treatment was recommended  
51 or received during the six months immediately preceding the  
52 effective date of coverage, or as to a pregnancy existing on the  
53 effective date of coverage; provided that, if 10 or more late  
54 enrollees request enrollment during any 30-day enrollment

1 period, then no preexisting condition provision shall apply to any  
2 such enrollee.<sup>1</sup>

3 b. In determining whether a preexisting condition provision  
4 applies to an eligible employee or dependent, all health benefits  
5 plans shall credit the time that person was covered under <sup>1</sup>[a]  
6 any<sup>1</sup> previous <sup>1</sup>[employer based]<sup>1</sup> health benefits plan if the  
7 previous coverage was continuous to a date not more than 90 days  
8 prior to the effective date of the new coverage, exclusive of any  
9 applicable waiting period under such plan.

10 <sup>1</sup>[9.] 7.<sup>1</sup> Every policy or contract issued to small employers in  
11 this State <sup>1</sup>[including, but not limited to, policies or contracts  
12 issued pursuant to the provisions of this act]<sup>1</sup> shall be renewable  
13 with respect to all eligible employees or dependents at the option  
14 of the policy or contract holder, or small employer except under  
15 the following circumstances:

16 a. Nonpayment of the required premiums by the policyholder,  
17 contract holder, or employer;

18 b. Fraud or misrepresentation of the policyholder, contract  
19 holder, or employer or, with respect to coverage of eligible  
20 employees or dependents, the enrollees or their representatives;

21 c. The number of employees covered under the health benefits  
22 plan is less than the number or percentage of employees required  
23 by participation requirements under the health benefits policy or  
24 contract;

25 d. Noncompliance with a carrier's employment contribution  
26 requirements;

27 e. <sup>1</sup>[The carrier withdraws the policy form, with the approval  
28 of the commissioner, in which case the group shall be offered an  
29 alternative policy or contract by the carrier which offers  
30 comparable benefits;

31 f.]<sup>1</sup> Any carrier doing business pursuant to the provisions of  
32 this act ceases doing business in the small employer market, if  
33 the 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 (3) of this  
42 section;

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.

2 <sup>1</sup>[10. Late enrollees may be excluded from coverage: a. for  
3 12 months for all coverage; or b. for 12 months for a preexisting  
4 condition. No combined period of total exclusion or exclusion for  
5 a preexisting condition shall exceed 12 months.]<sup>1</sup>

6 <sup>1</sup>[11.] g.<sup>1</sup> Any small employer carrier may require a reasonable  
7 specified minimum participation of eligible employees, which  
8 shall not exceed 75%, or reasonable minimum employer  
9 contributions in determining whether to accept a small group  
10 pursuant to this act. The standards so established by the carrier  
11 shall be first approved by the board and shall be applied uniformly  
12 to all small groups, except that in no event shall a carrier require  
13 an employer to contribute more than 10% to the annual cost of  
14 the policy or contract, or an amount as otherwise provided by the  
15 board, and any minimum participation standards established by  
16 the carrier shall be reasonable. In establishing the percentage of  
17 employee participation, a one-to-one credit shall be given for  
18 each employee covered by a spouse's health benefits coverage.

19 <sup>1</sup>[12. a. Rate differentials of any small group policies or  
20 contracts delivered, issued for delivery, or continued in this State  
21 may be based only on the factors of age, gender, and geography.  
22 No carrier shall issue any policy or contract in which the rates  
23 charged to any group exceed four times the base premium rate  
24 charged to the lowest-rated small employer group written by the  
25 carrier for a like benefits plan.

26 b. In establishing the rating classifications provided for by  
27 subsection a. of this section, no carrier shall establish an excess  
28 of six rating territories, and no rating territory shall be any  
29 smaller than a county.

30 c. No rate classifications based on age shall provide for rate  
31 changes within any period which is less than five years. Age  
32 ranges, which shall be in five-year increments, shall be  
33 established by the commissioner by regulation and shall apply to  
34 all small group policies, whether or not written pursuant to  
35 sections 4 and 5 of this act.

36 d. The premium rates charged to any small employer for  
37 policies or contracts issued before the effective date of this act  
38 by any carrier shall, within three years of the effective date of  
39 this act, conform to subsection a. of this section. The four to one  
40 ratio established by subsection a. of this section shall be applied  
41 separately to each type of benefits plan issued by the carrier.

42 e. Notwithstanding the provisions of subsection d. of this  
43 section to the contrary, the provisions of subsection a. of this  
44 section shall be applied separately to policies or contracts: (1) in  
45 the case of any small employer contracts issued by a hospital  
46 service corporation or medical service corporation or any  
47 successor corporation which constitute a closed block of business  
48 as of September 1, 1991; or (2) in the case of any small employer  
49 policies issued under an open enrollment plan by any other health  
50 insurer which have not been offered for sale as of January 1, 1989.

51 f. Any premium charged for excess coverage for policies  
52 issued pursuant to sections 4 or 5 of this act shall be subject to  
53 the limitations provided for in this section.

54 g. Rating classifications established by carriers for small

1 group policies or contracts shall not operate to produce rates for  
2 any small employer group which are excessive, inadequate, or  
3 unfairly discriminatory.

4 h. The provisions of this section shall apply to all small group  
5 business issued by any insurer in this State, whether or not  
6 written pursuant to section 4 or 5 of this act.]<sup>1</sup>

7 <sup>1</sup>[13. In connection with the offering for sale of any policy or  
8 contract to a small employer, each small employer carrier shall  
9 make a reasonable disclosure, as a part of its solicitation and  
10 sales materials, of the following:

11 a. The extent to which premium rates for a specified small  
12 employer are established or adjusted based upon the actual or  
13 expected variation in claims costs;

14 b. Any factors applicable to the policy or contract which are  
15 attributable to factors other than claim experience or duration of  
16 coverage, since issue, which affect changes in premium rates; and

17 c. Provisions relating to renewability of policies and  
18 contracts.]<sup>1</sup>

19 <sup>1</sup>[14. a. Every small employer carrier shall maintain at its  
20 principal place of business a complete and detailed description of  
21 its rating plan and underwriting practices, including renewal  
22 underwriting practices. Rating plans shall be based on commonly  
23 accepted actuarial assumptions and shall be in accordance with  
24 sound actuarial principles. This information shall be available to  
25 the commissioner upon request. Except in cases of any violation  
26 of this act, the information provided for herein shall be  
27 considered proprietary and trade secret information and shall not  
28 be subject to disclosure by the commissioner to persons outside of  
29 the department except as agreed to by the small employer carrier  
30 or as ordered by a court of competent jurisdiction.

31 b. Every small employer carrier shall file no later than March  
32 1 each year following the effective date of this act, a  
33 certification signed by an actuary and attested by an officer of  
34 the insurer that the carrier is in compliance with the act and that  
35 the rating methods of the small employer are actuarially sound.  
36 A copy of the certification shall be retained by the small  
37 employer carrier at its principal place of business.]<sup>1</sup>

38 <sup>19</sup> a. (1) Effective January 1, 1997, no small employer health  
39 benefits plan shall be issued in this State unless the plan is  
40 community rated.

41 (2) During the period January 1, 1994 to December 31, 1995,  
42 the premium rate charged by a carrier to the highest rated small  
43 group purchasing a small employer health benefits plan shall not  
44 be greater than 300% of the premium rate charged to the lowest  
45 rated small group purchasing that same health benefits plan.

46 (3) During the period January 1, 1996 to December 31, 1996,  
47 the premium rate charged by a carrier to the highest rated small  
48 group purchasing a small employer health benefits plan shall not  
49 be greater than 200% of the premium rate charged for the lowest  
50 rated small group purchasing that same health benefits plan.

51 (4) The commissioner shall study the impact on the health  
52 insurance marketplace of the transition from the rating  
53 methodology described in paragraph (3) of this subsection to  
54 community rating. In making this study the commissioner shall

1 consult with representatives of the health insurance industry,  
2 health care providers, consumer and public interest groups and  
3 such other persons with expertise deemed relevant by the  
4 commissioner. The commissioner shall report his findings to the  
5 Governor and the Legislature on a day that the Legislature is in  
6 session, on or before July 1, 1996. If the Legislature does not  
7 take action within 60 days after its receipt of the commissioner's  
8 report, to amend this act, community rating will become  
9 effective on January 1, 1997.

10 b. Notwithstanding any other provision of law to the contrary,  
11 group hospital or medical coverage obtained through an  
12 out-of-State trust covering a group of 49 or fewer employees or  
13 participating persons who are residents of this State shall be  
14 community rated regardless of the situs of delivery of the policy.

15 c. Notwithstanding any other provision of law to the contrary,  
16 no carrier offering any health benefits plan pursuant to the  
17 provisions of this act shall act to circumvent the intent of this  
18 act by acting as a third party administrator for groups of small  
19 employers, anyone of whom was insured as of September 1, 1992;  
20 provided, however, that this provision shall not act to limit a  
21 bona fide group of small employers who voluntarily act together  
22 to provide health benefits to their employees.

23 d. Notwithstanding any other provision of law to the contrary,  
24 this act shall apply to an association or trust of employers, if the  
25 group includes one or more member employers or other member  
26 groups which have 49 or fewer employees or members exclusive  
27 of spouses and dependents.

28 e. Nothing contained herein shall prohibit the use of premium  
29 rate structures to establish different premium rates for  
30 individuals and family units.

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

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

50 (2) Each calendar year, a carrier shall return, in the form of  
51 aggregate benefits for each of the five standard policy forms  
52 offered by the carrier pursuant to section 3 of this act, at least  
53 75% of the aggregate premiums collected for the policy form  
54 during that calendar year. Carriers shall annually report, no later

1 than August 1st of each year, the loss ratio calculated pursuant  
2 to this section for each such policy form for the previous  
3 calendar year. In each case where the loss ratio for a policy fails  
4 to substantially comply with the 75% loss ratio requirement, the  
5 carrier shall issue a dividend or credit against future premiums  
6 for all policyholders with that policy form in an amount sufficient  
7 to assure that the aggregate benefits paid in the previous  
8 calendar year plus the amount of the dividends and credits shall  
9 equal 75% of the aggregate premiums collected for the policy  
10 form in the previous calendar year. The dividend or credit shall  
11 be issued to each policy which was in effect as of March 30th of  
12 the applicable year and remains in effect as of the date the  
13 dividend or credit is issued. All dividends and credits must be  
14 distributed by December 31 of the year following the calendar  
15 year in which the loss ratio requirements were not satisfied. The  
16 annual report required by this paragraph shall include a carrier's  
17 calculation of the dividends and credits, as well as an explanation  
18 of the carrier's plan to issue dividends or credits. The  
19 instructions and format for calculating and reporting loss ratios  
20 and issuing dividends or credits shall be specified by the  
21 commissioner by regulation. Such regulations shall include  
22 provisions for the distribution of a dividend or credit in the event  
23 of cancellation or termination by a policyholder.

24 h. No carrier issuing health benefits plans covering two or  
25 more employees of a small employer shall issue a plan  
26 inconsistent with this act whose term extends beyond December  
27 31, 1993.

28 i. The provisions of this act shall apply to health benefits plans  
29 which are delivered, issued for delivery, renewed or continued on  
30 or after January 1, 1994. The commissioner shall withdraw  
31 approval for the issuance and use of all small employer policy  
32 forms, other than those approved by the board, effective January  
33 1, 1994.<sup>1</sup>

34 <sup>1</sup>[15.] 10.<sup>1</sup> a. No health maintenance organization shall be  
35 required to offer coverage or accept applications pursuant to  
36 <sup>1</sup>[sections 4 or 5] section 3<sup>1</sup> of this act to a small employer if the  
37 small employer is not physically located in the health  
38 maintenance organization's approved service area, to an  
39 employee when the employee does not work or reside within a  
40 service area, or if the health maintenance organization  
41 reasonably anticipates and demonstrates to the satisfaction of  
42 the commissioner that it will not have the capacity in its network  
43 of providers within the service area to deliver service adequately  
44 to the members of such groups because of its obligations to  
45 existing group contract holders and enrollees.

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

51 <sup>1</sup>c. A health maintenance organization which complies with  
52 the basic health benefits, underwriting and rating standards  
53 established by the federal government pursuant to subchapter XI  
54 of Pub.L.93-222 (42.U.S.C. §300e et seq.), and which also

1 provides the comprehensive health benefit plan coverage required  
2 by section 3 of this act, shall be deemed in compliance with this  
3 act.<sup>1</sup>

4 <sup>1</sup>[16. The provisions of sections 4 and 5 of this act shall apply  
5 to Basic and Basic Plus health benefits plans subject to this act  
6 which are delivered, issued for delivery, renewed or continued on  
7 or after the effective date of this act.]<sup>1</sup>

8 <sup>1</sup>[17.] 11.<sup>1</sup> a. Every policy or contract issued to a small  
9 employer in this State, including, but not limited to, policies or  
10 contracts which are subject to this act and which are delivered,  
11 issued, renewed, or continued on or after the effective date of  
12 this act, shall offer continued coverage under the plan to any  
13 employee whose employment was terminated for a reason other  
14 than for cause and to any employee covered by such plan whose  
15 hours of employment were reduced to less than 30 subsequent to  
16 the effective date of coverage for that employee. The employee  
17 shall make a written election for continued coverage within  
18 30 days of a qualifying event. For the purposes of this section,  
19 "qualifying event" shall mean the date of termination of  
20 employment, or the date on which a reduction in an employee's  
21 hours of employment becomes effective. For the purposes of this  
22 section, the date on which a health benefits plan is continued  
23 shall be the anniversary date of the issuance of the 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 <sup>1</sup>[18.] 12.<sup>1</sup> There is created a nonprofit entity to be known as  
26 the New Jersey Small Employer Health Excess Insurance  
27 Program. All carriers issuing health benefits plan policies and  
28 contracts in this State <sup>1</sup>[and any MEWA providing health  
29 benefits]<sup>1</sup> shall be members of this program. The program shall  
30 be administered by the board of directors established pursuant to  
31 section <sup>1</sup>[19.] 13<sup>1</sup> of this act.
- 32 <sup>1</sup>[19.] 13.<sup>1</sup> a. Within 60 days of the effective date of this act,  
33 the commissioner shall give notice to all members of the time  
34 and place for the initial organizational meeting, which shall take  
35 place within 90 days of the effective date. The members shall  
36 select the initial board, subject to the approval of the  
37 commissioner. The board shall consist of 11 persons, including  
38 the Commissioner of Health and the commissioner or their  
39 designees, both of whom shall sit ex officio. Initially, three of  
40 the public members of the board shall be elected for a three year  
41 term, three shall be elected for a two year term, and three shall  
42 be elected for a one year term. Thereafter, all board members  
43 shall be elected for a term of three years. The following  
44 categories shall be represented among the public members:
- 45 (1) Two carriers whose principal health insurance business is in  
46 the small employer market;
- 47 (2) One carrier whose principal health insurance business is in  
48 the large employer market;
- 49 (3) A health, hospital or medical service corporation;
- 50 (4) A health maintenance organization;
- 51 (5) A risk-assuming carrier;
- 52 (6) A reinsuring carrier utilizing the excess coverage provided  
53 for in this act; and
- 54 (7) Two persons representing small employers.

1 No carrier shall have more than one representative on the  
2 board.

3 b. If the initial board is not elected at the organizational  
4 meeting, the commissioner shall appoint the public members  
5 within 15 days of the organizational meeting, in accordance with  
6 the provisions of paragraphs (1) through (7) of subsection a. of  
7 this section.

8 <sup>1</sup>c. The board shall determine the Statewide average payment  
9 per insured for each benefit plan provided for under this act.  
10 Each carrier who satisfies the efficiency and risk management  
11 standards promulgated by the board pursuant to subsection f. of  
12 section 15 of this act and whose average cost of insuring  
13 individuals covered by small employer health benefits plans  
14 exceeds the Statewide average cost of insuring such individuals  
15 by 20%, shall be reimbursed by the program for 80% of its costs  
16 in excess thereof.

17 d. All meetings of the board shall be subject to the  
18 requirements of the "Open Public Meetings Act," P.L.1975, c.231  
19 (C.10:4-6 et seq.).

20 e. At least two copies of the minutes of every meeting of the  
21 board shall be delivered forthwith to the commissioner.<sup>1</sup>

22 <sup>1</sup>[20. a.] <sup>1</sup>14.<sup>1</sup> Within 90 days after the election of the initial  
23 board, the board shall submit to the commissioner a plan of  
24 operation which shall establish the administration of the program  
25 pursuant to the provisions of this act. The plan of operation and  
26 any subsequent amendments thereto shall be submitted to the  
27 commissioner who shall, after notice and hearing, approve the  
28 plan if he finds that it is reasonable and equitable and sufficiently  
29 carries out the provisions of this act. The plan of operation shall  
30 become effective after the commissioner has approved it in  
31 writing. The plan or any subsequent amendments thereto shall be  
32 deemed approved if not expressly disapproved by the  
33 commissioner in writing within 90 days of receipt by the  
34 commissioner.

35 <sup>1</sup>[b. If the board fails to submit a suitable plan of operation  
36 within 90 days after its appointment, the commissioner shall,  
37 after notice and hearing, adopt and promulgate a temporary plan  
38 of operation. The commissioner shall amend or rescind any such  
39 plan promulgated by him upon the submission and approval of a  
40 plan submitted by the board pursuant to subsection a. of this  
41 section.]<sup>1</sup>

42 <sup>1</sup>[21.] <sup>1</sup>15.<sup>1</sup> The plan of operation shall <sup>1</sup>constitute a public  
43 record and shall<sup>1</sup> include, but not be limited to, the following:

44 a. A method of handling and accounting for assets and moneys  
45 of the program and an annual fiscal reporting to the  
46 commissioner;

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

49 c. A means of selecting an administering carrier, and a  
50 statement of the powers and duties of the administering carrier  
51 and the compensation of the administering carrier <sup>1</sup>and a  
52 statement of the efficiency standards an administering carrier  
53 must meet<sup>1</sup> ;

54 d. The method to be used <sup>1</sup>[for securing excess insurance under

1 the provisions of this act] to determine the extent to which a  
2 carrier's payment per insured for each benefit plan provided for  
3 under this act, exceeds the Statewide average payment per  
4 insured for each benefit plan provided for under this act<sup>1</sup>;

5 e. The method <sup>1</sup>[to be used for establishing appropriate excess  
6 insurance premiums to be charged to carriers electing to reinsure  
7 risks in accordance with this act] for determining the extent to  
8 which a carrier whose average cost of insuring individuals  
9 covered by small employer health benefits plans exceeds the  
10 threshold described in subsection c. of section 13 of this act may  
11 receive reimbursement from the program<sup>1</sup> ;

12 f. <sup>1</sup>[The method to be used to make up any shortfall which may  
13 occur as the result of risks being reinsured under the provisions of  
14 this act.] A statement of the efficiency and risk management  
15 standards a carrier must meet before a carrier may receive  
16 reimbursement from the program; and<sup>1</sup>

17 g. <sup>1</sup>[A procedure for establishing the health benefits plans for  
18 which excess coverage is to be provided;

19 h.]<sup>1</sup> Any additional matters which are appropriate to  
20 effectuate the provisions of this act.

21 <sup>1</sup>[22.] 16.<sup>1</sup> The <sup>1</sup>[board shall have the general powers and  
22 authority granted under the laws of New Jersey to insurance  
23 companies writing health insurance pursuant to Title 17B of the  
24 New Jersey Statutes, to health maintenance organizations  
25 approved or qualified to transact business in this State, and to  
26 health service corporations, medical service corporations, and  
27 hospital service corporations, but in no case shall the program  
28 established under this act write any policy or contract of  
29 insurance directly. In addition to the aforementioned powers,  
30 the]<sup>1</sup> board shall have the authority to:

31 a. Enter into contracts as are necessary or proper to carry out  
32 the provisions and purposes of this act;

33 b. Sued or be sued, including taking any legal actions as may  
34 be necessary for recovery of any assessments due to the program  
35 or to avoid paying any improper claims;

36 c. <sup>1</sup>[Issue excess insurance policies or other documents  
37 evidencing such coverage;

38 d.]<sup>1</sup> Establish rules, conditions, and procedures pertaining to  
39 the <sup>1</sup>[reinsurance] reimbursement and assessment<sup>1</sup> of <sup>1</sup>[members'  
40 risks] members<sup>1</sup> by the program;

41 <sup>1</sup>[e. Establish appropriate rates, rate schedules, rate  
42 adjustments, rate classifications, and such other actuarial  
43 functions which may be appropriate to the operation of the  
44 program, for providing excess coverage;

45 f.] d.<sup>1</sup> Assess members in accordance with the provisions of  
46 this act, including such interim assessments as may be reasonable  
47 and necessary for organizational and interim operating expenses.  
48 Such interim assessments shall be credited as offsets against any  
49 regular assessments due following the close of the fiscal year;  
50 <sup>1</sup>and<sup>1</sup>

51 <sup>1</sup>[g.] e.<sup>1</sup> Appoint from among its members appropriate legal,  
52 actuarial, and other committees as necessary to provide technical  
53 assistance in the operation of the program, policy and other  
54 contract design, and any other function within the authority of

1 the program <sup>1</sup>; and  
2 h. Borrow money to effect the purposes of the program. Any  
3 notes or other evidence of indebtedness of the program not in  
4 default shall be legal investments for carriers and may be carried  
5 as admitted assets<sup>1</sup>.

6 <sup>1</sup>[23.] 17.<sup>1</sup> Subject to the approval of the commissioner, the  
7 board shall <sup>1</sup>[establish the form and level of coverages] formulate  
8 the five health benefits plans<sup>1</sup> to be made available by small  
9 employer carriers in accordance with the provisions of this  
10 act <sup>1</sup>, and shall promulgate five standard forms pursuant thereto<sup>1</sup>  
11 . The board may establish benefits levels, deductibles and  
12 copayments, exclusions, and limitations for the <sup>1</sup>[Basic and Basic  
13 Plus health care plan, consistent with sections 4 and 5 of this  
14 act. The board shall also determine what components of a small  
15 employer's health benefits plan may be reinsured] such health  
16 benefits plans in accordance with the law<sup>1</sup>.

17 One health care plan shall be established which contains  
18 benefits and cost sharing levels which are consistent with the  
19 basic method of operation and the benefits plans of health  
20 maintenance organizations, including any restrictions pursuant to  
21 subchapter XI of Pub.L.93-222 (42 U.S.C. §300 et seq.). The  
22 board shall submit the plans so established to the commissioner  
23 for his approval no later than 90 days after the election of the  
24 board pursuant to section <sup>1</sup>[19] 13<sup>1</sup> of this act. The commissioner  
25 shall approve the plan if he finds it to be consistent with the  
26 provisions of <sup>1</sup>[sections 4 and 5] section 3<sup>1</sup> of this act. Any plans  
27 submitted to the commissioner by the board shall be deemed  
28 approved if not expressly disapproved in writing within 60 days of  
29 its receipt by the commissioner. Such plans may contain, but  
30 shall not be limited to, the following provisions:

31 a. Utilization review of health care services, including review  
32 of medical necessity of hospital and physician services;  
33 b. Managed care systems, including large case management;  
34 c. Provision for selective contracting with hospitals,  
35 physicians, and other health care providers;  
36 d. Reasonable benefits differentials which are applicable to  
37 participating and nonparticipating providers;  
38 e. Notwithstanding the provisions of section 6 of this act to  
39 the contrary, the board may, from time to time, adjust  
40 coinsurance and deductibles; <sup>1</sup>[and]<sup>1</sup>  
41 f. Such other provisions which may be quantifiably established  
42 to be cost containment devices <sup>1</sup>;  
43 g. The department shall publish annually a list of the premiums  
44 charged for each of the five standard small employer health  
45 benefits plans and for any rider package by all carriers writing  
46 such plans. The department shall also publish the toll free  
47 telephone number of each such carrier<sup>1</sup> .

48 <sup>1</sup>[24. After the commissioner's approval of the health benefits  
49 plan guidelines formulated by the board pursuant to section 23 of  
50 this act, a small employer carrier shall file its policy or contract  
51 forms with the commissioner and shall certify to the  
52 commissioner, in a form required by the commissioner, that the  
53 plans filed by the carrier are in compliance with the guidelines  
54 established by the board. The certification shall be signed by the

1 chief executive officer of the carrier. Upon filing the  
2 certification with the commissioner, the carrier may use the  
3 certified plans until such time, after notice and hearing, as the  
4 commissioner disapproves their continued use.]<sup>1</sup>

5 <sup>1</sup>[25.] 18.<sup>1</sup> Every small employer carrier shall elect to be  
6 either a risk-assuming carrier or a reinsuring carrier and shall  
7 file notice of such election with the board. Carriers electing to  
8 be a risk-assuming carrier shall do so only with the approval of  
9 the commissioner. Application for risk-assuming status shall be  
10 filed with the commissioner on a form approved by the  
11 commissioner, and shall be deemed approved if it is not  
12 disapproved in writing within 90 days of the commissioner's  
13 receipt of the application. In determining whether to approve an  
14 application by a small employer carrier to become a  
15 risk-assuming carrier, the commissioner shall consider the  
16 carrier's financial condition, its history of assuming and  
17 managing risk, and its experience in managing small group  
18 business. The commissioner may also seek comments from the  
19 board prior to rendering a decision on the application. Any  
20 carrier which has made application for a risk-assuming status  
21 which has been disapproved by the commissioner shall be granted  
22 a hearing within 60 days of the disapproval.

23 <sup>1</sup>[26.] 19.<sup>1</sup> a. Any member which elects to be a reinsuring  
24 carrier may <sup>1</sup>[obtain excess insurance from the program on any  
25 new small employer group policy or contract issued pursuant to  
26 sections 4 or 5 of this act, on any small employer group, or any  
27 individual beneficiary for any amount payable for eligible claims  
28 in excess of \$7,500 per covered beneficiary per year. In such  
29 case, the program shall provide the excess coverage subject to  
30 the payment by the reinsuring carrier of an appropriate  
31 reinsurance premium. Coverage may be reinsured within 60 days  
32 of the commencement of the employer's coverage with the small  
33 employer carrier. With respect to eligible employees and their  
34 dependents who are hired subsequent to the commencement of  
35 the employer's coverage and who are not late enrollees to the  
36 plan, coverage may be reinsured within 60 days of the  
37 commencement of their coverage under the plan. Excess  
38 coverage may be terminated with respect to any employee or  
39 dependent on any plan anniversary] receive reimbursement in  
40 accordance with the standards developed by the board pursuant to  
41 subsections d., e. and f. of section 15 of this act<sup>1</sup>.

42 b. Election to <sup>1</sup>[purchase excess coverage through the  
43 program] become a reinsuring carrier<sup>1</sup> shall be binding for a  
44 five-year period, except that the initial election shall be made  
45 within 30 days of the submission to the commissioner of the plan  
46 of operation provided for in section <sup>1</sup>[20] 14<sup>1</sup> of this act, and  
47 shall be effective for two years.

48 <sup>1</sup>[27.] 20.<sup>1</sup> Every member which elects to be a reinsuring  
49 carrier shall apply its case management and claims handling  
50 techniques, including, but not limited to, utilization review,  
51 individual case management, preferred provider provisions and  
52 other methods of operation, in the same manner with respect to  
53 <sup>1</sup>[both reinsured and non-reinsured] all its<sup>1</sup> business.

54 <sup>1</sup>[28. a. Premium rates charged by the program for entire

1 groups shall not exceed 1.5 times the rate established by the  
2 board for similar groups for which excess coverage has not been  
3 purchased. In computing the premium, the board shall establish a  
4 rate from which the premium shall be computed which is not less  
5 than the average rate for like risks for the small group market as  
6 a whole.

7 b. Premium rates charged by the program for individuals shall  
8 not exceed 5.0 times the rate established by the program for  
9 similar persons for which excess coverage has not been purchased.

10 c. Premium rates charged for excess insurance by the program  
11 to a health maintenance organization that is approved by the  
12 United States Secretary of Health and Human Services as a  
13 federally qualified health maintenance organization pursuant to  
14 subchapter XI of Pub.L.93-222 (42 U.S.C. §300e et seq.), and as  
15 such is subject to requirements that limit the amount of risk that  
16 may be ceded to the program, shall be reduced to reflect the  
17 portion of the risk so ceded.

18 d. Premium rates charged for excess insurance shall not be  
19 charged directly back to the group or individual for whom the  
20 excess insurance is being obtained.]<sup>1</sup>

21 <sup>1</sup>[29.] 21.<sup>1</sup> a. Following the close of <sup>1</sup>[each fiscal year of the  
22 administering carrier, the administering carrier shall determine  
23 the net premiums, the administrative expenses of the program  
24 and the incurred losses, if any, for the year, taking into account  
25 investment income and other appropriate gains and losses.  
26 Health benefits plan premiums and benefits paid by a member  
27 that are less than an amount determined by the board to justify  
28 the cost of collection shall not be considered for purposes of  
29 determining assessments. For the purposes of this section, "net  
30 premiums" means health benefits plan premiums, less  
31 administrative expense allowances, and health benefits plan  
32 premiums earned by MEWAs shall be established by adding the  
33 paid losses and administrative expenses of such associations] the  
34 calendar year ending December 31, the administering carrier  
35 shall determine the total amount owed by the program in that  
36 calendar year to all carriers qualifying for reimbursement by the  
37 program. Such amount shall be known as the net loss of the  
38 program<sup>1</sup>.

39 b. Any net loss for the year shall be recouped by assessments  
40 of members. Assessments shall first be apportioned by the board  
41 among all reinsuring carrier members in proportion to their  
42 respective shares of the plan premiums earned in this State from  
43 health benefits plans covering small employers during the  
44 calendar year coinciding with or ending during the fiscal year of  
45 the program, or on any other equitable basis reflecting coverage  
46 of small employers as may be provided in the plan of operation.  
47 In making this determination, the board may base the assessments  
48 upon annual reports and other data filed by the member small  
49 employer carrier.

50 c. If the net loss is not recouped before assessments totaling  
51 4% of the aggregate premiums from policies or contracts  
52 covering small employers have been collected from reinsuring  
53 small employer carriers, additional assessments not to exceed 1%  
54 of the aggregate premiums from all health benefits policies or

1 contracts shall be apportioned by the board among all members,  
2 including risk-assuming carriers, in proportion to their respective  
3 shares of the total health benefits plan premiums earned in this  
4 State from all health benefits plans during the preceding calendar  
5 year. A carrier shall receive a credit against this assessment to  
6 the extent the carrier can demonstrate that its assumption of  
7 high-risk small employer groups which are not reinsured is  
8 proportionate to its market share of small employer health  
9 benefits plans, as such groups and market shares are defined by  
10 the board in the plan of operation. A carrier shall not be assessed  
11 for all individual non-group contracts or policies issued on a  
12 guaranteed issue basis or on any coverage issued by the carrier  
13 pursuant to the Medicaid program, P.L.1968, c.413 (C.30:4D-1  
14 et seq.).

15 d. If assessments exceed actual losses and administrative  
16 expenses of the program, the excess shall be held at interest and  
17 used by the board to offset future losses or to reduce program  
18 premiums. As used in this subsection, "future losses" includes  
19 reserves for incurred but not reported claims.

20 e. Provision may be established in the plan of operation for the  
21 imposition of an interest penalty for late payment of assessments.

22 <sup>1</sup>[30.] 22.<sup>1</sup> A member may seek from the commissioner a  
23 deferment in whole or in part from any assessment levied by the  
24 board. The commissioner may grant the deferment if, in his  
25 opinion, the payment of the assessment would endanger the  
26 ability of the member to fulfill its contractual obligations. In the  
27 event an assessment against a member is deferred in whole or in  
28 part, the amount by which the assessment is deferred may be  
29 assessed against the other members in a manner consistent with  
30 the basis for assessment set forth in this act. The member  
31 receiving a deferment shall remain liable to the program for the  
32 amount deferred and shall be prohibited from reinsuring any  
33 individuals or groups in the program if it fails to pay assessments.

34 <sup>1</sup>[31.] 23.<sup>1</sup> A small employer carrier which elects to cease  
35 participating as a reinsuring carrier and elects to become a  
36 risk-assuming carrier shall be prohibited from <sup>1</sup>[reinsuring or  
37 continuing to reinsure any small employer health benefits plan]  
38 receiving reimbursement from the program<sup>1</sup> pursuant to this act.  
39 Any reinsuring carrier electing to become a risk-assuming carrier  
40 shall pay a prorated assessment <sup>1</sup>[based upon business issued as a  
41 reinsuring carrier for any portion of the year that the business  
42 was reinsured]<sup>1</sup>.

43 <sup>1</sup>[32. a. The board may establish a subcommittee to monitor  
44 the market conduct of risk-assuming carriers and reinsuring  
45 carriers to assure that the provisions of this act are being carried  
46 out. The subcommittee shall, from time to time, recommend for  
47 the approval by the commissioner market conduct requirements  
48 for carriers and agents. The subcommittee shall also, in  
49 conjunction with the department, publish a list of all small  
50 employer carriers, as well as a list of toll free telephone numbers  
51 which are easily accessible by small employers. In the event that  
52 the board believes that any carrier is violating any provision of  
53 this act or is conducting itself improperly in the marketing or  
54 sale of its small group business, whether issued pursuant to this

1 act or otherwise, it shall report this to the commissioner, who  
2 shall conduct an investigation of that carrier, including, but not  
3 limited to, an audit of the carrier's records.

4 b.) 24.<sup>1</sup> The board shall <sup>1</sup>[also]<sup>1</sup> establish guidelines to ensure  
5 that small employer carriers are assuming their share of high risk  
6 small employer groups in proportion to their market share of  
7 small employer health benefits plan business. In the event that  
8 any carrier does not assume its reasonable share of the high risk  
9 market, the board may adjust the assessment formula, with the  
10 approval of the commissioner, to require a proportionally higher  
11 assessment for the carrier.

12 <sup>1</sup>[33.] 25.<sup>1</sup> Any carrier which violates this act shall be subject  
13 to a penalty assessment, as determined by the commissioner,  
14 whether or not the carrier is a risk-assuming carrier or a  
15 reinsuring carrier.

16 <sup>1</sup>[34.] 26.<sup>1</sup> The excess insurance program established pursuant  
17 to this act shall be exempt from <sup>1</sup>[any taxes levied by the State,  
18 including]<sup>1</sup> premium taxes.

19 <sup>1</sup>[35. No carrier writing small employer group insurance  
20 business pursuant to this act shall insure any small group under a  
21 policy or contract of insurance provided for in sections 4 or 5 of  
22 this act, which small group is insured by any carrier as of the  
23 effective date of the act or during the calendar year immediately  
24 preceding.]<sup>1</sup>

25 <sup>1</sup>[36. No later than one year following the effective date of  
26 this act and at least annually thereafter for the subsequent four  
27 years, the board shall conduct a review of the small group  
28 insurance market to examine the effectiveness of the insurance  
29 provided for in this act in terms of its acceptance among small  
30 employers and the adequacy of the benefits provided for. The  
31 review shall determine whether an additional product or products  
32 should be made available under the program provided for by this  
33 act, including major medical coverage. In addition, the board  
34 shall analyze the effect of the four to one premium ratio  
35 established pursuant to section 12 of this act to determine  
36 whether the relationship of the high-to-low rates established  
37 pursuant to that ratio are inequitably distributed throughout the  
38 small group market, and whether the ratio so established can be  
39 further reduced without negative economic effect on any group.

40 The board shall report to the Governor and the Legislature  
41 after each review required by this section, and include any  
42 recommendations it may have with respect to the modification or  
43 augmentation of the program.]<sup>1</sup>

44 <sup>1</sup>[37.] 27.<sup>1</sup> A carrier which violates any provision of this act  
45 shall be liable to a penalty of not less than \$2,000 and not greater  
46 than \$5,000 for each violation. The penalty shall be collected by  
47 the commissioner in the name of the State in a summary  
48 proceeding in accordance with "the penalty enforcement law,"  
49 N.J.S.2A:58-1 et seq..

50 <sup>1</sup>[38.] 28.<sup>1</sup> No assessment provided for under this act shall <sup>1</sup>[,  
51 under any circumstances, be an obligation of the State] be  
52 charged, directly or indirectly, to policyholders or the public,  
53 provided that a carrier may charge such an assessment to  
54 policyholders to the extent that the charging of the assessment is

1 necessary to enable the carrier to earn a constitutionally  
2 adequate rate of return<sup>1</sup>.

3 <sup>129.</sup> The board shall promulgate one standard claim form. In  
4 order to provide a standard system of payment for medical  
5 services, all claim forms for any claimant's use under any group  
6 health insurance policy issued or delivered in this State shall  
7 conform to the form adopted by the board.<sup>1</sup>

8 <sup>130.</sup> Notwithstanding any other provision of law to the  
9 contrary, all regulations concerning any health benefits plan  
10 subject to this act shall be promulgated pursuant to this act.<sup>1</sup>

11 <sup>1[39.] 31.</sup><sup>1</sup> This act shall take effect immediately.

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16 Requires certain insurers, service corporations and HMOs to offer  
17 standardized health insurance plans to small groups; establishes a  
18 reinsurance program.



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## OFFICE OF THE GOVERNOR NEWS RELEASE

**CN-001****Contact:** JON SHURE  
609-777-2600**TRENTON, N.J. 08625****Released** ay  
Sept. 8, 1992

### GOVERNOR FLORIO ANNOUNCES PLAN TO CONDITIONALLY VETO HEAL BILL

Governor Jim Florio announced today that he will conditionally veto the HEAL health insurance bill because it lacks critical measures that are essential to making real reforms to the health care system.

"In New Jersey alone, 800,000 people wake up every morning without any health insurance coverage," Gov. Florio said. "Too many people are being forced to choose between getting medical insurance and putting food on the table. Many who have insurance worry that it could be gone tomorrow -- lost in a layoff, cancelled by insurers or priced out of reach."

While the bill would require insurance companies doing business in the state to offer insurance policies to small businesses, companies could fulfill this obligation with skeleton policies that carry high pricetags and exclude or discriminate against certain individuals. Those people deemed to be bad risks would then be dumped into a state-sanctioned pool, similar to the Joint Underwriting Association that formerly existed for auto insurance.

The governor called for changes that would require companies to offer open enrollment so that no small group could be turned away. To lower the cost of health insurance, the governor said his veto will include a requirement for community rating, which requires insurers to spread the risk across a larger number of policyholders or businesses.

The governor also said he will include changes that require health insurers to offer five standard policies, in order to reduce the administrative costs of the insurance industry and make the process of buying health insurance easier for consumers. To assist consumers, the governor's changes would require the Insurance Department to annually publish a price list for the 20 leading companies for each of these five policies.

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Finally, the governor's changes will require the Legislature to eliminate the "JUA" provision of the bill. It would be replaced by a mechanism that requires the risk to be spread across as wide a base as possible while maximizing the incentive of insurers to control costs. All the changes would be required to be phased in over four years.

"The fact is, the health care industry is out of control. Up to 40 cents out of every dollar we spend on health care is squandered on administration and pushing paper by an insurance industry that is more concerned with denying people coverage than paying their medical bills," Gov. Florio said.

"And no one in the system has any incentive to keep costs down -- not doctors, not hospitals, or insurance companies, or lawyers, or even patients. The inefficiency and waste just multiplies and gets tacked on to the crippling premiums we all pay," Gov. Florio said.

The governor cited the case of, Roslyn Schwartz, a Bergen County woman who set out to walk from her Ridgefield home to Trenton last month to bring attention to the plight of citizens like her.

Ms. Schwartz has been battling cancer, which is now in remission, but has fallen deeply in debt from medical bills. She continues to live without insurance because no one will sell it to her, and she couldn't afford it if they did, and she is unable to afford critical follow-up tests designed to catch any recurrence of her cancer. She ended her walk to Trenton after meeting with the governor at a diner on Route 1 in Elizabeth.

"I told Roz that I heard her cries, and I vowed to fight for her and the hundreds of thousands of people like her who have the right to be treated with dignity and respect at the most difficult times in their lives," Gov. Florio said.

"But even this bill doesn't go far enough," The Governor said. "This will protect small groups, but there are thousands of individuals, like Roz, who don't fit in any category. I will not stop until we have made affordable health care available to all of New Jersey's citizens."

"With these changes, we can make New Jersey a national leader in health care. It won't be easy, the health insurance industry is a powerful special interest opposed to many of these changes," Gov. Florio said. "But we have to have the courage, inspired by people like Roslyn Schwartz, to follow through. Health insurance is too important to the people of our state to settle for half measures or empty promises."

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