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CL/JA

§7
C.17B:27A-33.1
and Note to
§§8-11
§8
C.17B:27A-33.2
§9,10
C.17B:27A-19.24a
and 17B:27A-19.24b
§11
C.17B:27A-20.1

P.L. 2023, CHAPTER 194, *approved December 21, 2023*
Senate, No. 3480 (*Fourth Reprint*)

1 AN ACT concerning small employer and individual health benefits
2 plans, amending P.L.1992, c.161 and P.L.1992, c.162, and
3 supplementing various parts of the statutory law.

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

7
8 1. Section 3 of P.L.1992, c.161 (C.17B:27A-4) is amended to
9 read as follows:

10 3. a. **[No later than 180 days after the effective date of this**
11 **section of P.L.2008, c.38, a carrier shall, as a condition of issuing**
12 **small employer health benefits plans in this State, also offer individual**
13 **health benefits plans. The plans shall be offered on an open**
14 **enrollment, modified community rated basis, pursuant to the**
15 **provisions of this act and P.L.2008, c.38. Every carrier that issues**
16 **small employer health benefits plans pursuant to P.L.1992, c.162**
17 **(C.17B:27A-17 et seq.) shall make a good faith effort to market**
18 **individual health benefits plans.]** ²**[(Deleted by amendment,**
19 **P.L. , c. (pending before the Legislature as this bill)]** **Every**
20 **carrier that offers individual health benefits plans shall make a good**
21 **faith effort to market the individual health benefits plans. The**
22 **department may impose fines against any carrier that violates the**
23 **provisions of this subsection**².

24 b. A carrier shall offer to an eligible person a choice of at least
25 three individual health benefits plans established by the board pursuant
26 to section 6 of P.L.1992, c.161 (C.17B:27A-7).

27 c. (1) (Deleted by amendment, P.L.2019, c.359).

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:

¹Senate floor amendments adopted February 27, 2023.

²Senate SBA committee amendments adopted March 16, 2023.

³Assembly floor amendments adopted May 25, 2023.

⁴Senate amendments adopted in accordance with Governor's recommendations December 11, 2023.

1 (2) (Deleted by amendment, P.L.2019, c.359).

2 (3) (Deleted by amendment, P.L.2019, c.359).

3 (4) (Deleted by amendment, P.L.2019, c.359).

4 (5) The provisions of section 13 of P.L.1985, c.236 (C.17:48E-13),
5 N.J.S.17B:26-1, and section 8 of P.L.1973, c.337 (C.26:2J-8) with
6 respect to the filing of policy forms shall not apply to health plans
7 issued on or after the effective date of **[this act]** P.L.1992, c.161
8 (C.17B:27A-2 et al.).

9 (6) The provisions of section 27 of P.L.1985, c.236 (C.17:48E-27)
10 and section 7 of P.L.1988, c.71 (C.17:48E-27.1) with respect to rate
11 filings shall not apply to individual health plans issued on or after the
12 effective date of **[this act]** P.L.1992, c.161 (C.17B:27A-2 et al.).

13 d. Every group conversion contract or policy issued after the
14 effective date of **[this act]** P.L.1992, c.161 (C.17B:27A-2 et al.) shall
15 be issued pursuant to this section; except that this requirement shall
16 not apply to any group conversion contract or policy in which a
17 portion of the premium is chargeable to, or subsidized by, the group
18 policy from which the conversion is made.

19 e. (Deleted by amendment, P.L.2008, c.38).

20 f. (Deleted by amendment, P.L.2019, c.359).

21 (cf: P.L.2019, c.359, s.2)

22

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

25 5. An individual health benefits plan issued pursuant to section 3
26 of **[this act]** P.L.1992, c.161 (C.17B:27A-4) is subject to the
27 following provisions:

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

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

35 (1) the policy or contract holder has failed to pay premiums in
36 accordance with the terms of the policy or contract or the carrier has
37 not received timely premium payments;

38 (2) the policy or contract holder has performed an act or practice
39 that constitutes fraud or made an intentional misrepresentation of
40 material fact under the terms of the coverage.

41 c. A carrier may not renew a health benefits plan only under the
42 following circumstances:

43 (1) termination of eligibility of the policy or contract holder if the
44 person is no longer a resident or becomes eligible for a group health
45 benefits plan, group health plan, governmental plan or church plan;

46 (2) cancellation or amendment by the board of the specific
47 individual health benefits plan;

1 (3) approval by the commissioner of a request by the individual
2 carrier to not renew a particular type of health benefits plan, in
3 accordance with rules adopted by the commissioner. After receiving
4 approval by the commissioner, a carrier may not renew a type of
5 health benefits plan only if the carrier: (a) provides notice to each
6 covered individual provided coverage of this type of the nonrenewal at
7 least 90 days prior to the date of the nonrenewal of the coverage; (b)
8 offers to each individual provided coverage of this type the option to
9 purchase any other individual health benefits plan currently being
10 offered by the carrier; and (c) in exercising the option to not renew
11 coverage of this type and in offering coverage as required under (b)
12 above, the carrier acts uniformly without regard to any health status-
13 related factor of enrolled individuals or individuals who may become
14 eligible for coverage;

15 (4) approval by the commissioner of a request by the individual
16 carrier to cease doing business in the individual health benefits market.
17 A carrier may not renew all individual health benefits plans only if the
18 carrier: (a) first receives approval from the commissioner; and (b)
19 provides notice to each individual of the nonrenewal at least 180 days
20 prior to the date of the expiration of such coverage【. A carrier ceasing
21 to do business in the individual health benefits market may not provide
22 for the issuance of any health benefits plan in the individual or small
23 employer markets during the five-year period beginning on the date of
24 the termination of the last health benefits plan not so renewed】². The
25 commissioner may impose a five-year prohibition on the issuance of
26 any health benefits plan in the individual or small employer markets if
27 the commissioner determines the prohibition would be beneficial to
28 the small employer and individual health benefits markets²; and

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

36 (cf: P.L.2008, c.38, s.14)

37

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

40 3. a. Except as provided in subsection f. of this section, every
41 small employer carrier shall, as a condition of transacting business
42 in this State, offer to every small employer at least three of the
43 health benefit plans established by the board, as provided in this
44 section【, and also offer and make a good faith effort to market
45 individual health benefits plans as provided in section 3 of
46 P.L.1992, c.161 (C.17B:27A-4)】. The board shall establish a
47 standard policy form for each of the plans, which except as

1 otherwise provided in subsection j. of this section, shall be the only
2 plans offered to small groups on or after January 1, 1994. One
3 policy form shall contain the benefits provided for in sections 55,
4 57, and 59 of P.L.1991, c. 187 (C.17:48E-22.2, 17B:26B-2 and
5 26:2J-4.3). In the case of indemnity carriers, one policy form shall
6 be established which contains benefits and cost sharing levels which
7 are equivalent to the health benefits plans of health maintenance
8 organizations pursuant to the "Health Maintenance Organization
9 Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.). The
10 remaining policy forms shall contain basic hospital and medical-
11 surgical benefits, including, but not limited to:

- 12 (1) Basic inpatient and outpatient hospital care;
- 13 (2) Basic and extended medical-surgical benefits;
- 14 (3) Diagnostic tests, including X-rays;
- 15 (4) Maternity benefits, including prenatal and postnatal care;
- 16 and
- 17 (5) Preventive medicine, including periodic physical
18 examinations and inoculations.

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

24 Notwithstanding the provisions of this subsection to the contrary,
25 the board also may establish additional policy forms by which a
26 small employer carrier, other than a health maintenance
27 organization, may provide indemnity benefits or health maintenance
28 organization enrollees by direct contract with the enrollees' small
29 employer through a dual arrangement with the health maintenance
30 organization. The dual arrangement shall be filed with the
31 commissioner for approval. The additional policy forms shall be
32 consistent with the general requirements of P.L.1992, c.162
33 (C.17B:27A-17 et seq.).

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

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

45 d. In addition to the standard policies described in subsection a.
46 of this section, the board may develop up to five rider packages.
47 Any such package which a carrier chooses to offer shall be issued to
48 a small employer who pays the premium therefor, and shall be

1 subject to rating methodology set forth in section 9 of P.L.1992,
2 c.162 (C.17B:27A-25).

3 e. (Deleted by amendment, P.L.2008, c.38).

4 f. Notwithstanding the provisions of this section to the
5 contrary, a health maintenance organization which is a qualified
6 health maintenance organization pursuant to the "Health
7 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
8 s.300e et seq.) shall be permitted to offer health benefits plans
9 formulated by the board and approved by the commissioner which
10 are in accordance with the provisions of that law in lieu of the five
11 plans required pursuant to this section.

12 Notwithstanding the provisions of this section to the contrary, a
13 health maintenance organization which is approved pursuant to
14 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health
15 benefits plans formulated by the board and approved by the
16 commissioner which are in accordance with the provisions of that
17 law in lieu of the plans required pursuant to this section, except that
18 the plans shall provide the same level of benefits as required for a
19 federally qualified health maintenance organization, including any
20 requirements concerning copayments by enrollees.

21 g. A carrier shall not be required to own or control a health
22 maintenance organization or otherwise affiliate with a health
23 maintenance organization in order to comply with the provisions of
24 this section, but the carrier shall be required to offer at least three of
25 the benefits plans which are formulated by the board and approved
26 by the commissioner, including one plan which contains benefits
27 and cost sharing levels that are equivalent to those required for
28 health maintenance organizations.

29 h. Notwithstanding the provisions of subsection a. of this
30 section to the contrary, the board may modify the benefits provided
31 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,
32 17B:26B-2 and 26:2J-4.3).

33 i. (1) In addition to the rider packages provided for in
34 subsection d. of this section, every carrier may offer, in connection
35 with the health benefits plans required to be offered by this section,
36 any number of riders which may revise the coverage offered by the
37 plans in any way, provided, however, that any form of such rider or
38 amendment thereof which decreases benefits or decreases the
39 actuarial value of a plan shall be filed for informational purposes
40 with the board and for approval by the commissioner before such
41 rider may be sold. Any rider or amendment thereof which adds
42 benefits or increases the actuarial value of a plan shall be filed with
43 the board for informational purposes before such rider may be sold.
44 The added premium or reduction in premium for each rider, as
45 applicable, shall be listed separately from the premium for the
46 standard plan.

47 The commissioner shall disapprove any rider filed pursuant to
48 this subsection that is unjust, unfair, inequitable, unreasonably

1 discriminatory, misleading, contrary to law or the public policy of
2 this State. The commissioner shall not approve any rider which
3 reduces benefits below those required by sections 55, 57 and 59 of
4 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and
5 required to be sold pursuant to this section. The commissioner's
6 determination shall be in writing and shall be appealable.

7 (2) The benefit riders provided for in paragraph (1) of this
8 subsection shall be subject to the provisions of section 2, subsection
9 b. of section 3, and sections 5, 7, 8, 9 and 11 of P.L.1992, c.162
10 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-
11 24, 17B:27A-25, and 17B:27A-27).

12 j. (1) Notwithstanding the provisions of P.L.1992, c.162
13 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
14 by or through a carrier, association, or multiple employer
15 arrangement prior to January 1, 1994 or, if the requirements of
16 subparagraph (c) of paragraph (6) of this subsection are met, issued
17 by or through an out-of-State trust prior to January 1, 1994, at the
18 option of a small employer policy or contract holder, may be
19 renewed or continued after February 28, 1994, or in the case of such
20 a health benefits plan whose anniversary date occurred between
21 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-
22 19.1 et al.), may be reinstated within 60 days of that anniversary
23 date and renewed or continued if, beginning on the first 12-month
24 anniversary date occurring on or after the sixtieth day after the
25 board adopts regulations concerning the implementation of the
26 rating factors permitted by section 9 of P.L.1992, c.162
27 (C.17B:27A-25) and, regardless of the situs of delivery of the health
28 benefits plan, the health benefits plan renewed, continued or
29 reinstated pursuant to this subsection complies with the provisions
30 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and
31 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,
32 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and
33 section 7 of P.L.1995, c.340 (C17B:27A-19.3).

34 Nothing in this subsection shall be construed to require an
35 association, multiple employer arrangement or out-of-State trust to
36 provide health benefits coverage to small employers that are not
37 contemplated by the organizational documents, bylaws, or other
38 regulations governing the purpose and operation of the association,
39 multiple employer arrangement or out-of-State trust.
40 Notwithstanding the foregoing provision to the contrary, an
41 association, multiple employer arrangement or out-of-State trust
42 that offers health benefits coverage to its members' employees and
43 dependents:

44 (a) shall offer coverage to all eligible employees and their
45 dependents within the membership of the association, multiple
46 employer arrangement or out-of-State trust;

47 (b) shall not use actual or expected health status in determining
48 its membership; and

1 (c) shall make available to its small employer members at least
2 one of the standard benefits plans, as determined by the
3 commissioner, in addition to any health benefits plan permitted to
4 be renewed or continued pursuant to this subsection.

5 (2) Notwithstanding the provisions of this subsection to the
6 contrary, a carrier or out-of-State trust which writes the health
7 benefits plans required pursuant to subsection a. of this section shall
8 be required to offer those plans to any small employer, association
9 or multiple employer arrangement.

10 (3) (a) A carrier, association, multiple employer arrangement, or
11 out-of-State trust may withdraw a health benefits plan marketed to
12 small employers that was in effect on December 31, 1993 with the
13 approval of the commissioner. The commissioner shall approve a
14 request to withdraw a plan, consistent with regulations adopted by
15 the commissioner, only on the grounds that retention of the plan
16 would cause an unreasonable financial burden to the issuing carrier,
17 taking into account the rating provisions of section 9 of P.L.1992,
18 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
19 (C.17B:27A-19.3).

20 (b) A carrier which has renewed, continued or reinstated a
21 health benefits plan pursuant to this subsection that has not been
22 newly issued to a new small employer group since January 1, 1994,
23 may, upon approval of the commissioner, continue to establish its
24 rates for that plan based on the loss experience of that plan if the
25 carrier does not issue that health benefits plan to any new small
26 employer groups.

27 (4) (Deleted by amendment, P.L.1995, c.340).

28 (5) A health benefits plan that otherwise conforms to the
29 requirements of this subsection shall be deemed to be in compliance
30 with this subsection, notwithstanding any change in the plan's
31 deductible or copayment.

32 (6) (a) Except as otherwise provided in subparagraphs (b) and
33 (c) of this paragraph, a health benefits plan renewed, continued or
34 reinstated pursuant to this subsection shall be filed with the
35 commissioner for informational purposes within 30 days after its
36 renewal date. No later than 60 days after the board adopts
37 regulations concerning the implementation of the rating factors
38 permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing
39 shall be amended to show any modifications in the plan that are
40 necessary to comply with the provisions of this subsection. The
41 commissioner shall monitor compliance of any such plan with the
42 requirements of this subsection, except that the board shall enforce
43 the loss ratio requirements.

44 (b) A health benefits plan filed with the commissioner pursuant
45 to subparagraph (a) of this paragraph may be amended as to its
46 benefit structure if the amendment does not reduce the actuarial
47 value and benefits coverage of the health benefits plan below that of
48 the lowest standard health benefits plan established by the board

1 pursuant to subsection a. of this section. The amendment shall be
2 filed with the commissioner for approval pursuant to the terms of
3 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,
4 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as
5 applicable, and shall comply with the provisions of sections 2 and 9
6 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7
7 of P.L.1995, c.340 (C.17B:27A-19.3).

8 (c) A health benefits plan issued by a carrier through an out-of-
9 State trust shall be permitted to be renewed or continued pursuant to
10 paragraph (1) of this subsection upon approval by the commissioner
11 and only if the benefits offered under the plan are at least equal to
12 the actuarial value and benefits coverage of the lowest standard
13 health benefits plan established by the board pursuant to subsection
14 a. of this section. For the purposes of meeting the requirements of
15 this subparagraph, carriers shall be required to file with the
16 commissioner the health benefits plans issued through an out-of-
17 State trust no later than 180 days after the date of enactment of
18 P.L.1995, c.340. A health benefits plan issued by a carrier through
19 an out-of-State trust that is not filed with the commissioner pursuant
20 to this subparagraph, shall not be permitted to be continued or
21 renewed after the 180-day period.

22 (7) Notwithstanding the provisions of P.L.1992, c.162
23 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
24 employer arrangement or out-of-State trust may offer a health
25 benefits plan authorized to be renewed, continued or reinstated
26 pursuant to this subsection to small employer groups that are
27 otherwise eligible pursuant to paragraph (1) of subsection j. of this
28 section during the period for which such health benefits plan is
29 otherwise authorized to be renewed, continued or reinstated.

30 (8) Notwithstanding the provisions of P.L.1992, c.162
31 (C.17B:27A-17 et seq.) to the contrary, a carrier, association,
32 multiple employer arrangement or out-of-State trust may offer
33 coverage under a health benefits plan authorized to be renewed,
34 continued or reinstated pursuant to this subsection to new
35 employees of small employer groups covered by the health benefits
36 plan in accordance with the provisions of paragraph (1) of this
37 subsection.

38 (9) Notwithstanding the provisions of P.L.1992, c.162
39 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et al.) to
40 the contrary, any individual, who is eligible for small employer
41 coverage under a policy issued, renewed, continued or reinstated
42 pursuant to this subsection, but who would be subject to a
43 preexisting condition exclusion under the small employer health
44 benefits plan, or who is a member of a small employer group who
45 has been denied coverage under the small employer group health
46 benefits plan for health reasons, may elect to purchase or continue
47 coverage under an individual health benefits plan until such time as
48 the group health benefits plan covering the small employer group of

1 which the individual is a member complies with the provisions of
2 P.L.1992, c.162 (C.17B:27A-17 et seq.).

3 (10) In a case in which an association made available a health
4 benefits plan on or before March 1, 1994 and subsequently changed
5 the issuing carrier between March 1, 1994 and the effective date of
6 P.L.1995, c.340, the new issuing carrier shall be deemed to have
7 been eligible to continue and renew the plan pursuant to paragraph
8 (1) of this subsection.

9 (11) In a case in which an association, multiple employer
10 arrangement or out-of-State trust made available a health benefits
11 plan on or before March 1, 1994 and subsequently changes the
12 issuing carrier for that plan after the effective date of P.L.1995,
13 c.340, the new issuing carrier shall file the health benefits plan with
14 the commissioner for approval in order to be deemed eligible to
15 continue and renew that plan pursuant to paragraph (1) of this
16 subsection.

17 (12) In a case in which a small employer purchased a health
18 benefits plan directly from a carrier on or before March 1, 1994 and
19 subsequently changes the issuing carrier for that plan after the
20 effective date of P.L.1995, c.340, the new issuing carrier shall file
21 the health benefits plan with the commissioner for approval in order
22 to be deemed eligible to continue and renew that plan pursuant to
23 paragraph (1) of this subsection.

24 Notwithstanding the provisions of subparagraph (b) of paragraph
25 (6) of this subsection to the contrary, a small employer who changes
26 its health benefits plan's issuing carrier pursuant to the provisions of
27 this paragraph, shall not, upon changing carriers, modify the benefit
28 structure of that health benefits plan within six months of the date
29 the issuing carrier was changed.

30 k. Effective immediately for a health benefits plan issued on or
31 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
32 and effective on the first 12-month anniversary date of a health
33 benefits plan in effect on the effective date of P.L.2005, c.248
34 (C.17:48E-35.27 et al.), the health benefits plans required pursuant
35 to this section, including any plans offered by a State approved or
36 federally qualified health maintenance organization, shall contain
37 benefits for expenses incurred in the following:

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

43 (2) All childhood immunizations as recommended by the
44 Advisory Committee on Immunization Practices of the United
45 States Public Health Service and the Department of Health pursuant
46 to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier shall
47 notify its insureds, in writing, of any change in the health care
48 services provided with respect to childhood immunizations and any

1 related changes in premium. Such notification shall be in a form
2 and manner to be determined by the Commissioner of Banking and
3 Insurance.

4 (3) Screening for newborn hearing loss by appropriate
5 electrophysiologic screening measures and periodic monitoring of
6 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
7 (C.26:2-103.1 et al.). Payment for this screening service shall be
8 separate and distinct from payment for routine new baby care in the
9 form of a newborn hearing screening fee as negotiated with the
10 provider and facility.

11 The benefits provided pursuant to this subsection shall be
12 provided to the same extent as for any other medical condition
13 under the health benefits plan, except that a deductible shall not be
14 applied for benefits provided pursuant to this subsection; however,
15 with respect to a small employer health benefits plan that qualifies
16 as a high deductible health plan for which qualified medical
17 expenses are paid using a health savings account established
18 pursuant to section 223 of the federal Internal Revenue Code of
19 1986 (26 U.S.C. s.223), a deductible shall not be applied for any
20 benefits that represent preventive care as permitted by that federal
21 law, and shall not be applied as provided pursuant to section 16 of
22 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to
23 all small employer health benefits plans in which the carrier has
24 reserved the right to change the premium.

25 l. The board shall consider including benefits for speech-
26 language pathology and audiology services, as rendered by speech-
27 language pathologists and audiologists within the scope of their
28 practices, in at least one of the standard policies and in at least one
29 of the five riders to be developed under this section.

30 m. Effective immediately for a health benefits plan issued on or
31 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
32 effective on the first 12-month anniversary date of a health benefits
33 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z
34 et al.), the health benefits plans required pursuant to this section
35 that provide benefits for expenses incurred in the purchase of
36 prescription drugs shall provide benefits for expenses incurred in
37 the purchase of specialized non-standard infant formulas, when the
38 covered infant's physician has diagnosed the infant as having
39 multiple food protein intolerance and has determined such formula
40 to be medically necessary, and when the covered infant has not been
41 responsive to trials of standard non-cow milk-based formulas,
42 including soybean and goat milk. The coverage may be subject to
43 utilization review, including periodic review, of the continued
44 medical necessity of the specialized infant formula.

45 The benefits shall be provided to the same extent as for any other
46 prescribed items under the health benefits plan.

1 This subsection shall apply to all small employer health benefits
2 plans in which the carrier has reserved the right to change the
3 premium.

4 n. Effective immediately for a health benefits plan issued on or
5 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
6 and effective on the first 12-month anniversary date of a small
7 employer health benefits plan in effect on the effective date of
8 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
9 required pursuant to this section that qualify as high deductible
10 health plans for which qualified medical expenses are paid using a
11 health savings account established pursuant to section 223 of the
12 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including
13 any plans offered by a State approved or federally qualified health
14 maintenance organization, shall contain benefits for expenses
15 incurred in connection with any medically necessary benefits
16 provided in-network that represent preventive care as permitted by
17 that federal law.

18 The benefits provided pursuant to this subsection shall be
19 provided to the same extent as for any other medical condition
20 under the health benefits plan, except that no deductible shall be
21 applied for benefits provided pursuant to this subsection. This
22 subsection shall apply to all small employer health benefits plans in
23 which the carrier has reserved the right to change the premium.

24 (cf: P.L.2012, c.17, s.58)

25

26 4. Section 4 of P.L.1992, c.162 (C.17B:27A-20) is amended to
27 read as follows:

28 4. Plans required to be offered under **[this act] P.L.1992, c.162**
29 **(C.17B:27A-17 et seq.)** may be subject to coinsurance and deductibles,
30 which may vary by selected portions of the coverage²**],** except that
31 **no]² [deductible applicable to any portion of the coverage shall**
32 **exceed \$250 for an individual or family unit during any benefit year,**
33 **and no coinsurance applicable to any portion of the coverage shall**
34 **exceed \$500 for an individual or family unit during any benefit year,**
35 **unless provided by the board pursuant to section 17 of P.L.1992, c.162**
36 **(C.17B:27A-33)]²[cost-sharing shall exceed the maximum out-of-**
37 **pocket limits established in the federal Patient Protection and**
38 **Affordable Care Act, Pub.L.111-148, as amended by the federal**
39 **"Health Care and Education Reconciliation Act of 2010," Pub.L.111-**
40 **152] . The department and the boards of directors of the New Jersey**
41 **Individual Health Coverage Program and New Jersey Small Employer**
42 **Health Benefits Program may promulgate regulations to create**
43 **standard plans or plan design requirements. The standard plans or plan**
44 **design requirements may include minimum cost sharing standards,**
45 **provided that the standards enable carriers to design and offer plans for**
46 **the bronze, silver, gold, and platinum metal levels as defined under the**
47 **actuarial value calculations pursuant to the federal "Patient Protection**

1 and Affordable Care Act," Pub.L.111-148, as amended by the "Health
2 Care and Education Reconciliation Act of 2010," Pub.L.111-152. In
3 promulgating these regulations, the commissioner and boards of
4 directors shall consider the best interests of consumers, the health of
5 the markets, and plan design that promotes utilization of high value
6 primary and preventative care to improve the health of the State's
7 population. Any minimum standard regulations and standard plans
8 promulgated by the commissioner or boards of directors pursuant to
9 this section shall be reviewed and adjusted annually to achieve the
10 goals of this section².

11 (cf: P.L.1993, c.162, s.3.)

12

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

15 7. Every policy or contract issued to small employers in this
16 State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be
17 renewable with respect to all eligible employees or dependents at
18 the option of the policy or contract holder, or small employer except
19 that a carrier may discontinue or not renew a health benefits plan in
20 accordance with the provisions of this section:

21 a. A carrier may discontinue such coverage only if:

22 (1) The policyholder, contract holder, or employer has failed to
23 pay premiums or contributions in accordance with the terms of the
24 health benefits plan or the carrier has not received timely premium
25 payments; or

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

30 b. (Deleted by amendment, P.L.1997, c.146).

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

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

37 e. Any carrier doing business pursuant to the provisions of
38 **【this act】** P.L.1992, c.162 (C17B:27A-17 et seq.) ceases doing
39 business in the small employer market, if the following conditions
40 are satisfied:

41 (1) The carrier gives notice to cease doing business in the small
42 employer market to the commissioner not later than eight months
43 prior to the date of the planned withdrawal from the small employer
44 market, during which time the carrier shall continue to be governed
45 by **【this act】** P.L.1992, c.162 (C.17B:27A-17 et seq.) with respect
46 to business written pursuant to **【this act】** P.L.1992, c.162
47 (C.17B:27A-17 et seq.) For the purposes of this subsection, "date
48 of withdrawal" means the date upon which the first notice to small

1 employers is sent by the carrier pursuant to paragraph (2) of this
2 subsection;

3 (2) No later than two months following the date of the
4 notification to the commissioner that the carrier intends to cease
5 doing business in the small employer market, the carrier shall mail a
6 notice to every small business employer insured by the carrier, and
7 all covered persons, that the policy or contract of insurance will not
8 be renewed. This notice shall be sent by certified mail to the small
9 business employer not less than six months in advance of the
10 effective date of the nonrenewal date of the policy or contract;

11 (3) ~~Any carrier that ceases to do business pursuant to this act~~
12 ~~shall be prohibited from writing new business in the small employer~~
13 ~~and individual health benefits plan markets for a period of five~~
14 ~~years from the date of termination of the last health insurance~~
15 ~~coverage not so renewed】 (Deleted by amendment,
16 P.L. ,c. (pending before the Legislature as this bill).~~

17 f. In the case of policies or contracts issued in connection with
18 membership in an association or trust of employers, an employer
19 ceases to maintain its membership in the association or trust, but
20 only if such coverage is terminated under this provision uniformly
21 without regard to any health status-related factor relating to any
22 covered individual;

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

24 h. A decision by the small employer carrier to cease offering
25 and not renew a particular type of group health benefits plan in the
26 small employer market, if the board discontinues a standard health
27 benefits plan or as permitted or required pursuant to subsection j. of
28 section 3 of P.L.1992, c.162 (C.17B:27A-19), and pursuant to the
29 regulations adopted by the commissioner;

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

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

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

41 (cf: P.L.2008, c.38, s.23)

42

43 ¹【6. Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to
44 read as follows:

45 9. a. (1) (Deleted by amendment, P.L.1997, c.146).

46 (2) (Deleted by amendment, P.L.1997, c.146).

47 (3) (a) For all policies or contracts providing health benefits
48 plans for small employers issued pursuant to section 3 of P.L.1992,

1 c.162 (C.17B:27A-19), and including policies or contracts offered
2 by a carrier to a small employer who is a member of a Small
3 Employer Purchasing Alliance pursuant to the provisions of
4 P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged
5 by a carrier to the highest rated small group purchasing a small
6 employer health benefits plan issued pursuant to section 3 of
7 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than **[200%]**
8 300% of the premium rate charged for the lowest rated small group
9 purchasing that same health benefits plan; provided, however, that
10 the only factors upon which the rate differential may be based are
11 age**[, gender]** and geography. Such factors shall be applied in a
12 manner consistent with regulations adopted by the commissioner.
13 For the purposes of this paragraph (3), policies or contracts offered
14 by a carrier to a small employer who is a member of a Small
15 Employer Purchasing Alliance shall be rated separately from the
16 carrier's other small employer health benefits policies or contracts.

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

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

23 (5) Any policy or contract issued after January 1, 1994 to a
24 small employer who was not previously covered by a health
25 benefits plan issued by the issuing small employer carrier, shall be
26 subject to the same premium rate restrictions as provided in
27 paragraph (3) of this subsection, which rate restrictions shall be
28 effective on the date the policy or contract is issued.

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

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

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

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

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

37 d. Notwithstanding any other provision of law to the contrary,
38 **[this act]** P.L.1992, c.162 (C.17B:27A-17 et seq.) shall apply to a
39 carrier which provides a health benefits plan to one or more small
40 employers through a policy issued to an association or trust of
41 employers.

42 A carrier which provides a health benefits plan to one or more
43 small employers through a policy issued to an association or trust of
44 employers after the effective date of P.L.1992, c.162 (C.17B:27A-
45 17 et seq.), shall be required to offer small employer health benefits
46 plans to non-association or trust employers in the same manner as
47 any other small employer carrier is required pursuant to P.L.1992,
48 c.162 (C.17B:27A-17 et seq.).

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

4 f. No insurance contract or policy subject to **[this act]**
5 P.L.1992, c.162 (C.17B:27A-17 et seq.), including a contract or
6 policy entered into with a small employer who is a member of a
7 Small Employer Purchasing Alliance pursuant to the provisions of
8 P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be entered into unless
9 and until the carrier has made an informational filing with the
10 commissioner of a schedule of premiums, not to exceed 12 months
11 in duration, to be paid pursuant to such contract or policy, of the
12 carrier's rating plan and classification system in connection with
13 such contract or policy, and of the actuarial assumptions and
14 methods used by the carrier in establishing premium rates for such
15 contract or policy.

16 g. (1) Beginning January 1, 1995, a carrier desiring to increase
17 or decrease premiums for any policy form or benefit rider offered
18 pursuant to subsection i. of section 3 of P.L.1992, c.162
19 (C.17B:27A-19) subject to **[this act]** P.L.1992, c.162 (C.17B:27A-
20 17 et seq.) may implement such increase or decrease upon making
21 an informational filing with the commissioner of such increase or
22 decrease, along with the actuarial assumptions and methods used by
23 the carrier in establishing such increase or decrease, provided that
24 the anticipated minimum loss ratio for all policy forms shall not be
25 less than 80% of the premium therefor as provided in paragraph (2)
26 of this subsection. The commissioner may disapprove any
27 informational filing on a finding that it is incomplete and not in
28 substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et
29 seq.), or that the rates are inadequate or unfairly discriminatory.
30 Until December 31, 1996, the informational filing shall also include
31 the carrier's rating plan and classification system in connection with
32 such increase or decrease.

33 (2) Each calendar year, a carrier shall return, in the form of
34 aggregate benefits for all of the standard policy forms offered by
35 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162
36 (C.17B:27A-19), at least 80% of the aggregate premiums collected
37 for all of the standard policy forms, other than alliance policy
38 forms, and at least 80% of the aggregate premiums collected for all
39 of the non-standard policy forms during that calendar year. A
40 carrier shall return at least 80% of the premiums collected for all of
41 the alliances during that calendar year, which loss ratio may be
42 calculated in the aggregate for all of the alliances or separately for
43 each alliance. Carriers shall annually report, no later than August
44 1st of each year, the loss ratio calculated pursuant to this section for
45 all of the standard, other than alliance policy forms, non-standard
46 policy forms and alliance policy forms for the previous calendar
47 year, provided that a carrier may annually report the loss ratio
48 calculated pursuant to this section for all of the alliances in the

1 aggregate or separately for each alliance. In each case where the
2 loss ratio fails to substantially comply with the 80% loss ratio
3 requirement, the carrier shall issue a dividend or credit against
4 future premiums for all policyholders with the standard, other than
5 alliance policy forms, nonstandard policy forms or alliance policy
6 forms, as applicable, in an amount sufficient to assure that the
7 aggregate benefits paid in the previous calendar year plus the
8 amount of the dividends and credits shall equal 80% of the
9 aggregate premiums collected for the respective policy forms in the
10 previous calendar year. All dividends and credits must be
11 distributed by December 31 of the year following the calendar year
12 in which the loss ratio requirements were not satisfied. The annual
13 report required by this paragraph shall include a carrier's calculation
14 of the dividends and credits applicable to standard, other than
15 alliance policy forms, non-standard policy forms and alliance policy
16 forms, as well as an explanation of the carrier's plan to issue
17 dividends or credits. The instructions and format for calculating
18 and reporting loss ratios and issuing dividends or credits shall be
19 specified by the commissioner by regulation. Such regulations shall
20 include provisions for the distribution of a dividend or credit in the
21 event of cancellation or termination by a policyholder. For
22 purposes of this paragraph, "alliance policy forms" means policies
23 purchased by small employers who are members of Small Employer
24 Purchasing Alliances.

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

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

31 i. The provisions of **【this act】** P.L.1992, c.162 (C.17B:27A-17
32 et seq.) shall apply to health benefits plans which are delivered,
33 issued for delivery, renewed or continued on or after January 1,
34 1994.

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

36 k. A carrier who negotiates a reduced premium rate with a
37 Small Employer Purchasing Alliance for members of that alliance
38 shall provide a reduction in the premium rate filed in accordance
39 with paragraph (3) of subsection a. of this section, expressed as a
40 percentage, which reduction shall be based on volume or other
41 efficiencies or economies of scale and shall not be based on health
42 status-related factors.

43 (cf: P.L.2008, c.38, s.24)】¹

44

45 ¹**【7.】**6.¹ Section 13 of P.L.1992, c.162 (C.17B:27A-29) is
46 amended to read as follows:

1 13. a. [Within 60 days of the effective date of this act, the
2 commissioner shall give notice to all members of the time and place
3 for the initial organizational meeting, which shall take place within
4 90 days of the effective date. The members shall elect the initial
5 board, subject to the approval of the commissioner. The board shall
6 consist of 10 elected public members and two ex officio members
7 who include the Commissioner of Health and the commissioner or
8 their designees. Initially, three of the public members of the board
9 shall be elected for a three-year term, three shall be elected for a
10 two-year term, and three shall be elected for a one-year term.
11 Thereafter, all elected board members shall serve for a term of three
12 years. The following categories shall be represented among the
13 elected public members:

14 (1) Three carriers whose principal health insurance business is
15 in the small employer market;

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

18 (3) A health service corporation or a domestic stock insurer
19 which converted from a health service corporation pursuant to the
20 provisions of P.L.2001, c.131 (C.17:48E-49 et al.) and is primarily
21 engaged in the business of issuing health benefit plans in this State;

22 (4) Two health maintenance organizations; and

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

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

25 (7) Three persons representing small employers, at least one of
26 whom represents minority small employers.

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

28 The board shall hold an election for the two members added
29 pursuant to P.L.1995, c.298 within 90 days of the date of enactment
30 of that act. Initially, one of the two new members shall serve for a
31 term of one year and one of the two new members shall serve for a
32 term of two years. Thereafter, the new members shall serve for a
33 term of three years. The terms of the risk-assuming carrier and
34 reinsuring carrier shall terminate upon the election of the two new
35 members added pursuant to P.L.1995, c.298, notwithstanding the
36 provisions of this section to the contrary.

37 In addition to the 10 elected public members, the] The board
38 shall [include six] consist of ²[12] ²13 public members appointed
39 by the Governor [with the advice and consent of the Senate] who
40 shall include:

41 (1) Two carriers that sell plans in the small employer market;

42 (2) One carrier that sells plans in the individual market or the
43 small employer market;

44 (3) Two representatives of or individuals employed by
45 businesses that purchase in small employer health benefits plans;

46 (4) Two health care provider representatives;

- 1 (5) Two insurance producers licensed to sell health insurance
2 pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.);
- 3 (6) One representative of organized labor;
- 4 **【**One physician licensed to practice medicine and surgery in this
5 State; and
- 6 Two persons who represent the general public and are not
7 employees of a health benefits plan provider. **】**
- 8 (7) One representative of an association representing small
9 business in the State; and
- 10 (8) ²**【**One person **】** Two persons² with knowledge or expertise in
11 New Jersey regulated health insurance markets who ³**【**represents**】**
12 represent³ the general public.
- 13 The ²Commissioner of Health and the² commissioner, or the
14 commissioner's designee, shall serve on the board as ²**【**an**】**² ex
15 officio ²**【**member**】** members². No carrier shall have more than one
16 representative on the board.
- 17 The public members shall be appointed for a term of three years,
18 except that of the members first appointed, **【**two**】** ²**【**four**】** five²
19 shall be appointed for a term of one year, **【**two**】** four for a term of
20 two years and **【**two**】** four for a term of three years.
- 21 A vacancy in the membership of the board shall be filled for an
22 unexpired term in the manner provided for the **【**original election
23 or**】** appointment**【**, as appropriate**】**.
- 24 ²The board shall continue in its existing form until there is
25 established a quorum of members newly appointed pursuant to the
26 provisions of P.L. , c. (C.) (pending before the Legislature
27 as this bill).²
- 28 b. **【**If the initial board is not elected at the organizational
29 meeting, the commissioner shall appoint the public members within
30 15 days of the organizational meeting, in accordance with the
31 provisions of paragraphs (1) through (7) of subsection a. of this
32 section. **】** (Deleted by amendment, P.L. , c.) (pending before
33 the Legislature as this bill).
- 34 c. (Deleted by amendment, P.L.1995, c.298).
- 35 d. All meetings of the board shall be subject to the
36 requirements of the "Open Public Meetings Act," P.L.1975, c.231
37 (C.10:4-6 et seq.).
- 38 e. At least two copies of the minutes of every meeting of the
39 board shall be delivered forthwith to the commissioner.
- 40 ³f. To the extent that any provision of P.L. , c. (C.)
41 (pending before the Legislature as this bill) is in conflict with any
42 provision of section 2 of P.L.2019, c.141 (C.17B:27A-58), the
43 provisions of section 2 of P.L.2019, c.141 (C.17B:27A-58) shall
44 govern.³
- 45 (cf: P.L.2012, c.17, s.60.)

1 ¹[8.] ⁷.¹ (New section) Sections ²[8] ⁷² through ²[13]
 2 ⁴[12²] ¹¹⁴ of P.L. , c. (C.) (pending before the Legislature
 3 as this bill) shall be known and may be cited as the “Small Business
 4 Health Insurance Affordability Act.”

5
 6 ¹[9.] ⁸.¹ (New section) a. The board shall annually review the
 7 small employer health benefits plans offered pursuant to P.L.1992,
 8 c.162 (C.17B:27A-17 et seq.) to ensure that each plan meets the
 9 requirements of section 2 of P.L.2019, c.354 (C.17B:27A-19.30),
 10 provides consumer choice and affordability, and maintains a relative
 11 level of consistency compared to previous years and to other plans in
 12 the small employer market. The board shall publish the findings of its
 13 review on the website of the Department of Banking and Insurance.

14 b. The board shall annually adjust the design of the small
 15 employer health benefits plans, including the out-of-pocket limits
 16 under those plans, to ensure premium affordability and to align the
 17 plans with the requirements of section 2 of P.L.2019, c.354
 18 (C.17B:27A-19.30). The adjustment shall be based on the annual
 19 review conducted pursuant to subsection a. of this section. The board
 20 may consider proposals for adjustments to plan design to improve
 21 affordability from carriers offering small employer health benefits
 22 plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

23 c. The board shall annually review the appropriateness of
 24 geographic rating areas ²and may adjust, by rule, as needed to achieve
 25 the goals of this subsection².

26 d. The board shall examine and, to the extent practicable, track
 27 where small employers who do not continue coverage through a small
 28 employer health benefits plan offered pursuant to P.L.1992, c.162
 29 (C.17B:27A-17 et seq.) elect to purchase coverage. The board shall
 30 have the authority to develop a sample survey that insurance ²[brokers
 31 may] producers shall² provide to clients. ²[Brokers who elect to
 32 provide the survey to clients] Insurance producers² shall report to the
 33 board ²[any] all² information received through the survey², which
 34 shall be de-identified by the insurance producer². The sample survey
 35 shall include, but may not be limited to, information concerning where
 36 small employers purchase health benefits coverage. The board shall
 37 publish ²a report on² the ²[findings of the] results of the² surveys
 38 received from ²[brokers] insurance producers² pursuant to this
 39 subsection on the website of the Department of Banking and
 40 Insurance.

41
 42 ¹[10.] ⁴[9].¹ (New section) a. Except as provided in subsection
 43 b. of this section, a carrier that offers an individual health benefits
 44 plan that provides benefits for expenses incurred in the purchase of
 45 prescription drugs and is delivered, issued, executed, or renewed in
 46 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), may
 47 use a prescription drug formulary to limit or exclude coverage for

1 prescription drugs, provided that ¹the carrier offers at least one plan
 2 with an open formulary and¹ the carrier demonstrates to the
 3 satisfaction of the board that utilization and medical review panels
 4 are in place to allow formulary flexibility as necessary in the best
 5 interest of the insured person.

6 b. A carrier that offers an individual health benefits plan that
 7 provides benefits for expenses incurred in the purchase of
 8 prescription drugs and is delivered, issued, executed, or renewed in
 9 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall
 10 not adopt a protocol, policy, or program that establishes the specific
 11 sequence in which prescription drugs for a specified medical
 12 condition, and medically appropriate for a particular patient, are
 13 required to be administered in order to be covered by a health
 14 benefits plan.

15 ²c. Notwithstanding the provisions of the “Administrative
 16 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.) to the
 17 contrary, the department shall, as appropriate and ³no later than³ in
 18 time for plan year ³[2024] 2025³, update rules and regulations to
 19 ensure consistency with the provisions of this section and P.L. _____,
 20 c. _____ (C. _____) (pending before the Legislature as this bill)
 21 immediately upon filing with the Office of Administrative Law.
 22 The rules and regulations adopted pursuant to this subsection shall
 23 be in effect only for plan year ³[2024] 2025³. The rules and
 24 regulations shall thereafter be adopted, amended, or readopted for
 25 plan years ³[2025] 2026³ and thereafter by the department in
 26 accordance with the requirements of the “Administrative Procedure
 27 Act,” P.L.1968, c.410 (C.52:14B-1 et seq.).²⁴

28
 29 ¹[11.] ⁴[10.1] 9.⁴ (New section) a. Except as provided in
 30 subsection b. of this section, a carrier that offers a small employer
 31 health benefits plan that provides benefits for expenses incurred in
 32 the purchase of prescription drugs and is delivered, issued,
 33 executed, or renewed in this State, pursuant to P.L.1992, c.162
 34 (C.17B:27A-17 et seq.), may use a prescription drug formulary to
 35 limit or exclude coverage for prescription drugs, provided that ¹the
 36 carrier offers at least one plan with an open formulary and¹ the
 37 carrier demonstrates to the satisfaction of the board that utilization
 38 and medical review panels are in place to allow formulary
 39 flexibility as necessary in the best interest of the insured person.

40 b. A carrier that offers a small employer health benefits plan
 41 that provides benefits for expenses incurred in the purchase of
 42 prescription drugs and is delivered, issued, executed, or renewed in
 43 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall
 44 not adopt a protocol, policy, or program that establishes the specific
 45 sequence in which prescription drugs for a specified medical
 46 condition, and medically appropriate for a particular patient, are

1 required to be administered in order to be covered by a health
2 benefits plan.

3 ²c. Notwithstanding the provisions of the “Administrative
4 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.) to the
5 contrary, the department shall, as appropriate and ³no later than³ in
6 time for plan year ³[2024] 2025³, update rules and regulations to
7 ensure consistency with the provisions of this section and P.L. ,
8 c. (C.) (pending before the Legislature as this bill)
9 immediately upon filing with the Office of Administrative Law.
10 The rules and regulations adopted pursuant to this subsection shall
11 be in effect only for plan year ³[2024] 2025³. The rules and
12 regulations shall thereafter be adopted, amended, or readopted for
13 plan years ³[2025] 2026³ and thereafter by the department in
14 accordance with the requirements of the “Administrative Procedure
15 Act,” P.L.1968, c.410 (C.52:14B-1 et seq.).²
16

17 ¹[12.] ²[11.¹ (New section) a. The department shall establish a
18 clinically sound and well-communicated exceptions and appeals
19 process for any carrier that uses a prescription drug formulary
20 pursuant to sections 10 and 11 of P.L. , c. (C.) (pending
21 before the Legislature as this bill). The exceptions and appeals
22 process shall allow insureds to appeal to an independent, objective
23 third party which shall render a decision as promptly as the
24 patient’s condition mandates.

25 b. A carrier subject to the exceptions and appeals process
26 established pursuant to this section shall:

27 (1) show cause before denying payment for a prescription drug
28 when a prescriber has deemed the carrier’s recommended substitute
29 medically inappropriate;

30 (2) provide insureds with step-by-step directions to initiate the
31 exceptions and appeals process; and

32 (3) for a prescription drug that is nonpreferred, not require an
33 insured who obtains that prescription drug to pay an amount greater
34 than the cost sharing tier level associated with the preferred
35 prescription drug, if the prescriber determines that therapeutically
36 similar drugs are medically inappropriate.

37 c. The department shall collect the information it requires to
38 conduct an annual evaluation of the exceptions and appeals process
39 established pursuant to this section with regard to the
40 appropriateness of the burden of the process on consumers and
41 clinicians and the effects on patient health outcomes.]²
42

43 ⁴[²11.] ⁴10.⁴ (New section) a. A carrier that uses a prescription
44 drug formulary pursuant to ⁴[sections] section⁴ 9 ⁴[and 10]⁴ of
45 P.L. , c. (C.) (pending before the Legislature as this bill)
46 shall establish a clinically sound and well-communicated exceptions

1 and appeals process, or incorporate into the carrier's existing
2 appeals process, the requirements of this section.

3 b. The process shall provide insureds with step-by-step
4 directions to initiate the exceptions and appeals process and, for a
5 prescription drug that is nonpreferred, not require an insured who
6 obtains that prescription drug to pay an amount greater than the cost
7 sharing tier level associated with the preferred prescription drug, if
8 the prescriber determines that therapeutically similar drug is
9 medically inappropriate.

10 c. A carrier shall show cause before denying payment for a
11 prescription drug when a prescriber has deemed the carrier's
12 recommended substitute medically inappropriate.

13 d. An insured may apply to the Independent Health Care
14 Appeals Program established pursuant to section 11 of P.L.1997,
15 c.192 (C.26:2S-11) to appeal a carrier decision, and the program
16 shall render a decision as promptly as the patient's condition
17 mandates.

18 e. The department shall collect information from each carrier
19 subject to this section to conduct an annual evaluation of the
20 exceptions and appeals processes established pursuant to this
21 section with regard to the appropriateness of the burden of the
22 process on consumers and clinicians and the effects on patient
23 health outcomes.²

24
25 ¹[13.] ⁴[12.1] 11.⁴ (New section) The department shall, ³no
26 later than³ in time for plan year ³[2024] 2025³ ²and immediately
27 upon filing with the Office of Administrative Law², adopt rules and
28 regulations, ²[pursuant to] notwithstanding the provisions of² the
29 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
30 seq.) ²to the contrary², requiring ²[the minimum standards] no
31 additional limitations on copayments, coinsurance, or deductibles²
32 for small employer health benefits plans pursuant to P.L.1992,
33 c.162 (C.17B:27A-17 et seq.) ²[be no greater than the minimum
34 standards] beyond those² set forth in the federal Patient Protection
35 and Affordable Care Act, Pub.L.111-148, as amended by the federal
36 "Health Care and Education Reconciliation Act of 2010,"
37 Pub.L.111-152 for plans issued pursuant to P.L.1992, c.161
38 (C.17B:27A-2 et seq.). ²The rules and regulations adopted pursuant
39 to this section shall be in effect only for plan year ³[2024] 2025³.
40 Rules and regulations shall thereafter be adopted, amended, or
41 readopted for plan years ³[2025] 2026³ and thereafter by the
42 department in accordance with the requirements of section 4 of
43 ⁴[P.L. , c. (C.) (pending before the Legislature as this act)]
44 P.L.1992, c.162 (C.17B:27A-20)⁴ and the requirements of the
45 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
46 seq.)²

1 ¹[14.]⁴[13.¹] 12.⁴ This act shall take effect immediately.

2

3

4

5

6 _____

7 “The Small Business Health Insurance Affordability Act”;

8 revises certain requirements for individual and small employer

 health benefits plans.

SENATE, No. 3480

STATE OF NEW JERSEY
220th LEGISLATURE

INTRODUCED JANUARY 12, 2023

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Senator NELLIE POU

District 35 (Bergen and Passaic)

SYNOPSIS

“The Small Business Health Insurance Affordability Act”; revises certain requirements for individual and small employer health benefits plans.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 1/19/2023)

1 AN ACT concerning small employer and individual health benefits
2 plans, amending P.L.1992, c.161 and P.L.1992, c.162, and
3 supplementing various parts of the statutory law.

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

7
8 1. Section 3 of P.L.1992, c.161 (C.17B:27A-4) is amended to
9 read as follows:

10 3. a. **[No later than 180 days after the effective date of this**
11 **section of P.L.2008, c.38, a carrier shall, as a condition of issuing**
12 **small employer health benefits plans in this State, also offer**
13 **individual health benefits plans. The plans shall be offered on an**
14 **open enrollment, modified community rated basis, pursuant to the**
15 **provisions of this act and P.L.2008, c.38. Every carrier that issues**
16 **small employer health benefits plans pursuant to P.L.1992, c.162**
17 **(C.17B:27A-17 et seq.) shall make a good faith effort to market**
18 **individual health benefits plans.]** (Deleted by amendment,
19 P.L. , c. (pending before the Legislature as this bill).

20 b. A carrier shall offer to an eligible person a choice of at least
21 three individual health benefits plans established by the board
22 pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7).

23 c. (1) (Deleted by amendment, P.L.2019, c.359).

24 (2) (Deleted by amendment, P.L.2019, c.359).

25 (3) (Deleted by amendment, P.L.2019, c.359).

26 (4) (Deleted by amendment, P.L.2019, c.359).

27 (5) The provisions of section 13 of P.L.1985, c.236 (C.17:48E-
28 13), N.J.S.17B:26-1, and section 8 of P.L.1973, c.337 (C.26:2J-8)
29 with respect to the filing of policy forms shall not apply to health
30 plans issued on or after the effective date of **[this act]** P.L.1992,
31 c.161 (C.17B:27A-2 et al.).

32 (6) The provisions of section 27 of P.L.1985, c.236 (C.17:48E-
33 27) and section 7 of P.L.1988, c.71 (C.17:48E-27.1) with respect to
34 rate filings shall not apply to individual health plans issued on or
35 after the effective date of **[this act]** P.L.1992, c.161 (C.17B:27A-2
36 et al.).

37 d. Every group conversion contract or policy issued after the
38 effective date of **[this act]** P.L.1992, c.161 (C.17B:27A-2 et al.)
39 shall be issued pursuant to this section; except that this requirement
40 shall not apply to any group conversion contract or policy in which
41 a portion of the premium is chargeable to, or subsidized by, the
42 group policy from which the conversion is made.

43 e. (Deleted by amendment, P.L.2008, c.38).

44 f. (Deleted by amendment, P.L.2019, c.359).

45 (cf: P.L.2019, c.359, s.2)

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

Matter underlined thus is new matter.

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

3 5. An individual health benefits plan issued pursuant to section
4 3 of **【this act】** P.L.1992, c.161 (C.17B:27A-4) is subject to the
5 following provisions:

6 a. The health benefits plan shall guarantee coverage for an
7 eligible person and his dependents on a modified community rated
8 basis.

9 b. A health benefits plan shall be renewable with respect to an
10 eligible person and his dependents at the option of the policy or
11 contract holder. A carrier may terminate a health benefits plan
12 under the following circumstances:

13 (1) the policy or contract holder has failed to pay premiums in
14 accordance with the terms of the policy or contract or the carrier has
15 not received timely premium payments;

16 (2) the policy or contract holder has performed an act or practice
17 that constitutes fraud or made an intentional misrepresentation of
18 material fact under the terms of the coverage.

19 c. A carrier may not renew a health benefits plan only under
20 the following circumstances:

21 (1) termination of eligibility of the policy or contract holder if
22 the person is no longer a resident or becomes eligible for a group
23 health benefits plan, group health plan, governmental plan or church
24 plan;

25 (2) cancellation or amendment by the board of the specific
26 individual health benefits plan;

27 (3) approval by the commissioner of a request by the individual
28 carrier to not renew a particular type of health benefits plan, in
29 accordance with rules adopted by the commissioner. After
30 receiving approval by the commissioner, a carrier may not renew a
31 type of health benefits plan only if the carrier: (a) provides notice to
32 each covered individual provided coverage of this type of the
33 nonrenewal at least 90 days prior to the date of the nonrenewal of
34 the coverage; (b) offers to each individual provided coverage of this
35 type the option to purchase any other individual health benefits plan
36 currently being offered by the carrier; and (c) in exercising the
37 option to not renew coverage of this type and in offering coverage
38 as required under (b) above, the carrier acts uniformly without
39 regard to any health status-related factor of enrolled individuals or
40 individuals who may become eligible for coverage;

41 (4) approval by the commissioner of a request by the individual
42 carrier to cease doing business in the individual health benefits
43 market. A carrier may not renew all individual health benefits plans
44 only if the carrier: (a) first receives approval from the
45 commissioner; and (b) provides notice to each individual of the
46 nonrenewal at least 180 days prior to the date of the expiration of
47 such coverage**【**. A carrier ceasing to do business in the individual
48 health benefits market may not provide for the issuance of any

1 health benefits plan in the individual or small employer markets
2 during the five-year period beginning on the date of the termination
3 of the last health benefits plan not so renewed】; and

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

11 (cf: P.L.2008, c.38, s.14)

12

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

15 3. a. Except as provided in subsection f. of this section, every
16 small employer carrier shall, as a condition of transacting business
17 in this State, offer to every small employer at least three of the
18 health benefit plans established by the board, as provided in this
19 section【, and also offer and make a good faith effort to market
20 individual health benefits plans as provided in section 3 of
21 P.L.1992, c.161 (C.17B:27A-4)】. The board shall establish a
22 standard policy form for each of the plans, which except as
23 otherwise provided in subsection j. of this section, shall be the only
24 plans offered to small groups on or after January 1, 1994. One
25 policy form shall contain the benefits provided for in sections 55,
26 57, and 59 of P.L.1991, c. 187 (C.17:48E-22.2, 17B:26B-2 and
27 26:2J-4.3). In the case of indemnity carriers, one policy form shall
28 be established which contains benefits and cost sharing levels which
29 are equivalent to the health benefits plans of health maintenance
30 organizations pursuant to the “Health Maintenance Organization
31 Act of 1973,” Pub.L.93-222 (42 U.S.C. s.300e et seq.). The
32 remaining policy forms shall contain basic hospital and medical-
33 surgical benefits, including, but not limited to:

34 (1) Basic inpatient and outpatient hospital care;

35 (2) Basic and extended medical-surgical benefits;

36 (3) Diagnostic tests, including X-rays;

37 (4) Maternity benefits, including prenatal and postnatal care;

38 and

39 (5) Preventive medicine, including periodic physical
40 examinations and inoculations.

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

46 Notwithstanding the provisions of this subsection to the contrary,
47 the board also may establish additional policy forms by which a
48 small employer carrier, other than a health maintenance

1 organization, may provide indemnity benefits or health maintenance
2 organization enrollees by direct contract with the enrollees' small
3 employer through a dual arrangement with the health maintenance
4 organization. The dual arrangement shall be filed with the
5 commissioner for approval. The additional policy forms shall be
6 consistent with the general requirements of P.L.1992, c.162
7 (C.17B:27A-17 et seq.).

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

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

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

25 e. (Deleted by amendment, P.L.2008, c.38).

26 f. Notwithstanding the provisions of this section to the
27 contrary, a health maintenance organization which is a qualified
28 health maintenance organization pursuant to the "Health
29 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
30 s.300e et seq.) shall be permitted to offer health benefits plans
31 formulated by the board and approved by the commissioner which
32 are in accordance with the provisions of that law in lieu of the five
33 plans required pursuant to this section.

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

43 g. A carrier shall not be required to own or control a health
44 maintenance organization or otherwise affiliate with a health
45 maintenance organization in order to comply with the provisions of
46 this section, but the carrier shall be required to offer at least three of
47 the benefits plans which are formulated by the board and approved
48 by the commissioner, including one plan which contains benefits

1 and cost sharing levels that are equivalent to those required for
2 health maintenance organizations.

3 h. Notwithstanding the provisions of subsection a. of this
4 section to the contrary, the board may modify the benefits provided
5 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,
6 17B:26B-2 and 26:2J-4.3).

7 i. (1) In addition to the rider packages provided for in
8 subsection d. of this section, every carrier may offer, in connection
9 with the health benefits plans required to be offered by this section,
10 any number of riders which may revise the coverage offered by the
11 plans in any way, provided, however, that any form of such rider or
12 amendment thereof which decreases benefits or decreases the
13 actuarial value of a plan shall be filed for informational purposes
14 with the board and for approval by the commissioner before such
15 rider may be sold. Any rider or amendment thereof which adds
16 benefits or increases the actuarial value of a plan shall be filed with
17 the board for informational purposes before such rider may be sold.
18 The added premium or reduction in premium for each rider, as
19 applicable, shall be listed separately from the premium for the
20 standard plan.

21 The commissioner shall disapprove any rider filed pursuant to
22 this subsection that is unjust, unfair, inequitable, unreasonably
23 discriminatory, misleading, contrary to law or the public policy of
24 this State. The commissioner shall not approve any rider which
25 reduces benefits below those required by sections 55, 57 and 59 of
26 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and
27 required to be sold pursuant to this section. The commissioner's
28 determination shall be in writing and shall be appealable.

29 (2) The benefit riders provided for in paragraph (1) of this
30 subsection shall be subject to the provisions of section 2, subsection
31 b. of section 3, and sections 5, 7, 8, 9 and 11 of P.L.1992, c.162
32 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-
33 24, 17B:27A-25, and 17B:27A-27).

34 j. (1) Notwithstanding the provisions of P.L.1992, c.162
35 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
36 by or through a carrier, association, or multiple employer
37 arrangement prior to January 1, 1994 or, if the requirements of
38 subparagraph (c) of paragraph (6) of this subsection are met, issued
39 by or through an out-of-State trust prior to January 1, 1994, at the
40 option of a small employer policy or contract holder, may be
41 renewed or continued after February 28, 1994, or in the case of such
42 a health benefits plan whose anniversary date occurred between
43 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-
44 19.1 et al.), may be reinstated within 60 days of that anniversary
45 date and renewed or continued if, beginning on the first 12-month
46 anniversary date occurring on or after the sixtieth day after the
47 board adopts regulations concerning the implementation of the
48 rating factors permitted by section 9 of P.L.1992, c.162

1 (C.17B:27A-25) and, regardless of the situs of delivery of the health
2 benefits plan, the health benefits plan renewed, continued or
3 reinstated pursuant to this subsection complies with the provisions
4 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and
5 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,
6 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and
7 section 7 of P.L.1995, c.340 (C17B:27A-19.3).

8 Nothing in this subsection shall be construed to require an
9 association, multiple employer arrangement or out-of-State trust to
10 provide health benefits coverage to small employers that are not
11 contemplated by the organizational documents, bylaws, or other
12 regulations governing the purpose and operation of the association,
13 multiple employer arrangement or out-of-State trust.
14 Notwithstanding the foregoing provision to the contrary, an
15 association, multiple employer arrangement or out-of-State trust
16 that offers health benefits coverage to its members' employees and
17 dependents:

18 (a) shall offer coverage to all eligible employees and their
19 dependents within the membership of the association, multiple
20 employer arrangement or out-of-State trust;

21 (b) shall not use actual or expected health status in determining
22 its membership; and

23 (c) shall make available to its small employer members at least
24 one of the standard benefits plans, as determined by the
25 commissioner, in addition to any health benefits plan permitted to
26 be renewed or continued pursuant to this subsection.

27 (2) Notwithstanding the provisions of this subsection to the
28 contrary, a carrier or out-of-State trust which writes the health
29 benefits plans required pursuant to subsection a. of this section shall
30 be required to offer those plans to any small employer, association
31 or multiple employer arrangement.

32 (3) (a) A carrier, association, multiple employer arrangement, or
33 out-of-State trust may withdraw a health benefits plan marketed to
34 small employers that was in effect on December 31, 1993 with the
35 approval of the commissioner. The commissioner shall approve a
36 request to withdraw a plan, consistent with regulations adopted by
37 the commissioner, only on the grounds that retention of the plan
38 would cause an unreasonable financial burden to the issuing carrier,
39 taking into account the rating provisions of section 9 of P.L.1992,
40 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
41 (C.17B:27A-19.3).

42 (b) A carrier which has renewed, continued or reinstated a
43 health benefits plan pursuant to this subsection that has not been
44 newly issued to a new small employer group since January 1, 1994,
45 may, upon approval of the commissioner, continue to establish its
46 rates for that plan based on the loss experience of that plan if the
47 carrier does not issue that health benefits plan to any new small
48 employer groups.

1 (4) (Deleted by amendment, P.L.1995, c.340).

2 (5) A health benefits plan that otherwise conforms to the
3 requirements of this subsection shall be deemed to be in compliance
4 with this subsection, notwithstanding any change in the plan's
5 deductible or copayment.

6 (6) (a) Except as otherwise provided in subparagraphs (b) and
7 (c) of this paragraph, a health benefits plan renewed, continued or
8 reinstated pursuant to this subsection shall be filed with the
9 commissioner for informational purposes within 30 days after its
10 renewal date. No later than 60 days after the board adopts
11 regulations concerning the implementation of the rating factors
12 permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing
13 shall be amended to show any modifications in the plan that are
14 necessary to comply with the provisions of this subsection. The
15 commissioner shall monitor compliance of any such plan with the
16 requirements of this subsection, except that the board shall enforce
17 the loss ratio requirements.

18 (b) A health benefits plan filed with the commissioner pursuant
19 to subparagraph (a) of this paragraph may be amended as to its
20 benefit structure if the amendment does not reduce the actuarial
21 value and benefits coverage of the health benefits plan below that of
22 the lowest standard health benefits plan established by the board
23 pursuant to subsection a. of this section. The amendment shall be
24 filed with the commissioner for approval pursuant to the terms of
25 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,
26 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as
27 applicable, and shall comply with the provisions of sections 2 and 9
28 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7
29 of P.L.1995, c.340 (C.17B:27A-19.3).

30 (c) A health benefits plan issued by a carrier through an out-of-
31 State trust shall be permitted to be renewed or continued pursuant to
32 paragraph (1) of this subsection upon approval by the commissioner
33 and only if the benefits offered under the plan are at least equal to
34 the actuarial value and benefits coverage of the lowest standard
35 health benefits plan established by the board pursuant to subsection
36 a. of this section. For the purposes of meeting the requirements of
37 this subparagraph, carriers shall be required to file with the
38 commissioner the health benefits plans issued through an out-of-
39 State trust no later than 180 days after the date of enactment of
40 P.L.1995, c.340. A health benefits plan issued by a carrier through
41 an out-of-State trust that is not filed with the commissioner pursuant
42 to this subparagraph, shall not be permitted to be continued or
43 renewed after the 180-day period.

44 (7) Notwithstanding the provisions of P.L.1992, c.162
45 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
46 employer arrangement or out-of-State trust may offer a health
47 benefits plan authorized to be renewed, continued or reinstated
48 pursuant to this subsection to small employer groups that are

1 otherwise eligible pursuant to paragraph (1) of subsection j. of this
2 section during the period for which such health benefits plan is
3 otherwise authorized to be renewed, continued or reinstated.

4 (8) Notwithstanding the provisions of P.L.1992, c.162
5 (C.17B:27A-17 et seq.) to the contrary, a carrier, association,
6 multiple employer arrangement or out-of-State trust may offer
7 coverage under a health benefits plan authorized to be renewed,
8 continued or reinstated pursuant to this subsection to new
9 employees of small employer groups covered by the health benefits
10 plan in accordance with the provisions of paragraph (1) of this
11 subsection.

12 (9) Notwithstanding the provisions of P.L.1992, c.162
13 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et al.) to
14 the contrary, any individual, who is eligible for small employer
15 coverage under a policy issued, renewed, continued or reinstated
16 pursuant to this subsection, but who would be subject to a
17 preexisting condition exclusion under the small employer health
18 benefits plan, or who is a member of a small employer group who
19 has been denied coverage under the small employer group health
20 benefits plan for health reasons, may elect to purchase or continue
21 coverage under an individual health benefits plan until such time as
22 the group health benefits plan covering the small employer group of
23 which the individual is a member complies with the provisions of
24 P.L.1992, c.162 (C.17B:27A-17 et seq.).

25 (10) In a case in which an association made available a health
26 benefits plan on or before March 1, 1994 and subsequently changed
27 the issuing carrier between March 1, 1994 and the effective date of
28 P.L.1995, c.340, the new issuing carrier shall be deemed to have
29 been eligible to continue and renew the plan pursuant to paragraph
30 (1) of this subsection.

31 (11) In a case in which an association, multiple employer
32 arrangement or out-of-State trust made available a health benefits
33 plan on or before March 1, 1994 and subsequently changes the
34 issuing carrier for that plan after the effective date of P.L.1995,
35 c.340, the new issuing carrier shall file the health benefits plan with
36 the commissioner for approval in order to be deemed eligible to
37 continue and renew that plan pursuant to paragraph (1) of this
38 subsection.

39 (12) In a case in which a small employer purchased a health
40 benefits plan directly from a carrier on or before March 1, 1994 and
41 subsequently changes the issuing carrier for that plan after the
42 effective date of P.L.1995, c.340, the new issuing carrier shall file
43 the health benefits plan with the commissioner for approval in order
44 to be deemed eligible to continue and renew that plan pursuant to
45 paragraph (1) of this subsection.

46 Notwithstanding the provisions of subparagraph (b) of paragraph
47 (6) of this subsection to the contrary, a small employer who changes
48 its health benefits plan's issuing carrier pursuant to the provisions of

1 this paragraph, shall not, upon changing carriers, modify the benefit
2 structure of that health benefits plan within six months of the date
3 the issuing carrier was changed.

4 k. Effective immediately for a health benefits plan issued on or
5 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
6 and effective on the first 12-month anniversary date of a health
7 benefits plan in effect on the effective date of P.L.2005, c.248
8 (C.17:48E-35.27 et al.), the health benefits plans required pursuant
9 to this section, including any plans offered by a State approved or
10 federally qualified health maintenance organization, shall contain
11 benefits for expenses incurred in the following:

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

17 (2) All childhood immunizations as recommended by the
18 Advisory Committee on Immunization Practices of the United
19 States Public Health Service and the Department of Health pursuant
20 to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier shall
21 notify its insureds, in writing, of any change in the health care
22 services provided with respect to childhood immunizations and any
23 related changes in premium. Such notification shall be in a form
24 and manner to be determined by the Commissioner of Banking and
25 Insurance.

26 (3) Screening for newborn hearing loss by appropriate
27 electrophysiologic screening measures and periodic monitoring of
28 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
29 (C.26:2-103.1 et al.). Payment for this screening service shall be
30 separate and distinct from payment for routine new baby care in the
31 form of a newborn hearing screening fee as negotiated with the
32 provider and facility.

33 The benefits provided pursuant to this subsection shall be
34 provided to the same extent as for any other medical condition
35 under the health benefits plan, except that a deductible shall not be
36 applied for benefits provided pursuant to this subsection; however,
37 with respect to a small employer health benefits plan that qualifies
38 as a high deductible health plan for which qualified medical
39 expenses are paid using a health savings account established
40 pursuant to section 223 of the federal Internal Revenue Code of
41 1986 (26 U.S.C. s.223), a deductible shall not be applied for any
42 benefits that represent preventive care as permitted by that federal
43 law, and shall not be applied as provided pursuant to section 16 of
44 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to
45 all small employer health benefits plans in which the carrier has
46 reserved the right to change the premium.

47 l. The board shall consider including benefits for speech-
48 language pathology and audiology services, as rendered by speech-

1 language pathologists and audiologists within the scope of their
2 practices, in at least one of the standard policies and in at least one
3 of the five riders to be developed under this section.

4 m. Effective immediately for a health benefits plan issued on or
5 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
6 effective on the first 12-month anniversary date of a health benefits
7 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z
8 et al.), the health benefits plans required pursuant to this section
9 that provide benefits for expenses incurred in the purchase of
10 prescription drugs shall provide benefits for expenses incurred in
11 the purchase of specialized non-standard infant formulas, when the
12 covered infant's physician has diagnosed the infant as having
13 multiple food protein intolerance and has determined such formula
14 to be medically necessary, and when the covered infant has not been
15 responsive to trials of standard non-cow milk-based formulas,
16 including soybean and goat milk. The coverage may be subject to
17 utilization review, including periodic review, of the continued
18 medical necessity of the specialized infant formula.

19 The benefits shall be provided to the same extent as for any other
20 prescribed items under the health benefits plan.

21 This subsection shall apply to all small employer health benefits
22 plans in which the carrier has reserved the right to change the
23 premium.

24 n. Effective immediately for a health benefits plan issued on or
25 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
26 and effective on the first 12-month anniversary date of a small
27 employer health benefits plan in effect on the effective date of
28 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
29 required pursuant to this section that qualify as high deductible
30 health plans for which qualified medical expenses are paid using a
31 health savings account established pursuant to section 223 of the
32 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including
33 any plans offered by a State approved or federally qualified health
34 maintenance organization, shall contain benefits for expenses
35 incurred in connection with any medically necessary benefits
36 provided in-network that represent preventive care as permitted by
37 that federal law.

38 The benefits provided pursuant to this subsection shall be
39 provided to the same extent as for any other medical condition
40 under the health benefits plan, except that no deductible shall be
41 applied for benefits provided pursuant to this subsection. This
42 subsection shall apply to all small employer health benefits plans in
43 which the carrier has reserved the right to change the premium.

44 (cf: P.L.2012, c.17, s.58)

45

46 4. Section 4 of P.L.1992, c.162 (C.17B:27A-20) is amended to
47 read as follows:

1 4. Plans required to be offered under **【this act】** P.L.1992, c.162
2 (C.17B:27A-17 et seq.) may be subject to coinsurance and
3 deductibles, which may vary by selected portions of the coverage,
4 except that no **【deductible applicable to any portion of the coverage**
5 **shall exceed \$250 for an individual or family unit during any**
6 **benefit year, and no coinsurance applicable to any portion of the**
7 **coverage shall exceed \$500 for an individual or family unit during**
8 **any benefit year, unless provided by the board pursuant to section**
9 **17 of P.L.1992, c.162 (C.17B:27A-33)】** cost-sharing shall exceed
10 the maximum out-of-pocket limits established in the federal Patient
11 Protection and Affordable Care Act, Pub.L.111-148, as amended by
12 the federal "Health Care and Education Reconciliation Act of
13 2010," Pub.L.111-152.
14 (cf: P.L.1993, c.162, s.3.)
15

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

18 7. Every policy or contract issued to small employers in this
19 State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be
20 renewable with respect to all eligible employees or dependents at
21 the option of the policy or contract holder, or small employer except
22 that a carrier may discontinue or not renew a health benefits plan in
23 accordance with the provisions of this section:

24 a. A carrier may discontinue such coverage only if:

25 (1) The policyholder, contract holder, or employer has failed to
26 pay premiums or contributions in accordance with the terms of the
27 health benefits plan or the carrier has not received timely premium
28 payments; or

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

33 b. (Deleted by amendment, P.L.1997, c.146).

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

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

40 e. Any carrier doing business pursuant to the provisions of
41 **【this act】** P.L.1992, c.162 (C17B:27A-17 et seq.) ceases doing
42 business in the small employer market, if the following conditions
43 are satisfied:

44 (1) The carrier gives notice to cease doing business in the small
45 employer market to the commissioner not later than eight months
46 prior to the date of the planned withdrawal from the small employer
47 market, during which time the carrier shall continue to be governed

1 by **【this act】** P.L.1992, c.162 (C.17B:27A-17 et seq.) with respect
2 to business written pursuant to **【this act】** P.L.1992, c.162
3 (C.17B:27A-17 et seq.) For the purposes of this subsection, "date
4 of withdrawal" means the date upon which the first notice to small
5 employers is sent by the carrier pursuant to paragraph (2) of this
6 subsection;

7 (2) No later than two months following the date of the
8 notification to the commissioner that the carrier intends to cease
9 doing business in the small employer market, the carrier shall mail a
10 notice to every small business employer insured by the carrier, and
11 all covered persons, that the policy or contract of insurance will not
12 be renewed. This notice shall be sent by certified mail to the small
13 business employer not less than six months in advance of the
14 effective date of the nonrenewal date of the policy or contract;

15 (3) **【Any carrier that ceases to do business pursuant to this act**
16 **shall be prohibited from writing new business in the small employer**
17 **and individual health benefits plan markets for a period of five**
18 **years from the date of termination of the last health insurance**
19 **coverage not so renewed】** (Deleted by amendment,
20 P.L. .c. (pending before the Legislature as this bill).

21 f. In the case of policies or contracts issued in connection with
22 membership in an association or trust of employers, an employer
23 ceases to maintain its membership in the association or trust, but
24 only if such coverage is terminated under this provision uniformly
25 without regard to any health status-related factor relating to any
26 covered individual;

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

28 h. A decision by the small employer carrier to cease offering
29 and not renew a particular type of group health benefits plan in the
30 small employer market, if the board discontinues a standard health
31 benefits plan or as permitted or required pursuant to subsection j. of
32 section 3 of P.L.1992, c.162 (C.17B:27A-19), and pursuant to the
33 regulations adopted by the commissioner;

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

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

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

45 (cf: P.L.2008, c.38, s.23)

46

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

- 1 9. a. (1) (Deleted by amendment, P.L.1997, c.146).
- 2 (2) (Deleted by amendment, P.L.1997, c.146).
- 3 (3) (a) For all policies or contracts providing health benefits
4 plans for small employers issued pursuant to section 3 of P.L.1992,
5 c.162 (C.17B:27A-19), and including policies or contracts offered
6 by a carrier to a small employer who is a member of a Small
7 Employer Purchasing Alliance pursuant to the provisions of
8 P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged
9 by a carrier to the highest rated small group purchasing a small
10 employer health benefits plan issued pursuant to section 3 of
11 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than **[200%]**
12 300% of the premium rate charged for the lowest rated small group
13 purchasing that same health benefits plan; provided, however, that
14 the only factors upon which the rate differential may be based are
15 age**[, gender]** and geography. Such factors shall be applied in a
16 manner consistent with regulations adopted by the commissioner.
17 For the purposes of this paragraph (3), policies or contracts offered
18 by a carrier to a small employer who is a member of a Small
19 Employer Purchasing Alliance shall be rated separately from the
20 carrier's other small employer health benefits policies or contracts.
- 21 (b) A health benefits plan issued pursuant to subsection j. of
22 section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in
23 accordance with the provisions of section 7 of P.L.1995, c.340
24 (C.17B:27A-19.3), for the purposes of meeting the requirements of
25 this paragraph.
- 26 (4) (Deleted by amendment, P.L.1994, c.11).
- 27 (5) Any policy or contract issued after January 1, 1994 to a
28 small employer who was not previously covered by a health
29 benefits plan issued by the issuing small employer carrier, shall be
30 subject to the same premium rate restrictions as provided in
31 paragraph (3) of this subsection, which rate restrictions shall be
32 effective on the date the policy or contract is issued.
- 33 (6) The board shall establish, pursuant to section 17 of
34 P.L.1993, c.162 (C.17B:27A-51):
- 35 (a) up to six geographic territories, none of which is smaller
36 than a county; and
- 37 (b) age classifications which, at a minimum, shall be in five-
38 year increments.
- 39 b. (Deleted by amendment, P.L.1993, c.162).
- 40 c. (Deleted by amendment, P.L.1995, c.298).
- 41 d. Notwithstanding any other provision of law to the contrary,
42 **[this act]** P.L.1992, c.162 (C.17B:27A-17 et seq.) shall apply to a
43 carrier which provides a health benefits plan to one or more small
44 employers through a policy issued to an association or trust of
45 employers.
- 46 A carrier which provides a health benefits plan to one or more
47 small employers through a policy issued to an association or trust of
48 employers after the effective date of P.L.1992, c.162 (C.17B:27A-

1 17 et seq.), shall be required to offer small employer health benefits
2 plans to non-association or trust employers in the same manner as
3 any other small employer carrier is required pursuant to P.L.1992,
4 c.162 (C.17B:27A-17 et seq.).

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

8 f. No insurance contract or policy subject to **[this act]**
9 P.L.1992, c.162 (C.17B:27A-17 et seq.), including a contract or
10 policy entered into with a small employer who is a member of a
11 Small Employer Purchasing Alliance pursuant to the provisions of
12 P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be entered into unless
13 and until the carrier has made an informational filing with the
14 commissioner of a schedule of premiums, not to exceed 12 months
15 in duration, to be paid pursuant to such contract or policy, of the
16 carrier's rating plan and classification system in connection with
17 such contract or policy, and of the actuarial assumptions and
18 methods used by the carrier in establishing premium rates for such
19 contract or policy.

20 g. (1) Beginning January 1, 1995, a carrier desiring to increase
21 or decrease premiums for any policy form or benefit rider offered
22 pursuant to subsection i. of section 3 of P.L.1992, c.162
23 (C.17B:27A-19) subject to **[this act]** P.L.1992, c.162 (C.17B:27A-
24 17 et seq.) may implement such increase or decrease upon making
25 an informational filing with the commissioner of such increase or
26 decrease, along with the actuarial assumptions and methods used by
27 the carrier in establishing such increase or decrease, provided that
28 the anticipated minimum loss ratio for all policy forms shall not be
29 less than 80% of the premium therefor as provided in paragraph (2)
30 of this subsection. The commissioner may disapprove any
31 informational filing on a finding that it is incomplete and not in
32 substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et
33 seq.), or that the rates are inadequate or unfairly discriminatory.
34 Until December 31, 1996, the informational filing shall also include
35 the carrier's rating plan and classification system in connection with
36 such increase or decrease.

37 (2) Each calendar year, a carrier shall return, in the form of
38 aggregate benefits for all of the standard policy forms offered by
39 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162
40 (C.17B:27A-19), at least 80% of the aggregate premiums collected
41 for all of the standard policy forms, other than alliance policy
42 forms, and at least 80% of the aggregate premiums collected for all
43 of the non-standard policy forms during that calendar year. A
44 carrier shall return at least 80% of the premiums collected for all of
45 the alliances during that calendar year, which loss ratio may be
46 calculated in the aggregate for all of the alliances or separately for
47 each alliance. Carriers shall annually report, no later than August
48 1st of each year, the loss ratio calculated pursuant to this section for

1 all of the standard, other than alliance policy forms, non-standard
2 policy forms and alliance policy forms for the previous calendar
3 year, provided that a carrier may annually report the loss ratio
4 calculated pursuant to this section for all of the alliances in the
5 aggregate or separately for each alliance. In each case where the
6 loss ratio fails to substantially comply with the 80% loss ratio
7 requirement, the carrier shall issue a dividend or credit against
8 future premiums for all policyholders with the standard, other than
9 alliance policy forms, nonstandard policy forms or alliance policy
10 forms, as applicable, in an amount sufficient to assure that the
11 aggregate benefits paid in the previous calendar year plus the
12 amount of the dividends and credits shall equal 80% of the
13 aggregate premiums collected for the respective policy forms in the
14 previous calendar year. All dividends and credits must be
15 distributed by December 31 of the year following the calendar year
16 in which the loss ratio requirements were not satisfied. The annual
17 report required by this paragraph shall include a carrier's calculation
18 of the dividends and credits applicable to standard, other than
19 alliance policy forms, non-standard policy forms and alliance policy
20 forms, as well as an explanation of the carrier's plan to issue
21 dividends or credits. The instructions and format for calculating
22 and reporting loss ratios and issuing dividends or credits shall be
23 specified by the commissioner by regulation. Such regulations shall
24 include provisions for the distribution of a dividend or credit in the
25 event of cancellation or termination by a policyholder. For
26 purposes of this paragraph, "alliance policy forms" means policies
27 purchased by small employers who are members of Small Employer
28 Purchasing Alliances.

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

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

35 i. The provisions of **【this act】** P.L.1992, c.162 (C.17B:27A-17
36 et seq.) shall apply to health benefits plans which are delivered,
37 issued for delivery, renewed or continued on or after January 1,
38 1994.

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

40 k. A carrier who negotiates a reduced premium rate with a
41 Small Employer Purchasing Alliance for members of that alliance
42 shall provide a reduction in the premium rate filed in accordance
43 with paragraph (3) of subsection a. of this section, expressed as a
44 percentage, which reduction shall be based on volume or other
45 efficiencies or economies of scale and shall not be based on health
46 status-related factors.

47 (cf: P.L.2008, c.38, s.24)

1 7. Section 13 of P.L.1992, c.162 (C.17B:27A-29) is amended
2 to read as follows:

3 13. a. **【**Within 60 days of the effective date of this act, the
4 commissioner shall give notice to all members of the time and place
5 for the initial organizational meeting, which shall take place within
6 90 days of the effective date. The members shall elect the initial
7 board, subject to the approval of the commissioner. The board shall
8 consist of 10 elected public members and two ex officio members
9 who include the Commissioner of Health and the commissioner or
10 their designees. Initially, three of the public members of the board
11 shall be elected for a three-year term, three shall be elected for a
12 two-year term, and three shall be elected for a one-year term.
13 Thereafter, all elected board members shall serve for a term of three
14 years. The following categories shall be represented among the
15 elected public members:

16 (1) Three carriers whose principal health insurance business is
17 in the small employer market;

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

20 (3) A health service corporation or a domestic stock insurer
21 which converted from a health service corporation pursuant to the
22 provisions of P.L.2001, c.131 (C.17:48E-49 et al.) and is primarily
23 engaged in the business of issuing health benefit plans in this State;

24 (4) Two health maintenance organizations; and

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

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

27 (7) Three persons representing small employers, at least one of
28 whom represents minority small employers.

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

30 The board shall hold an election for the two members added
31 pursuant to P.L.1995, c.298 within 90 days of the date of enactment
32 of that act. Initially, one of the two new members shall serve for a
33 term of one year and one of the two new members shall serve for a
34 term of two years. Thereafter, the new members shall serve for a
35 term of three years. The terms of the risk-assuming carrier and
36 reinsuring carrier shall terminate upon the election of the two new
37 members added pursuant to P.L.1995, c.298, notwithstanding the
38 provisions of this section to the contrary.

39 In addition to the 10 elected public members, the **】** The board
40 shall **【**include six**】** consist of 12 public members appointed by the
41 Governor **【**with the advice and consent of the Senate**】** who shall
42 include:

43 (1) Two carriers that sell plans in the small employer market;

44 (2) One carrier that sells plans in the individual market or the
45 small employer market;

46 (3) Two representatives of or individuals employed by
47 businesses that purchase in small employer health benefits plans;

48 (4) Two health care provider representatives;

1 (5) Two insurance producers licensed to sell health insurance
2 pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.);

3 (6) One representative of organized labor;

4 **【**One physician licensed to practice medicine and surgery in this
5 State; and

6 Two persons who represent the general public and are not
7 employees of a health benefits plan provider. **】**

8 (7) One representative of an association representing small
9 business in the State; and

10 (8) One person with knowledge or expertise in New Jersey
11 regulated health insurance markets who represents the general
12 public.

13 The commissioner, or the commissioner's designee, shall serve
14 on the board as an ex officio member. No carrier shall have more
15 than one representative on the board.

16 The public members shall be appointed for a term of three years,
17 except that of the members first appointed, **【two】** four shall be
18 appointed for a term of one year, **【two】** four for a term of two years
19 and **【two】** four for a term of three years.

20 A vacancy in the membership of the board shall be filled for an
21 unexpired term in the manner provided for the **【**original election
22 **or】** appointment**【**, as appropriate**】**.

23 b. **【**If the initial board is not elected at the organizational
24 meeting, the commissioner shall appoint the public members within
25 15 days of the organizational meeting, in accordance with the
26 provisions of paragraphs (1) through (7) of subsection a. of this
27 section. **】** (Deleted by amendment, P.L. , c.) (pending before
28 the Legislature as this bill).

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

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

33 e. At least two copies of the minutes of every meeting of the
34 board shall be delivered forthwith to the commissioner.

35 (cf: P.L.2012, c.17, s.60.)

36

37 8. (New section) Sections 8 through 13 of
38 P.L. , c. (C.) (pending before the Legislature as this bill)
39 shall be known and may be cited as the "Small Business Health
40 Insurance Affordability Act."

41

42 9. (New section) a. The board shall annually review the small
43 employer health benefits plans offered pursuant to P.L.1992, c.162
44 (C.17B:27A-17 et seq.) to ensure that each plan meets the
45 requirements of section 2 of P.L.2019, c.354 (C.17B:27A-19.30),
46 provides consumer choice and affordability, and maintains a
47 relative level of consistency compared to previous years and to

1 other plans in the small employer market. The board shall publish
2 the findings of its review on the website of the Department of
3 Banking and Insurance.

4 b. The board shall annually adjust the design of the small
5 employer health benefits plans, including the out-of-pocket limits
6 under those plans, to ensure premium affordability and to align the
7 plans with the requirements of section 2 of P.L.2019, c.354
8 (C.17B:27A-19.30). The adjustment shall be based on the annual
9 review conducted pursuant to subsection a. of this section. The
10 board may consider proposals for adjustments to plan design to
11 improve affordability from carriers offering small employer health
12 benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

13 c. The board shall annually review the appropriateness of
14 geographic rating areas.

15 d. The board shall examine and, to the extent practicable, track
16 where small employers who do not continue coverage through a
17 small employer health benefits plan offered pursuant to P.L.1992,
18 c.162 (C.17B:27A-17 et seq.) elect to purchase coverage. The
19 board shall have the authority to develop a sample survey that
20 insurance brokers may provide to clients. Brokers who elect to
21 provide the survey to clients shall report to the board any
22 information received through the survey. The sample survey shall
23 include, but may not be limited to, information concerning where
24 small employers purchase health benefits coverage. The board shall
25 publish the findings of the surveys received from brokers pursuant
26 to this subsection on the website of the Department of Banking and
27 Insurance.

28

29 10. (New section) a. Except as provided in subsection b. of this
30 section, a carrier that offers an individual health benefits plan that
31 provides benefits for expenses incurred in the purchase of
32 prescription drugs and is delivered, issued, executed, or renewed in
33 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), may
34 use a prescription drug formulary to limit or exclude coverage for
35 prescription drugs, provided that the carrier demonstrates to the
36 satisfaction of the board that utilization and medical review panels
37 are in place to allow formulary flexibility as necessary in the best
38 interest of the insured person.

39 b. A carrier that offers an individual health benefits plan that
40 provides benefits for expenses incurred in the purchase of
41 prescription drugs and is delivered, issued, executed, or renewed in
42 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall
43 not adopt a protocol, policy, or program that establishes the specific
44 sequence in which prescription drugs for a specified medical
45 condition, and medically appropriate for a particular patient, are
46 required to be administered in order to be covered by a health
47 benefits plan.

1 11. (New section) a. Except as provided in subsection b. of this
2 section, a carrier that offers a small employer health benefits plan
3 that provides benefits for expenses incurred in the purchase of
4 prescription drugs and is delivered, issued, executed, or renewed in
5 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), may
6 use a prescription drug formulary to limit or exclude coverage for
7 prescription drugs, provided that the carrier demonstrates to the
8 satisfaction of the board that utilization and medical review panels
9 are in place to allow formulary flexibility as necessary in the best
10 interest of the insured person.

11 b. A carrier that offers a small employer health benefits plan
12 that provides benefits for expenses incurred in the purchase of
13 prescription drugs and is delivered, issued, executed, or renewed in
14 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall
15 not adopt a protocol, policy, or program that establishes the specific
16 sequence in which prescription drugs for a specified medical
17 condition, and medically appropriate for a particular patient, are
18 required to be administered in order to be covered by a health
19 benefits plan.

20

21 12. (New section) a. The department shall establish a clinically
22 sound and well-communicated exceptions and appeals process for
23 any carrier that uses a prescription drug formulary pursuant to
24 sections 10 and 11 of P.L. , c. (C.) (pending before the
25 Legislature as this bill). The exceptions and appeals process shall
26 allow insureds to appeal to an independent, objective third party
27 which shall render a decision as promptly as the patient's condition
28 mandates.

29 b. A carrier subject to the exceptions and appeals process
30 established pursuant to this section shall:

31 (1) show cause before denying payment for a prescription drug
32 when a prescriber has deemed the carrier's recommended substitute
33 medically inappropriate;

34 (2) provide insureds with step-by-step directions to initiate the
35 exceptions and appeals process; and

36 (3) for a prescription drug that is nonpreferred, not require an
37 insured who obtains that prescription drug to pay an amount greater
38 than the cost sharing tier level associated with the preferred
39 prescription drug, if the prescriber determines that therapeutically
40 similar drugs are medically inappropriate.

41 c. The department shall collect the information it requires to
42 conduct an annual evaluation of the exceptions and appeals process
43 established pursuant to this section with regard to the
44 appropriateness of the burden of the process on consumers and
45 clinicians and the effects on patient health outcomes.

46

47 13. (New section) The department shall, in time for plan year
48 2024, adopt rules and regulations, pursuant to the "Administrative

1 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), requiring the
2 minimum standards for small employer health benefits plans
3 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) be no greater
4 than the minimum standards set forth in the federal Patient
5 Protection and Affordable Care Act, Pub.L.111-148, as amended by
6 the federal "Health Care and Education Reconciliation Act of
7 2010," Pub.L.111-152 for plans issued pursuant to P.L.1992, c.161
8 (C.17B:27A-2 et seq.).

9
10 14. This act shall take effect immediately.

11
12
13 STATEMENT

14
15 This bill revises various requirements for individual and small
16 employer health benefits plans.

17 The bill removes a provision of law that requires health
18 insurance carriers to offer individual health plans, through the
19 Individual Health Coverage Program, as a condition of participation
20 in the small employer health insurance market. The bill removes a
21 provision of law that requires health insurance carriers that
22 participate in the small employer health insurance market to
23 participate in the Individual Health Coverage Program.

24 The bill also removes a 5-year prohibition on carriers re-entering
25 the individual and small employer health insurance markets if the
26 carrier ceases to offer either plan.

27 The bill modifies the age rating band by requiring that the
28 premium rate charged by a carrier to the highest rated small group
29 purchasing a small employer health benefits plan may not be greater
30 than 300% of the premium rate charged for the lowest rated small
31 group purchasing that same health benefits plan; provided, however,
32 that the only factors upon which the rate differential may be based
33 are age and geography. Current law provides that the rate of the
34 highest rated small group may not be greater than 200% of the
35 premium rate charged for the lowest rated small group.

36 The bill removes provisions of current law that provide certain
37 caps on cost-sharing amounts in small employer health plans. The
38 bill instead provides that cost-sharing may not exceed the maximum
39 out-of-pocket limits established in the federal Patient Protection and
40 Affordable Care Act. This bill also requires the board of directors
41 of the New Jersey Small Employer Health Benefits Program to
42 annually review and adjust certain requirements, including out-of-
43 pocket limits, for small employer health benefits plans. In addition,
44 the bill requires the board to examine and track where small
45 employers who do not continue coverage through a small employer
46 health benefits plan elect to purchase coverage.

47 The bill provides that a carrier that offers an individual or small
48 employer health benefits plan that provides benefits for expenses

1 incurred in the purchase of prescription drugs may use a
2 prescription drug formulary to limit or exclude coverage for
3 prescription drugs, provided that the carrier demonstrates to the
4 satisfaction of the board that utilization and medical review panels
5 are in place to allow formulary flexibility when necessary, provided
6 that the carrier may not adopt a protocol, policy, or program that
7 establishes the specific sequence in which prescription drugs for a
8 specified medical condition, and medically appropriate for a
9 particular patient, are required to be administered in order to be
10 covered by a health benefits plan.

11 The bill requires the department to establish a clinically sound
12 and well-communicated exceptions and appeals process for any
13 carrier offering an individual or small employer health benefits plan
14 and that uses a prescription drug formulary pursuant to the bill. The
15 exceptions and appeals process is to allow insureds to appeal to an
16 independent, objective third party which shall render a decision as
17 promptly as the patient's condition mandates.

18 The bill requires the department to adopt rules and regulations,
19 for plan year 2024, requiring the minimum standards for small
20 employer health benefits plans to be no greater than the minimum
21 standards set forth in the federal Patient Protection and Affordable
22 Care Act, for individual health benefits plans.

23 The bill revises the membership of the New Jersey Small
24 Employer Health Benefits Program Board. The bill provides that
25 the board will consist of the following members:

- 26 (1) One carrier that sells plans in the small employer market;
- 27 (2) Two carriers that sell plans in the small employer market or
28 the individual market;
- 29 (3) Two representatives of or individuals employed by
30 businesses that purchase in small employer health benefits plans;
- 31 (4) Two individuals who are licensed insurance brokers;
- 32 (5) Two health care provider representatives;
- 33 (6) One individual representing organized labor; and
- 34 (7) One individual representing an association that represents
35 small businesses in the State; and
- 36 (8) One person with knowledge or expertise in New Jersey
37 regulated health insurance markets who represents the general
38 public.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 3480

STATE OF NEW JERSEY

DATED: JANUARY 26, 2023

The Senate Commerce Committee reports favorably Senate Bill No. 3480.

This bill revises various requirements for individual and small employer health benefits plans.

The bill removes a provision of law that requires health insurance carriers to offer individual health plans, through the Individual Health Coverage Program, as a condition of participation in the small employer health insurance market.

The bill also removes a 5-year prohibition on carriers re-entering the individual and small employer health insurance markets if the carrier ceases to offer either plan.

The bill modifies the age rating band by requiring that the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan may not be greater than 300% of the premium rate charged for the lowest rated small group purchasing that same health benefits plan; provided, however, that the only factors upon which the rate differential may be based are age and geography. Current law provides that the rate of the highest rated small group may not be greater than 200% of the premium rate charged for the lowest rated small group.

The bill removes provisions of current law that provide certain caps on cost-sharing amounts in small employer health plans. The bill instead provides that cost-sharing may not exceed the maximum out-of-pocket limits established in the federal Patient Protection and Affordable Care Act. This bill also requires the board of directors of the New Jersey Small Employer Health Benefits Program to annually review and adjust certain requirements, including out-of-pocket limits, for small employer health benefits plans. In addition, the bill requires the board to examine and track where small employers who do not continue coverage through a small employer health benefits plan elect to purchase coverage.

The bill provides that a carrier that offers an individual or small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs may use a prescription drug formulary to limit or exclude coverage for prescription drugs, provided that the carrier demonstrates to the satisfaction of the board that utilization and medical review panels are in place to allow formulary flexibility when necessary, provided that the carrier may not

adopt a protocol, policy, or program that establishes the specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are required to be administered in order to be covered by a health benefits plan.

The bill requires the department to establish a clinically sound and well-communicated exceptions and appeals process for any carrier offering an individual or small employer health benefits plan and that uses a prescription drug formulary pursuant to the bill. The exceptions and appeals process is to allow insureds to appeal to an independent, objective third party which shall render a decision as promptly as the patient's condition mandates.

The bill requires the department to adopt rules and regulations, for plan year 2024, requiring the minimum standards for small employer health benefits plans to be no greater than the minimum standards set forth in the federal Patient Protection and Affordable Care Act, for individual health benefits plans.

The bill revises the membership of the New Jersey Small Employer Health Benefits Program Board. The bill provides that the board will consist of the following members:

- (1) One carrier that sells plans in the small employer market;
- (2) Two carriers that sell plans in the small employer market or the individual market;
- (3) Two representatives of or individuals employed by businesses that purchase in small employer health benefits plans;
- (4) Two individuals who are licensed insurance brokers;
- (5) Two health care provider representatives;
- (6) One individual representing organized labor; and
- (7) One individual representing an association that represents small businesses in the State; and
- (8) One person with knowledge or expertise in New Jersey regulated health insurance markets who represents the general public.

STATEMENT TO

SENATE, No. 3480

with Senate Floor Amendments
(Proposed by Senator VITALE)

ADOPTED: FEBRUARY 27, 2023

These Senate amendments:

(1) remove from the bill a provision modifying the age rating band for small employer health benefits plans; and

(2) stipulate that individual and small employer health benefits plans may use a prescription drug formulary only if the carrier offers at least one plan with an open formulary, in addition to the other requirements already enumerated in the bill.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 3480

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 16, 2023

The Senate Budget and Appropriations Committee reports favorably and with committee amendments Senate Bill No. 3480 (1R).

As amended, this bill revises various requirements for individual and small employer health benefits plans.

The bill removes a provision of law that requires health insurance carriers to offer individual health plans, through the Individual Health Coverage Program, as a condition of participation in the small employer health insurance market. The bill requires carriers issuing individual health benefits plans to make a good faith effort to market individual health benefits plans and makes the violation of that requirement punishable by a fine.

The bill also replaces a mandatory five-year prohibition on carriers re-entering the individual and small employer health insurance markets if the carrier ceases to offer either plan with a provision permitting the Commissioner of Banking and Insurance to impose a five-year prohibition on the issuance of any health benefits plan in the individual or small employer markets if the commissioner determines the prohibition would be beneficial to those markets.

The bill removes provisions of current law that provide certain caps on cost-sharing amounts in small employer health plans. The bill instead permits the Department of Banking and Insurance and the boards of directors of the New Jersey Individual Health Coverage Program and New Jersey Small Employer Health Benefits Program to issue regulations creating standard plans or plan design requirements, including minimum cost sharing standards. In addition, the bill requires the board to examine and track where small employers who do not continue coverage through a small employer health benefits plan elect to purchase coverage.

The bill provides that a carrier that offers an individual or small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs may use a prescription drug formulary to limit or exclude coverage for prescription drugs, provided that the carrier offers at least one plan with an open formulary and the carrier demonstrates to the satisfaction of the board that

utilization and medical review panels are in place to allow formulary flexibility when necessary, provided that the carrier may not adopt a protocol, policy, or program that establishes the specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are required to be administered in order to be covered by a health benefits plan.

Carriers using a prescription drug formulary pursuant to the bill are required to develop a clinically sound and well-communicated exceptions and appeals process or incorporate certain requirements in the bill into the carrier's existing appeals process. The bill delineates certain requirements for the process and directs the department to collect certain information from carriers for the purposes of conducting an annual evaluation.

The bill requires the department to adopt rules and regulations, for plan year 2024, requiring no additional limitations on copayments, coinsurance, or deductibles for small employer health benefits plans to beyond those set forth in the federal Patient Protection and Affordable Care Act, for individual health benefits plans.

The bill revises the membership of the New Jersey Small Employer Health Benefits Program Board. The bill provides that the board will consist of the following members:

- (1) Two carriers that sell plans in the small employer market;
- (2) One carrier that sells plans in the small employer market or the individual market;
- (3) Two representatives of or individuals employed by businesses that purchase in small employer health benefits plans;
- (4) Two individuals who are licensed insurance producers;
- (5) Two health care provider representatives;
- (6) One individual representing organized labor; and
- (7) One individual representing an association that represents small businesses in the State; and
- (8) Two persons with knowledge or expertise in New Jersey regulated health insurance markets who represent the general public.

In addition, the board is to include the Commissioner of Health and the Commissioner of Banking and Insurance or the commissioner's designee, as ex officio members.

COMMITTEE AMENDMENTS:

The committee amended the bill to:

- (1) require carriers offering individual health benefits plans to make a good faith effort to market individual health benefits plans and make a violation of this provision punishable by fine;
- (2) allow the Department of Banking and Insurance and the boards of directors of the New Jersey Individual Health Coverage Program and New Jersey Small Employer Health Benefits Program to issue regulations creating standard plans or plan design requirements that may incorporate minimum cost sharing standards;
- (3) expand the board of directors of the New Jersey Small Employer Health Benefits Program to 13 members by adding an additional person,

for a total of two persons, with knowledge or expertise in the New Jersey regulated health insurance markets representing the general public;

(4) add the Commissioner of Health as an ex officio member of the board of directors of the New Jersey Small Employer Health Benefits Program and permit the existing board to continue until a quorum of members newly appointed pursuant to the provisions of the bill is established;

(5) require carriers using a prescription drug formulary pursuant to the bill to develop a clinically sound and well-communicated exceptions and appeals process or incorporate certain requirements in the bill into the carrier's existing appeals process;

(6) permit the Department of Banking and Insurance to issue certain regulations pursuant to the bill without regard to timelines relating to administrative rulemaking required under current law; and

(7) require the department to adopt rules and regulations, for plan year 2024, requiring no additional limitations on copayments, coinsurance, or deductibles for small employer health benefits plans to beyond those set forth in the federal Patient Protection and Affordable Care Act, for individual health benefits plans.

STATEMENT TO
[Second Reprint]
SENATE, No. 3480

with Assembly Floor Amendments
(Proposed by Assemblyman McKEON)

ADOPTED: MAY 25, 2023

These floor amendments stipulate that the provisions of the bill are to be in effect no later than in time for plan year 2025, rather than plan year 2024, stipulate that the bill will not impact the existing relationship between the Department of Banking and Insurance and the board of directors of the New Jersey Small Employer Health Benefits Program as it relates to the State-based Exchange, and make a technical correction.

ASSEMBLY, No. 5137

STATE OF NEW JERSEY 220th LEGISLATURE

INTRODUCED FEBRUARY 6, 2023

Sponsored by:

Assemblyman JOHN F. MCKEON

District 27 (Essex and Morris)

SYNOPSIS

“The Small Business Health Insurance Affordability Act”; revises certain requirements for individual and small employer health benefits plans.

CURRENT VERSION OF TEXT

As introduced.



A5137 MCKEON

2

1 AN ACT concerning small employer and individual health benefits
2 plans, amending P.L.1992, c.161 and P.L.1992, c.162, and
3 supplementing various parts of the statutory law.

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

7
8 1. Section 3 of P.L.1992, c.161 (C.17B:27A-4) is amended to
9 read as follows:

10 3. a. **[No later than 180 days after the effective date of this**
11 **section of P.L.2008, c.38, a carrier shall, as a condition of issuing**
12 **small employer health benefits plans in this State, also offer**
13 **individual health benefits plans. The plans shall be offered on an**
14 **open enrollment, modified community rated basis, pursuant to the**
15 **provisions of this act and P.L.2008, c.38. Every carrier that issues**
16 **small employer health benefits plans pursuant to P.L.1992, c.162**
17 **(C.17B:27A-17 et seq.) shall make a good faith effort to market**
18 **individual health benefits plans.]** (Deleted by amendment,
19 P.L. , c. (pending before the Legislature as this bill).

20 b. A carrier shall offer to an eligible person a choice of at least
21 three individual health benefits plans established by the board
22 pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7).

23 c. (1) (Deleted by amendment, P.L.2019, c.359).

24 (2) (Deleted by amendment, P.L.2019, c.359).

25 (3) (Deleted by amendment, P.L.2019, c.359).

26 (4) (Deleted by amendment, P.L.2019, c.359).

27 (5) The provisions of section 13 of P.L.1985, c.236 (C.17:48E-
28 13), N.J.S.17B:26-1, and section 8 of P.L.1973, c.337 (C.26:2J-8)
29 with respect to the filing of policy forms shall not apply to health
30 plans issued on or after the effective date of **[this act]** P.L.1992,
31 c.161 (C.17B:27A-2 et al.).

32 (6) The provisions of section 27 of P.L.1985, c.236 (C.17:48E-
33 27) and section 7 of P.L.1988, c.71 (C.17:48E-27.1) with respect to
34 rate filings shall not apply to individual health plans issued on or
35 after the effective date of **[this act]** P.L.1992, c.161 (C.17B:27A-2
36 et al.).

37 d. Every group conversion contract or policy issued after the
38 effective date of **[this act]** P.L.1992, c.161 (C.17B:27A-2 et al.)
39 shall be issued pursuant to this section; except that this requirement
40 shall not apply to any group conversion contract or policy in which
41 a portion of the premium is chargeable to, or subsidized by, the
42 group policy from which the conversion is made.

43 e. (Deleted by amendment, P.L.2008, c.38).

44 f. (Deleted by amendment, P.L.2019, c.359).

45 (cf: P.L.2019, c.359, s.2)

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

Matter underlined thus is new matter.

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

3 5. An individual health benefits plan issued pursuant to section
4 3 of **[this act]** P.L.1992, c.161 (C.17B:27A-4) is subject to the
5 following provisions:

6 a. The health benefits plan shall guarantee coverage for an
7 eligible person and his dependents on a modified community rated
8 basis.

9 b. A health benefits plan shall be renewable with respect to an
10 eligible person and his dependents at the option of the policy or
11 contract holder. A carrier may terminate a health benefits plan
12 under the following circumstances:

13 (1) the policy or contract holder has failed to pay premiums in
14 accordance with the terms of the policy or contract or the carrier has
15 not received timely premium payments;

16 (2) the policy or contract holder has performed an act or practice
17 that constitutes fraud or made an intentional misrepresentation of
18 material fact under the terms of the coverage.

19 c. A carrier may not renew a health benefits plan only under
20 the following circumstances:

21 (1) termination of eligibility of the policy or contract holder if
22 the person is no longer a resident or becomes eligible for a group
23 health benefits plan, group health plan, governmental plan or church
24 plan;

25 (2) cancellation or amendment by the board of the specific
26 individual health benefits plan;

27 (3) approval by the commissioner of a request by the individual
28 carrier to not renew a particular type of health benefits plan, in
29 accordance with rules adopted by the commissioner. After
30 receiving approval by the commissioner, a carrier may not renew a
31 type of health benefits plan only if the carrier: (a) provides notice to
32 each covered individual provided coverage of this type of the
33 nonrenewal at least 90 days prior to the date of the nonrenewal of
34 the coverage; (b) offers to each individual provided coverage of this
35 type the option to purchase any other individual health benefits plan
36 currently being offered by the carrier; and (c) in exercising the
37 option to not renew coverage of this type and in offering coverage
38 as required under (b) above, the carrier acts uniformly without
39 regard to any health status-related factor of enrolled individuals or
40 individuals who may become eligible for coverage;

41 (4) approval by the commissioner of a request by the individual
42 carrier to cease doing business in the individual health benefits
43 market. A carrier may not renew all individual health benefits plans
44 only if the carrier: (a) first receives approval from the
45 commissioner; and (b) provides notice to each individual of the
46 nonrenewal at least 180 days prior to the date of the expiration of
47 such coverage**].** A carrier ceasing to do business in the individual
48 health benefits market may not provide for the issuance of any
49 health benefits plan in the individual or small employer markets

1 during the five-year period beginning on the date of the termination
2 of the last health benefits plan not so renewed】; and

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

10 (cf: P.L.2008, c.38, s.14)

11

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

14 3. a. Except as provided in subsection f. of this section, every
15 small employer carrier shall, as a condition of transacting business
16 in this State, offer to every small employer at least three of the
17 health benefit plans established by the board, as provided in this
18 section【, and also offer and make a good faith effort to market
19 individual health benefits plans as provided in section 3 of
20 P.L.1992, c.161 (C.17B:27A-4)】. The board shall establish a
21 standard policy form for each of the plans, which except as
22 otherwise provided in subsection j. of this section, shall be the only
23 plans offered to small groups on or after January 1, 1994. One
24 policy form shall contain the benefits provided for in sections 55,
25 57, and 59 of P.L.1991, c. 187 (C.17:48E-22.2, 17B:26B-2 and
26 26:2J-4.3). In the case of indemnity carriers, one policy form shall
27 be established which contains benefits and cost sharing levels which
28 are equivalent to the health benefits plans of health maintenance
29 organizations pursuant to the “Health Maintenance Organization
30 Act of 1973,” Pub.L.93-222 (42 U.S.C. s.300e et seq.). The
31 remaining policy forms shall contain basic hospital and medical-
32 surgical benefits, including, but not limited to:

33 (1) Basic inpatient and outpatient hospital care;

34 (2) Basic and extended medical-surgical benefits;

35 (3) Diagnostic tests, including X-rays;

36 (4) Maternity benefits, including prenatal and postnatal care;

37 and

38 (5) Preventive medicine, including periodic physical
39 examinations and inoculations.

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

45 Notwithstanding the provisions of this subsection to the contrary,
46 the board also may establish additional policy forms by which a
47 small employer carrier, other than a health maintenance
48 organization, may provide indemnity benefits or health maintenance

1 organization enrollees by direct contract with the enrollees' small
2 employer through a dual arrangement with the health maintenance
3 organization. The dual arrangement shall be filed with the
4 commissioner for approval. The additional policy forms shall be
5 consistent with the general requirements of P.L.1992, c.162
6 (C.17B:27A-17 et seq.).

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

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

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

24 e. (Deleted by amendment, P.L.2008, c.38).

25 f. Notwithstanding the provisions of this section to the
26 contrary, a health maintenance organization which is a qualified
27 health maintenance organization pursuant to the "Health
28 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.
29 s.300e et seq.) shall be permitted to offer health benefits plans
30 formulated by the board and approved by the commissioner which
31 are in accordance with the provisions of that law in lieu of the five
32 plans required pursuant to this section.

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

42 g. A carrier shall not be required to own or control a health
43 maintenance organization or otherwise affiliate with a health
44 maintenance organization in order to comply with the provisions of
45 this section, but the carrier shall be required to offer at least three of
46 the benefits plans which are formulated by the board and approved
47 by the commissioner, including one plan which contains benefits
48 and cost sharing levels that are equivalent to those required for
49 health maintenance organizations.

1 h. Notwithstanding the provisions of subsection a. of this
2 section to the contrary, the board may modify the benefits provided
3 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,
4 17B:26B-2 and 26:2J-4.3).

5 i. (1) In addition to the rider packages provided for in
6 subsection d. of this section, every carrier may offer, in connection
7 with the health benefits plans required to be offered by this section,
8 any number of riders which may revise the coverage offered by the
9 plans in any way, provided, however, that any form of such rider or
10 amendment thereof which decreases benefits or decreases the
11 actuarial value of a plan shall be filed for informational purposes
12 with the board and for approval by the commissioner before such
13 rider may be sold. Any rider or amendment thereof which adds
14 benefits or increases the actuarial value of a plan shall be filed with
15 the board for informational purposes before such rider may be sold.
16 The added premium or reduction in premium for each rider, as
17 applicable, shall be listed separately from the premium for the
18 standard plan.

19 The commissioner shall disapprove any rider filed pursuant to
20 this subsection that is unjust, unfair, inequitable, unreasonably
21 discriminatory, misleading, contrary to law or the public policy of
22 this State. The commissioner shall not approve any rider which
23 reduces benefits below those required by sections 55, 57 and 59 of
24 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and
25 required to be sold pursuant to this section. The commissioner's
26 determination shall be in writing and shall be appealable.

27 (2) The benefit riders provided for in paragraph (1) of this
28 subsection shall be subject to the provisions of section 2, subsection
29 b. of section 3, and sections 5, 7, 8, 9 and 11 of P.L.1992, c.162
30 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-
31 24, 17B:27A-25, and 17B:27A-27).

32 j. (1) Notwithstanding the provisions of P.L.1992, c.162
33 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued
34 by or through a carrier, association, or multiple employer
35 arrangement prior to January 1, 1994 or, if the requirements of
36 subparagraph (c) of paragraph (6) of this subsection are met, issued
37 by or through an out-of-State trust prior to January 1, 1994, at the
38 option of a small employer policy or contract holder, may be
39 renewed or continued after February 28, 1994, or in the case of such
40 a health benefits plan whose anniversary date occurred between
41 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-
42 19.1 et al.), may be reinstated within 60 days of that anniversary
43 date and renewed or continued if, beginning on the first 12-month
44 anniversary date occurring on or after the sixtieth day after the
45 board adopts regulations concerning the implementation of the
46 rating factors permitted by section 9 of P.L.1992, c.162
47 (C.17B:27A-25) and, regardless of the situs of delivery of the health
48 benefits plan, the health benefits plan renewed, continued or
49 reinstated pursuant to this subsection complies with the provisions

1 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and
2 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,
3 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and
4 section 7 of P.L.1995, c.340 (C17B:27A-19.3).

5 Nothing in this subsection shall be construed to require an
6 association, multiple employer arrangement or out-of-State trust to
7 provide health benefits coverage to small employers that are not
8 contemplated by the organizational documents, bylaws, or other
9 regulations governing the purpose and operation of the association,
10 multiple employer arrangement or out-of-State trust.
11 Notwithstanding the foregoing provision to the contrary, an
12 association, multiple employer arrangement or out-of-State trust
13 that offers health benefits coverage to its members' employees and
14 dependents:

15 (a) shall offer coverage to all eligible employees and their
16 dependents within the membership of the association, multiple
17 employer arrangement or out-of-State trust;

18 (b) shall not use actual or expected health status in determining
19 its membership; and

20 (c) shall make available to its small employer members at least
21 one of the standard benefits plans, as determined by the
22 commissioner, in addition to any health benefits plan permitted to
23 be renewed or continued pursuant to this subsection.

24 (2) Notwithstanding the provisions of this subsection to the
25 contrary, a carrier or out-of-State trust which writes the health
26 benefits plans required pursuant to subsection a. of this section shall
27 be required to offer those plans to any small employer, association
28 or multiple employer arrangement.

29 (3) (a) A carrier, association, multiple employer arrangement, or
30 out-of-State trust may withdraw a health benefits plan marketed to
31 small employers that was in effect on December 31, 1993 with the
32 approval of the commissioner. The commissioner shall approve a
33 request to withdraw a plan, consistent with regulations adopted by
34 the commissioner, only on the grounds that retention of the plan
35 would cause an unreasonable financial burden to the issuing carrier,
36 taking into account the rating provisions of section 9 of P.L.1992,
37 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340
38 (C.17B:27A-19.3).

39 (b) A carrier which has renewed, continued or reinstated a
40 health benefits plan pursuant to this subsection that has not been
41 newly issued to a new small employer group since January 1, 1994,
42 may, upon approval of the commissioner, continue to establish its
43 rates for that plan based on the loss experience of that plan if the
44 carrier does not issue that health benefits plan to any new small
45 employer groups.

46 (4) (Deleted by amendment, P.L.1995, c.340).

47 (5) A health benefits plan that otherwise conforms to the
48 requirements of this subsection shall be deemed to be in compliance

1 with this subsection, notwithstanding any change in the plan's
2 deductible or copayment.

3 (6) (a) Except as otherwise provided in subparagraphs (b) and
4 (c) of this paragraph, a health benefits plan renewed, continued or
5 reinstated pursuant to this subsection shall be filed with the
6 commissioner for informational purposes within 30 days after its
7 renewal date. No later than 60 days after the board adopts
8 regulations concerning the implementation of the rating factors
9 permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing
10 shall be amended to show any modifications in the plan that are
11 necessary to comply with the provisions of this subsection. The
12 commissioner shall monitor compliance of any such plan with the
13 requirements of this subsection, except that the board shall enforce
14 the loss ratio requirements.

15 (b) A health benefits plan filed with the commissioner pursuant
16 to subparagraph (a) of this paragraph may be amended as to its
17 benefit structure if the amendment does not reduce the actuarial
18 value and benefits coverage of the health benefits plan below that of
19 the lowest standard health benefits plan established by the board
20 pursuant to subsection a. of this section. The amendment shall be
21 filed with the commissioner for approval pursuant to the terms of
22 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,
23 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as
24 applicable, and shall comply with the provisions of sections 2 and 9
25 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7
26 of P.L.1995, c.340 (C.17B:27A-19.3).

27 (c) A health benefits plan issued by a carrier through an out-of-
28 State trust shall be permitted to be renewed or continued pursuant to
29 paragraph (1) of this subsection upon approval by the commissioner
30 and only if the benefits offered under the plan are at least equal to
31 the actuarial value and benefits coverage of the lowest standard
32 health benefits plan established by the board pursuant to subsection
33 a. of this section. For the purposes of meeting the requirements of
34 this subparagraph, carriers shall be required to file with the
35 commissioner the health benefits plans issued through an out-of-
36 State trust no later than 180 days after the date of enactment of
37 P.L.1995, c.340. A health benefits plan issued by a carrier through
38 an out-of-State trust that is not filed with the commissioner pursuant
39 to this subparagraph, shall not be permitted to be continued or
40 renewed after the 180-day period.

41 (7) Notwithstanding the provisions of P.L.1992, c.162
42 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
43 employer arrangement or out-of-State trust may offer a health
44 benefits plan authorized to be renewed, continued or reinstated
45 pursuant to this subsection to small employer groups that are
46 otherwise eligible pursuant to paragraph (1) of subsection j. of this
47 section during the period for which such health benefits plan is
48 otherwise authorized to be renewed, continued or reinstated.

1 (8) Notwithstanding the provisions of P.L.1992, c.162
2 (C.17B:27A-17 et seq.) to the contrary, a carrier, association,
3 multiple employer arrangement or out-of-State trust may offer
4 coverage under a health benefits plan authorized to be renewed,
5 continued or reinstated pursuant to this subsection to new
6 employees of small employer groups covered by the health benefits
7 plan in accordance with the provisions of paragraph (1) of this
8 subsection.

9 (9) Notwithstanding the provisions of P.L.1992, c.162
10 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et al.) to
11 the contrary, any individual, who is eligible for small employer
12 coverage under a policy issued, renewed, continued or reinstated
13 pursuant to this subsection, but who would be subject to a
14 preexisting condition exclusion under the small employer health
15 benefits plan, or who is a member of a small employer group who
16 has been denied coverage under the small employer group health
17 benefits plan for health reasons, may elect to purchase or continue
18 coverage under an individual health benefits plan until such time as
19 the group health benefits plan covering the small employer group of
20 which the individual is a member complies with the provisions of
21 P.L.1992, c.162 (C.17B:27A-17 et seq.).

22 (10) In a case in which an association made available a health
23 benefits plan on or before March 1, 1994 and subsequently changed
24 the issuing carrier between March 1, 1994 and the effective date of
25 P.L.1995, c.340, the new issuing carrier shall be deemed to have
26 been eligible to continue and renew the plan pursuant to paragraph
27 (1) of this subsection.

28 (11) In a case in which an association, multiple employer
29 arrangement or out-of-State trust made available a health benefits
30 plan on or before March 1, 1994 and subsequently changes the
31 issuing carrier for that plan after the effective date of P.L.1995,
32 c.340, the new issuing carrier shall file the health benefits plan with
33 the commissioner for approval in order to be deemed eligible to
34 continue and renew that plan pursuant to paragraph (1) of this
35 subsection.

36 (12) In a case in which a small employer purchased a health
37 benefits plan directly from a carrier on or before March 1, 1994 and
38 subsequently changes the issuing carrier for that plan after the
39 effective date of P.L.1995, c.340, the new issuing carrier shall file
40 the health benefits plan with the commissioner for approval in order
41 to be deemed eligible to continue and renew that plan pursuant to
42 paragraph (1) of this subsection.

43 Notwithstanding the provisions of subparagraph (b) of paragraph
44 (6) of this subsection to the contrary, a small employer who changes
45 its health benefits plan's issuing carrier pursuant to the provisions of
46 this paragraph, shall not, upon changing carriers, modify the benefit
47 structure of that health benefits plan within six months of the date
48 the issuing carrier was changed.

1 k. Effective immediately for a health benefits plan issued on or
2 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
3 and effective on the first 12-month anniversary date of a health
4 benefits plan in effect on the effective date of P.L.2005, c.248
5 (C.17:48E-35.27 et al.), the health benefits plans required pursuant
6 to this section, including any plans offered by a State approved or
7 federally qualified health maintenance organization, shall contain
8 benefits for expenses incurred in the following:

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

14 (2) All childhood immunizations as recommended by the
15 Advisory Committee on Immunization Practices of the United
16 States Public Health Service and the Department of Health pursuant
17 to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier shall
18 notify its insureds, in writing, of any change in the health care
19 services provided with respect to childhood immunizations and any
20 related changes in premium. Such notification shall be in a form
21 and manner to be determined by the Commissioner of Banking and
22 Insurance.

23 (3) Screening for newborn hearing loss by appropriate
24 electrophysiologic screening measures and periodic monitoring of
25 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
26 (C.26:2-103.1 et al.). Payment for this screening service shall be
27 separate and distinct from payment for routine new baby care in the
28 form of a newborn hearing screening fee as negotiated with the
29 provider and facility.

30 The benefits provided pursuant to this subsection shall be
31 provided to the same extent as for any other medical condition
32 under the health benefits plan, except that a deductible shall not be
33 applied for benefits provided pursuant to this subsection; however,
34 with respect to a small employer health benefits plan that qualifies
35 as a high deductible health plan for which qualified medical
36 expenses are paid using a health savings account established
37 pursuant to section 223 of the federal Internal Revenue Code of
38 1986 (26 U.S.C. s.223), a deductible shall not be applied for any
39 benefits that represent preventive care as permitted by that federal
40 law, and shall not be applied as provided pursuant to section 16 of
41 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to
42 all small employer health benefits plans in which the carrier has
43 reserved the right to change the premium.

44 l. The board shall consider including benefits for speech-
45 language pathology and audiology services, as rendered by speech-
46 language pathologists and audiologists within the scope of their
47 practices, in at least one of the standard policies and in at least one
48 of the five riders to be developed under this section.

1 m. Effective immediately for a health benefits plan issued on or
2 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
3 effective on the first 12-month anniversary date of a health benefits
4 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z
5 et al.), the health benefits plans required pursuant to this section
6 that provide benefits for expenses incurred in the purchase of
7 prescription drugs shall provide benefits for expenses incurred in
8 the purchase of specialized non-standard infant formulas, when the
9 covered infant's physician has diagnosed the infant as having
10 multiple food protein intolerance and has determined such formula
11 to be medically necessary, and when the covered infant has not been
12 responsive to trials of standard non-cow milk-based formulas,
13 including soybean and goat milk. The coverage may be subject to
14 utilization review, including periodic review, of the continued
15 medical necessity of the specialized infant formula.

16 The benefits shall be provided to the same extent as for any other
17 prescribed items under the health benefits plan.

18 This subsection shall apply to all small employer health benefits
19 plans in which the carrier has reserved the right to change the
20 premium.

21 n. Effective immediately for a health benefits plan issued on or
22 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)
23 and effective on the first 12-month anniversary date of a small
24 employer health benefits plan in effect on the effective date of
25 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
26 required pursuant to this section that qualify as high deductible
27 health plans for which qualified medical expenses are paid using a
28 health savings account established pursuant to section 223 of the
29 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including
30 any plans offered by a State approved or federally qualified health
31 maintenance organization, shall contain benefits for expenses
32 incurred in connection with any medically necessary benefits
33 provided in-network that represent preventive care as permitted by
34 that federal law.

35 The benefits provided pursuant to this subsection shall be
36 provided to the same extent as for any other medical condition
37 under the health benefits plan, except that no deductible shall be
38 applied for benefits provided pursuant to this subsection. This
39 subsection shall apply to all small employer health benefits plans in
40 which the carrier has reserved the right to change the premium.
41 (cf: P.L.2012, c.17, s.58)

42

43 4. Section 4 of P.L.1992, c.162 (C.17B:27A-20) is amended to
44 read as follows:

45 4. Plans required to be offered under **[this act]** P.L.1992, c.162
46 (C.17B:27A-17 et seq.) may be subject to coinsurance and
47 deductibles, which may vary by selected portions of the coverage,
48 except that no **[deductible applicable to any portion of the coverage**
49 shall exceed \$250 for an individual or family unit during any

1 benefit year, and no coinsurance applicable to any portion of the
2 coverage shall exceed \$500 for an individual or family unit during
3 any benefit year, unless provided by the board pursuant to section
4 17 of P.L.1992, c.162 (C.17B:27A-33) **】** cost-sharing shall exceed
5 the maximum out-of-pocket limits established in the federal Patient
6 Protection and Affordable Care Act, Pub.L.111-148, as amended by
7 the federal "Health Care and Education Reconciliation Act of
8 2010," Pub.L.111-152.
9 (cf: P.L.1993, c.162, s.3.)

10

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

13 7. Every policy or contract issued to small employers in this
14 State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be
15 renewable with respect to all eligible employees or dependents at
16 the option of the policy or contract holder, or small employer except
17 that a carrier may discontinue or not renew a health benefits plan in
18 accordance with the provisions of this section:

19 a. A carrier may discontinue such coverage only if:

20 (1) The policyholder, contract holder, or employer has failed to
21 pay premiums or contributions in accordance with the terms of the
22 health benefits plan or the carrier has not received timely premium
23 payments; or

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

28 b. (Deleted by amendment, P.L.1997, c.146).

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

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

35 e. Any carrier doing business pursuant to the provisions of
36 **【this act】** P.L.1992, c.162 (C17B:27A-17 et seq.) ceases doing
37 business in the small employer market, if the following conditions
38 are satisfied:

39 (1) The carrier gives notice to cease doing business in the small
40 employer market to the commissioner not later than eight months
41 prior to the date of the planned withdrawal from the small employer
42 market, during which time the carrier shall continue to be governed
43 by **【this act】** P.L.1992, c.162 (C.17B:27A-17 et seq.) with respect
44 to business written pursuant to **【this act】** P.L.1992, c.162
45 (C.17B:27A-17 et seq.) For the purposes of this subsection, "date
46 of withdrawal" means the date upon which the first notice to small
47 employers is sent by the carrier pursuant to paragraph (2) of this
48 subsection;

1 (2) No later than two months following the date of the
2 notification to the commissioner that the carrier intends to cease
3 doing business in the small employer market, the carrier shall mail a
4 notice to every small business employer insured by the carrier, and
5 all covered persons, that the policy or contract of insurance will not
6 be renewed. This notice shall be sent by certified mail to the small
7 business employer not less than six months in advance of the
8 effective date of the nonrenewal date of the policy or contract;

9 (3) ~~Any carrier that ceases to do business pursuant to this act~~
10 ~~shall be prohibited from writing new business in the small employer~~
11 ~~and individual health benefits plan markets for a period of five~~
12 ~~years from the date of termination of the last health insurance~~
13 ~~coverage not so renewed~~ (Deleted by amendment,
14 P.L. ,c. (pending before the Legislature as this bill).

15 f. In the case of policies or contracts issued in connection with
16 membership in an association or trust of employers, an employer
17 ceases to maintain its membership in the association or trust, but
18 only if such coverage is terminated under this provision uniformly
19 without regard to any health status-related factor relating to any
20 covered individual;

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

22 h. A decision by the small employer carrier to cease offering
23 and not renew a particular type of group health benefits plan in the
24 small employer market, if the board discontinues a standard health
25 benefits plan or as permitted or required pursuant to subsection j. of
26 section 3 of P.L.1992, c.162 (C.17B:27A-19), and pursuant to the
27 regulations adopted by the commissioner;

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

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

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

39 (cf: P.L.2008, c.38, s.23)

40
41 6. Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to
42 read as follows:

43 9. a. (1) (Deleted by amendment, P.L.1997, c.146).

44 (2) (Deleted by amendment, P.L.1997, c.146).

45 (3) (a) For all policies or contracts providing health benefits
46 plans for small employers issued pursuant to section 3 of P.L.1992,
47 c.162 (C.17B:27A-19), and including policies or contracts offered
48 by a carrier to a small employer who is a member of a Small
49 Employer Purchasing Alliance pursuant to the provisions of

1 P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged
2 by a carrier to the highest rated small group purchasing a small
3 employer health benefits plan issued pursuant to section 3 of
4 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than **[200%]**
5 300% of the premium rate charged for the lowest rated small group
6 purchasing that same health benefits plan; provided, however, that
7 the only factors upon which the rate differential may be based are
8 age**[, gender]** and geography. Such factors shall be applied in a
9 manner consistent with regulations adopted by the commissioner.
10 For the purposes of this paragraph (3), policies or contracts offered
11 by a carrier to a small employer who is a member of a Small
12 Employer Purchasing Alliance shall be rated separately from the
13 carrier's other small employer health benefits policies or contracts.

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

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

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

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

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

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

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

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

34 d. Notwithstanding any other provision of law to the contrary,
35 **[this act]** P.L.1992, c.162 (C.17B:27A-17 et seq.) shall apply to a
36 carrier which provides a health benefits plan to one or more small
37 employers through a policy issued to an association or trust of
38 employers.

39 A carrier which provides a health benefits plan to one or more
40 small employers through a policy issued to an association or trust of
41 employers after the effective date of P.L.1992, c.162 (C.17B:27A-
42 17 et seq.), shall be required to offer small employer health benefits
43 plans to non-association or trust employers in the same manner as
44 any other small employer carrier is required pursuant to P.L.1992,
45 c.162 (C.17B:27A-17 et seq.).

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

1 f. No insurance contract or policy subject to **[this act]**
2 P.L.1992, c.162 (C.17B:27A-17 et seq.), including a contract or
3 policy entered into with a small employer who is a member of a
4 Small Employer Purchasing Alliance pursuant to the provisions of
5 P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be entered into unless
6 and until the carrier has made an informational filing with the
7 commissioner of a schedule of premiums, not to exceed 12 months
8 in duration, to be paid pursuant to such contract or policy, of the
9 carrier's rating plan and classification system in connection with
10 such contract or policy, and of the actuarial assumptions and
11 methods used by the carrier in establishing premium rates for such
12 contract or policy.

13 g. (1) Beginning January 1, 1995, a carrier desiring to increase
14 or decrease premiums for any policy form or benefit rider offered
15 pursuant to subsection i. of section 3 of P.L.1992, c.162
16 (C.17B:27A-19) subject to **[this act]** P.L.1992, c.162 (C.17B:27A-
17 17 et seq.) may implement such increase or decrease upon making
18 an informational filing with the commissioner of such increase or
19 decrease, along with the actuarial assumptions and methods used by
20 the carrier in establishing such increase or decrease, provided that
21 the anticipated minimum loss ratio for all policy forms shall not be
22 less than 80% of the premium therefor as provided in paragraph (2)
23 of this subsection. The commissioner may disapprove any
24 informational filing on a finding that it is incomplete and not in
25 substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et
26 seq.), or that the rates are inadequate or unfairly discriminatory.
27 Until December 31, 1996, the informational filing shall also include
28 the carrier's rating plan and classification system in connection with
29 such increase or decrease.

30 (2) Each calendar year, a carrier shall return, in the form of
31 aggregate benefits for all of the standard policy forms offered by
32 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162
33 (C.17B:27A-19), at least 80% of the aggregate premiums collected
34 for all of the standard policy forms, other than alliance policy
35 forms, and at least 80% of the aggregate premiums collected for all
36 of the non-standard policy forms during that calendar year. A
37 carrier shall return at least 80% of the premiums collected for all of
38 the alliances during that calendar year, which loss ratio may be
39 calculated in the aggregate for all of the alliances or separately for
40 each alliance. Carriers shall annually report, no later than August
41 1st of each year, the loss ratio calculated pursuant to this section for
42 all of the standard, other than alliance policy forms, non-standard
43 policy forms and alliance policy forms for the previous calendar
44 year, provided that a carrier may annually report the loss ratio
45 calculated pursuant to this section for all of the alliances in the
46 aggregate or separately for each alliance. In each case where the
47 loss ratio fails to substantially comply with the 80% loss ratio
48 requirement, the carrier shall issue a dividend or credit against
49 future premiums for all policyholders with the standard, other than

1 alliance policy forms, nonstandard policy forms or alliance policy
2 forms, as applicable, in an amount sufficient to assure that the
3 aggregate benefits paid in the previous calendar year plus the
4 amount of the dividends and credits shall equal 80% of the
5 aggregate premiums collected for the respective policy forms in the
6 previous calendar year. All dividends and credits must be
7 distributed by December 31 of the year following the calendar year
8 in which the loss ratio requirements were not satisfied. The annual
9 report required by this paragraph shall include a carrier's calculation
10 of the dividends and credits applicable to standard, other than
11 alliance policy forms, non-standard policy forms and alliance policy
12 forms, as well as an explanation of the carrier's plan to issue
13 dividends or credits. The instructions and format for calculating
14 and reporting loss ratios and issuing dividends or credits shall be
15 specified by the commissioner by regulation. Such regulations shall
16 include provisions for the distribution of a dividend or credit in the
17 event of cancellation or termination by a policyholder. For
18 purposes of this paragraph, "alliance policy forms" means policies
19 purchased by small employers who are members of Small Employer
20 Purchasing Alliances.

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

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

27 i. The provisions of **【this act】** P.L.1992, c.162 (C.17B:27A-17
28 et seq.) shall apply to health benefits plans which are delivered,
29 issued for delivery, renewed or continued on or after January 1,
30 1994.

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

32 k. A carrier who negotiates a reduced premium rate with a
33 Small Employer Purchasing Alliance for members of that alliance
34 shall provide a reduction in the premium rate filed in accordance
35 with paragraph (3) of subsection a. of this section, expressed as a
36 percentage, which reduction shall be based on volume or other
37 efficiencies or economies of scale and shall not be based on health
38 status-related factors.

39 (cf: P.L.2008, c.38, s.24)

40

41 7. Section 13 of P.L.1992, c.162 (C.17B:27A-29) is amended
42 to read as follows:

43 13. a. **【**Within 60 days of the effective date of this act, the
44 commissioner shall give notice to all members of the time and place
45 for the initial organizational meeting, which shall take place within
46 90 days of the effective date. The members shall elect the initial
47 board, subject to the approval of the commissioner. The board shall
48 consist of 10 elected public members and two ex officio members
49 who include the Commissioner of Health and the commissioner or

1 their designees. Initially, three of the public members of the board
2 shall be elected for a three-year term, three shall be elected for a
3 two-year term, and three shall be elected for a one-year term.
4 Thereafter, all elected board members shall serve for a term of three
5 years. The following categories shall be represented among the
6 elected public members:

7 (1) Three carriers whose principal health insurance business is
8 in the small employer market;

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

11 (3) A health service corporation or a domestic stock insurer
12 which converted from a health service corporation pursuant to the
13 provisions of P.L.2001, c.131 (C.17:48E-49 et al.) and is primarily
14 engaged in the business of issuing health benefit plans in this State;

15 (4) Two health maintenance organizations; and

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

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

18 (7) Three persons representing small employers, at least one of
19 whom represents minority small employers.

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

21 The board shall hold an election for the two members added
22 pursuant to P.L.1995, c.298 within 90 days of the date of enactment
23 of that act. Initially, one of the two new members shall serve for a
24 term of one year and one of the two new members shall serve for a
25 term of two years. Thereafter, the new members shall serve for a
26 term of three years. The terms of the risk-assuming carrier and
27 reinsuring carrier shall terminate upon the election of the two new
28 members added pursuant to P.L.1995, c.298, notwithstanding the
29 provisions of this section to the contrary.

30 In addition to the 10 elected public members, the **】** The board
31 shall **【include six】** consist of 12 public members appointed by the
32 Governor **【with the advice and consent of the Senate】** who shall
33 include:

34 (1) Two carriers that sell plans in the small employer market;

35 (2) One carrier that sells plans in the individual market or the
36 small employer market;

37 (3) Two representatives of or individuals employed by
38 businesses that purchase in small employer health benefits plans;

39 (4) Two health care provider representatives;

40 (5) Two insurance producers licensed to sell health insurance
41 pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.);

42 (6) One representative of organized labor;

43 **【One physician licensed to practice medicine and surgery in this**
44 **State; and**

45 **Two persons who represent the general public and are not**
46 **employees of a health benefits plan provider.】**

47 (7) One representative of an association representing small
48 business in the State; and

1 (8) One person with knowledge or expertise in New Jersey
2 regulated health insurance markets who represents the general
3 public.

4 The commissioner, or the commissioner's designee, shall serve
5 on the board as an ex officio member. No carrier shall have more
6 than one representative on the board.

7 The public members shall be appointed for a term of three years,
8 except that of the members first appointed, **two** four shall be
9 appointed for a term of one year, **two** four for a term of two years
10 and **two** four for a term of three years.

11 A vacancy in the membership of the board shall be filled for an
12 unexpired term in the manner provided for the **original election**
13 **or** **appointment**, as appropriate.

14 b. **If the initial board is not elected at the organizational**
15 **meeting, the commissioner shall appoint the public members within**
16 **15 days of the organizational meeting, in accordance with the**
17 **provisions of paragraphs (1) through (7) of subsection a. of this**
18 **section.** (Deleted by amendment, P.L. , c.) (pending before
19 the Legislature as this bill).

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

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

24 e. At least two copies of the minutes of every meeting of the
25 board shall be delivered forthwith to the commissioner.
26 (cf: P.L.2012, c.17, s.60.)

27
28 8. (New section) Sections 8 through 13 of
29 P.L. , c. (C.) (pending before the Legislature as this bill)
30 shall be known and may be cited as the "Small Business Health
31 Insurance Affordability Act."

32
33 9. (New section) a. The board shall annually review the small
34 employer health benefits plans offered pursuant to P.L.1992, c.162
35 (C.17B:27A-17 et seq.) to ensure that each plan meets the
36 requirements of section 2 of P.L.2019, c.354 (C.17B:27A-19.30),
37 provides consumer choice and affordability, and maintains a
38 relative level of consistency compared to previous years and to
39 other plans in the small employer market. The board shall publish
40 the findings of its review on the website of the Department of
41 Banking and Insurance.

42 b. The board shall annually adjust the design of the small
43 employer health benefits plans, including the out-of-pocket limits
44 under those plans, to ensure premium affordability and to align the
45 plans with the requirements of section 2 of P.L.2019, c.354
46 (C.17B:27A-19.30). The adjustment shall be based on the annual
47 review conducted pursuant to subsection a. of this section. The
48 board may consider proposals for adjustments to plan design to

1 improve affordability from carriers offering small employer health
2 benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

3 c. The board shall annually review the appropriateness of
4 geographic rating areas.

5 d. The board shall examine and, to the extent practicable, track
6 where small employers who do not continue coverage through a
7 small employer health benefits plan offered pursuant to P.L.1992,
8 c.162 (C.17B:27A-17 et seq.) elect to purchase coverage. The
9 board shall have the authority to develop a sample survey that
10 insurance brokers may provide to clients. Brokers who elect to
11 provide the survey to clients shall report to the board any
12 information received through the survey. The sample survey shall
13 include, but may not be limited to, information concerning where
14 small employers purchase health benefits coverage. The board shall
15 publish the findings of the surveys received from brokers pursuant
16 to this subsection on the website of the Department of Banking and
17 Insurance.

18

19 10. (New section) a. Except as provided in subsection b. of this
20 section, a carrier that offers an individual health benefits plan that
21 provides benefits for expenses incurred in the purchase of
22 prescription drugs and is delivered, issued, executed, or renewed in
23 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), may
24 use a prescription drug formulary to limit or exclude coverage for
25 prescription drugs, provided that the carrier demonstrates to the
26 satisfaction of the board that utilization and medical review panels
27 are in place to allow formulary flexibility as necessary in the best
28 interest of the insured person.

29 b. A carrier that offers an individual health benefits plan that
30 provides benefits for expenses incurred in the purchase of
31 prescription drugs and is delivered, issued, executed, or renewed in
32 this State, pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), shall
33 not adopt a protocol, policy, or program that establishes the specific
34 sequence in which prescription drugs for a specified medical
35 condition, and medically appropriate for a particular patient, are
36 required to be administered in order to be covered by a health
37 benefits plan.

38

39 11. (New section) a. Except as provided in subsection b. of this
40 section, a carrier that offers a small employer health benefits plan
41 that provides benefits for expenses incurred in the purchase of
42 prescription drugs and is delivered, issued, executed, or renewed in
43 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), may
44 use a prescription drug formulary to limit or exclude coverage for
45 prescription drugs, provided that the carrier demonstrates to the
46 satisfaction of the board that utilization and medical review panels
47 are in place to allow formulary flexibility as necessary in the best
48 interest of the insured person.

1 b. A carrier that offers a small employer health benefits plan
2 that provides benefits for expenses incurred in the purchase of
3 prescription drugs and is delivered, issued, executed, or renewed in
4 this State, pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), shall
5 not adopt a protocol, policy, or program that establishes the specific
6 sequence in which prescription drugs for a specified medical
7 condition, and medically appropriate for a particular patient, are
8 required to be administered in order to be covered by a health
9 benefits plan.

10

11 12. (New section) a. The department shall establish a clinically
12 sound and well-communicated exceptions and appeals process for
13 any carrier that uses a prescription drug formulary pursuant to
14 sections 10 and 11 of P.L. , c. (C.) (pending before the
15 Legislature as this bill). The exceptions and appeals process shall
16 allow insureds to appeal to an independent, objective third party
17 which shall render a decision as promptly as the patient's condition
18 mandates.

19 b. A carrier subject to the exceptions and appeals process
20 established pursuant to this section shall:

21 (1) show cause before denying payment for a prescription drug
22 when a prescriber has deemed the carrier's recommended substitute
23 medically inappropriate;

24 (2) provide insureds with step-by-step directions to initiate the
25 exceptions and appeals process; and

26 (3) for a prescription drug that is nonpreferred, not require an
27 insured who obtains that prescription drug to pay an amount greater
28 than the cost sharing tier level associated with the preferred
29 prescription drug, if the prescriber determines that therapeutically
30 similar drugs are medically inappropriate.

31 c. The department shall collect the information it requires to
32 conduct an annual evaluation of the exceptions and appeals process
33 established pursuant to this section with regard to the
34 appropriateness of the burden of the process on consumers and
35 clinicians and the effects on patient health outcomes.

36

37 13. (New section) The department shall, in time for plan year
38 2024, adopt rules and regulations, pursuant to the "Administrative
39 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), requiring the
40 minimum standards for small employer health benefits plans
41 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) be no greater
42 than the minimum standards set forth in the federal Patient
43 Protection and Affordable Care Act, Pub.L.111-148, as amended by
44 the federal "Health Care and Education Reconciliation Act of
45 2010," Pub.L.111-152 for plans issued pursuant to P.L.1992, c.161
46 (C.17B:27A-2 et seq.).

47

48 14. This act shall take effect immediately.

STATEMENT

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This bill revises various requirements for individual and small employer health benefits plans.

The bill removes a provision of law that requires health insurance carriers to offer individual health plans, through the Individual Health Coverage Program, as a condition of participation in the small employer health insurance market. The bill removes a provision of law that requires health insurance carriers that participate in the small employer health insurance market to participate in the Individual Health Coverage Program.

The bill also removes a 5-year prohibition on carriers re-entering the individual and small employer health insurance markets if the carrier ceases to offer either plan.

The bill modifies the age rating band by requiring that the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan may not be greater than 300% of the premium rate charged for the lowest rated small group purchasing that same health benefits plan; provided, however, that the only factors upon which the rate differential may be based are age and geography. Current law provides that the rate of the highest rated small group may not be greater than 200% of the premium rate charged for the lowest rated small group.

The bill removes provisions of current law that provide certain caps on cost-sharing amounts in small employer health plans. The bill instead provides that cost-sharing may not exceed the maximum out-of-pocket limits established in the federal Patient Protection and Affordable Care Act. This bill also requires the board of directors of the New Jersey Small Employer Health Benefits Program to annually review and adjust certain requirements, including out-of-pocket limits, for small employer health benefits plans. In addition, the bill requires the board to examine and track where small employers who do not continue coverage through a small employer health benefits plan elect to purchase coverage.

The bill provides that a carrier that offers an individual or small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs may use a prescription drug formulary to limit or exclude coverage for prescription drugs, provided that the carrier demonstrates to the satisfaction of the board that utilization and medical review panels are in place to allow formulary flexibility when necessary, provided that the carrier may not adopt a protocol, policy, or program that establishes the specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are required to be administered in order to be covered by a health benefits plan.

The bill requires the department to establish a clinically sound and well-communicated exceptions and appeals process for any carrier offering an individual or small employer health benefits plan

1 and that uses a prescription drug formulary pursuant to the bill. The
2 exceptions and appeals process is to allow insureds to appeal to an
3 independent, objective third party which shall render a decision as
4 promptly as the patient's condition mandates.

5 The bill requires the department to adopt rules and regulations,
6 for plan year 2024, requiring the minimum standards for small
7 employer health benefits plans to be no greater than the minimum
8 standards set forth in the federal Patient Protection and Affordable
9 Care Act, for individual health benefits plans.

10 The bill revises the membership of the New Jersey Small
11 Employer Health Benefits Program Board. The bill provides that
12 the board will consist of the following members:

- 13 (1) One carrier that sells plans in the small employer market;
- 14 (2) Two carriers that sell plans in the small employer market or
15 the individual market;
- 16 (3) Two representatives of or individuals employed by
17 businesses that purchase in small employer health benefits plans;
- 18 (4) Two individuals who are licensed insurance brokers;
- 19 (5) Two health care provider representatives;
- 20 (6) One individual representing organized labor; and
- 21 (7) One individual representing an association that represents
22 small businesses in the State; and
- 23 (8) One person with knowledge or expertise in New Jersey
24 regulated health insurance markets who represents the general
25 public.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE
COMMITTEE

STATEMENT TO
ASSEMBLY, No. 5137

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 9, 2023

The Assembly Financial Institutions and Insurance Committee reports favorably and with committee amendments Assembly Bill No. 5137.

As amended, this bill revises various requirements for individual and small employer health benefits plans.

The bill removes a provision of law that requires health insurance carriers to offer individual health plans, through the Individual Health Coverage Program, as a condition of participation in the small employer health insurance market. The bill requires carriers issuing small employer health benefits plans that also issue individual health benefits plans to make a good faith effort to market individual health benefits plans and makes the violation of that requirement punishable by a fine.

The bill also replaces a mandatory five-year prohibition on carriers re-entering the individual and small employer health insurance markets if the carrier ceases to offer either plan with a provision permitting the Commissioner of Banking and Insurance to impose a five-year prohibition on the issuance of any health benefits plan in the individual or small employer markets if the commissioner determines the prohibition would be beneficial to those markets.

The bill removes provisions of current law that provide certain caps on cost-sharing amounts in small employer health plans. The bill instead provides that cost-sharing may not exceed the maximum out-of-pocket limits established in the federal Patient Protection and Affordable Care Act. This bill also requires the board of directors of the New Jersey Small Employer Health Benefits Program to annually review and adjust certain requirements, including out-of-pocket limits, for small employer health benefits plans. In addition, the bill requires the board to examine and track where small employers who do not continue coverage through a small employer health benefits plan elect to purchase coverage.

The bill permits the Department of Banking and Insurance and the boards of directors of the New Jersey Individual Health Coverage Program and New Jersey Small Employer Health Benefits Program to

issue regulations creating standard plans or plan design requirements with certain minimum standards and requires the department to repeal or update any regulation in conflict with the goals of the bill. Under the bill, inconsistent regulatory provisions are rendered void.

The bill provides that a carrier that offers an individual or small employer health benefits plan that provides benefits for expenses incurred in the purchase of prescription drugs may use a prescription drug formulary to limit or exclude coverage for prescription drugs, provided that the carrier offers at least one plan with an open formulary and the carrier demonstrates to the satisfaction of the board that utilization and medical review panels are in place to allow formulary flexibility when necessary, provided that the carrier may not adopt a protocol, policy, or program that establishes the specific sequence in which prescription drugs for a specified medical condition, and medically appropriate for a particular patient, are required to be administered in order to be covered by a health benefits plan.

Carriers using a prescription drug formulary pursuant to the bill are required to develop a clinically sound and well-communicated exceptions and appeals process. The bill delineates certain requirements for the process and directs the department to collect certain information from carriers for the purposes of conducting an annual evaluation

The bill requires the department to adopt rules and regulations, for plan year 2024, requiring the minimum standards for small employer health benefits plans to be no greater than the minimum standards set forth in the federal Patient Protection and Affordable Care Act, for individual health benefits plans.

The bill revises the membership of the New Jersey Small Employer Health Benefits Program Board. The bill provides that the board will consist of the following members:

- (1) One carrier that sells plans in the small employer market;
- (2) Two carriers that sell plans in the small employer market or the individual market;
- (3) Two representatives of or individuals employed by businesses that purchase in small employer health benefits plans;
- (4) Two individuals who are licensed insurance brokers;
- (5) Two health care provider representatives;
- (6) One individual representing organized labor; and
- (7) One individual representing an association that represents small businesses in the State; and
- (8) Two persons with knowledge or expertise in New Jersey regulated health insurance markets who represents the general public.

In addition, the board is to include the Commission of Health and the Commissioner of Banking and Insurance or the commissioner's designee, as ex officio members.

COMMITTEE AMENDMENTS:

The committee amended the bill to:

(1) remove from the bill a provision modifying the age rating band for small employer health benefits plans;

(2) stipulate that individual and small employer health benefits plans may use a prescription drug formulary only if the carrier offers at least one plan with an open formulary, in addition to the other requirements already enumerated in the bill;

(3) require carriers issuing small employer health benefits plans that also issue individual health benefits plans to make a good faith effort to market individual health benefits plans and make a violation of this provision punishable by fine;

(4) allow the Department of Banking and Insurance and the boards of directors of the New Jersey Individual Health Coverage Program and New Jersey Small Employer Health Benefits Program to issue regulations creating standard plans or plan design requirements with certain minimum standards;

(5) require the Department of Banking and Insurance to repeal or update any regulation in conflict with the goals of the bill, and render inconsistent provisions void;

(6) expand the board of directors of the New Jersey Small Employer Health Benefits Program to 13 members by adding an additional person with knowledge or expertise in the New Jersey regulated health insurance markets representing the general public;

(7) add the Commissioner of Health as an ex officio member of the board of directors of the New Jersey Small Employer Health Benefits Program and permit the existing board to continue until a quorum of members newly appointed pursuant to the provisions of the bill is established;

(8) require carriers using a prescription drug formulary pursuant to the bill to develop a clinically sound and well-communicated exceptions and appeals process; and

(9) permit the Department of Banking and Insurance to issue certain regulations pursuant to the bill without regard to timelines relating to administrative rulemaking required under current law.

STATEMENT TO
[First Reprint]
ASSEMBLY, No. 5137

with (1R) Assembly Floor Amendments
(Proposed by Assemblyman McKEON)

ADOPTED: MARCH 30, 2023

This floor amendment makes Assembly Bill 5137 (1R) identical to Senate Bill 3480 (2R) by:

(1) stipulating that carriers offering individual health benefits plans are required to make a good faith effort to market individual health benefits plans;

(2) removing from the bill a provision requiring the department to repeal or update any regulation in conflict with the goals of the bill, and render inconsistent provisions void;

(3) allowing carriers using a prescription drug formulary pursuant to the bill to use an existing exceptions and appeals process if the process meets the requirements of the bill;

(4) requiring the department to adopt rules and regulations, for plan year 2024, requiring no additional limitations on copayments, coinsurance, or deductibles for small employer health benefits plans to be beyond those set forth in the federal Patient Protection and Affordable Care Act, for individual health benefits plans; and

(5) making certain technical changes.

STATEMENT TO
[Second Reprint]
ASSEMBLY, No. 5137

with Assembly Floor Amendments
(Proposed by Assemblyman McKEON)

ADOPTED: MAY 25, 2023

These floor amendments stipulate that the provisions of the bill are to be in effect no later than in time for plan year 2025, rather than plan year 2024, stipulate that the bill will not impact the existing relationship between the Department of Banking and Insurance and the board of directors of the New Jersey Small Employer Health Benefits Program as it relates to the State-based Exchange, and make a technical correction.

SENATE BILL NO. 3480
(Third Reprint)

To the Senate:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Senate Bill No. 3480 (Third Reprint) with my recommendations for reconsideration.

This bill revises various requirements for the Individual Health Coverage ("IHC") Program and the Small Employer Health Benefits ("SEH") Program. The bill eliminates outdated statutory provisions that provide certain limitations on cost-sharing and plan design that have been revised through subsequent rulemaking and the promulgation of standard policy forms by the SEH and IHC Boards. The bill also removes the requirement under current law for carriers offering plans in the SEH Program to also offer plans in the IHC Program, and modifies the mandatory five-year prohibition on doing business in the SEH and IHC markets following market withdrawal. Additionally, the bill revises the membership of the SEH Board, which is responsible for overseeing plan design and the administration of the SEH Program.

While many provisions of the bill are primarily aimed at making health insurance plans more accessible and affordable for small businesses, I am concerned with one provision that would allow carriers to utilize a closed formulary in the IHC Program. A closed formulary is one in which non-formulary drugs (both branded and generic) are not reimbursed by the payer. Current law prohibits the use of closed formularies in the IHC Program, ensuring that patients enrolled in the IHC market have the broadest access possible when filling their prescriptions.

I commend the sponsors of this legislation for their efforts to begin to address the long-term viability of the SEH Program. The SEH market has been losing upwards of 41,000 covered lives per year. In 2005, nearly 1 million small business employees and their

families obtained their health insurance through the SEH Program. By 2020, enrollment had dropped to 295,000. The exodus has been driven mainly by federal law changes and increased premiums, which increased by an average rate of 10.4 percent for plan year 2022.

While I am supportive of most of the changes that this bill seeks to implement, including allowing limited plans in the SEH Program to utilize a closed formulary, the bill's authorization of closed formularies in the IHC Program is unwarranted. While the SEH Program has been seeing a decrease in covered lives, the IHC Program, bolstered by the State-based exchange, Get Covered New Jersey, has thrived. More than 341,000 New Jerseyans signed up for health coverage through Get Covered New Jersey during the 2023 Open Enrollment Period - a record high in New Jersey. There has been a nearly 40 percent increase in enrollment since my Administration assumed operation of the health insurance exchange from the federal government in 2019. The unprecedented number of signups follows policy actions taken in partnership with the Legislature to significantly increase and expand financial help to boost affordability of quality, comprehensive health insurance.

The current struggles of the SEH Program are simply not applicable to the IHC Program and, in comparing the two markets, there is no justification to authorize the use of closed formularies in the IHC Program, which would serve no discernible benefit to consumers. In the insurance marketplace, SEH plans compete with self-funded plans for business, while IHC plans do not. The SEH market is the only insurance market in which a small employer is guaranteed the right to purchase insurance regardless of its risk profile. Federal and State laws concerning insurance premium restrictions, guaranteed issue, and renewability do not apply to self-funded policies. Because of the breadth of coverage and consumer protections offered in the SEH market, along with the deterioration of the risk pool, the cost of SEH Program plans tends

to be higher than their self-funded counterparts. Closed formularies are a standard plan design element in the self-funded commercial market and other small employer markets throughout the country. Allowing a closed formulary option in the SEH market would improve the competitiveness of the SEH plans and potentially make SEH plans more attractive for the State's small employers. These same considerations are simply not present in the IHC market.

I am optimistic that the enactment of this bill with my recommended changes will begin to bolster the SEH Program. If the changes set forth in this bill are successful at increasing participation in the SEH market, especially among lower-risk populations, we should see a reduction in premiums and increased affordability of SEH plans. I am confident that the goals of this legislation can be achieved without removing the long-standing protection of an open formulary that New Jersey has offered all persons covered under individual plans.

Therefore, I herewith return Senate Bill No. 3480 (Third Reprint) and recommend that it be amended as follows:

<u>Page 19, Section 7, Line 31:</u>	Delete "12" and insert "11"
<u>Page 20, Section 9, Lines 25-47:</u>	Delete in their entirety
<u>Page 21, Section 9, Lines 1-10:</u>	Delete in their entirety
<u>Page 21, Section 10, Line 12:</u>	Delete "10." and insert "9."
<u>Page 22, Section 11, Line 25:</u>	Delete "11." and insert "10."
<u>Page 22, Section 11, Line 26:</u>	Delete "sections" and insert "section"
<u>Page 22, Section 11, Line 26:</u>	Delete "and 10"
<u>Page 23, Section 12, Line 5:</u>	Delete "12." and insert "11."
<u>Page 23, Section 12, Line 23:</u>	Delete "P.L. , c. (C.) (pending before the Legislature as this act)" and insert "P.L.1992, c.162 (C.17B:27A-20)"
<u>Page 23, Section 13, Line 27:</u>	Delete "13." and insert "12."

[seal]

Respectfully,

/s/ Philip D. Murphy

Governor

Attest:

/s/ Parimal Garg

Chief Counsel to the Governor

Governor Murphy Takes Action on Legislation

12/21/2023

TRENTON – Today, Governor Murphy signed the following bills into law:

SCS for S-524wGR/ACS for A-1700 (Ruiz, Cunningham/Quijano, Mukherji, Atkins) - Creates Mental Health Diversion Program to divert eligible persons away from criminal justice system and into appropriate case management and mental health services

S-2818wGR/A-4394 (Turner/Kennedy) - Establishes "Working Group to Study Pricing of Motor Fuels by Retail Dealers"

SCS for S-2848wGR/A-4328 (Smith, Greenstein/DeAngelo, Karabinchak) - Revises criteria for remote net metering program established by BPU

S-3011/A-4800 (Scutari/Murphy, McKeon, Mukherji) - Concerns use of ignition interlock devices for drunk driving offenses

S-3044wGR/A-4716 (Diegnan, Greenstein/Stanley, Benson, Mukherji) - Makes supplemental appropriation of \$15 million to DEP for implementation of Electric School Bus Program

S-3153wGR/A-4548 (Codey/Kennedy, Haider, Stanley) - Authorizes schools to receive certain food waste from other schools, and provides exemption to such receiving schools for certain DEP permits, under certain conditions

S-3480wGR/A-5137 (Vitale, Pou/McKeon, Park, Murphy) – "The Small Business Health Insurance Affordability Act"; revises certain requirements for individual and small employer health benefits plans

SCS for -3756wGR/ACS for A-5363 (Scutari, Sarlo/Schaer, Wimberly) - Permits SHBP and SEHBP to award contracts for more claims administrators for each program plan; requires claims data and trend reports to be provided to certain persons

S-3839wGR/A-4061 (Greenstein, Steinhardt/Mukherji, Wirths, Space) - Requires Commissioner of Corrections to institute 10-minute shift overlap in State correctional facilities; appropriates \$13 million

S-4011wGR/A-5650 (Ruiz/Coughlin, Pintor Marin, Wimberly) - Modifies New Jersey Community-Anchored Development Program

A-5549/S-3960 (Lopez, Benson, McKnight/Vitale) - Extends eligibility for certain individuals for emergency assistance

ACS for A-5757/S-4127 (Conaway, Speight, Sumter/Gopal) - Extends certain pay parity regarding telemedicine and telehealth for one year