26:15-1

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2008 **CHAPTER:** 38

NJSA: 26:15-1 (Expands NJ FamilyCare, establishes mandate for health care coverage of children, makes Various reforms to individual and small employer insurance markets and certain dependent coverage; appropriates $1 million.)

BILL NO: S1557 (Substituted for A2624)

SPONSOR(S) Vitale and others

DATE INTRODUCED: April 7, 2008

COMMITTEE: **ASSEMBLY:** ---

SENATE: Health, Human Services and Senior Citizens; Budget and Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** June 23, 2008

SENATE: June 23, 2008

DATE OF APPROVAL: July 8, 2008

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Third reprint enacted)

S1557

SPONSOR'S STATEMENT: (Begins on page 54 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes Health 5-15-08
Budget 5-19-08
Budget 6-19-08

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

A2624

SPONSOR'S STATEMENT: (Begins on page 54 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

(continued)

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext. 103 or mailto:refdesk@njstatelib.org

REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

"Gov. signs health bill," Courier-Post, 7-9-08, p.2B
"Gov. signs law mandating kids' health coverage," Asbury Park Press, 7-9-08, p.A1
"N.J. expands health insurance plan," The Philadelphia Inquirer, 7-9-08, p.B2
"Health program's new aim: Insure 1.3M poor Jerseyans," The Star-Ledger, 7-9-08, p.15
"N.J. Mandates health insurance for all children," The Record, 7-9-08, p.News02
"Corzine signs bill to widen N.J. health care as national effort kicks off," The Press, 7-9-08, p.A1

LAW

Title 26.
Chapter 15. (New)
Health Care
Coverage
§§1,2 -
C.26:15-1 &
26:15-2
§5 - C.30:4J-11.1
§6 –
C.26:2H-18.59j
§7 - C.54A:8-6.2
§25 –
C.17:22A-41.1
§§26,27 -
C.30:4J-18 &
30:4J-19
§28 - Approp.
§36 –
C.17B:27A-2.1 &
Note to §§20,29
§37 –
C.17B:27A-2.2 &
Note to §§2, 6, 20,
25, 26, 28, 29

P.L. 2008, CHAPTER 38, ***approved July 8, 2008***
Senate, No. 1557 ***(Third Reprint)***

AN ACT concerning health care coverage [1]**[**and**]**,[1] revising parts of statutory law [1], and making an appropriation[1].

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

1. (New section) The Legislature finds and declares:

a. There are an estimated 1.25 million residents of the State who have no health insurance coverage, of which over 240,000 are children, and the number of uninsured residents is increasing each year;

b. While employer-sponsored health care coverage in the State is well above the national average and has been a major factor in keeping the number of uninsured lower than in many states, because of the rising cost of the coverage, increasing numbers of employers are considering dropping coverage for their employees and

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SHH committee amendments adopted May 15, 2008.
[2]Senate SBA committee amendments adopted May 19, 2008.
[3]Senate SBA committee amendments adopted June 19, 2008.

dependents, or are requiring employees to share in a greater percentage of premium costs and to bear larger copayments and coinsurance, which is making health care coverage increasingly unaffordable to low and moderate income working families;

c. Persons without health insurance coverage receive less preventive care, poorer treatment for both minor and serious chronic and acute illnesses, and in many cases live shorter lives than comparable insured populations;

d. Many uninsured are forced to seek health care in inappropriate settings such as hospital emergency rooms because they cannot obtain needed health care services in a convenient and more cost-effective setting such as a primary care provider's office or clinic, which contributes to higher health care costs;

e. The uninsured are commonly billed at higher rates than those who have health care coverage. Health care costs have become a leading cause of bankruptcy in this country, and those without insurance are most at risk;

f. The State has recognized the importance of increasing access to health care coverage and, over the last several years, has enacted several reforms to make health care coverage more affordable and accessible to residents of the State. Among these reforms are the expansions of coverage under the State Medicaid and NJ FamilyCare programs. Despite these efforts, too many low income parents and children lack access to health care coverage;

g. In order to ensure that more low income parents in the State have access to health care coverage and all children in the State are covered under a health plan, thus moving closer to providing universal coverage for all residents of this State, it is necessary to further expand coverage for parents under the NJ FamilyCare Program, and mandate that all children in the State have health care coverage, either through public programs or private coverage; and

h. In order to make insurance coverage more affordable to residents and small businesses in this State, and to stabilize enrollment in, and the costs of, individual and small employer health benefits plans, it is also necessary to adopt comprehensive reform measures to the insurance marketplace.

2. (New section) a. Beginning one year after the date of enactment of this act, all residents of this State 18 years of age and younger shall obtain and maintain health care coverage that provides hospital and medical benefits. The coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid program, NJ FamilyCare Program, or the NJ FamilyCare Advantage buy-in program.

b. As used in this section:

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" means the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

"NJ FamilyCare Advantage" means the buy-in program established pursuant to subsection j. of section 5 of P.L.2005, c.156 (C.30:4J-12).

3. Section 4 of P.L.2005, 156 (C.30:4J-11) is amended to read as follows:

4. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" or "program" means the NJ FamilyCare Program established pursuant to sections 3 through 5 of P.L.2005, 156 (C.30:4J-10 though C.30:4J-12).

"Poverty level" means the official federal poverty level based on family size, established and adjusted under Section 673(2) of Subtitle B, the "Community Services Block Grant Act," Pub.L.97-35 (42 U.S.C. s.9902(2)).

"Qualified applicant" means:

a. a child under 19 years of age: (1) whose family gross income does not exceed 350% of the poverty level; (2) who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States;

b. a parent or caretaker: (1) whose gross family income does not exceed 200% of the poverty level; (2) **[**who is enrolled in NJ FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et al.); (3)**]** who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; **[**(4)**]** (3) who is a resident of this State; and **[**(5)**]** (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States; and

c. a single adult or couple without dependent children: (1) whose family gross income does not exceed 100% of the poverty level; (2) who is enrolled in NJ FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et al.) and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States.

(cf: P.L.2005, c.156, s.4)

4. Section 5 of P.L.2005, c.156 (C.30:4J-12) is amended to read as follows:

5. a. The purpose of the program shall be to provide subsidized health insurance coverage, and other health care benefits as determined by the commissioner, to children under 19 years of age and their parents or caretakers and to adults without dependent children, within the limits of funds appropriated or otherwise made available for the program.

The program shall require families to pay copayments and make premium contributions, based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner shall take such actions as are necessary to implement and operate the program in accordance with the State Children's Health Insurance Program established pursuant to 42 U.S.C.s.1397aa et seq.

c. The commissioner:

(1) shall, by regulation, establish standards for determining eligibility and other program requirements, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

(2) shall require that a parent or caretaker who is a qualified applicant purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner, and shall provide assistance to the qualified applicant to purchase that coverage, except that the provisions of this paragraph shall not be construed to require an employer to provide health insurance coverage for any employee or employee's spouse or dependent child;

(3) may, by regulation, establish plans of coverage and benefits to be covered under the program, except that the provisions of this section shall not apply to coverage for medications used exclusively to treat AIDS or HIV infection; and

(4) shall establish, by regulation, other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities, including managed care organizations, to assist in administering the program. The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.

d. The commissioner shall establish procedures for determining eligibility, which shall include, at a minimum, the following enrollment simplification practices:

(1) A streamlined application form as established pursuant to subsection k. of this section;

(2) Require new applicants to submit no more than one recent pay stub from the applicant's employer, or, if the applicant has more than one employer, no more than one from each of the applicant's

employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's income by reviewing available Department of the Treasury or Department of Labor and Workforce Development records concerning the applicant, or such other records as the commissioner determines appropriate.

The commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor and Workforce Development or such other records as the commissioner determines appropriate.

If the commissioner elects to match reported income with confidential records of the Department of the Treasury, the commissioner shall require an applicant to provide written authorization for the Division of Taxation in the Department of the Treasury to release applicable tax information to the commissioner for the purposes of establishing income eligibility for the program. The authorization, which shall be included on the program application form, shall be developed by the commissioner, in consultation with the State Treasurer;

(3) Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

(4) Continuous enrollment;

(5) Simplified renewal by sending an enrollee a preprinted renewal form and requiring the enrollee to sign and return the form, with any applicable changes in the information provided in the form, no later than 30 days after the date the enrollee's annual eligibility expires. The commissioner may establish such auditing or income verification procedures as he deems appropriate, as provided in paragraph (1) of this subsection; and

(6) Provision of program eligibility-identification cards that are issued no more frequently than once a year.

e. The commissioner shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year. In this regard, notwithstanding the definition of "qualified applicant," the commissioner may enroll in the program such children or their parents or caretakers who may otherwise be eligible for the

Medicaid program in order to maximize use of federal funds that may be available pursuant to 42 U.S.C. s.1397aa et seq.

f. Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.

g. The commissioner shall provide, by regulation, for presumptive eligibility for the program in accordance with the following provisions:

(1) A child who presents himself for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care, or other State licensed community-based primary care provider shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center, local health department or licensed health care provider staff indicates that the child meets program eligibility standards and is a member of a household with an income that does not exceed 350% of the poverty level;

(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is deemed presumptively eligible for Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) The parent or caretaker of a child deemed presumptively eligible pursuant to this subsection shall be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined;

(4) A child shall be eligible to receive all services covered by the program during the period in which the child is presumptively eligible; and

(5) The commissioner may, by regulation, establish a limit on the number of times a child may be deemed presumptively eligible for NJ FamilyCare.

h. The commissioner, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

(1) With respect to school-age children, the commissioner, in consultation with the Commissioner of Education and the Secretary of Agriculture, shall develop a form that provides information about the NJ FamilyCare and Medicaid programs and provides an opportunity for the parent or guardian who signs the school lunch application form to give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the programs. The form shall be attached to, included with, or incorporated into, the school lunch application form.

The commissioner, in consultation with the Commissioner of Education, shall establish procedures for schools to transmit information attached to, included with, or provided on the school

lunch application form regarding the NJ FamilyCare and Medicaid programs to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

(2) The commissioner or the Commissioner of Education, as applicable, shall:

(a) make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form.

The entity shall make the informational and application materials available, upon request, to persons interested in the program; and

(b) request each entity to distribute a notice at least annually, as developed by the commissioner, to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials. In the case of elementary and secondary schools, the information attached to, included with, or incorporated into, the school lunch application form for school-age children pursuant to this subparagraph shall be deemed to meet the requirements of this paragraph.

i. Subject to federal approval, the commissioner shall, by regulation, establish that in determining income eligibility for a child, any gross family income above 200% of the poverty level, up to a maximum of 350% of the poverty level, shall be disregarded.

j. The commissioner shall establish a NJ FamilyCare coverage buy-in program through which a parent or caretaker whose family income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. <u>The program shall be known as NJ FamilyCare Advantage.</u>

The commissioner shall establish the premium and cost sharing amounts required to purchase coverage, except that the premium shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the poverty level, plus a reasonable processing fee.

k. The commissioner, in consultation with the Rutgers Center for State Health Policy, shall develop a streamlined application form for the NJ FamilyCare and Medicaid programs.

[3]<u>l. Subject to federal approval, the Commissioner of Human Services shall establish a hardship waiver for part or all of the premium for an eligible child under the NJ FamilyCare program. A parent or caretaker may apply to the commissioner for a hardship</u>

waiver in a manner and form established by the commissioner. If the parent or caretaker can demonstrate to the satisfaction of the commissioner, pursuant to regulations adopted by the commissioner, that payment of all or part of the premium for the parent or caretaker's child presents a hardship, the commissioner shall grant the waiver for a prescribed period of time.[3]
(cf: P.L.2005, c.156, s.5)

5. (New section) The Commissioner of Human Services shall apply for such waivers as may be necessary to implement the provisions of section 4 of P.L.2005, c.156 (C.30:4J-11) and to secure federal financial participation for NJ FamilyCare expenditures under the State Children's Health Insurance Program pursuant to 42 U.S.C.s.1397aa et seq.

6. (New section) Notwithstanding the provisions of section 3 of P.L.2004, c.113 (C.26:2H-18.59i) to the contrary, a hospital shall not submit charity care claims to the Department of Health and Senior Services for health care services provided to a child under 19 years of age who presents at a hospital for emergency care and who may be deemed presumptively eligible for NJ FamilyCare coverage pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) or Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

7. (New section) a. Beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual [2][taxpayer] who files a resident New Jersey Gross Income Tax return[2] indicate on the taxpayer's income tax return whether the taxpayer and dependents, if applicable, has health insurance coverage on the date of filing of the return.

b. The department shall[3][, in consultation with the Commissioner] transmit to the Department[3] of Human Services[3][, administer an ongoing enrollment initiative to identify and provide outreach to] information permitting the Department of Human Services to identify[3] taxpayers who are uninsured and may be eligible to enroll in the Medicaid or NJ FamilyCare program. [3][As part of the initiative, the department shall send an application for the Medicaid or NJ FamilyCare program, as applicable, to any taxpayer who reports on the tax return form that he or his dependents do not have health insurance coverage and who, based on the income reported on the tax return form and the tax payer's family size, may be eligible for either of the State's health care coverage programs.] The Department of Human Services shall use this information in furtherance of its Medicaid and NJ FamilyCare outreach and enrollment initiative established pursuant to section 26 of P.L., c. (C.)(pending before the Legislature as this bill).[3]

c. As used in this section:

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" or "program" means the NJ FamilyCare Program established pursuant to P.L.2005, [2]**[**156**]** c.156[2] (C.30:4J-8 et al.).

8. R.S.54:50-9 is amended to read as follows:

54:50-9. Nothing herein contained shall be construed to prevent:

a. The delivery to a taxpayer or the taxpayer's duly authorized representative of a copy of any report or any other paper filed by the taxpayer pursuant to the provisions of this subtitle or of any such State tax law;

b. The publication of statistics so classified as to prevent the identification of a particular report and the items thereof;

c. The director, in the director's discretion and subject to reasonable conditions imposed by the director, from disclosing the name and address of any licensee under any State tax law, unless expressly prohibited by such State tax law;

d. The inspection by the Attorney General or other legal representative of this State of the reports or files relating to the claim of any taxpayer who shall bring an action to review or set aside any tax imposed under any State tax law or against whom an action or proceeding has been instituted in accordance with the provisions thereof;

e. The examination of said records and files by the Comptroller, State Auditor or State Commissioner of Finance, or by their respective duly authorized agents;

f. The furnishing, at the discretion of the director, of any information contained in tax reports or returns or any audit thereof or the report of any investigation made with respect thereto, filed pursuant to the tax laws, to the taxing officials of any other state, the District of Columbia, the United States and the territories thereof, providing said jurisdictions grant like privileges to this State and providing such information is to be used for tax purposes only;

g. The furnishing, at the discretion of the director, of any material information disclosed by the records or files to any law enforcing authority of this State who shall be charged with the investigation or prosecution of any violation of the criminal provisions of this subtitle or of any State tax law;

h. The furnishing by the director to the State agency responsible for administering the Child Support Enforcement program pursuant to Title IV-D of the federal Social Security Act, Pub.L.93-647 (42 U.S.C. s.651 et seq.), with the names, home addresses, social security numbers and sources of income and assets of all absent parents who are certified by that agency as being

required to pay child support, upon request by the State agency and pursuant to procedures and in a form prescribed by the director;

i. The furnishing by the director to the Board of Public Utilities any information contained in tax information statements, reports or returns or any audit thereof or a report of any investigation made with respect thereto, as may be necessary for the administration of P.L.1991, c.184 (C.54:30A-18.6 et al.) and P.L.1997, c.162 (C.54:10A-5.25 et al.);

j. The furnishing by the director to the Director of the Division of Alcoholic Beverage Control in the Department of Law and Public Safety any information contained in tax information statements, reports or returns or any audit thereof or a report of any investigation made with respect thereto, as may be relevant, in the discretion of the director, in any proceeding conducted for the issuance, suspension or revocation of any license authorized pursuant to Title 33 of the Revised Statutes;

k. The inspection by the Attorney General or other legal representative of this State of the reports or files of any tobacco product manufacturer, as defined in section 2 of P.L.1999, c.148 (C.52:4D-2), for any period in which that tobacco product manufacturer was not or is not in compliance with subsection a. of section 3 of P.L.1999, c.148 (C.52:4D-3), or of any licensed distributor as defined in section 102 of P.L.1948, c.65 (C.54:40A-2), for the purpose of facilitating the administration of the provisions of P.L.1999, c.148 (C.52:4D-1 et seq.);

l. The furnishing, at the discretion of the director, of information as to whether a contractor or subcontractor holds a valid business registration as defined in section 1 of P.L.2001, c.134 (C.52:32-44);

m. The furnishing by the director to a State agency as defined in section 1 of P.L.1995, c.158 (C.54:50-24) the names of licensees subject to suspension for non-payment of State tax indebtedness pursuant to P.L.2004, c.58 (C.54:50-26.1 et al.);

n. The release to the United States Department of the Treasury, Bureau of Financial Management Service, or its successor of relevant taxpayer information for purposes of implementing a reciprocal collection and offset of indebtedness agreement entered into between the State of New Jersey and the federal government pursuant to section 1 of P.L.2006, c.32 (C.54:49-12.7);

o. The examination of said records and files by the Commissioner of Health and Senior Services, <u>the Commissioner of Human Services,</u> the Medicaid Inspector General, or their respective duly authorized agents, pursuant to section 5 of P.L.2007, c.217 (C.26:2H-18.60e)[2]<u>, section 3 of P.L.1968, c.413 (C.30:4D-3), or section 5 of P.L.2005, c.156 (C.30:4J-12)</u>[2];

p. The furnishing at the discretion of the director of employer provided wage and tax withholding information contained in tax reports or returns filed pursuant to N.J.S.54A:7-2, 54A:7-4 and

54A:7-7, to the designated municipal officer of a municipality authorized to impose an employer payroll tax pursuant to the provisions of Article 5 (Employer Payroll Tax) of the "Local Tax Authorization Act," P.L.1970, c.326 (C.40:48C-14 et seq.), for the limited purpose of verifying the payroll information reported by employers subject to the employer payroll tax.
(cf: P.L.2007, c.294, s.2)

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

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

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier.

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

"Department" means the Department of Banking and Insurance.

"Dependent" means the spouse, domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an eligible person, subject to applicable terms of the individual health benefits plan.

"Eligible person" means a person who is a resident who is not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan, or Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.).

"Federally defined eligible individual" means an eligible person: (1) for whom, as of the date on which the individual seeks coverage under P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months; (2) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan; (3) who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C.s.1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan; (4) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; (5) who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and (6) who has elected continuation coverage described in (5) above and has exhausted that continuation coverage.

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

"Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental

plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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

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

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this act, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code

(10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

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

Individual health benefits plan shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan, to the extent the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1001 et seq.) preempts the application of P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. Member shall not include a carrier whose combined average Medicare, Medicaid, and NJ FamilyCare **[**and NJ KidCare**]** enrollment represents more than 75% of its average total enrollment for all health benefits plans or whose combined Medicare, Medicaid, and NJ FamilyCare **[**and NJ KidCare**]** net earned premium for the two-year calculation period represents more than 75% of its total net earned premium for the two-year calculation period.

"Modified community rating" means a rating system in which the premium for all persons covered **[**by a contract is formulated based on the experience of all persons covered by that contract, without regard to age, sex, occupation and geographical location, but which may differ by health status. The term modified community rating shall apply to contracts and policies issued prior to the effective date of this act which are subject to the provisions of subsection e. of section 2 of this act.**]** under a policy or contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical

location or any other factor or characteristic of covered persons, other than age.

The rating system shall provide that the premium rate charged by the carrier for the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits plans shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with regulations promulgated by the commissioner, which shall include age classifications established, at a minimum, in five year increments. There may be a reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or for different health benefits plans offered by the carrier.

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid, or NJ FamilyCare or **[**NJ KidCare**]** contracts with the State or federal government, but shall not include premiums earned from contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

"NJ FamilyCare" means the NJ FamilyCare **[**Health Coverage**]** Program established pursuant to **[**P.L.2000, c.71 (C.30:4J-1 et seq.)**]** P.L.2005, c.156 (C.30:4J-8 et al.).

["NJ KidCare" means the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.).**]**

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

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

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

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

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

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

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

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

(cf: P.L.2001, c.349, s.1)

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

2. a. An individual health benefits plan issued on or after **[**August 1, 1993 shall be subject to the provisions of this act**]** the effective date of [1]this section of[1] P.L. , c. (pending before the Legislature as this bill) shall be subject to the rating provisions established in P.L. , c. (pending before the Legislature as this bill)[3]; except that for the four years next following the effective date of this section, in the case of a person who is 55 years of age or older who purchases a health benefits plan on or after that effective date, the annual rate increase for that person shall be limited to the lower of 15% or the medical trend assumption used by the carrier to project claims[3].

In the case of an individual health benefits plan issued to a covered person prior to the effective date [1]this section of[1] of P.L. , c. (pending before the Legislature as this bill) and renewed thereafter, for the [3]**[**five**]** four[3] years next following [1]**[**enactment of P.L. , c. (pending before the Legislature as this bill)**]** that effective date[1], the annual rate increase filed for the plan shall be limited to the lower of 15% or the medical trend assumption used by the carrier to project claims.

b. **[**(1) An individual health benefits plan issued on an open enrollment, modified community rated basis or community rated

basis prior to August 1, 1993 shall not be subject to sections 3 through 8, inclusive, of this act, unless otherwise specified therein.

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

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

(4) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation prior to the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that the plan shall guarantee renewal pursuant to subsection b. of section 5 of P.L.1992, c.161 (C.17B:27A-6).

(5) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation to an eligible person or federally defined eligible individual after the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the provisions of subsections c. and d. of section 2, subsection b. of section 3, section 5, subsection b. of section 6, and subsections c., d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3, C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall not be subject to the remaining provisions of P.L.1992, c. 161.**]**

[3]**[**(Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).**]**

(1) An individual health benefits plan issued on an open enrollment, modified community rated basis or community rated basis prior to August 1, 1993 shall not be subject to sections 3 through 8, inclusive, of P.L.1992, c.161 (C.17B:27A-4 through 17B:27A-9), unless otherwise specified therein.

(2) An individual health benefits plan issued other than on an open enrollment basis prior to August 1, 1993 shall not be subject to the provisions of this act, except that the plan shall be liable for assessments made pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-12).

(3) A group conversion contract or policy issued prior to August 1, 1993 that is not issued on a modified community rated basis or community rated basis, shall not be subject to the provisions of this act, except that the contract or policy shall be liable for assessments made pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-12).

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

date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that the plan shall guarantee renewal pursuant to subsection b. of section 5 of P.L.1992, c.161 (C.17B:27A-6).

(5) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation to an eligible person or federally defined eligible individual after the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the provisions of subsections c. and d. of section 2, subsection b. of section 3, section 5, subsection b. of section 6, and subsections c., d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3, C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall not be subject to the remaining provisions of P.L.1992, c. 161.[3]

c. **[**After August 1, 1993, an individual who is eligible to participate in a group health benefits plan that provides coverage for hospital or medical expenses shall not be covered by an individual health benefits plan which provides benefits for hospital and medical expenses that are the same or similar to coverage provided in the group health benefits plan, except that an individual who is eligible to participate in a group health benefits plan but is currently covered by an individual health benefits plan may continue to be covered by that plan until the first anniversary date of the group health benefits plan occurring on or after January 1, 1994. **]** [1]**[**(Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).**]**

After August 1, 1993, an individual who is eligible to participate in a group health benefits plan that provides coverage for hospital or medical expenses shall not be covered by an individual health benefits plan which provides benefits for hospital and medical expenses that are the same or similar to coverage provided in the group health benefits plan, except that an individual who is eligible to participate in a group health benefits plan but is currently covered by an individual health benefits plan may continue to be covered by that plan until the first anniversary date of the group health benefits plan occurring on or after January 1, 1994.[1]

d. **[**Except as otherwise provided in subsection c. of this section, after August 1, 1993, a person who is covered by an individual health benefits plan who is a participant in, or is eligible to participate in, a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, and a person, including an employer or insurance producer, who causes another person to be covered by an individual health benefits plan which person is a participant in, or who is eligible to participate in a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, shall be subject to a fine by the commissioner in an amount not less than twice the

annual premium paid for the individual health benefits plan, together with any other penalties permitted by law.] ¹[(Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).]

Except as otherwise provided in subsection c. of this section, after August 1, 1993, a person who is covered by an individual health benefits plan who is a participant in, or is eligible to participate in, a group health benefits plan that provides the same or similar coverage as the individual health benefits plan, and a person, including an employer or insurance producer, who causes another person to be covered by an individual health benefits plan which person is a participant in, or who is eligible to participate in a group health benefits plan that provides the same or similar coverage as the individual health benefits plan, shall be subject to a fine by the commissioner in an amount not less than twice the annual premium paid for the individual health benefits plan, together with any other penalties permitted by law.¹

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

(cf: P.L.1997, c.146, s.2)

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

3. a. No later than 180 days after the effective date of [this act] ¹this section of¹ P.L. , c. (pending before the Legislature as this bill), a carrier shall, as a condition of issuing small employer health benefits plans in this State, also offer individual health benefits plans. The plans shall be offered on an open enrollment, modified community rated basis, pursuant to the provisions of this act[; except that a carrier shall be deemed to have satisfied its obligation to provide the individual health benefits plans by paying an assessment or receiving an exemption pursuant to section 11 of this act] and P.L. , c. (pending before the Legislature as this bill). Every carrier that issues small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall make a good faith effort to market individual health benefits plans.

b. A carrier shall offer to an eligible person a choice of [five] at least three individual health benefits plans [any of which may contain provisions for managed care] established by the board pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7). One plan shall be a basic health benefits plan[, one plan shall be a managed care plan and three plans shall include enhanced benefits of proportionally increasing actuarial value]. A carrier may elect to convert any individual contract or policy forms in force on the effective date of [this act] P.L. , c. (pending before the Legislature as this bill) to any of the [five] benefit plans, except that the carrier may not convert more than 25% of existing contracts or policies

each year, and the replacement plan shall be of no less actuarial value than the policy or contract being replaced.

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

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

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

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

(3) A contract or policy for a basic health benefits plan provided for in this section may contain or provide for coinsurance or deductibles, or both, except that no deductible shall be payable in excess of a total of $250 by an individual or $500 by a family unit during any benefit year; and no coinsurance shall be payable in excess of a total of $500 by an individual or by a family unit during any benefit year.

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

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

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

d. Every group conversion contract or policy issued after the effective date of this act shall be issued pursuant to this section; except that this requirement shall not apply to any group conversion

contract or policy in which a portion of the premium is chargeable to, or subsidized by, the group policy from which the conversion is made.

e. [If all five of the individual health benefits plans are not established by the board by the effective date of P.L.1993, c.164 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the five health benefits plans by offering each health benefits plan as it is established by the board; however, once the board establishes all five plans, the carrier shall be required to offer the five plans in accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et al.).] (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

f. In addition to the rider packages provided for in subsection c. of section 6 of P.L.1992, c.161 (C.17B:27A-7), every carrier may offer, in connection with the health benefits plans required to be offered by this section, any number of riders which may '[revise the coverage offered by the plans in any way, provided, however, that any form of such rider or amendment thereof which decreases benefits or decreases the actuarial value of one of the plans shall be filed for informational purposes with the board and for approval by the commissioner before such rider may be sold] add benefits or increase the actuarial value of any of the plans'. Any 'such' rider or amendment thereof '[which adds benefits or increases the actuarial value of one of the plans]' shall be filed with the board for informational purposes before '[such] the' rider may be sold. The added premium '[or reduction in premium]' for each rider '[, as applicable,]' shall be listed separately from the premium for the standard plan.

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

(cf: P.L.1994, c.102, s.1)

12. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to read as follows:

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 copayment per hospital stay;

Outpatient and ambulatory surgery- $250 copayment per surgery;
Physicians' fees connected with hospital care, including general acute care and surgery;
Physicians' fees connected with outpatient and ambulatory surgery;
Anesthesia and the administration of anesthesia;
Coverage for newborns;
Treatment for complications of pregnancy;
Intravenous solutions, blood and blood plasma;
Oxygen and the administration of oxygen;
Radiation and x-ray therapy;
Inpatient physical therapy and hydrotherapy;
Outpatient physical therapy - 30 visits annually per covered person- $20 copayment per treatment;
Dialysis - inpatient or outpatient;
Inpatient diagnostic tests and $500 annual aggregate per covered person for out-of-hospital diagnostic tests;
Laboratory fees for treatment in hospital;
Delivery room fees;
Operating room fees;
Special care unit;
Treatment room fees;
Emergency room services for medically necessary treatment - $100 copayment per visit;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for biologically-based mental illness, as defined in subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;
Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;
Wellness benefit - $600 annual aggregate per covered person, $50 annual deductible, 20% coinsurance per service; and
Physicians visits for diagnosed illness or injury - to a $700 annual aggregate per covered person.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network, including an exclusive provider organization, or the carrier's preferred provider organization; or (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with 30% coinsurance in addition to whatever other coinsurance may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to preexisting conditions, guaranteed issue, and calculation of loss ratio.

f. No later than one year following enactment of this act, every carrier shall make an informational filing with the **[**board**]** commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the **[**board**]** commissioner has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and shall make a good faith effort to market the contract or policy established pursuant to this section. A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.

(cf: P.L.2001, c.368, s.2)

13. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to read as follows:

4. In addition to the **[**five**]** health benefits plans offered by a carrier on the effective date of this act, a carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the

Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).
(cf: P.L.2001, c.368, s.4)

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

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

a. The health benefits plan shall guarantee coverage for an eligible person and his dependents on a <u>modified</u> community rated basis.

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

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

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

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

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

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

(3) **[**board**]** approval <u>by the commissioner</u> of a request by the individual carrier to not renew a particular type of health benefits plan, in accordance with rules adopted by the **[**board**]** <u>commissioner</u>. After receiving **[**board**]** approval <u>by the commissioner</u>, a carrier may not renew a type of health benefits plan only if the carrier: (a) provides notice to each covered individual provided coverage of this type of the nonrenewal at least 90 days prior to the date of the nonrenewal of the coverage; (b) offers to each individual provided coverage of this type the option to purchase any other individual health benefits plan currently being

offered by the carrier; and (c) in exercising the option to not renew coverage of this type and in offering coverage as required under (b) above, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for coverage;

(4) [board] approval by the commissioner of a request by the individual carrier to cease doing business in the individual health benefits market. A carrier may not renew all individual health benefits plans only if the carrier: (a) first receives approval from the [board] commissioner; and (b) provides notice to each individual of the nonrenewal at least 180 days prior to the date of the expiration of such coverage. A carrier ceasing to do business in the individual health benefits market may not provide for the issuance of any health benefits plan in the individual [market] or small employer markets during the five-year period beginning on the date of the termination of the last health benefits plan not so renewed; and

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

(cf. P.L.1997, c.146, s.3)

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

6. The [board] commissioner shall [establish] approve the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications to one or more plans as the board determines are necessary to make available a "high deductible health plan" or plans consistent with section 301 of Title III of the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical savings accounts, within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The [board] commissioner shall provide the [commissioner] board with an informational filing of the policy and contract forms and benefit levels it [establishes] approves.

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

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

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

(1) to an individual who has, under creditable coverage, with no intervening lapse in coverage of more than 31 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12-month preexisting condition limitation; or

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

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

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

e. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

(1) Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health and Senior Services pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any

necessary medical follow-up and treatment for lead poisoned children.

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

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

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a health benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this subsection that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

f. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

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

This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

g. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically necessary benefits provided in-network which represent preventive care as permitted by that federal law.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection. This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2005, c.248, s.13)

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

8. a. **[**The board shall make application to the Hospital Rate Setting Commission on behalf of all carriers for approval of discounted or reduced rates of payment to hospitals for health care services provided under an individual health benefits plan provided pursuant to this act.**]** (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

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

c. A carrier shall not issue individual health benefits plans on a new contract or policy form pursuant to this act until an informational filing of a full schedule of rates which applies to the contract or policy form has been filed with the **[**board**]** commissioner. The **[**board**]** commissioner shall **[**forward**]** provide

a copy of the informational filing to the [commissioner and the] Attorney General and the board.

d. [A carrier shall make an informational filing with the board of any change in its rates for individual health benefits plans pursuant to section 3 of this act prior to the date the rates become effective. The board shall file the informational filing with the commissioner and the Attorney General. If the carrier has filed all information required by the board, the filing shall be deemed to be complete.] A carrier desiring to increase or decrease premiums for any contract or policy form may implement that increase or decrease upon making an informational filing with the commissioner of that increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing that increase or decrease. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.161 (C.17B:27A-2 et seq.), or that the rates are inadequate or unfairly discriminatory.

e. (1) Rates shall be formulated on contracts or policies required pursuant to section 3 of this act so that the anticipated minimum loss ratio for a contract or policy form shall not be less than [75%] 80% of the premium. The carrier shall submit with its rate filing supporting data, as determined by the [board] commissioner, and a certification by a member of the American Academy of Actuaries, or other individuals in a format acceptable to the [board and to the] commissioner, that the carrier is in compliance with the provisions of this subsection.

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

Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the policy or contract forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161 (C.17:B:27A-4), at least 80% of the aggregate premiums collected for all of the policy or contract forms during that calendar year. Carriers shall annually report, no later than August 1 of each year, the loss ratio calculated pursuant to this section for all of the policy or contract forms for the previous calendar year. In each case in which the loss ratio fails to comply with the 80% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policy or contract holders, as applicable, in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits equal 80% of the aggregate premiums collected for the policy or contract forms in the previous calendar year. All dividends and

credits shall be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this subsection shall include a carrier's calculation of the dividends and credits applicable to all policy or contract forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Those regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder.

f. **[**Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed pursuant to this section by a carrier which insured at least 50% of the community-rated individually insured persons on the effective date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required to produce a loss ratio which when combined with the carrier's administrative costs and investment income results in self-sustaining rates prior to January 1, 1996, for individual policies or contracts issued prior to August 1, 1993. The carrier shall, not later than 30 days after the effective date of P.L.1994, c.102 (C.17B;27A-4 et al.), file with the board for approval, a plan to achieve this objective.**]** (Deleted by amendment, P.L., c. }(pending before the Legislature as this bill).

(cf: P.L.1994, c.102, s.2)

17. Section 10 of P.L.1992, c.161 (C.17B:27A-11) is amended to read as follows:

10. The program shall have the general powers and authority granted under the laws of New Jersey to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the program shall not have the power to issue health benefits plans directly to either groups or individuals.

The board shall have the specific authority to:

a. assess members their proportionate share of program losses and administrative expenses in accordance with the provisions of section 11 of this act, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

b. establish rules, conditions, and procedures pertaining to the sharing of program losses and administrative expenses among the members of the program;

c. **[**review rate applications and form filings submitted by carriers in accordance with this act;**]** (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

d. define the provisions of individual health benefits plans in accordance with the requirements of this act;

e. enter into contracts which are necessary or proper to carry out the provisions and purposes of this act;

f. establish a procedure for the joint distribution of information on individual health benefits plans issued pursuant to section 3 of this act;

g. establish, at the board's discretion, standards for the application of a means test for individual health benefits plans issued pursuant to section 3 of this act;

h. establish, at the board's discretion, reasonable guidelines for the purchase of new individual health benefits plans by persons who already are enrolled in or insured by another individual health benefits plan;

i. establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the program and provide for performance audits from time to time;

j. sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the program or a member;

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

l. borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets; and

m. contract for an independent actuary and any other professional services the board deems necessary to carry out its duties under P.L.1992, c.161 (C.17B:27A-2 et al.).

(cf: P.L.1993, c.164, s.6)

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

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

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

(a) every carrier issuing health benefits plans in this State shall file with the board its net earned premium for the preceding two-year calculation period; and

(b) every carrier issuing individual health benefits plans in the State shall file with the board the net earned premium on health benefits plans issued pursuant to paragraph (1) of subsection b. of

section 2 and section 3 of this act and the claims paid. If the claims paid for all health benefits plans during the two-year calculation period exceed 115% of the net earned premium and any investment income thereon for the two-year calculation period, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this act.

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

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

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

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

d. (1) Notwithstanding the provisions of this act to the contrary, a carrier may apply to the board, by a date established by the board, for an exemption from the assessment and reimbursement for losses provided for in this section. A carrier which applies for an exemption shall agree to cover a minimum number of non-group

person life years on an open enrollment community rated basis, under a managed care or indemnity plan, as specified in this subsection, provided that any indemnity plan so issued conforms with sections 2 through 7, inclusive, of P.L.1992, c.161 (C.17B:27A-3 through 17B:27A-8). For the purposes of this subsection, non-group persons include individually enrolled persons, conversion policies issued pursuant to this act, Medicare cost and risk lives and Medicaid recipients; except that in determining whether the carrier meets the minimum number of non-group person life years required to be covered pursuant to this subsection, the number of Medicaid recipients and Medicare cost and risk lives shall not exceed 50% of the total. Pursuant to regulations adopted by the board, the carrier shall determine the number of non-group person life years it has covered by adding the number of non-group persons covered on the last day of each calendar quarter of the two-year calculation period, taking into account the limitations on counting Medicaid recipients and Medicare cost and risk lives, and dividing the total by eight.

(2) Notwithstanding the provisions of paragraph (1) of this subsection to the contrary, a health maintenance organization qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub.L93-222 (42U.S.C. s.300e et seq.) and tax exempt pursuant to paragraph (3) of subsection (c) of section 501 of the federal Internal Revenue Code of 1986, 26U.S.C. s.501, may include up to one third Medicaid recipients and up to one third Medicare recipients in determining whether it meets its minimum number of non-group person life years.

(3) The minimum number of non-group person life years required to be covered, as determined by the board, shall equal the total number of non-group person life years of community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives, of all carriers subject to this act for the two-year calculation period, multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for that two-year calculation period, including those carriers that are exempt from the assessment.

(4) On or before March 1 of the first year of each two-year calculation period, every carrier seeking an exemption pursuant to this subsection shall file with the board a statement of its net earned premium for the two-year calculation period. The board shall determine each carrier's minimum number of non-group person life years in accordance with this subsection.

(5) On or before March 1 of each year immediately following the close of a two-year calculation period, every carrier that was granted an exemption for the preceding two-year calculation period shall file with the board the number of non-group person life years, by category, covered for the two-year calculation period.

To the extent that the carrier has failed to cover the minimum number of non-group person life years established by the board, the carrier shall be assessed by the board on a pro rata basis for any differential between the minimum number established by the board and the actual number covered by the carrier.

(6) A carrier that applies for the exemption shall be deemed to be in compliance with the requirements of this subsection if it has covered 100% of the minimum number of non-group person life years required.

(7) Any carrier that writes both managed care and indemnity business that is granted an exemption pursuant to this subsection may satisfy its obligation to cover a minimum number of non-group person life years by issuing either managed care or indemnity business, or both.

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

f. The loss assessment for the '2007-2008' two-year calculation period '[in which P.L. , c. (pending before the Legislature as this bill) takes effect]' shall be the last loss assessment authorized under this section, and no further loss assessments shall be calculated or collected; provided, however, that nothing in this subsection shall relieve a carrier of its obligations for loss assessments authorized under this section prior to the effective date of 'this section of' P.L. , c. (pending before the Legislature as this bill).

(cf: P.L.1997, c.146, s.6)

19. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended to read as follows:

5. A domestic mutual insurer which has converted from a health service corporation pursuant to the provisions of sections 2 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48) shall not renew individual hospital or medical insurance policies or health service contracts originally issued prior to November 30, 1992, until it has made an informational filing with the [New Jersey Individual Health Coverage Program Board, of a full schedule of rates which are to apply to those contracts. The New Jersey Individual Health Coverage Program Board shall forward a copy of such filing to the] commissioner. The rates shall be formulated so that the anticipated minimum loss ratio for such policy or contract form shall not be less than [75%] 80% of the premium. Such domestic mutual insurer shall submit with its rate filing supporting data and a certification that the insurer is in compliance with the anticipated loss ratio requirement. The content and form of the supporting data and certification required pursuant to subsection e. of section 8 of P.L.1992, c.161 (C.17B:27A-9) shall satisfy the requirements of this section. Any other insurer may irrevocably elect to become subject to the provisions of this section by written

notice to the commissioner**[**, except that such informational filing by any other insurer shall be**]** in a format specified by the commissioner **[**and shall be made directly to the commissioner and not to the New Jersey Individual Health Coverage Program Board**]**.
(cf: P.L.1995, c.196, s.5)

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

1. As used in this act:

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

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

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

"Department" means the Department of Banking and Insurance.

"Dependent" means the spouse<u>, domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as defined in section 2 of P.L.2006, c.103 (C.37:1-29),</u> or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

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

an employee welfare arrangement established pursuant to a collective bargaining agreement.

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

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

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

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

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health benefits plan" shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits

are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: a. was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such a statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; b. has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, death of a spouse, or divorce or legal separation; and c. requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; the individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and

request for enrollment is made within 30 days after issuance of that court order.

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

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

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

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

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

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

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

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, and the majority of the employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C.s.414) shall be treated as one employer. Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of

P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L.1992, c.162 (C.17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such employer.

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

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

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

a. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $20,000 per covered person per plan year; and

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

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

(cf: P.L.1997, c.146, s.7)

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

3. a. Except as provided in subsection f. of this section, every small employer carrier shall, as a condition of transacting business in this State, offer to every small employer <u>at least three of</u> the **[**five**]** health benefit plans <u>established by the board,</u> as provided in this section<u>, and also offer and make a good faith effort to market individual health benefits plans as provided in section 3 of P.L.1992, c.161 (C.17B:27A-4)</u>. The board shall establish a standard policy form for each of the **[**five**]** plans, which except as otherwise provided in subsection j. of this section, shall be the only

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

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

(3) Diagnostic tests, including X-rays;

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

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

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

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

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

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

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

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

e. **[**Notwithstanding the provisions of subsection a. of this section to the contrary, the board may approve a health benefits plan containing only medical-surgical benefits or major medical expense benefits, or a combination thereof, which is issued as a separate policy in conjunction with a contract of insurance for hospital expense benefits issued by a hospital service corporation, if the health benefits plan and hospital service corporation contract combined otherwise comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the contract combined may be allocated between the separate contracts at the discretion of the carrier and the hospital service corporation.**]** (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).

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

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

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

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

i. (1) In addition to the rider packages provided for in subsection d. of this section, every carrier may offer, in connection with the **[**five**]** health benefits plans required to be offered by this

section, any number of riders which may revise the coverage offered by the [five] plans in any way, provided, however, that any form of such rider or amendment thereof which decreases benefits or decreases the actuarial value of [one of the five plans] a plan shall be filed for informational purposes with the board and for approval by the commissioner before such rider may be sold. Any rider or amendment thereof which adds benefits or increases the actuarial value of [one of the five plans] a plan shall be filed with the board for informational purposes before such rider may be sold. The added premium or reduction in premium for each rider, as applicable, shall be listed separately from the premium for the standard plan.

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

(2) The benefit riders provided for in paragraph (1) of this subsection shall be subject to the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).

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

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

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

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

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

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

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

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

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

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

(6) (a) Except as otherwise provided in subparagraphs (b) and (c) of this paragraph, a health benefits plan renewed, continued or

reinstated pursuant to this subsection shall be filed with the commissioner for informational purposes within 30 days after its renewal date. No later than 60 days after the board adopts regulations concerning the implementation of the rating factors permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be amended to show any modifications in the plan that are necessary to comply with the provisions of this subsection. The commissioner shall monitor compliance of any such plan with the requirements of this subsection, except that the board shall enforce the loss ratio requirements.

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

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

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

(8) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple employer arrangement or out-of-State trust may offer coverage under a health benefits plan authorized to be renewed,

continued or reinstated pursuant to this subsection to new employees of small employer groups covered by the health benefits plan in accordance with the provisions of paragraph (1) of this subsection.

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

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

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

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

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

k. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2005, c.248

(C.17:48E-35.27 et al.), the health benefits plans required pursuant to this section, including any plans offered by a State approved or federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

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

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

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

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

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

m. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits

plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to this section that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

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

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

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

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

(cf: P.L.2005, c.248, s.15)

22. Section 5 of P.L.2001, c.368 (C.17B:27A-19.11) is amended to read as follows:

5. In addition to the **[**five**]** <u>standard</u> health benefits plans offered by a carrier on the effective date of this act, a carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's

network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

(cf: P.L.2001, c.368, s.5)

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

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

a. A carrier may discontinue such coverage only if:

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

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

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

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

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

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

(1) The carrier gives notice to cease doing business in the small employer market to the commissioner not later than eight months prior to the date of the planned withdrawal from the small [group market] employer market, during which time the carrier shall continue to be governed by this act with respect to business written pursuant to this act. For the purposes of this subsection, "date of

withdrawal" means the date upon which the first notice to small employers is sent by the carrier pursuant to paragraph (2) of this subsection;

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

(3) Any carrier that ceases to do business pursuant to this act shall be prohibited from writing new business in the small employer **[**market**]** and individual health benefits plan markets for a period of five years from the date of termination of the last health insurance coverage not so renewed;

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

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

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

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

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

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

(cf: P.L.1997, c.146, s.10)

'[25.**]** 24.' Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to read as follows:

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

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

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

c.162 (C.17B:27A-19), and including policies or contracts offered by a carrier to a small employer who is a member of a Small Employer Purchasing Alliance pursuant to the provisions of P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19) shall not be greater than 200% 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, gender and geography [1][, and provided further, that such] .[3] [In addition, rates may vary to reflect commissions and other compensation actually paid as provided in subparagraph (c) of this paragraph (3).][3] Such[1] factors [1][are] shall be[1] applied in a manner consistent with regulations adopted by the [1][board] commissioner[1]. For the purposes of this paragraph (3), policies or contracts offered by a carrier to a small employer who is a member of a Small Employer Purchasing Alliance shall be rated separately from the carrier's other small employer health benefits policies or contracts.

[1](b)[1] A health benefits plan issued pursuant to subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in accordance with the provisions of section 7 of P.L.1995, c.340 (C.17B:27A-19.3), for the purposes of meeting the requirements of this paragraph.

[3][[1](c) The amount of the commission or other compensation paid to an insurance producer in connection with a policy or contract issued to a small employer shall be disclosed to the small employer, as provided in section 25 of P.L. , c. (pending before the Legislature as this bill). Rates charged to a small employer shall differ based on the actual compensation paid to an insurance producer, in a manner consistent with regulations adopted by the commissioner. Variations in rates attributable solely to differences in commissions or other compensation paid are not subject to the 200% limitation provided in subparagraph (a) of this paragraph (3).[1]][3]

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

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

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

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

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

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

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

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

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

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

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

g. (1) Beginning January 1, 1995, a carrier desiring to increase or decrease premiums for any policy form or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19) subject to this act may implement such increase or decrease upon making an informational filing with the commissioner of such increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing such increase or decrease, provided that the anticipated minimum loss ratio for all policy forms shall not be less than **[**75%**]** 80% of the premium therefor as provided in paragraph (2) of this subsection. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are inadequate or unfairly discriminatory. Until December 31, 1996, the informational filing shall also include the carrier's rating plan and classification system in connection with such increase or decrease.

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the **[**five**]** standard policy forms

offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19), at least [75%] 80% of the aggregate premiums collected for all of the standard policy forms, other than alliance policy forms, and at least [75%] 80% of the aggregate premiums collected for all of the non-standard policy forms during that calendar year. A carrier shall return at least [75%] 80% of the premiums collected for all of the alliances during that calendar year, which loss ratio may be calculated in the aggregate for all of the alliances or separately for each alliance. Carriers shall annually report, no later than August 1st of each year, the loss ratio calculated pursuant to this section for all of the standard, other than alliance policy forms, non-standard policy forms and alliance policy forms for the previous calendar year, provided that a carrier may annually report the loss ratio calculated pursuant to this section for all of the alliances in the aggregate or separately for each alliance. In each case where the loss ratio fails to substantially comply with the [75%] 80% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with the standard, other than alliance policy forms, nonstandard policy forms or alliance policy forms, as applicable, in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal [75%] 80% of the aggregate premiums collected for the respective policy forms in the previous calendar year. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits applicable to standard, other than alliance policy forms, non-standard policy forms and alliance policy forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder. For purposes of this paragraph, "alliance policy forms" means policies purchased by small employers who are members of Small Employer Purchasing Alliances.

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

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

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

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

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

(cf: P.L.2003, c.163, s.1)

'[26.] 25.' (New section) a. An insurance producer licensed pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.) who sells, solicits, or negotiates health insurance policies or contracts to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.

b. '[Upon seeking renewal of a license issued pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.), an insurance producer shall report to the Commissioner of Banking and Insurance, in a form and manner specified by the commissioner, how the producer is compensated for the sale, solicitation, or negotiation of health insurance policies and contracts, including the basis for determining a commission, service fee, brokerage, or other valuable consideration for the sale, solicitation, or negotiation of a health insurance policy or contract. The insurance producer shall provide such other information regarding compensation as the commissioner deems appropriate.

c. Notwithstanding the provisions of any law to the contrary, the commissioner shall not renew the license of an insurance producer who is subject to the provisions of this section unless the insurance producer provides the information required pursuant to this section.

d.] b.' The commissioner may specify, by regulation, the information that shall be provided by an insurance producer in the notification to a purchaser of health insurance and the procedure for providing the notification.

'26. (New section) The Commissioner of Human Services shall establish an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about the availability of, and

benefits to enrolling in, Medicaid, NJ FamilyCare, and the NJ FamilyCare Advantage buy-in programs.

The initiative shall include culturally sensitive, Statewide and local media public awareness campaigns addressing the availability of health care coverage for parents and children under the Medicaid and NJ FamilyCare programs and health care coverage for children under the NJ FamilyCare Advantage buy-in program.

The initiative shall also include the provision of training and support services, upon request, to community groups, legislative district offices, and community-based health care providers to enable these parties to assist in enrolling parents and children in the applicable programs.[1]

[1]27. (New section) The Commissioner of Human Services shall establish an Outreach, Enrollment, and Retention Working Group to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare, or NJ Family Care Advantage, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

a. The members of the working group shall include:

(1) The Commissioners of Human Services, Health and Senior Services, Banking and Insurance, Labor and Workforce Development, Education, and Community Affairs, the Secretary of Agriculture, and the Child Advocate, or their designees, who shall serve ex officio; and

(2) Six public members appointed by the Commissioner of Human Services who shall include: one person who represents racial and ethnic minorities in this State; one person who represents managed care organizations that participate in the Medicaid and NJ FamilyCare programs; one person who represents the vendor under contract with the Division of Medical Assistance and Health Services to provide NJ FamilyCare eligibility, enrollment, and health benefit coordinator services to the division; one person who represents New Jersey Policy Perspective; one person who represents the Association for Children of New Jersey; and one person who represents Legal Services of New Jersey.

b. As part of the plan, the working group shall:

(1) determine if there are obstacles to enrollment of minorities in the State in the Medicaid, NJ FamilyCare and NJ FamilyCare Advantage programs due to ethnic and cultural differences and, if so, develop strategies for the Department of Human Services to overcome these obstacles and increase enrollment among minorities;

(2) recommend outreach strategies to identify and enroll all eligible children in the Medicaid, NJ FamilyCare and NJ FamilyCare Advantage programs and to retain enrollment of children and their parents in the programs;

(3) establish monthly enrollment goals for the number of children who need to be enrolled in Medicaid, NJ FamilyCare, and NJ FamilyCare Advantage in order to ensure that as many children as possible who are eligible for these programs are enrolled within a reasonable period of time, in accordance with the mandate established pursuant to section 2 of P.L. , c. (C.) (pending before the Legislature as this bill); and

(4) make such other recommendations to the Commissioner of Human Services as the working group determines necessary and appropriate to achieve the purposes of this section.

c. The working group shall organize as soon as practicable following the appointment of its members and shall select a chairperson and vice-chairperson from among the members. The chairperson shall appoint a secretary who need not be a member of the working group.

(1) The public members shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties and within the limits of funds available to the working group.

(2) The working group shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for its purposes.

d. Upon completion of the plan, the working group shall report on its activities to the chairmen of the Senate and Assembly standing reference committees on health and human services, and include a copy of the plan and any recommendations for legislative action it deems appropriate.

e. The Commissioner of Human Services shall post the plan on the department's Internet website and include a table showing the monthly enrollment goals established in the plan and the actual new and continued enrollments for that month. The commissioner shall update the table monthly.

f. The Department of Human Services shall provide staff support to the working group.[1]

[1]28. There is appropriated to the Department of Human Services from the General Fund $1 million for the purpose of carrying out the enhanced NJ FamilyCare outreach, enrollment, and retention initiative established pursuant to section 26 of this act.[1]

[3]29. Section 1 of P.L.2005 c.375 (C.17:48-6.19) is amended to read as follows:

1. a. As used in this section, "dependent" means a subscriber's child by blood or by law who:

(1) is [less than] 30 years of age or younger;

(2) is unmarried;

(3) has no dependent of his own;

(4) is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education; and

(5) (a) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, [Pub.L.89-97] Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time dependent coverage pursuant to this section begins or will begin; and

(b) there is evidence of prior creditable coverage or receipt of benefits under a benefits plan or by law as set forth in subparagraph (a) of this paragraph.

b. (1) A hospital service corporation contract that provides coverage for a subscriber's dependent under which coverage of the dependent terminates at a specific age on or before the dependent's 30th birthday, and is delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this section of P.L. , c. (pending before the Legislature as this bill), shall, upon application of the dependent as set forth in subsection c. of this section, provide coverage to the dependent after that specific age, until the dependent's [30th] 31st birthday.

(2) Nothing herein shall be construed to require:

(a) coverage for services provided to a dependent before the effective date of this section of P.L. , c. (pending before the Legislature as this bill); or

(b) that an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section.

c. (1) A dependent covered by a subscriber's contract, which coverage under the contract terminates at a specific age on or before the dependent's 30th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 30th birthday:

(a) within 30 days prior to the termination of coverage at the specific age provided in the contract;

(b)within 30 days after meeting the requirements for dependent status as set forth in subsection a. of this section, when coverage for the dependent under the contract previously terminated; or

(c) during an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection a. of this section during the open enrollment period.

(2) [For 12 months after the effective date of this section, a dependent who qualifies for dependent status as set forth in

subsection a. of this section, but whose coverage as a dependent under a subscriber's contract terminated under the terms of the contract prior to the effective date of this section, may make a written election to reinstate coverage under that contract as a dependent pursuant to this section.**]** (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

d. (1) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall consist of coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the specific age provided in the contract. If coverage is modified under the contract for any similarly situated dependents for coverage prior to the termination of coverage at the specific age provided in the contract, the coverage shall also be modified in the same manner for the dependent.

(2) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

e. (1) The subscriber's contract may require payment of a premium by the subscriber or dependent, as appropriate, subject to the approval of the Commissioner of Banking and Insurance, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection c. of this section. The payment shall not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage under the contract prior to the termination of coverage at the specific age provided in the contract.

(2) The applicable portion of the premium previously paid for the dependent's coverage under the contract shall be determined pursuant to regulations promulgated by the Commissioner of Banking and Insurance, based upon the difference between the contract's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the commissioner which provides a substantially similar result.

(3) Payments of the premium may, at the election of the payor, be made in monthly installments.

f. Coverage for a dependent provided pursuant to this section shall be provided until the earlier of the following:

(1) the date upon which the dependent is disqualified for dependent status as set forth in subsection a. of this section;

(2) the date **[**on**]** upon which coverage ceases under the contract by reason of a failure to make a timely payment of any premium required under the contract by the subscriber or dependent for coverage provided pursuant to this section. The payment of any premium shall be considered to be timely if made within 30 days

after the due date or within a longer period as may be provided for by the contract; or

(3) the date upon which the [employer under whose] contract , under which coverage is provided to a dependent, ceases to provide coverage to the subscriber.

Nothing herein shall be construed to permit a hospital service corporation to refuse a written election for coverage by a dependent pursuant to subsection c. of this section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection, other than a disqualification based on age or lack of evidence of prior, creditable coverage or receipt of benefits.

g. Notice regarding coverage for a dependent as provided pursuant to this section shall be provided to a subscriber by the hospital service corporation:

(1) in the certificate of coverage or other equivalent document prepared for subscribers [by the hospital service corporation] and delivered on or about the date of commencement of the subscribers' coverage; and

(2) [by the subscriber's employer:

(a) on or before the coverage of a subscriber's dependent terminates at the specific age as provided in the contract;

(b) at the time coverage of the dependent is no longer provided pursuant to this section because the dependent is disqualified for dependent status as set forth in subsection a. of this section, except this employer notice shall not be required when a dependent no longer qualifies based upon paragraph (1) or (3) of subsection a. of this section;

(c) before any open enrollment period permitting a dependent to make a written election for coverage pursuant to subsection c. of this section; and

(d) immediately following the effective date of this section, with respect to information concerning a dependent's opportunity, for 12 months after the effective date of the section, to make a written election to reinstate coverage under a contract pursuant to paragraph (2) of subsection c. of this section] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

(3) in a notice delivered to subscribers on a quarterly basis.

h. This section shall apply to those contracts in which the hospital service corporation has reserved the right to change the premium.[3]

(cf: P.L.2005, c.375, s.1)

[3]30. Section 2 of P.L.2005, c.375 (C.17:48A-7.13) is amended to read as follows:

2. a. As used in this section, "dependent" means a subscriber's child by blood or by law who:

(1) is [less than] 30 years of age or younger;

(2) is unmarried;

(3) has no dependent of his own;

(4) is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education; and

(5) (a) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, **[**Pub.L.89-97**]** Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time dependent coverage pursuant to this section begins or will begin; and

(b) there is evidence of prior, creditable coverage or receipt of benefits under a benefits plan or by law as set forth in subparagraph (a) of this paragraph.

b. (1) A medical service corporation contract that provides coverage for a subscriber's dependent under which coverage of the dependent terminates at a specific age on or before the dependent's 30th birthday, and is delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A 1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this section of P.L. , c. (pending before the Legislature as this bill), shall, upon application of the dependent as set forth in subsection c. of this section, provide coverage to the dependent after that specific age, until the dependent's **[**30th**]** 31st birthday.

(2) Nothing herein shall be construed to require:

(a) coverage for services provided to a dependent before the effective date of this section of P.L. , c. (pending before the Legislature as this bill); or

(b) that an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section.

c. (1) A dependent covered by a subscriber's contract, which coverage under the contract terminates at a specific age on or before the dependent's 30th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 30th birthday:

(a) within 30 days prior to the termination of coverage at the specific age provided in the contract;

(b) within 30 days after meeting the requirements for dependent status as set forth in subsection a. of this section, when coverage for the dependent under the contract previously terminated; or

(c) during an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection a. of this section during the open enrollment period.

(2) [For 12 months after the effective date of this section, a dependent who qualifies for dependent status as set forth in subsection a. of this section, but whose coverage as a dependent under a subscriber's contract terminated under the terms of the contract prior to the effective date of this section, may make a written election to reinstate coverage under that contract as a dependent pursuant to this section.] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

d. (1) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall consist of coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the specific age provided in the contract. If coverage is modified under the contract for any similarly situated dependents for coverage prior to the termination of coverage at the specific age provided in the contract, the coverage shall also be modified in the same manner for the dependent.

(2) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

e. (1) The subscriber's contract may require payment of a premium by the subscriber or dependent, as appropriate, subject to the approval of the Commissioner of Banking and Insurance, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection c. of this section. The premium shall not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage under the contract prior to the termination of coverage at the specific age provided in the contract.

(2) The applicable portion of the premium previously paid for the dependent's coverage under the contract shall be determined pursuant to regulations promulgated by the Commissioner of Banking and Insurance, based upon the difference between the contract's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the commissioner which provides a substantially similar result.

(3) Payments of the premium may, at the election of the payor, be made in monthly installments.

f. Coverage for a dependent provided pursuant to this section shall be provided until the earlier of the following:

(1) the date upon which the dependent is disqualified for dependent status as set forth in subsection a. of this section;

(2) the date [on] upon which coverage ceases under the contract by reason of a failure to make a timely payment of any premium required under the contract by the subscriber or dependent for coverage provided pursuant to this section. The payment of any

premium shall be considered to be timely if made within 30 days after the due date or within a longer period as may be provided for by the contract; or

(3) the date upon which the **[**employer under whose**]** contract, under which coverage is provided to a dependent, ceases to provide coverage to the subscriber.

Nothing herein shall be construed to permit a medical service corporation to refuse a written election for coverage by a dependent pursuant to subsection c. of this section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection, other than a disqualification based on age or lack of evidence of prior, creditable coverage or receipt of benefits.

g. Notice regarding coverage for a dependent as provided pursuant to this section shall be provided to a subscriber by the medical service corporation:

(1) in the certificate of coverage or other equivalent document prepared for subscribers **[**by the medical service corporation**]** and delivered on or about the date of commencement of the subscribers' coverage; and

(2) **[**by the subscriber's employer:

(a) on or before the coverage of a subscriber's dependent terminates at the specific age as provided in the contract;

(b) at the time coverage of the dependent is no longer provided pursuant to this section because the dependent is disqualified for dependent status as set forth in subsection a. of this section, except this employer notice shall not be required when a dependent no longer qualifies based upon paragraph (1) or (3) of subsection a. of this section;

(c) before any open enrollment period permitting a dependent to make a written election for coverage pursuant to subsection c. of this section; and

(d) immediately following the effective date of this section, with respect to information concerning a dependent's opportunity, for 12 months after the effective date of the section, to make a written election to reinstate coverage under a contract pursuant to paragraph (2) of subsection c. of this section.**]** (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

(3) in a notice delivered to subscribers on a quarterly basis.

h. This section shall apply to those contracts in which the medical service corporation has reserved the right to change the premium.**[3]**

(cf: P.L.2005, c.375, s.2)

[3]31. Section 3 of P.L.2005, c.375 (C.17:48E-30.1) is amended to read as follows:

3. a. As used in this section, "dependent" means a subscriber's child by blood or by law who:

(1) is ⟦less than⟧ 30 years of age or younger;

(2) is unmarried;

(3) has no dependent of his own;

(4) is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education; and

(5) (a) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, ⟦Pub.L.89-97⟧ Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time the dependent coverage pursuant to this section begins or will begin; and

(b) there is evidence of prior, creditable coverage or receipt of benefits under a benefits plan or by law as set forth in subparagraph (a) of this paragraph.

b. (1) A health service corporation contract that provides coverage for a subscriber's dependent under which coverage of the dependent terminates at a specific age on or before the dependent's 30th birthday, and is delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E 1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this section of P.L. , c. (pending before the Legislature as this bill), shall, upon application of the dependent as set forth in subsection c. of this section, provide coverage to the dependent after that specific age, until the dependent's ⟦30th⟧ 31st birthday.

(2) Nothing herein shall be construed to require:

(a) coverage for services provided to a dependent before the effective date of this section of P.L. , c. (pending before the Legislature as this bill); or

(b) that an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section.

c. (1) A dependent covered by a subscriber's contract, which coverage under the contract terminates at a specific age on or before the dependent's 30th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 30th birthday:

(a) within 30 days prior to the termination of coverage at the specific age provided in the contract;

(b) within 30 days after meeting the requirements for dependent status as set forth in subsection a. of this section, when coverage for the dependent under the contract previously terminated; or

(c) during an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection a. of this section during the open enrollment period.

(2) [For 12 months after the effective date of this section, a dependent who qualifies for dependent status as set forth in subsection a. of this section, but whose coverage as a dependent under a subscriber's contract terminated under the terms of the contract prior to the effective date of this section, may make a written election to reinstate coverage under that contract as a dependent pursuant to this section.] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

d. (1) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall consist of coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the specific age provided in the contract. If coverage is modified under the contract for any similarly situated dependents for coverage prior to the termination of coverage at the specific age provided in the contract, the coverage shall also be modified in the same manner for the dependent.

(2) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

e. (1) The subscriber's contract may require payment of a premium by the subscriber or dependent, as appropriate, subject to the approval of the Commissioner of Banking and Insurance, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection c. of this section. The premium shall not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage under the contract prior to the termination of coverage at the specific age provided in the contract.

(2) The applicable portion of the premium previously paid for the dependent's coverage under the contract shall be determined pursuant to regulations promulgated by the Commissioner of Banking and Insurance, based upon the difference between the contract's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the commissioner which provides a substantially similar result.

(3) Payments of the premium may, at the election of the payor, be made in monthly installments.

f. Coverage for a dependent provided pursuant to this section shall be provided until the earlier of the following:

(1) the date upon which the dependent is disqualified for dependent status as set forth in subsection a. of this section;

(2) the date [on] upon which coverage ceases under the contract by reason of a failure to make a timely payment of any premium required under the contract by the subscriber or dependent for coverage provided pursuant to this section. The payment of any

premium shall be considered to be timely if made within 30 days after the due date or within a longer period as may be provided for by the contract; or

(3) the date upon which the **[**employer under whose**]** contract, under which coverage is provided to a dependent, ceases to provide coverage to the subscriber.

Nothing herein shall be construed to permit a health service corporation to refuse a written election for coverage by a dependent pursuant to subsection c. of this section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection, other than a disqualification based on age or lack of evidence of prior, creditable coverage or receipt of benefits.

g. Notice regarding coverage for a dependent as provided pursuant to this section shall be provided to a subscriber by the health service corporation:

(1) in the certificate of coverage or other equivalent document prepared for subscribers **[**by the health service corporation**]** and delivered on or about the date of commencement of the subscribers' coverage; and

(2) **[**by the subscriber's employer:

(a) on or before the coverage of a subscriber's dependent terminates at the specific age as provided in the contract;

(b) at the time coverage of the dependent is no longer provided pursuant to this section because the dependent is disqualified for dependent status as set forth in subsection a. of this section, except this employer notice shall not be required when a dependent no longer qualifies based upon paragraphs (1) or (3) of subsection a. of this section;

(c) before any open enrollment period permitting a dependent to make a written election for coverage pursuant to subsection c. of this section; and

(d) immediately following the effective date of this section, with respect to information concerning a dependent's opportunity, for 12 months after the effective date of the section, to make a written election to reinstate coverage under a contract pursuant to paragraph (2) of subsection c. of this section**]** (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

(3) in a notice delivered to subscribers on a quarterly basis.

h. This section shall apply to those contracts in which the health service corporation has reserved the right to change the premium.**[3]**

(cf: P.L.2005, c.375, s.3)

[3]32. Section 4 of P.L.2005, c.375 (C.17B:27-30.5) is amended to read as follows:

4. a. As used in this section, "dependent" means an insured's child by blood or by law who:

(1) is ⟦less than⟧ 30 years of age or younger;

(2) is unmarried;

(3) has no dependent of his own;

(4) is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education; and

(5) (a) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, ⟦Pub.L.89-97⟧ Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time dependent coverage pursuant to this section begins or will begin; and

(b) there is evidence of prior, creditable coverage or receipt of benefits under a benefits plan or by law as set forth in subparagraph (a) of this paragraph.

b. (1) A group health insurance policy that provides coverage for an insured's dependent under which coverage of the dependent terminates at a specific age on or before the dependent's 30th birthday, and is delivered, issued, executed or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this section of P.L. , c. (pending before the Legislature as this bill), shall, upon application of the dependent as set forth in subsection c. of this section, provide coverage to the dependent after that specific age, until the dependent's ⟦30th⟧ 31st birthday.

(2) Nothing herein shall be construed to require:

(a) coverage for services provided to a dependent before the effective date of this section of P.L. , c. (pending before the Legislature as this bill); or

(b) that an employer or other group policyholder pay all or part of the cost of coverage for a dependent as provided pursuant to this section .

c. (1) A dependent covered by an insured's policy, which coverage under the policy terminates at a specific age on or before the dependent's 30th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 30th birthday:

(a) within 30 days prior to the termination of coverage at the specific age provided in the policy;

(b) within 30 days after meeting the requirements for dependent status as set forth in subsection a. of this section, when coverage for the dependent under the policy previously terminated; or

(c) during an open enrollment period, as provided pursuant to the policy, if the dependent meets the requirements for dependent status as set forth in subsection a. of this section during the open enrollment period.

(2) [For 12 months after the effective date of this section, a dependent who qualifies for dependent status as set forth in subsection a. of this section, but whose coverage as a dependent under an insured's policy terminated under the terms of the policy prior to the effective date of this section, may make a written election to reinstate coverage under that policy as a dependent pursuant to this section.] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

d. (1) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall consist of coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the specific age provided in the policy. If coverage is modified under the policy for any similarly situated dependents for coverage prior to the termination of coverage at the specific age provided in the policy, the coverage shall also be modified in the same manner for the dependent.

(2) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

e. (1) The insured's policy may require payment of a premium by the insured or dependent, as appropriate, subject to the approval of the Commissioner of Banking and Insurance, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection c. of this section. The premium shall not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage under the policy prior to the termination of coverage at the specific age provided in the policy.

(2) The applicable portion of the premium previously paid for the dependent's coverage under the policy shall be determined pursuant to regulations promulgated by the Commissioner of Banking and Insurance, based upon the difference between the policy's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the commissioner which provides a substantially similar result.

(3) Payments of the premium may, at the election of the payor, be made in monthly installments.

f. Coverage for a dependent provided pursuant to this section shall be provided until the earlier of the following:

(1) the date upon which the dependent is disqualified for dependent status as set forth in subsection a. of this section;

(2) the date [on] upon which coverage ceases under the policy by reason of a failure to make a timely payment of any premium required under the policy by the insured or dependent for coverage provided pursuant to this section. The payment of any premium shall be considered to be timely if made within 30 days after the

due date or within a longer period as may be provided for by the policy; or

(3) the date upon which the [employer under whose] policy, under which coverage is provided to a dependent, ceases to provide coverage to the insured.

Nothing herein shall be construed to permit an insurer to refuse a written election for coverage by a dependent pursuant to subsection c. of this section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection, other than a disqualification based on age or lack of evidence of prior, creditable coverage or receipt of benefits.

g. Notice regarding coverage for a dependent as provided pursuant to this section shall be provided to an insured by the insurer:

(1) in the certificate of coverage or other equivalent document prepared for insureds [by the insurer] and delivered on or about the date of commencement of the insureds' coverage; and

(2) [by the insured's employer:

(a) on or before the coverage of an insured's dependent terminates at the specific age as provided in the policy;

(b) at the time coverage of the dependent is no longer provided pursuant to this section because the dependent is disqualified for dependent status as set forth in subsection a. of this section, except this employer notice shall not be required when a dependent no longer qualifies based upon paragraph (1) or (3) of subsection a. of this section;

(c) before any open enrollment period permitting a dependent to make a written election for coverage pursuant to subsection c. of this section; and

(d) immediately following the effective date of this section, with respect to information concerning a dependent's opportunity, for 12 months after the effective date of the section, to make a written election to reinstate coverage under a policy pursuant to paragraph (2) of subsection c. of this section.] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

h. This section shall apply to those policies in which the insurer has reserved the right to change the premium.[3]

(cf: P.L.2005, c.375, s.4)

[3]33. Section 5 of P.L.2005, c.375 (C.17B:27A-19.16) is amended to read as follows:

5. a. As used in this section, "dependent" means a covered person's child by blood or by law who:

(1) is [less than] 30 years of age or younger;

(2) is unmarried;

(3) has no dependent of his own;

(4) is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education; and

(5) (a) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, **[**Pub.L.89-97**]** Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time dependent coverage pursuant to this section begins or will begin; and

(b) there is evidence of prior, creditable coverage or receipt of benefits under a benefits plan or by law as set forth in subparagraph (a) of this paragraph.

b. (1) A small employer health benefits plan that provides coverage for a covered person's dependent under which coverage of the dependent terminates at a specific age on or before the dependent's 30th birthday, and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this section of P.L. , c. (pending before the Legislature as this bill), shall, upon application of the dependent as set forth in subsection c. of this section, provide coverage to the dependent after that specific age, until the dependent's **[**30th**]** 31st birthday.

(2) Nothing herein shall be construed to require:

(a) coverage for services provided to a dependent before the effective date of this section of P.L. , c. (pending before the Legislature as this bill); or

(b) that an employer pay all or part of the cost of coverage for a dependent as provided pursuant to this section.

c. (1) A dependent covered by a covered person's plan, which coverage under the plan terminates at a specific age on or before the dependent's 30th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 30th birthday:

(a) within 30 days prior to the termination of coverage at the specific age provided in the plan;

(b) within 30 days after meeting the requirements for dependent status as set forth in subsection a. of this section, when coverage for the dependent under the plan previously terminated; or

(c) during a 30-day period in each year following the year coverage terminates at the specific age as provided in the plan, which period shall begin on the anniversary date on which the dependent's coverage terminates at the specific age as provided in the plan, if the dependent meets the requirements for dependent status as set forth in subsection a. of this section during the 30-day period.

(2) [For 12 months after the effective date of this section, a dependent who qualifies for dependent status as set forth in subsection a. of this section, but whose coverage as a dependent under a covered person's plan terminated under the terms of the plan prior to the effective date of this section, may make a written election to reinstate coverage under that plan as a dependent pursuant to this section.] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

d. (1) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall consist of coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the specific age provided in the plan. If coverage is modified under the plan for any similarly situated dependents for coverage prior to the termination of coverage at the specific age provided in the plan, the coverage shall also be modified in the same manner for the dependent.

(2) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

e. (1) The covered person's plan may require payment of a premium by the covered person or dependent, as appropriate, subject to the approval of the Commissioner of Banking and Insurance, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection c. of this section. The premium shall not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage under the plan prior to the termination of coverage at the specific age provided in the plan.

(2) The applicable portion of the premium previously paid for the dependent's coverage under the plan shall be determined pursuant to regulations promulgated by the Commissioner of Banking and Insurance, based upon the difference between the plan's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the commissioner which provides a substantially similar result.

(3) Payments of the premium may, at the election of the payor, be made in monthly installments.

f. Coverage for a dependent provided pursuant to this section shall be provided until the earlier of the following:

(1) the date upon which the dependent is disqualified for dependent status as set forth in subsection a. of this section;

(2) the date [on] upon which coverage ceases under the plan by reason of a failure to make a timely payment of any premium required under the plan by the covered person or dependent for coverage provided pursuant to this section. The payment of any premium shall be considered to be timely if made within 30 days

after the due date or within a longer period as may be provided for by the plan; or

(3) the date upon which the [employer under whose] plan, under which coverage is provided to a dependent, ceases to provide coverage to the covered person.

Nothing herein shall be construed to permit a carrier to refuse a written election for coverage by a dependent pursuant to subsection c. of this section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection, other than a disqualification based on age or lack of evidence of prior, creditable coverage or receipt of benefits.

g. Notice regarding coverage for a dependent as provided pursuant to this section shall be provided to a covered person by the carrier:

(1) in the certificate of coverage or other equivalent document prepared for covered persons [by the carrier] and delivered on or about the date of commencement of the covered persons' coverage; and

(2) [by the covered person's employer:

(a) on or before the coverage of a covered person's dependent terminates at the specific age as provided in the plan;

(b) at the time coverage of the dependent is no longer provided pursuant to this section because the dependent is disqualified for dependent status as set forth in subsection a. of this section, except this employer notice shall not be required when a dependent no longer qualifies based upon paragraph (1) or (3) of subsection a. of this section;

(c) before the 30 day period in each year following the year coverage terminates at the specific age as provided in the plan, permitting a dependent to make a written election for coverage pursuant to subsection c. of this section; and

(d) immediately following the effective date of this section, with respect to information concerning a dependent's opportunity, for 12 months after the effective date of this section, to make a written election to reinstate coverage under a plan pursuant to paragraph (2) of subsection c. of this section.] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

(3) in a notice delivered to covered persons on a quarterly basis.

h. This section shall apply to those plans in which the carrier has reserved the right to change the premium.[3]

(cf: P.L.2005, c.375, s.5)

[3]34. Section 6 of P.L.2005, c.375 (C.26:2J-10.3) is amended to read as follows:

6. a. As used in this section, "dependent" means an enrollee's child by blood or by law who:

(1) is [less than] 30 years of age or younger;

(2) is unmarried;

(3) has no dependent of his own;

(4) is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education; and

(5) (a) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, **[**Pub.L.89-97**]** Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time dependent coverage pursuant to this section begins or will begin; and

(b) there is evidence of prior, creditable coverage or receipt of benefits under a benefits plan or by law as set forth in subparagraph (a) of this paragraph.

b. (1) A health maintenance organization contract that provides coverage for an enrollee's dependent under which coverage of the dependent terminates at a specific age before the dependent's 30th birthday, and is delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) on or after the effective date of this section of P.L. , c. (pending before the Legislature as this bill), shall, upon the application of the dependent as set forth in subsection c. of this section, provide coverage to the dependent after that specific age, until the dependent's **[**30th**]** 31st birthday.

(2) Nothing herein shall be construed to require:

(a) coverage for services provided to a dependent before the effective date of this section of P.L. , c. (pending before the Legislature as this bill); or

(b) that an employer or other group contract holder pay all or part of the cost of coverage for a dependent as provided pursuant to this section.

c. (1) A dependent covered by an enrollee's contract, which coverage under the contract terminates at a specific age on or before the dependent's 30th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 30th birthday:

(a) within 30 days prior to the termination of coverage at the specific age provided in the contract;

(b) within 30 days after meeting the requirements for dependent status as set forth in subsection a. of this section, when coverage for the dependent under the contract previously terminated; or

(c) during an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection a. of this section during the open enrollment period.

(2) **[**For 12 months after the effective date of this section, a dependent who qualifies for dependent status as set forth in

subsection a. of this section, but whose coverage as a dependent under an enrollee's contract terminated under the terms of the contract prior to the effective date of this section, may make a written election to reinstate coverage under that contract as a dependent pursuant to this section.**]** (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

d. (1) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall consist of coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the specific age provided in the contract. If coverage is modified under the contract for any similarly situated dependents for coverage prior to the termination of coverage at the specific age provided in the contract, the coverage shall also be modified in the same manner for the dependent.

(2) Coverage for a dependent who makes a written election for coverage pursuant to subsection c. of this section shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

e. (1) The enrollee's contract may require payment under the schedule of charges by the enrollee or dependent, as appropriate, subject to the approval of the Commissioner of Banking and Insurance, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection c. of this section. The payment shall not exceed 102% of the applicable portion of the schedule of charges previously paid for that dependent's coverage under the contract prior to the termination of coverage at the specific age provided in the contract.

(2) The applicable portion of the schedule of charges previously paid for the dependent's coverage under the contract shall be determined pursuant to regulations promulgated by the Commissioner of Banking and Insurance, based upon the difference between the contract's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the commissioner which provides a substantially similar result.

(3) Payments under the schedule of charges may, at the election of the payor, be made in monthly installments.

f. Coverage for a dependent provided pursuant to this section shall be provided until the earlier of the following:

(1) the date upon which the dependent is disqualified for dependent status as set forth in subsection a. of this section;

(2) the date **[**on**]** upon which coverage ceases under the contract by reason of a failure to make a timely payment under any schedule of charges required under the contract by the enrollee or dependent for coverage provided pursuant to this section. The payment under any schedule of charges shall be considered to be timely if made

within 30 days after the due date or within a longer period as may be provided for by the contract; or

(3) the date upon which the [employer under whose] contract, under which coverage is provided to a dependent, ceases to provide coverage to the enrollee.

Nothing herein shall be construed to permit a health maintenance organization to refuse a written election for coverage by a dependent pursuant to subsection c. of this section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection, other than a disqualification based on age or lack of evidence of prior, creditable coverage or receipt of benefits.

g. Notice regarding coverage for a dependent as provided pursuant to this section shall be provided to an enrollee by the health maintenance organization:

(1) in the certificate of coverage or other equivalent document prepared for enrollees [by the health maintenance organization] and delivered on or about the date of commencement of the enrollees' coverage; and

(2) [by the enrollee's employer:

(a) on or before the coverage of an enrollee's dependent terminates at the specific age as provided in the contract;

(b) at the time coverage of the dependent is no longer provided pursuant to this section because the dependent is disqualified for dependent status as set forth in subsection a. of this section, except this employer notice shall not be required when a dependent no longer qualifies based upon paragraph (1) or (3) of subsection a. of this section;

(c) before any open enrollment period permitting a dependent to make a written election for coverage pursuant to subsection c. of this section; and

(d) immediately following the effective date of this section, with respect to information concerning a dependent's opportunity, for 12 months after the effective date of the section, to make a written election to reinstate coverage under a contract pursuant to paragraph (2) of subsection c. of this section.] (Deleted by amendment, P.L. , c. (pending before the Legislature as this bill)

(3) in a notice delivered to enrollees on a quarterly basis.

h. This section shall apply to those contracts in which the health maintenance organization has reserved the right to change the schedule of charges.[3]

(cf: P.L.2005, c.375, s.6)

[3]35. Section 7 of P.L.2005, c.375 (C.52:14-17.29k) is amended to read as follows:

7. a. As used in this section, "dependent" means a covered person's child by blood or by law who:

(1) is [less than] 30 years of age or younger;

(2) is unmarried;

(3) has no dependent of his own;

(4) is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education; and

(5) (a) is not actually provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, **[**Pub.L.89-97**]** Pub.L.74-271 (42 U.S.C. s.1395 et seq.) at the time dependent coverage pursuant to this section begins or will begin; and

(b) there is evidence of prior, creditable coverage or receipt of benefits under a benefits plan or by law as set forth in subparagraph (a) of this paragraph.

b. The State Health Benefits Commission shall ensure that every contract purchased or renewed by the commission on or after the effective date of P.L.2005, c.375 (C.17:48-6.19 et al.), prohibits the termination of coverage of a dependent before the dependent's 23rd birthday by reason of age, and complies with the provisions of **[**P.L.2005, c.375 (C.17:48-6.19 et al.)**]** this section of P.L. , c. (pending before the Legislature as this bill) concerning the coverage of a dependent by written election, as set forth in subsection d. of this section, until the dependent's **[**30th**]** 31st birthday. **[**The cost of coverage pursuant to this section shall be reimbursed by the employee to the New Jersey State Health Benefits Program, in accordance with a rate to be determined by the commission.**]**

c. Nothing within this section shall be construed to: (1) prevent any contract purchased or renewed by the commission from providing coverage for a dependent which terminates at a specific age after the dependent child's 23rd birthday; or (2) require coverage for services provided to a dependent before the effective date of **[**P.L.2005, c.375 (C.17:48-6.19 et al.)**]** this section of P.L. , c. (pending before the Legislature as this bill).

d. A dependent covered by a covered person’s contract, which coverage under the contract terminates at a specific age on or before the dependent's 30th birthday, may make a written election for coverage as a dependent pursuant to this section, until the dependent's 30th birthday:

(a) within 30 days prior to the termination of coverage at the specific age provided in the contract;

(b) within 30 days after meeting the requirements for dependent status as set forth in subsection a. of this section, when coverage for the dependent under the contract previously terminated; or

(c) during an open enrollment period, as provided pursuant to the contract, if the dependent meets the requirements for dependent status as set forth in subsection a. of this section.

e. (1) Coverage for a dependent who makes a written election for coverage pursuant to subsection d. of this section shall consist of coverage which is identical to the coverage provided to that dependent prior to the termination of coverage at the specific age provided in the contract. If coverage is modified under the contract for any similarly situated dependents for coverage prior to the termination of coverage at the specific age provided in the contract, the coverage shall also be modified in the same manner for the dependent.

(2) Coverage for a dependent who makes a written election for coverage pursuant to subsection d. of this section shall not be conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

f. (1) The covered person's contract may require payment of a premium by the covered person or dependent, as appropriate, for any period of coverage relating to a dependent's written election for coverage pursuant to subsection d. of this section. The premium shall not exceed 102% of the applicable portion of the premium previously paid for that dependent's coverage under the contract prior to the termination of coverage at the specific age provided in the contract.

(2) The applicable portion of the premium previously paid for the dependent's coverage under the contract shall be determined by the commission, based upon the difference between the contract's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the commission which provides a substantially similar result.

(3) Payments of the premium may, at the election of the payor, be made in monthly installments.

g. Coverage for a dependent provided pursuant to this section shall be provided until the earlier of the following:

(1) the date upon which the dependent is disqualified for dependent status as set forth in subsection a. of this section;

(2) the date upon which coverage ceases under the contract by reason of a failure to make a timely payment of any premium required under the contract by the covered person or dependent for coverage provided pursuant to this section. The payment of any premium shall be considered to be timely if made within 30 days after the due date or within a longer period as may be provided for by the contract; or

(3) the date upon which the contract, under which coverage is provided to a dependent, ceases to provide coverage to the covered person.

Nothing herein shall be construed to permit the commission to refuse a written election for coverage by a dependent pursuant to subsection d. of this section, based upon the dependent's prior disqualification pursuant to paragraph (1) of this subsection, other

than a disqualification based on age or lack of evidence or prior, creditable coverage or receipt of benefits.

h. Notice regarding coverage for a dependent as provided pursuant to this section shall be provided to a covered person by the commission:

(1) in the certificate of coverage or other equivalent document prepared for covered persons and delivered on or about the date of commencement of the covered persons' coverage; and

(2) in a notice delivered to covered persons on a quarterly basis.[3]

(cf: P.L.2005, c.375, s.7)

[1][27.] [3][29.[1]] 36.[3] The Commissioner of Banking and Insurance shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt regulations necessary to implement [1][the provisions] sections 9 through 25[1] [3]and sections 29 through 34[3]of this act.

[1][28.] [3][30.[1]] 37.[3] Sections 1 through [1][7 and 27] 8, 26 through 28, 36 and this section[1] of this act shall take effect immediately and sections [1][8] 9[1] through [1][26] 25[1] [3]and 29 through 35[3]of this act shall take effect on the 180th day after enactment [1][and] , except that the 80% minimum loss ratio requirements in sections 16, 19, and 24 of this bill shall take effect on January 1 next following the date of enactment. Sections 9 through 25[1] [3]and 29 through 35[3] shall apply to all contracts and policies that are delivered, issued, executed or renewed or approved for issuance or renewal in this State on or after the effective date [1]provided herein,[1] but the Commissioner of Banking and Insurance may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

Expands NJ FamilyCare, establishes mandate for health care coverage of children, makes various reforms to individual and small employer insurance markets and certain dependent coverage; appropriates $1 million.

SENATE, No. 1557

STATE OF NEW JERSEY

213th LEGISLATURE

INTRODUCED APRIL 7, 2008

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator ROBERT W. SINGER
District 30 (Burlington, Mercer, Monmouth and Ocean)

Co-Sponsored by:
Senators Gordon, Redd, Rice and Whelan

SYNOPSIS

Expands NJ FamilyCare, establishes mandate for health care coverage of children, and makes various reforms to individual and small employer insurance markets.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 5/16/2008)

AN ACT concerning health care coverage and revising parts of statutory law.

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

1. (New section) The Legislature finds and declares:

a. There are an estimated 1.25 million residents of the State who have no health insurance coverage, of which over 240,000 are children, and the number of uninsured residents is increasing each year;

b. While employer-sponsored health care coverage in the State is well above the national average and has been a major factor in keeping the number of uninsured lower than in many states, because of the rising cost of the coverage, increasing numbers of employers are considering dropping coverage for their employees and dependents, or are requiring employees to share in a greater percentage of premium costs and to bear larger copayments and coinsurance, which is making health care coverage increasingly unaffordable to low and moderate income working families;

c. Persons without health insurance coverage receive less preventive care, poorer treatment for both minor and serious chronic and acute illnesses, and in many cases live shorter lives than comparable insured populations;

d. Many uninsured are forced to seek health care in inappropriate settings such as hospital emergency rooms because they cannot obtain needed health care services in a convenient and more cost-effective setting such as a primary care provider's office or clinic, which contributes to higher health care costs;

e. The uninsured are commonly billed at higher rates than those who have health care coverage. Health care costs have become a leading cause of bankruptcy in this country, and those without insurance are most at risk;

f. The State has recognized the importance of increasing access to health care coverage and, over the last several years, has enacted several reforms to make health care coverage more affordable and accessible to residents of the State. Among these reforms are the expansions of coverage under the State Medicaid and NJ FamilyCare programs. Despite these efforts, too many low income parents and children lack access to health care coverage;

g. In order to ensure that more low income parents in the State have access to health care coverage and all children in the State are covered under a health plan, thus moving closer to providing universal coverage for all residents of this State, it is necessary to further expand coverage for parents under the NJ FamilyCare

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 <u>thus</u> is new matter.

Program, and mandate that all children in the State have health care coverage, either through public programs or private coverage; and

h. In order to make insurance coverage more affordable to residents and small businesses in this State, and to stabilize enrollment in, and the costs of, individual and small employer health benefits plans, it is also necessary to adopt comprehensive reform measures to the insurance marketplace.

2. (New section) a. Beginning one year after the date of enactment of this act, all residents of this State 18 years of age and younger shall obtain and maintain health care coverage that provides hospital and medical benefits. The coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid program, NJ FamilyCare Program, or the NJ FamilyCare Advantage buy-in program.

b. As used in this section:

“Medicaid” means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

“NJ FamilyCare” means the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

“NJ FamilyCare Advantage” means the buy-in program established pursuant to subsection j. of section 5 of P.L.2005, c.156 (C.30:4J-12).

3. Section 4 of P.L.2005, 156 (C.30:4J-11) is amended to read as follows:

4. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" or "program" means the NJ FamilyCare Program established pursuant to sections 3 through 5 of P.L.2005, 156 (C.30:4J-10 though C.30:4J-12).

"Poverty level" means the official federal poverty level based on family size, established and adjusted under Section 673(2) of Subtitle B, the "Community Services Block Grant Act," Pub.L.97-35 (42 U.S.C. s.9902(2)).

"Qualified applicant" means:

a. a child under 19 years of age: (1) whose family gross income does not exceed 350% of the poverty level; (2) who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States;

b. a parent or caretaker: (1) whose gross family income does not exceed 200% of the poverty level; (2) [who is enrolled in NJ FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et al.); (3)] who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; [(4)] (3) who is a resident of this State; and [(5)] (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States; and

c. a single adult or couple without dependent children: (1) whose family gross income does not exceed 100% of the poverty level; (2) who is enrolled in NJ FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et al.) and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States.

(cf: P.L.2005, c.156, s.4)

4. Section 5 of P.L.2005, 156 (C.30:4J-12) is amended to read as follows:

5. a. The purpose of the program shall be to provide subsidized health insurance coverage, and other health care benefits as determined by the commissioner, to children under 19 years of age and their parents or caretakers and to adults without dependent children, within the limits of funds appropriated or otherwise made available for the program.

The program shall require families to pay copayments and make premium contributions, based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner shall take such actions as are necessary to implement and operate the program in accordance with the State Children's Health Insurance Program established pursuant to 42 U.S.C.s.1397aa et seq.

c. The commissioner:

(1) shall, by regulation, establish standards for determining eligibility and other program requirements, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

(2) shall require that a parent or caretaker who is a qualified applicant purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner, and shall provide assistance to the qualified applicant to purchase that coverage, except that the provisions of this paragraph shall not be construed to require an employer to provide health insurance coverage for any employee or employee's spouse or dependent child;

(3) may, by regulation, establish plans of coverage and benefits to be covered under the program, except that the provisions of this section shall not apply to coverage for medications used exclusively to treat AIDS or HIV infection; and

(4) shall establish, by regulation, other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities, including managed care organizations, to assist in administering the program. The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.

d. The commissioner shall establish procedures for determining eligibility, which shall include, at a minimum, the following enrollment simplification practices:

(1) A streamlined application form as established pursuant to subsection k. of this section;

(2) Require new applicants to submit no more than one recent pay stub from the applicant's employer, or, if the applicant has more than one employer, no more than one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's income by reviewing available Department of the Treasury or Department of Labor and Workforce Development records concerning the applicant, or such other records as the commissioner determines appropriate.

The commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor and Workforce Development or such other records as the commissioner determines appropriate.

If the commissioner elects to match reported income with confidential records of the Department of the Treasury, the commissioner shall require an applicant to provide written authorization for the Division of Taxation in the Department of the Treasury to release applicable tax information to the commissioner for the purposes of establishing income eligibility for the program. The authorization, which shall be included on the program application form, shall be developed by the commissioner, in consultation with the State Treasurer;

(3) Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

(4) Continuous enrollment;

(5) Simplified renewal by sending an enrollee a preprinted renewal form and requiring the enrollee to sign and return the form, with any applicable changes in the information provided in the form, no later than 30 days after the date the enrollee's annual eligibility expires. The commissioner may establish such auditing or income verification procedures as he deems appropriate, as provided in paragraph (1) of this subsection; and

(6) Provision of program eligibility-identification cards that are issued no more frequently than once a year.

e. The commissioner shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year. In this regard, notwithstanding the definition of "qualified applicant," the commissioner may enroll in the program such children or their parents or caretakers who may otherwise be eligible for the Medicaid program in order to maximize use of federal funds that may be available pursuant to 42 U.S.C. s.1397aa et seq.

f. Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.

g. The commissioner shall provide, by regulation, for presumptive eligibility for the program in accordance with the following provisions:

(1) A child who presents himself for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care, or other State licensed community-based primary care provider shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center, local health department or licensed health care provider staff indicates that the child meets program eligibility standards and is a member of a household with an income that does not exceed 350% of the poverty level;

(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is deemed presumptively eligible for Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) The parent or caretaker of a child deemed presumptively eligible pursuant to this subsection shall be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined;

(4) A child shall be eligible to receive all services covered by the program during the period in which the child is presumptively eligible; and

(5) The commissioner may, by regulation, establish a limit on the number of times a child may be deemed presumptively eligible for NJ FamilyCare.

h. The commissioner, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

(1) With respect to school-age children, the commissioner, in consultation with the Commissioner of Education and the Secretary of Agriculture, shall develop a form that provides information about the NJ FamilyCare and Medicaid programs and provides an opportunity for the parent or guardian who signs the school lunch application form to give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the programs. The form shall be attached to, included with, or incorporated into, the school lunch application form.

The commissioner, in consultation with the Commissioner of Education, shall establish procedures for schools to transmit information attached to, included with, or provided on the school lunch application form regarding the NJ FamilyCare and Medicaid programs to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

(2) The commissioner or the Commissioner of Education, as applicable, shall:

(a) make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form.

The entity shall make the informational and application materials available, upon request, to persons interested in the program; and

(b) request each entity to distribute a notice at least annually, as developed by the commissioner, to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials. In the case of elementary and secondary schools, the information attached to, included with, or incorporated into, the school lunch application form for school-age children pursuant to this subparagraph shall be deemed to meet the requirements of this paragraph.

i. Subject to federal approval, the commissioner shall, by regulation, establish that in determining income eligibility for a child, any gross family income above 200% of the poverty level, up to a maximum of 350% of the poverty level, shall be disregarded.

j. The commissioner shall establish a NJ FamilyCare coverage buy-in program through which a parent or caretaker whose family

income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. <u>The program shall be known as NJ FamilyCare Advantage.</u>

The commissioner shall establish the premium and cost sharing amounts required to purchase coverage, except that the premium shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the poverty level, plus a reasonable processing fee.

k. The commissioner, in consultation with the Rutgers Center for State Health Policy, shall develop a streamlined application form for the NJ FamilyCare and Medicaid programs.

(cf: P.L.2005, c.156, s.5).

5. (New section) The Commissioner of Human Services shall apply for such waivers as may be necessary to implement the provisions of section 4 of P.L.2005, c.156 (C.30:4J-11) and to secure federal financial participation for NJ FamilyCare expenditures under the State Children's Health Insurance Program pursuant to 42 U.S.C.s.1397aa et seq.

6. (New section) Notwithstanding the provisions of section 3 of P.L.2004, c.113 (C.26:2H-18.59i) to the contrary, a hospital shall not submit charity care claims to the Department of Health and Senior Services for health care services provided to a child under 19 years of age who presents at a hospital for emergency care and who may be deemed presumptively eligible for NJ FamilyCare coverage pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) or Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

7. (New section) a. Beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual taxpayer indicate on the taxpayer's income tax return whether the taxpayer and dependents, if applicable, has health insurance coverage on the date of filing of the return.

b. The department shall, in consultation with the Commissioner of Human Services, administer an ongoing enrollment initiative to identify and provide outreach to taxpayers who are uninsured and may be eligible to enroll in the Medicaid or NJ FamilyCare program. As part of the initiative, the department shall send an application for the Medicaid or NJ FamilyCare program, as applicable, to any taxpayer who reports on the tax return form that he or his dependents do not have health insurance coverage and who, based on the income reported on the tax return form and the

tax payer’s family size, may be eligible for either of the State’s health care coverage programs.

c. As used in this section:

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" or "program" means the NJ FamilyCare Program established pursuant to P.L.2005, 156 (C.30:4J-8 et al.).

8. R.S.54:50-9 is amended to read as follows:

54:50-9. Nothing herein contained shall be construed to prevent:

a. The delivery to a taxpayer or the taxpayer's duly authorized representative of a copy of any report or any other paper filed by the taxpayer pursuant to the provisions of this subtitle or of any such State tax law;

b. The publication of statistics so classified as to prevent the identification of a particular report and the items thereof;

c. The director, in the director's discretion and subject to reasonable conditions imposed by the director, from disclosing the name and address of any licensee under any State tax law, unless expressly prohibited by such State tax law;

d. The inspection by the Attorney General or other legal representative of this State of the reports or files relating to the claim of any taxpayer who shall bring an action to review or set aside any tax imposed under any State tax law or against whom an action or proceeding has been instituted in accordance with the provisions thereof;

e. The examination of said records and files by the Comptroller, State Auditor or State Commissioner of Finance, or by their respective duly authorized agents;

f. The furnishing, at the discretion of the director, of any information contained in tax reports or returns or any audit thereof or the report of any investigation made with respect thereto, filed pursuant to the tax laws, to the taxing officials of any other state, the District of Columbia, the United States and the territories thereof, providing said jurisdictions grant like privileges to this State and providing such information is to be used for tax purposes only;

g. The furnishing, at the discretion of the director, of any material information disclosed by the records or files to any law enforcing authority of this State who shall be charged with the investigation or prosecution of any violation of the criminal provisions of this subtitle or of any State tax law;

h. The furnishing by the director to the State agency responsible for administering the Child Support Enforcement program pursuant to Title IV-D of the federal Social Security Act, Pub.L.93-647 (42 U.S.C. s.651 et seq.), with the names, home addresses, social security numbers and sources of income and assets

of all absent parents who are certified by that agency as being required to pay child support, upon request by the State agency and pursuant to procedures and in a form prescribed by the director;

i. The furnishing by the director to the Board of Public Utilities any information contained in tax information statements, reports or returns or any audit thereof or a report of any investigation made with respect thereto, as may be necessary for the administration of P.L.1991, c.184 (C.54:30A-18.6 et al.) and P.L.1997, c.162 (C.54:10A-5.25 et al.);

j. The furnishing by the director to the Director of the Division of Alcoholic Beverage Control in the Department of Law and Public Safety any information contained in tax information statements, reports or returns or any audit thereof or a report of any investigation made with respect thereto, as may be relevant, in the discretion of the director, in any proceeding conducted for the issuance, suspension or revocation of any license authorized pursuant to Title 33 of the Revised Statutes;

k. The inspection by the Attorney General or other legal representative of this State of the reports or files of any tobacco product manufacturer, as defined in section 2 of P.L.1999, c.148 (C.52:4D-2), for any period in which that tobacco product manufacturer was not or is not in compliance with subsection a. of section 3 of P.L.1999, c.148 (C.52:4D-3), or of any licensed distributor as defined in section 102 of P.L.1948, c.65 (C.54:40A-2), for the purpose of facilitating the administration of the provisions of P.L.1999, c.148 (C.52:4D-1 et seq.);

l. The furnishing, at the discretion of the director, of information as to whether a contractor or subcontractor holds a valid business registration as defined in section 1 of P.L.2001, c.134 (C.52:32-44);

m. The furnishing by the director to a State agency as defined in section 1 of P.L.1995, c.158 (C.54:50-24) the names of licensees subject to suspension for non-payment of State tax indebtedness pursuant to P.L.2004, c.58 (C.54:50-26.1 et al.);

n. The release to the United States Department of the Treasury, Bureau of Financial Management Service, or its successor of relevant taxpayer information for purposes of implementing a reciprocal collection and offset of indebtedness agreement entered into between the State of New Jersey and the federal government pursuant to section 1 of P.L.2006, c.32 (C.54:49-12.7);

o. The examination of said records and files by the Commissioner of Health and Senior Services, <u>the Commissioner of Human Services,</u> the Medicaid Inspector General, or their respective duly authorized agents, pursuant to section 5 of P.L.2007, c.217 (C.26:2H-18.60e);

p. The furnishing at the discretion of the director of employer provided wage and tax withholding information contained in tax reports or returns filed pursuant to N.J.S.54A:7-2, 54A:7-4 and

54A:7-7, to the designated municipal officer of a municipality authorized to impose an employer payroll tax pursuant to the provisions of Article 5 (Employer Payroll Tax) of the "Local Tax Authorization Act," P.L.1970, c.326 (C.40:48C-14 et seq.), for the limited purpose of verifying the payroll information reported by employers subject to the employer payroll tax.
(cf: P.L.2007, c.294, s.2)

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

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

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier.

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

"Department" means the Department of Banking and Insurance.

"Dependent" means the spouse, domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an eligible person, subject to applicable terms of the individual health benefits plan.

"Eligible person" means a person who is a resident who is not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan, or Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.).

"Federally defined eligible individual" means an eligible person: (1) for whom, as of the date on which the individual seeks coverage under P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months; (2) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan; (3) who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C.s.1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan; (4) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; (5) who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and (6) who has elected continuation coverage described in (5) above and has exhausted that continuation coverage.

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

"Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental

plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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

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

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this act, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code

(10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

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

Individual health benefits plan shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan, to the extent the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1001 et seq.) preempts the application of P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. Member shall not include a carrier whose combined average Medicare, Medicaid, and NJ FamilyCare **[**and NJ KidCare**]** enrollment represents more than 75% of its average total enrollment for all health benefits plans or whose combined Medicare, Medicaid, and NJ FamilyCare **[**and NJ KidCare**]** net earned premium for the two-year calculation period represents more than 75% of its total net earned premium for the two-year calculation period.

"Modified community rating" means a rating system in which the premium for all persons covered **[**by a contract is formulated based on the experience of all persons covered by that contract, without regard to age, sex, occupation and geographical location, but which may differ by health status. The term modified community rating shall apply to contracts and policies issued prior to the effective date of this act which are subject to the provisions of subsection e. of section 2 of this act.**]** under a policy or contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical

location or any other factor or characteristic of covered persons, other than age.

The rating system shall provide that the premium rate charged by the carrier for the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits plans shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with regulations promulgated by the commissioner, which shall include age classifications established, at a minimum, in five year increments. There may be a reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or for different health benefits plans offered by the carrier.

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid, or NJ FamilyCare or **[**NJ KidCare**]** contracts with the State or federal government, but shall not include premiums earned from contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

"NJ FamilyCare" means the NJ FamilyCare **[**Health Coverage**]** Program established pursuant to **[**P.L.2000, c.71 (C.30:4J-1 et seq.)**]** P.L.2005, c.156 (C.30:4J-8 et al.).

["NJ KidCare" means the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.).**]**

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

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

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

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

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

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

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

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

(cf: P.L.2001, c.349, s.1)

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

2. a. An individual health benefits plan issued on or after [August 1, 1993 shall be subject to the provisions of this act] the effective date of P.L. , c. (pending before the Legislature as this bill) shall be subject to the rating provisions established in P.L. , c. (pending before the Legislature as this bill). In the case of an individual health benefits plan issued to a covered person prior to the effective date of P.L. , c. (pending before the Legislature as this bill) and renewed thereafter, for the five years next following enactment of P.L. , c. (pending before the Legislature as this bill), the annual rate increase filed for the plan shall be limited to the lower of 15% or the medical trend assumption used by the carrier to project claims.

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

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

(3) A group conversion contract or policy issued prior to August 1, 1993 that is not issued on a modified community rated basis or

community rated basis, shall not be subject to the provisions of this act, except that the contract or policy shall be liable for assessments made pursuant to section 11 of this act.

(4) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation prior to the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that the plan shall guarantee renewal pursuant to subsection b. of section 5 of P.L.1992, c.161 (C.17B:27A-6).

(5) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation to an eligible person or federally defined eligible individual after the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the provisions of subsections c. and d. of section 2, subsection b. of section 3, section 5, subsection b. of section 6, and subsections c., d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3, C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall not be subject to the remaining provisions of P.L.1992, c. 161.**]** (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).

c. **[**After August 1, 1993, an individual who is eligible to participate in a group health benefits plan that provides coverage for hospital or medical expenses shall not be covered by an individual health benefits plan which provides benefits for hospital and medical expenses that are the same or similar to coverage provided in the group health benefits plan, except that an individual who is eligible to participate in a group health benefits plan but is currently covered by an individual health benefits plan may continue to be covered by that plan until the first anniversary date of the group health benefits plan occurring on or after January 1, 1994. **]** (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).

d. **[**Except as otherwise provided in subsection c. of this section, after August 1, 1993, a person who is covered by an individual health benefits plan who is a participant in, or is eligible to participate in, a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, and a person, including an employer or insurance producer, who causes another person to be covered by an individual health benefits plan which person is a participant in, or who is eligible to participate in a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, shall be subject to a fine by the commissioner in an amount not less than twice the annual premium paid for the individual health benefits plan,

together with any other penalties permitted by law.] (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

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

(cf: P.L.1997, c.146, s.2)

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

3. a. No later than 180 days after the effective date of [this act] P.L. , c. (pending before the Legislature as this bill), a carrier shall, as a condition of issuing small employer health benefits plans in this State, also offer individual health benefits plans. The plans shall be offered on an open enrollment, modified community rated basis, pursuant to the provisions of this act[; except that a carrier shall be deemed to have satisfied its obligation to provide the individual health benefits plans by paying an assessment or receiving an exemption pursuant to section 11 of this act] and P.L. , c. (pending before the Legislature as this bill). Every carrier that issues small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall make a good faith effort to market individual health benefits plans.

b. A carrier shall offer to an eligible person a choice of [five] at least three individual health benefits plans [any of which may contain provisions for managed care] established by the board pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7). One plan shall be a basic health benefits plan[, one plan shall be a managed care plan and three plans shall include enhanced benefits of proportionally increasing actuarial value]. A carrier may elect to convert any individual contract or policy forms in force on the effective date of [this act] P.L. , c. (pending before the Legislature as this bill) to any of the [five] benefit plans, except that the carrier may not convert more than 25% of existing contracts or policies each year, and the replacement plan shall be of no less actuarial value than the policy or contract being replaced.

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

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

c. (1) A basic health benefits plan shall provide the benefits set forth in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section 57

of P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991, c.187 (C.26:2J-4.3), as the case may be.

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

(3) A contract or policy for a basic health benefits plan provided for in this section may contain or provide for coinsurance or deductibles, or both, except that no deductible shall be payable in excess of a total of $250 by an individual or $500 by a family unit during any benefit year; and no coinsurance shall be payable in excess of a total of $500 by an individual or by a family unit during any benefit year.

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

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

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

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

e. **[**If all five of the individual health benefits plans are not established by the board by the effective date of P.L.1993, c.164 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the five health benefits plans by offering each health benefits plan as it is established by the board; however, once the board establishes all five plans, the carrier shall be required to offer the five plans in accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et al.).**]** (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

f. In addition to the rider packages provided for in subsection c. of section 6 of P.L.1992, c.161 (C.17B:27A-7), every carrier may offer, in connection with the health benefits plans required to be

offered by this section, any number of riders which may revise the coverage offered by the plans in any way, provided, however, that any form of such rider or amendment thereof which decreases benefits or decreases the actuarial value of one of the plans shall be filed for informational purposes with the board and for approval by the commissioner before such rider may be sold. Any rider or amendment thereof which adds benefits or increases the actuarial value of one of the plans shall be filed with the board for informational purposes before such rider may be sold. The added premium or reduction in premium for each rider, as applicable, shall be listed separately from the premium for the standard plan.

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

(cf: P.L.1994, c.102, s.1)

12. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to read as follows:

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 copayment per hospital stay;

Outpatient and ambulatory surgery- $250 copayment per surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Physicians' fees connected with outpatient and ambulatory surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

Intravenous solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Inpatient physical therapy and hydrotherapy;

Outpatient physical therapy - 30 visits annually per covered person- $20 copayment per treatment;

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate per covered person for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;
Special care unit;
Treatment room fees;
Emergency room services for medically necessary treatment - $100 copayment per visit;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for biologically-based mental illness, as defined in subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;
Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;
Wellness benefit - $600 annual aggregate per covered person, $50 annual deductible, 20% coinsurance per service; and
Physicians visits for diagnosed illness or injury - to a $700 annual aggregate per covered person.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network, including an exclusive provider organization, or the carrier's preferred provider organization; or (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with 30% coinsurance in addition to whatever other coinsurance may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to preexisting conditions, guaranteed issue, and calculation of loss ratio.

f. No later than one year following enactment of this act, every carrier shall make an informational filing with the **[**board**]** commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the **[**board**]** commissioner has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and shall make a good faith effort to market the contract or policy established pursuant to this section. A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.

(cf: P.L.2001, c.368, s.2)

13. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to read as follows:

4. In addition to the **[**five**]** health benefits plans offered by a carrier on the effective date of this act, a carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).

(cf: P.L.2001, c.368, s.4)

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

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

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

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

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

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

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

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

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

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

(4) **[**board**]** approval by the commissioner of a request by the individual carrier to cease doing business in the individual health benefits market. A carrier may not renew all individual health benefits plans only if the carrier: (a) first receives approval from the **[**board**]** commissioner; and (b) provides notice to each individual of the nonrenewal at least 180 days prior to the date of the expiration of such coverage. A carrier ceasing to do business in the individual health benefits market may not provide for the issuance of any health benefits plan in the individual **[**market**]** or small employer markets during the five-year period beginning on

the date of the termination of the last health benefits plan not so renewed; and

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

(cf. P.L.1997, c.146, s.3)

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

6. The **[**board**]** commissioner shall **[**establish**]** approve the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications to one or more plans as the board determines are necessary to make available a "high deductible health plan" or plans consistent with section 301 of Title III of the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical savings accounts, within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The **[**board**]** commissioner shall provide the **[**commissioner**]** board with an informational filing of the policy and contract forms and benefit levels it **[**establishes**]** approves.

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

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

(1) to an individual who has, under creditable coverage, with no intervening lapse in coverage of more than 31 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12-month preexisting condition limitation; or

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

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

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

e. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

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

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

(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the

form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a health benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this subsection that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

f. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

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

This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

g. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically

necessary benefits provided in-network which represent preventive care as permitted by that federal law.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection. This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2005, c.248, s.13)

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

8. a. **[**The board shall make application to the Hospital Rate Setting Commission on behalf of all carriers for approval of discounted or reduced rates of payment to hospitals for health care services provided under an individual health benefits plan provided pursuant to this act.**]** (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

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

c. A carrier shall not issue individual health benefits plans on a new contract or policy form pursuant to this act until an informational filing of a full schedule of rates which applies to the contract or policy form has been filed with the **[**board**]** commissioner. The **[**board**]** commissioner shall **[**forward**]** provide a copy of the informational filing to the **[**commissioner and the**]** Attorney General and the board.

d. **[**A carrier shall make an informational filing with the board of any change in its rates for individual health benefits plans pursuant to section 3 of this act prior to the date the rates become effective. The board shall file the informational filing with the commissioner and the Attorney General. If the carrier has filed all information required by the board, the filing shall be deemed to be complete.**]** A carrier desiring to increase or decrease premiums for any contract or policy form may implement that increase or decrease upon making an informational filing with the commissioner of that increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing that increase or decrease. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.161 (C.17B:27A-2 et seq.), or that the rates are inadequate or unfairly discriminatory.

e. (1) Rates shall be formulated on contracts or policies required pursuant to section 3 of this act so that the anticipated minimum loss ratio for a contract or policy form shall not be less than **[**75%**]** 80% of the premium. The carrier shall submit with its rate filing supporting data, as determined by the **[**board**]** commissioner, and a certification by a member of the American Academy of Actuaries, or other individuals in a format acceptable to the **[**board and to the**]** commissioner, that the carrier is in compliance with the provisions of this subsection.

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

Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the policy or contract forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161 (C.17:B:27A-4), at least 80% of the aggregate premiums collected for all of the policy or contract forms during that calendar year. Carriers shall annually report, no later than August 1 of each year, the loss ratio calculated pursuant to this section for all of the policy or contract forms for the previous calendar year. In each case in which the loss ratio fails to comply with the 80% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policy or contract holders, as applicable, in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits equal 80% of the aggregate premiums collected for the policy or contract forms in the previous calendar year. All dividends and credits shall be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this subsection shall include a carrier's calculation of the dividends and credits applicable to all policy or contract forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Those regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder.

f. **[**Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed pursuant to this section by a carrier which insured at least 50% of the community-rated individually insured persons on the effective date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required to produce a loss ratio which when combined with the carrier's

administrative costs and investment income results in self-sustaining rates prior to January 1, 1996, for individual policies or contracts issued prior to August 1, 1993. The carrier shall, not later than 30 days after the effective date of P.L.1994, c.102 (C.17B;27A-4 et al.), file with the board for approval, a plan to achieve this objective.**]** (Deleted by amendment, P.L., c. }(pending before the Legislature as this bill).

(cf: P.L.1994, c.102, s.2)

17. Section 10 of P.L.1992, c.161 (C.17B:27A-11) is amended to read as follows:

10. The program shall have the general powers and authority granted under the laws of New Jersey to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the program shall not have the power to issue health benefits plans directly to either groups or individuals.

The board shall have the specific authority to:

a. assess members their proportionate share of program losses and administrative expenses in accordance with the provisions of section 11 of this act, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

b. establish rules, conditions, and procedures pertaining to the sharing of program losses and administrative expenses among the members of the program;

c. **[**review rate applications and form filings submitted by carriers in accordance with this act;**]** (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

d. define the provisions of individual health benefits plans in accordance with the requirements of this act;

e. enter into contracts which are necessary or proper to carry out the provisions and purposes of this act;

f. establish a procedure for the joint distribution of information on individual health benefits plans issued pursuant to section 3 of this act;

g. establish, at the board's discretion, standards for the application of a means test for individual health benefits plans issued pursuant to section 3 of this act;

h. establish, at the board's discretion, reasonable guidelines for the purchase of new individual health benefits plans by persons who already are enrolled in or insured by another individual health benefits plan;

i. establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the program and provide for performance audits from time to time;

j. sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the program or a member;

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

l. borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets; and

m. contract for an independent actuary and any other professional services the board deems necessary to carry out its duties under P.L.1992, c.161 (C.17B:27A-2 et al.).

(cf: P.L.1993, c.164, s.6)

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

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

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

(a) every carrier issuing health benefits plans in this State shall file with the board its net earned premium for the preceding two-year calculation period; and

(b) every carrier issuing individual health benefits plans in the State shall file with the board the net earned premium on health benefits plans issued pursuant to paragraph (1) of subsection b. of section 2 and section 3 of this act and the claims paid. If the claims paid for all health benefits plans during the two-year calculation period exceed 115% of the net earned premium and any investment income thereon for the two-year calculation period, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this act.

(2) Every member shall be liable for an assessment to reimburse carriers issuing individual health benefits plans in this State which sustain net paid losses during the two-year calculation period, unless the member has received an exemption from the board pursuant to subsection d. of this section and has written a minimum number of non-group person life years as provided for in that subsection. The assessment of each member shall be in the proportion that the net earned premium of the member for the two-year calculation period preceding the assessment bears to the net earned premium of all members for the two-year calculation period preceding the assessment. Notwithstanding the provisions of this

subsection to the contrary, a medical service corporation or a hospital service corporation shall not be liable for an assessment to reimburse carriers which sustain net paid losses.

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

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

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

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

account the limitations on counting Medicaid recipients and Medicare cost and risk lives, and dividing the total by eight.

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

(3) The minimum number of non-group person life years required to be covered, as determined by the board, shall equal the total number of non-group person life years of community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives, of all carriers subject to this act for the two-year calculation period, multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for that two-year calculation period, including those carriers that are exempt from the assessment.

(4) On or before March 1 of the first year of each two-year calculation period, every carrier seeking an exemption pursuant to this subsection shall file with the board a statement of its net earned premium for the two-year calculation period. The board shall determine each carrier's minimum number of non-group person life years in accordance with this subsection.

(5) On or before March 1 of each year immediately following the close of a two-year calculation period, every carrier that was granted an exemption for the preceding two-year calculation period shall file with the board the number of non-group person life years, by category, covered for the two-year calculation period.

To the extent that the carrier has failed to cover the minimum number of non-group person life years established by the board, the carrier shall be assessed by the board on a pro rata basis for any differential between the minimum number established by the board and the actual number covered by the carrier.

(6) A carrier that applies for the exemption shall be deemed to be in compliance with the requirements of this subsection if it has covered 100% of the minimum number of non-group person life years required.

(7) Any carrier that writes both managed care and indemnity business that is granted an exemption pursuant to this subsection may satisfy its obligation to cover a minimum number of non-group person life years by issuing either managed care or indemnity business, or both.

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

f. The loss assessment for the two-year calculation period in which P.L. , c. (pending before the Legislature as this bill) takes

effect shall be the last loss assessment authorized under this section, and no further loss assessments shall be calculated or collected; provided, however, that nothing in this subsection shall relieve a carrier of its obligations for loss assessments authorized under this section prior to the effective date of P.L. , c. (pending before the Legislature as this bill).

(cf: P.L.1997, c.146, s.6)

19. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended to read as follows:

5. A domestic mutual insurer which has converted from a health service corporation pursuant to the provisions of sections 2 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48) shall not renew individual hospital or medical insurance policies or health service contracts originally issued prior to November 30, 1992, until it has made an informational filing with the **[**New Jersey Individual Health Coverage Program Board, of a full schedule of rates which are to apply to those contracts. The New Jersey Individual Health Coverage Program Board shall forward a copy of such filing to the**]** commissioner. The rates shall be formulated so that the anticipated minimum loss ratio for such policy or contract form shall not be less than **[**75%**]** 80% of the premium. Such domestic mutual insurer shall submit with its rate filing supporting data and a certification that the insurer is in compliance with the anticipated loss ratio requirement. The content and form of the supporting data and certification required pursuant to subsection e. of section 8 of P.L.1992, c.161 (C.17B:27A-9) shall satisfy the requirements of this section. Any other insurer may irrevocably elect to become subject to the provisions of this section by written notice to the commissioner**[**, except that such informational filing by any other insurer shall be**]** in a format specified by the commissioner **[**and shall be made directly to the commissioner and not to the New Jersey Individual Health Coverage Program Board**]**.

(cf: P.L.1995, c.196, s.5)

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

1. As used in this act:

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

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

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or part B of Title XVIII of the federal Social Security Act (42 U.S.C. s.1395 et seq.); Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (42 U.S.C.s.1396s); chapter 55 of Title 10, United States Code (10 U.S.C. 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health plan

offered under chapter 89 of Title 5, United States Code (5 U.S.C. s.8901 et seq.); a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e)); or coverage under any other type of plan as set forth by the commissioner by regulation.

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

"Department" means the Department of Banking and Insurance.

"Dependent" means the spouse, domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

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

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

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

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

"Group health plan" means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee

Retirement Income Security Act of 1974" (29 U.S.C.s.1002(1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health benefits plan" shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

"Health status-related factor" means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history;

genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

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

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

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

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

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

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

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

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

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, and the majority of the employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C.s.414) shall be treated as one employer. Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L.1992, c.162 (C.17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such employer.

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

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

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

a. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $20,000 per covered person per plan year; and

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

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

(cf: P.L.1997, c.146, s.7)

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

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

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

(3) Diagnostic tests, including X-rays;

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

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

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

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

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

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

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

e. **[**Notwithstanding the provisions of subsection a. of this section to the contrary, the board may approve a health benefits plan containing only medical-surgical benefits or major medical expense benefits, or a combination thereof, which is issued as a separate policy in conjunction with a contract of insurance for hospital expense benefits issued by a hospital service corporation, if the health benefits plan and hospital service corporation contract combined otherwise comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the contract combined may be allocated between the separate contracts at the discretion of the carrier and the hospital service corporation.**]** (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).

f. Notwithstanding the provisions of this section to the contrary, a health maintenance organization which is a qualified health maintenance organization pursuant to the "Health

Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.s.300e et seq.) shall be permitted to offer health benefits plans formulated by the board and approved by the commissioner which are in accordance with the provisions of that law in lieu of the **[**five**]** plans required pursuant to this section.

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

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

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

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

The commissioner shall disapprove any rider filed pursuant to this subsection that is unjust, unfair, inequitable, unreasonably discriminatory, misleading, contrary to law or the public policy of this State. The commissioner shall not approve any rider which reduces benefits below those required by sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and

required to be sold pursuant to this section. The commissioner's determination shall be in writing and shall be appealable.

(2) The benefit riders provided for in paragraph (1) of this subsection shall be subject to the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).

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

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

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

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

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

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

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

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

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

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

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

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

applicable, and shall comply with the provisions of sections 2 and 9 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

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

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

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

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

(10) In a case in which an association made available a health benefits plan on or before March 1, 1994 and subsequently changed

the issuing carrier between March 1, 1994 and the effective date of P.L.1995, c.340, the new issuing carrier shall be deemed to have been eligible to continue and renew the plan pursuant to paragraph (1) of this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

n. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)

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

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

(cf: P.L.2005, c.248, s.15)

22. Section 5 of P.L.2001, c.368 (C.17B:27A-19.11) is amended to read as follows:

5. In addition to the **[**five**]** standard health benefits plans offered by a carrier on the effective date of this act, a carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

(cf: P.L.2001, c.368, s.5)

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

7. Every policy or contract issued to small employers in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be

renewable with respect to all eligible employees or dependents at the option of the policy or contract holder, or small employer except that a carrier may discontinue or not renew a health benefits plan in accordance with the provisions of this section:

a. A carrier may discontinue such coverage only if:

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

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

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

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

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

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

(1) The carrier gives notice to cease doing business in the small employer market to the commissioner not later than eight months prior to the date of the planned withdrawal from the small **[**group market**]** <u>employer</u> market, during which time the carrier shall continue to be governed by this act with respect to business written pursuant to this act. For the purposes of this subsection, "date of withdrawal" means the date upon which the first notice to small employers is sent by the carrier pursuant to paragraph (2) of this subsection;

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

(3) Any carrier that ceases to do business pursuant to this act shall be prohibited from writing new business in the small employer **[**market**]** <u>and individual health benefits plan markets</u> for a period of five years from the date of termination of the last health insurance coverage not so renewed;

f. In the case of policies or contracts issued in connection with membership in an association or trust of employers, an employer ceases to maintain its membership in the association or trust, but

only if such coverage is terminated under this provision uniformly without regard to any health status-related factor relating to any covered individual.

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

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

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

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

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

(cf: P.L.1997, c.146, s.10)

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

8. Any small employer carrier may require a reasonable specified minimum participation <u>with the same carrier</u> of eligible employees, which shall not exceed 75%, or reasonable minimum employer contributions in determining whether to accept a small group pursuant to this act. The standards so established by the carrier shall be first approved by the board and shall be applied uniformly to all small groups, except that in no event shall a carrier require an employer to contribute more than 10% to the annual cost of the policy or contract, or an amount as otherwise provided by the board, and any minimum participation standards established by the carrier shall be reasonable. In establishing the percentage of employee participation, a one-to-one credit shall be given for each employee covered by a spouse's health benefits coverage, Medicare, Medicaid, NJ FamilyCare or another group health benefits plan. In calculating an employer's participation, the carrier shall include all insured employees, regardless of whether the employees chose an indemnity plan or a health maintenance organization, or a combination thereof.

(cf: P.L. 2005, c.166, s.1)

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

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

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

(3) For all policies or contracts providing health benefits plans for small employers issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19), and including policies or contracts offered by a carrier to a small employer who is a member of a Small Employer Purchasing Alliance pursuant to the provisions of P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19) shall not be greater than 200% 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, gender and geography, and provided further, that such factors are applied in a manner consistent with regulations adopted by the board. For the purposes of this paragraph (3), policies or contracts offered by a carrier to a small employer who is a member of a Small Employer Purchasing Alliance shall be rated separately from the carrier's other small employer health benefits policies or contracts.

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

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

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

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

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

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

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

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

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

A carrier which provides a health benefits plan to one or more small employers through a policy issued to an association or trust of employers after the effective date of P.L.1992, c.162 (C.17B:27A-

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

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

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

g. (1) Beginning January 1, 1995, a carrier desiring to increase or decrease premiums for any policy form or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19) subject to this act may implement such increase or decrease upon making an informational filing with the commissioner of such increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing such increase or decrease, provided that the anticipated minimum loss ratio for all policy forms shall not be less than **[**75%**]** 80% of the premium therefor as provided in paragraph (2) of this subsection. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are inadequate or unfairly discriminatory. Until December 31, 1996, the informational filing shall also include the carrier's rating plan and classification system in connection with such increase or decrease.

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the **[**five**]** standard policy forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19), at least **[**75%**]** 80% of the aggregate premiums collected for all of the standard policy forms, other than alliance policy forms, and at least **[**75%**]** 80% of the aggregate premiums collected for all of the non-standard policy forms during that calendar year. A carrier shall return at least **[**75%**]** 80% of the premiums collected for all of the alliances during that calendar year, which loss ratio may be calculated in the aggregate for all of the alliances or separately for each alliance. Carriers shall annually report, no later than August 1st of each year,

the loss ratio calculated pursuant to this section for all of the standard, other than alliance policy forms, non-standard policy forms and alliance policy forms for the previous calendar year, provided that a carrier may annually report the loss ratio calculated pursuant to this section for all of the alliances in the aggregate or separately for each alliance. In each case where the loss ratio fails to substantially comply with the [75%] 80% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with the standard, other than alliance policy forms, nonstandard policy forms or alliance policy forms, as applicable, in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal [75%] 80% of the aggregate premiums collected for the respective policy forms in the previous calendar year. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits applicable to standard, other than alliance policy forms, non-standard policy forms and alliance policy forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder. For purposes of this paragraph, "alliance policy forms" means policies purchased by small employers who are members of Small Employer Purchasing Alliances.

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

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

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

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

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

(cf: P.L.2003, c.163, s.1)

26. (New section) a. An insurance producer licensed pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.) who sells, solicits, or negotiates health insurance policies or contracts to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.

b. Upon seeking renewal of a license issued pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.), an insurance producer shall report to the Commissioner of Banking and Insurance, in a form and manner specified by the commissioner, how the producer is compensated for the sale, solicitation, or negotiation of health insurance policies and contracts, including the basis for determining a commission, service fee, brokerage, or other valuable consideration for the sale, solicitation, or negotiation of a health insurance policy or contract. The insurance producer shall provide such other information regarding compensation as the commissioner deems appropriate.

c. Notwithstanding the provisions of any law to the contrary, the commissioner shall not renew the license of an insurance producer who is subject to the provisions of this section unless the insurance producer provides the information required pursuant to this section.

d. The commissioner may specify, by regulation, the information that shall be provided by an insurance producer in the notification to a purchaser of health insurance and the procedure for providing the notification.

27. The Commissioner of Banking and Insurance shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt regulations necessary to implement the provisions of this act.

28. Sections 1 through 7 and 27 of this act shall take effect immediately and sections 8 through 26 of this act shall take effect on the 180th day after enactment and shall apply to all contracts and policies that are delivered, issued, executed or renewed or approved for issuance or renewal in this State on or after the effective date, but the Commissioner of Banking and Insurance may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

The purpose of this bill is to ensure that more residents in this State have access to affordable health care coverage. The bill achieves this goal by expanding the NJ FamilyCare Program to more low income parents, mandating that all children in the State have health care coverage either through public programs or private coverage, and adopting various reform measures to the individual and small employer insurance markets to increase the affordability of, and stabilize enrollment in, health benefits plans for individuals and small businesses. The provisions of this bill represent the first phase of a comprehensive reform of the health care system in this State which, when fully implemented, will ensure universal health care coverage for all residents of this State.

Health Care Coverage Reforms:

- To ensure that all children in the State are able to access health care, the bill establishes a "Kids First" mandate that requires all children 18 years of age and younger in the State to have health insurance coverage, beginning one year after the date of enactment of the bill. This coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid program, NJ FamilyCare Program, or the NJ FamilyCare Advantage buy-in program.
- To make health care coverage more accessible to low income parents, eligibility for the NJ FamilyCare Program is expanded to include parents whose income is up to 200% of the federal poverty level.
- In order to ensure that hospitals assess patients under 19 years of age who present at the hospital for emergency care as to whether they may be presumptively eligible for NJ FamilyCare or Medicaid, the bill prohibits hospitals from submitting charity care claims for these patients. The cost of emergency care for patients who are determined to be presumptively eligible for NJ FamilyCare or Medicaid is shared by the federal government and, therefore, this provision will ensure more effective use of the State's limited charity care funds for patient care that is not reimbursed by the federal government.
- In order to identify, and provide increased State outreach to, residents of the State who are uninsured and may be eligible to enroll in the Medicaid or NJ FamilyCare program, the bill establishes an ongoing enrollment initiative through the Department of the Treasury, in consultation with the Department of Human Services. Under the initiative, beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual taxpayer indicate on the taxpayer's income tax return whether the taxpayer and dependents, if applicable, has health insurance coverage on the

date of filing of the return. If a taxpayer reports that he or his dependents are uninsured, and the State Treasurer determines that based on the taxpayer's reported income the taxpayer or his dependents may be eligible for either Medicaid or NJ FamilyCare, the State Treasurer would to send the taxpayer an application for the Medicaid or NJ FamilyCare program, as applicable.

Individual and Small Employer Health Insurance Reforms:

The bill implements several reforms to the individual and small employer markets to make health benefits plans more affordable to individuals and small businesses in the State. Specifically, the bill:

- Seeks to make individual health benefits plans more affordable to younger persons, by revising the rating system for individual plans for new policies and contracts issued after the effective date of the bill, so that the premium rate differential can be up to 350%, but the only factor that the rating differential may be based on is the age of the person covered under the plan and the factor must be applied in a manner consistent with regulations of the Commissioner of Banking and Insurance, which include age classifications in a minimum of five-year increments. The bill provides, however, that in order to protect consumers who currently have coverage under an individual health benefits plan, rate increases for these consumers would be limited for the next five years to an amount no more than the lower of 15% or the medical trend assumption used by the carrier to project claims.
- Requires that a carrier must offer and make a good faith effort to market individual policies as a condition of participation in the small employer market, in order to ensure greater participation by carriers in the individual market.
- Reduces the number of standard plans that a carrier must offer in the individual and small employer markets from five to at least three plans.
- Authorizes carriers in the individual market to offer any number of riders which may revise the coverage offered by the standard plans in any way, but any form of such rider which decreases the actuarial value of one of the plans shall be filed for informational purposes with the board and for approval by the commissioner before any such rider may be sold. Any rider which adds benefits or increases the actuarial value of one of the plans shall be filed with the board or informational purposes before the rider may be sold. The additional premium for a rider shall be listed separately from the premium for the standard plan.
- Transfers regulatory oversight regarding approval of policy and contract forms, and review of premium rate filings and other similar matters, from the Individual Health Coverage Program Board to the Commissioner of Banking and Insurance, as is

currently provided in the New Jersey Small Employer Health Benefits Program.

- Requires carriers in the individual market to make an informational filing to the Commissioner of Banking and Insurance in the event the carrier seeks to increase or decrease premiums for any contract or policy form.
- Revises provisions concerning the minimum loss ratio for individual and small employer plans and provides that rates shall be formulated so that the anticipated minimum loss ratio is not less than 80% of the premium.
- Provides that after the effective date of the bill, no further loss assessments shall be calculated or collected, although carriers are not relieved of their obligations for loss assessments authorized prior to the effective date of the bill.
- Permits small employer carriers to require a reasonable specified minimum participation “with the same carrier” of eligible employees.
- Establishes transparency with respect to insurance broker fees by requiring insurance producers to notify a purchaser of insurance, in writing, of the amount of any commission, service fee, brokerage, other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. The bill also requires producers, as a condition of licensure by the Department of Banking and Insurance, to notify the department how the producer is compensated by carriers for the sale, solicitation or negotiation of the health insurance policy or contract.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 1557

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 15, 2008

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with amendments Senate Bill No. 1557.

As amended by committee, the purpose of this bill is to ensure that more residents in this State have access to affordable health care coverage. The bill achieves this goal by expanding the NJ FamilyCare Program to more low income parents, mandating that all children in the State have health care coverage either through public programs or private coverage, and adopting various reform measures to the individual and small employer insurance markets to increase the affordability of, and stabilize enrollment in, health benefits plans for individuals and small businesses. The provisions of this bill represent the first phase of a comprehensive reform of the health care system in this State which, when fully implemented, will ensure universal health care coverage for all residents of this State.

Health Care Coverage Reforms:

- To ensure that all children in the State are able to access health care, the bill establishes a "Kids First" mandate that requires all children 18 years of age and younger in the State to have health insurance coverage, beginning one year after the date of enactment of the bill. This coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid or NJ FamilyCare programs, or the NJ FamilyCare Advantage buy-in program.
- To make health care coverage more accessible to low income parents, eligibility for the NJ FamilyCare Program is expanded to include parents whose income is up to 200% of the federal poverty level.
- In order to ensure that hospitals assess patients under 19 years of age who present at the hospital for emergency care as to whether they may be presumptively eligible for NJ FamilyCare or Medicaid, the bill prohibits hospitals from submitting charity care claims for these patients. The cost of emergency care for patients who are

determined to be presumptively eligible for NJ FamilyCare or Medicaid is shared by the federal government and, therefore, this provision will ensure more effective use of the State's limited charity care funds for patient care that is not reimbursed by the federal government.

- In order to identify, and provide increased State outreach to, residents of the State who are uninsured and may be eligible to enroll in the Medicaid, NJ FamilyCare, or NJ FamilyCare Advantage buy-in programs, the bill establishes various enrollment and retention initiatives:

(1) The bill provides for an ongoing enrollment initiative through the Department of the Treasury, in consultation with the Department of Human Services. Under the initiative, beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual taxpayer indicate on the taxpayer's income tax return whether the taxpayer and dependents, if applicable, has health insurance coverage on the date of filing of the return. If a taxpayer reports that he or his dependents are uninsured, and the State Treasurer determines that based on the taxpayer's reported income the taxpayer or his dependents may be eligible for either Medicaid or NJ FamilyCare, the State Treasurer would be required to send the taxpayer an application for the Medicaid or NJ FamilyCare program, as applicable;

(2) The bill directs the Commissioner of Human Services to establish an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about the availability of, and benefits to enrolling in, Medicaid, NJ FamilyCare, and the NJ FamilyCare Advantage buy-in programs. The initiative shall include culturally sensitive, Statewide and local media public awareness campaigns addressing the availability of health care coverage for parents and children under the Medicaid and NJ FamilyCare programs and health care coverage for children under the NJ FamilyCare Advantage buy-in program. The initiative shall also include the provision of training and support services, upon request, to community groups, legislative district offices, and community-based health care providers to enable these parties to assist in enrolling parents and children in the applicable programs. The bill provides an appropriation of $1 million to the department for this purpose; and

(3) The bill directs the Commissioner of Human Services to establish an Outreach, Enrollment, and Retention Working Group to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare, or NJ Family Care Advantage, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs. The members of

the working group shall include: the Commissioners of Human Services, Health and Senior Services, Banking and Insurance, Labor and Workforce Development, Education, and Community Affairs, the Secretary of Agriculture, and the Child Advocate, or their designees, who shall serve ex officio; and six public members appointed by the Commissioner of Human Services who include one person each who represents racial and ethnic minorities in this State, managed care organizations that participate in the Medicaid and NJ FamilyCare programs, the vendor under contract with the Division of Medical Assistance and Health Services to provide NJ FamilyCare eligibility, enrollment, and health benefit coordinator services to the division, New Jersey Policy Perspective, the Association for Children of New Jersey, and Legal Services of New Jersey.

Individual and Small Employer Health Insurance Reforms:

The bill implements several reforms to the individual and small employer markets to make health benefits plans more affordable to individuals and small businesses in the State. Specifically, the bill:

- Seeks to make individual health benefits plans more affordable to younger persons, by revising the rating system for individual plans for new policies and contracts issued after the effective date of the bill, so that the premium rate differential can be up to 350%, but the only factor that the rating differential may be based on is the age of the person covered under the plan and the factor must be applied in a manner consistent with regulations of the Commissioner of Banking and Insurance, which shall include age classifications established, at a minimum, in five-year increments. The bill provides, however, that in order to protect consumers who currently have coverage under an individual health benefits plan, rate increases for these consumers would be limited for the next five years to an amount no more than the lower of 15% or the medical trend assumption used by the carrier to project claims.
- Requires that a carrier must offer and make a good faith effort to market individual policies as a condition of participation in the small employer market, in order to ensure greater participation by carriers in the individual market.
- Reduces the number of standard plans that a carrier must offer in the individual and small employer markets from five to at least three plans.
- Authorizes carriers in the individual market to offer any number of riders which may add benefits or increase the actuarial value of any of the standard plans. Any such rider shall be filed with the board for informational purposes before the rider may be sold. The additional premium for a rider shall be listed separately from the premium for the standard plan.

- Transfers regulatory oversight regarding approval of policy and contract forms, and review of premium rate filings and other similar matters, from the Individual Health Coverage Program Board to the Commissioner of Banking and Insurance, as is currently provided in the New Jersey Small Employer Health Benefits Program.
- Requires carriers in the individual market to make an informational filing to the Commissioner of Banking and Insurance in the event the carrier seeks to increase or decrease premiums for any contract or policy form.
- Revises provisions concerning the minimum loss ratio for individual and small employer plans and provides that rates shall be formulated so that the anticipated minimum loss ratio is not less than 80% of the premium.
- Provides that after the 2007-08 calculation period, no further loss assessments shall be calculated or collected in the Individual Health Coverage Program, although carriers are not relieved of their obligations for loss assessments authorized prior to the effective date of the bill.
- Establishes transparency with respect to insurance broker fees by requiring insurance producers (brokers and agents) to notify a purchaser of insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. The bill also provides that in the small employer market rates charged to a small employer may vary to reflect commissions actually paid to a producer, and these variations in rates that are attributable solely to commissions and other compensation are not subject to the 200% rating band limitations in section 9 of P.L.1992, c.162 (C.17B:27A-25).
- The "Kids First" initiative and expansion of NJ FamilyCare take effect immediately upon enactment of the bill, and the insurance reforms take effect 180 days after the date of enactment of the bill, except that the changes to the minimum loss ratio will take effect on January 1 next following enactment of the bill.

This bill is similar to Assembly Bill No. 2624 (Cohen) which is pending before the Assembly Financial Institutions and Insurance Committee.

The committee amended the bill to:

-- establish the Medicaid, NJ FamilyCare, and NJ FamilyCare Advantage outreach and enrollment initiative in the Department of Human Services;

--add an appropriation of $1 million to the Department of Human Services for the enrollment and retention initiative;

-- establish the Outreach, Enrollment, and Retention Working Group in the Department of Human Services;

-- restore language in section 2 of P.L.1992, c.161 (C.17B:27A-3) (that had been deleted in the bill) providing restrictions on persons who are eligible to participate in group health benefits plans who seek coverage under an individual health benefits plan;

-- delete language in the bill that would have permitted carriers in the Individual Health Coverage Program to offer riders that would decrease benefits or decrease the actuarial value of a standard plan;

-- provide that the loss assessment in the Individual Health Coverage Program for the 2007-08 two-year calculation period will be the last loss assessment under the program;

-- specify that the increase in the minimum loss ratio to 80% in both the Individual Health Coverage Program and Small Employer Health Benefits Program would take effect on January 1 next following the date of enactment of the bill;

-- delete section 24 of the bill which amended section 8 of P.L.1992, c.162 (C.17B:27A-24) to change provisions governing carrier participation rates in small employer health benefits plans, so that the current provisions concerning participation rates remain in effect;

-- add language to specify that rates in the small employer market may vary to reflect commissions and other compensation actually paid by an employer to an insurance producer, and that these variations in rates solely attributable to commissions and other compensation are not subject to the 200% rating band limitations in the statute; and

-- delete the requirement that an insurance producer report to the Commissioner of Banking and Insurance how the producer is compensated for the sale, solicitation, or negotiation of health insurance policies and contracts.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]
SENATE, No. 1557

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 19, 2008

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 1557 (1R), with committee amendments.

As amended, the purpose of this bill is to ensure that more residents in this State have access to affordable health care coverage. The bill achieves this goal by expanding the NJ FamilyCare Program to more low income parents, mandating that all children in the State have health care coverage either through public programs or private coverage, and adopting various reform measures to the individual and small employer insurance markets to increase the affordability of, and stabilize enrollment in, health benefits plans for individuals and small businesses. The provisions of this bill represent the first phase of a comprehensive reform of the health care system in this State which, when fully implemented, will ensure universal health care coverage for all residents of this State.

Health Care Coverage Reforms:

- To ensure that all children in the State are able to access health care, the bill establishes a "Kids First" mandate that requires all children 18 years of age and younger in the State to have health insurance coverage, beginning one year after the date of enactment of the bill. This coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid or NJ FamilyCare programs, or the NJ FamilyCare Advantage buy-in program.
- To make health care coverage more accessible to low income parents, eligibility for the NJ FamilyCare Program is expanded to include parents whose income is up to 200% of the federal poverty level.
- In order to ensure that hospitals assess patients under 19 years of age who present at the hospital for emergency care as to whether they may be presumptively eligible for NJ FamilyCare or Medicaid, the bill prohibits hospitals from submitting charity care claims for these patients. The cost of emergency care for patients who are determined to be presumptively eligible for NJ FamilyCare or

Medicaid is shared by the federal government and, therefore, this provision will ensure more effective use of the State's limited charity care funds for patient care that is not reimbursed by the federal government.

- In order to identify, and provide increased State outreach to, residents of the State who are uninsured and may be eligible to enroll in the Medicaid, NJ FamilyCare, or NJ FamilyCare Advantage buy-in programs, the bill establishes various enrollment and retention initiatives:

(1) The bill provides for an ongoing enrollment initiative through the Department of the Treasury, in consultation with the Department of Human Services. Under the initiative, beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual who files a resident New Jersey Gross Income Tax return indicate on the return whether the taxpayer and dependents, if applicable, has health insurance coverage on the date of filing of the return. If a taxpayer reports that he or his dependents are uninsured, and the State Treasurer determines that based on the taxpayer's reported income the taxpayer or his dependents may be eligible for either Medicaid or NJ FamilyCare, the State Treasurer would be required to send the taxpayer an application for the Medicaid or NJ FamilyCare program, as applicable;

(2) The bill directs the Commissioner of Human Services to establish an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about the availability of, and benefits to enrolling in, Medicaid, NJ FamilyCare, and the NJ FamilyCare Advantage buy-in programs. The initiative shall include culturally sensitive, Statewide and local media public awareness campaigns addressing the availability of health care coverage for parents and children under the Medicaid and NJ FamilyCare programs and health care coverage for children under the NJ FamilyCare Advantage buy-in program. The initiative shall also include the provision of training and support services, upon request, to community groups, legislative district offices, and community-based health care providers to enable these parties to assist in enrolling parents and children in the applicable programs. The bill provides an appropriation of $1 million to the department for this purpose; and

(3) The bill directs the Commissioner of Human Services to establish an Outreach, Enrollment, and Retention Working Group to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare, or NJ Family Care Advantage, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs. The members of the working group shall include: the Commissioners of Human

Services, Health and Senior Services, Banking and Insurance, Labor and Workforce Development, Education, and Community Affairs, the Secretary of Agriculture, and the Child Advocate, or their designees, who shall serve ex officio; and six public members appointed by the Commissioner of Human Services who include one person each who represents racial and ethnic minorities in this State, managed care organizations that participate in the Medicaid and NJ FamilyCare programs, the vendor under contract with the Division of Medical Assistance and Health Services to provide NJ FamilyCare eligibility, enrollment, and health benefit coordinator services to the division, New Jersey Policy Perspective, the Association for Children of New Jersey, and Legal Services of New Jersey.

Individual and Small Employer Health Insurance Reforms:

The bill implements several reforms to the individual and small employer markets to make health benefits plans more affordable to individuals and small businesses in the State. Specifically, the bill:

- Seeks to make individual health benefits plans more affordable to younger persons, by revising the rating system for individual plans for new policies and contracts issued after the effective date of the bill, so that the premium rate differential can be up to 350%, but the only factor that the rating differential may be based on is the age of the person covered under the plan and the factor must be applied in a manner consistent with regulations of the Commissioner of Banking and Insurance, which shall include age classifications established, at a minimum, in five-year increments. The bill provides, however, that in order to protect consumers who currently have coverage under an individual health benefits plan, rate increases for these consumers would be limited for the next five years to an amount no more than the lower of 15% or the medical trend assumption used by the carrier to project claims.
- Requires that a carrier must offer and make a good faith effort to market individual policies as a condition of participation in the small employer market, in order to ensure greater participation by carriers in the individual market.
- Reduces the number of standard plans that a carrier must offer in the individual and small employer markets from five to at least three plans.
- Authorizes carriers in the individual market to offer any number of riders which may add benefits or increase the actuarial value of any of the standard plans. Any such rider shall be filed with the board for informational purposes before the rider may be sold. The additional premium for a rider shall be listed separately from the premium for the standard plan.
- Transfers regulatory oversight regarding approval of policy and contract forms, and review of premium rate filings and other similar

matters, from the Individual Health Coverage Program Board to the Commissioner of Banking and Insurance, as is currently provided in the New Jersey Small Employer Health Benefits Program.

- Requires carriers in the individual market to make an informational filing to the Commissioner of Banking and Insurance in the event the carrier seeks to increase or decrease premiums for any contract or policy form.
- Revises provisions concerning the minimum loss ratio for individual and small employer plans and provides that rates shall be formulated so that the anticipated minimum loss ratio is not less than 80% of the premium.
- Provides that after the 2007-08 calculation period, no further loss assessments shall be calculated or collected in the Individual Health Coverage Program, although carriers are not relieved of their obligations for loss assessments authorized prior to the effective date of the bill.
- Establishes transparency with respect to insurance broker fees by requiring insurance producers (brokers and agents) to notify a purchaser of insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. The bill also provides that in the small employer market rates charged to a small employer may vary to reflect commissions actually paid to a producer, and these variations in rates that are attributable solely to commissions and other compensation are not subject to the 200% rating band limitations in section 9 of P.L.1992, c.162 (C.17B:27A-25).
- The "Kids First" initiative and expansion of NJ FamilyCare take effect immediately upon enactment of the bill, and the insurance reforms take effect 180 days after the date of enactment of the bill, except that the changes to the minimum loss ratio will take effect on January 1 next following enactment of the bill.

COMMITTEE AMENDMENTS:

The committee adopted technical amendments to the bill to clarify which tax returns the State Treasurer should review with respect to the ongoing enrollment initiative, and to specify in R.S.54:50-9 that authority for examination of certain tax records and files by the Commissioner of Human Services is for the purpose of eligibility determination in the Medicaid and NJ FamilyCare programs.

FISCAL IMPACT:

The Office of Legislative Services is unable to independently estimate the cost of this legislation; however, information provided to the committee by the Department of Human Services indicates that the bill, as amended and with the outreach and enrollment campaign as

provided in the bill, would result in State costs of $11.9 million in FY 2009, $40.5 million in FY 2010 and $68.0 million in FY 2011, resulting in total costs over the three year period of $120.5 million. Specifically, the department's estimates for program enrollment and costs is as follows:

Additional State Enrollment and *Costs if Parent Expansion plus Outreach Campaign							
	Children		Parents		Total		
	Enrolled	State Costs	Enrolled	State Costs	Enrolled	State Costs	
SFY08	-	-	-	-	-	$	-
SFY09	11,111	$ 2,838,969	17,844	$ 9,104,352	28,954	$	11,943,321
SFY10	15,962	$ 8,003,130	37,667	$ 32,511,666	53,629	$	40,514,795
SFY11	19,806	$ 11,096,106	57,668	$ 56,944,850	77,474	$	68,040,956
3-YEAR TOTAL		$ 21,938,205		$ 98,560,868		$	120,499,073

*Costs do not include expenditures associated with an outreach campaign estimated to be between $3m and $5m state share

Costs and enrollment for Parent Expansion and Outreach include the costs of the Parent Expansion only estimates.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[Second Reprint]
SENATE, No. 1557

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 19, 2008

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 1557 (2R), with committee amendments.

As amended by committee, the purpose of this bill is to ensure that more residents in this State have access to affordable health care coverage. The bill achieves this goal by: expanding the NJ FamilyCare Program to more low income parents; mandating that all children in the State have health care coverage either through public programs or private coverage; adopting various reform measures to the individual and small employer insurance markets to increase the affordability of, and stabilize enrollment in, health benefits plans for individuals and small businesses; and making various changes to the eligibility criteria, terms, and administration of continued dependent coverage for dependents 30 years of age or younger, initially mandated pursuant to P.L.2005, c.375 (C.17:48-6.19 et al.).

The provisions of this bill represent the first phase of a comprehensive reform of the health care system in this State which, when fully implemented, will ensure universal health care coverage for all residents of this State.

Health Care Coverage Reforms:

- To ensure that all children in the State are able to access health care, the bill establishes a “Kids First” mandate that requires all children 18 years of age and younger in the State to have health insurance coverage, beginning one year after the date of enactment of the bill. This coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid or NJ FamilyCare programs, or the NJ FamilyCare Advantage buy-in program.
- To make health care coverage more accessible to low income parents, eligibility for the NJ FamilyCare Program is expanded to include parents whose income is up to 200% of the federal poverty level.
- To ensure that the cost of the premium for coverage of a child in the NJ FamilyCare program does not present a hardship for the child’s

parent or caretaker, the bill directs the Commissioner of Human Services to establish a hardship waiver for part or all of the premium for an eligible child under the NJ FamilyCare program.

- In order to ensure that hospitals assess patients under 19 years of age who present at the hospital for emergency care as to whether they may be presumptively eligible for NJ FamilyCare or Medicaid, the bill prohibits hospitals from submitting charity care claims for these patients. The cost of emergency care for patients who are determined to be presumptively eligible for NJ FamilyCare or Medicaid is shared by the federal government and, therefore, this provision will ensure more effective use of the State's limited charity care funds for patient care that is not reimbursed by the federal government.
- In order to identify, and provide increased State outreach to, residents of the State who are uninsured and may be eligible to enroll in the Medicaid, NJ FamilyCare, or NJ FamilyCare Advantage buy-in programs, the bill establishes various enrollment and retention initiatives:

  (1) The bill provides for an ongoing enrollment initiative with the Department of the Treasury and the Department of Human Services (DHS). Under the initiative, beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual who files a resident New Jersey Gross Income Tax return indicate on the return whether the taxpayer and dependents, if applicable, has health insurance coverage on the date of filing of the return. The State Treasurer would transmit to DHS information permitting DHS to identify taxpayers who are uninsured and may be eligible to enroll in the Medicaid or NJ FamilyCare program. DHS would use this information in furtherance of its Medicaid and NJ FamilyCare outreach and enrollment initiative established pursuant to section 26 of the bill, and described below.

  (2) The bill directs the Commissioner of Human Services to establish an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about the availability of, and benefits to enrolling in, Medicaid, NJ FamilyCare, and the NJ FamilyCare Advantage buy-in programs. The initiative shall include culturally sensitive, Statewide and local media public awareness campaigns addressing the availability of health care coverage for parents and children under the Medicaid and NJ FamilyCare programs and health care coverage for children under the NJ FamilyCare Advantage buy-in program. The initiative shall also include the provision of training and support services, upon request, to community groups, legislative district offices, and community-based health care providers to enable these parties to assist in enrolling parents and children in the applicable programs. The bill provides an appropriation of $1 million to the department for this purpose; and

(3) The bill directs the Commissioner of Human Services to establish an Outreach, Enrollment, and Retention Working Group to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare, or NJ Family Care Advantage, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs. The members of the working group shall include: the Commissioners of Human Services, Health and Senior Services, Banking and Insurance, Labor and Workforce Development, Education, and Community Affairs, the Secretary of Agriculture, and the Child Advocate, or their designees, who shall serve ex officio; and six public members appointed by the Commissioner of Human Services who include one person each who represents racial and ethnic minorities in this State, managed care organizations that participate in the Medicaid and NJ FamilyCare programs, the vendor under contract with the Division of Medical Assistance and Health Services to provide NJ FamilyCare eligibility, enrollment, and health benefit coordinator services to the division, New Jersey Policy Perspective, the Association for Children of New Jersey, and Legal Services of New Jersey.

Individual and Small Employer Health Insurance Reforms:

The bill implements several reforms to the individual and small employer markets to make health benefits plans more affordable to individuals and small businesses in the State. Specifically, the bill:

- Seeks to make individual health benefits plans more affordable to younger persons, by revising the rating system for individual plans for new policies and contracts issued after the effective date of the bill, so that the premium rate differential can be up to 350%, but the only factor that the rating differential may be based on is the age of the person covered under the plan and the factor must be applied in a manner consistent with regulations of the Commissioner of Banking and Insurance, which shall include age classifications established, at a minimum, in five-year increments. The bill provides, however, that in order to protect consumers who currently have coverage under an individual health benefits plan, or who are 55 years of age or older and newly purchase an individual health benefits plan, rate increases for these consumers would be limited for the next four years to an amount no more than the lower of 15% or the medical trend assumption used by the carrier to project claims.
- Requires that a carrier must offer and make a good faith effort to market individual policies as a condition of participation in the small employer market, in order to ensure greater participation by carriers in the individual market.

- Reduces the number of standard plans that a carrier must offer in the individual and small employer markets from five to at least three plans.
- Authorizes carriers in the individual market to offer any number of riders which may add benefits or increase the actuarial value of any of the standard plans. Any such rider shall be filed with the board for informational purposes before the rider may be sold. The additional premium for a rider shall be listed separately from the premium for the standard plan.
- Transfers regulatory oversight regarding approval of policy and contract forms, and review of premium rate filings and other similar matters, from the Individual Health Coverage Program Board to the Commissioner of Banking and Insurance, as is currently provided in the New Jersey Small Employer Health Benefits Program.
- Requires carriers in the individual market to make an informational filing to the Commissioner of Banking and Insurance in the event the carrier seeks to increase or decrease premiums for any contract or policy form.
- Revises provisions concerning the minimum loss ratio for individual and small employer plans and provides that rates shall be formulated so that the anticipated minimum loss ratio is not less than 80% of the premium.
- Provides that after the 2007-08 calculation period, no further loss assessments shall be calculated or collected in the Individual Health Coverage Program, although carriers are not relieved of their obligations for loss assessments authorized prior to the effective date of the bill.
- Establishes transparency with respect to insurance broker fees by requiring insurance producers (brokers and agents) to notify a purchaser of insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract.
- The "Kids First" initiative and expansion of NJ FamilyCare take effect immediately upon enactment of the bill, and the insurance reforms take effect 180 days after the date of enactment of the bill, except that the changes to the minimum loss ratio will take effect on January 1 next following enactment of the bill.

Dependent Coverage for Dependents 30 Years of Age or Younger Reforms:

The bill makes various changes to the eligibility criteria, terms, and administration of continued dependent coverage for dependents 30 years of age or younger, initially mandated pursuant to P.L.2005, c.375 (C.17:48-6.19 et al.). Specifically, the bill:

- Requires proof of prior, creditable health benefits coverage or receipt of benefits from another group or individual benefits

coverage source to be eligible to elect or subsequently reinstate continued dependent coverage.

- Provides that once an individual elects dependent coverage, that coverage shall not terminate before the individual reaches age 31. The cut off for electing coverage, as with the current law, remains 30 years of age, but the bill clarifies that the dependent coverage shall remain in effect while the individual is 30 years of age.
- To increase awareness of continued dependent coverage, requires health insurers and the State Health Benefits Program (SHBP) to provide notice to the parents of dependents (as covered persons under the insurance contracts) in the certificates of coverage or other equivalent documents prepared and delivered on or about the date parents' coverage commences, and on a quarterly basis thereafter. Provisions requiring employers to provide notices of coverage are eliminated in recognition that employers may have no obligation to comply with the notice requirements due to federal preemption concerning such matters provided by the "Employee Retirement Income Security Act of 1974," Pub.L.93-406 (29 U.S.C. s.1001 et seq.).
- With respect to the SHBP only, establishes that the State Health Benefits Commission may require payment of a premium by dependents or their parents, which shall be capped, for any period of continued dependent coverage under one of its contracts. The premium cannot exceed 102% of the applicable "dependent portion" of the premium previously paid for a dependent's coverage under a contract prior to the dependent initially aging out of coverage under the contract. The calculation of this premium cap is identical to the calculation of the 102% premium cap on continued dependent coverage already established for health insurers pursuant to P.L.2005, c.375 (C.17:48-6.19 et al.).

COMMITTEE AMENDMENTS:

The committee amended the bill to:

-- establish a hardship waiver for all or part of the premium for a child under the NJ FamilyCare program;

--coordinate the Department of the Treasury/Department of Human Services (DHS) Medicaid and NJ FamilyCare enrollment initiative established in section 7 of the bill with the enrollment initiative established in section 26 of the bill, by providing that the Department of the Treasury would transmit to DHS information permitting DHS to identify taxpayers who are uninsured and may be eligible for Medicaid or NJ FamilyCare, rather than requiring the Department of the Treasury to administer a separate enrollment initiative;

-- extend the limitation on rate increases provided to current policyholders under section 10 of the bill (for a four-year period, increases are limited to an amount no more than the lower of 15% or the medical trend assumption used by the carrier to project claims) to

include persons who are 55 years of age or older and newly purchase an individual health benefits plan, and reduce the period for the rate increase limitation from five years to four years;

-- restore language in section 2 of P.L.1992, c.161 (C.17B:27A-3) (that had been deleted in the bill) concerning health benefits plans issued prior to August 1, 1993;

-- delete the provision in section 24 of the bill that would have permitted premium rates to differ based on the actual compensation paid to an insurance producer; and

-- amend the provisions of P.L.2005, c.375 concerning coverage for dependents 30 years of age or younger, for health insurers and the State Health Benefits Program to alter the eligibility criteria, terms and administration of the coverage.

As amended by committee, this bill is identical to Assembly Bill No. 2624 ACA (Cohen/Greenwald/Ramos).

FISCAL IMPACT:

Assuming a start date of September 2008 for the program expansion provided in the bill as amended, State expenditures are projected to increase by $8.0 million in FY 2009. In anticipation of the bill's enactment, the FY 2009 State appropriations bill, Senate Bill No. 2009, includes the $8 million in State funds needed for program expansion. (The appropriation increase for NJ Family Care was proposed in Administration Budget Resolution No. 166.2.)

LEGISLATIVE FISCAL ESTIMATE

[Third Reprint]

SENATE, No. 1557

STATE OF NEW JERSEY
213th LEGISLATURE

DATED: JUNE 26, 2008

SUMMARY

Synopsis: Expands NJ FamilyCare, establishes mandate for health care coverage of children, and makes various reforms to individual and small employer insurance markets; appropriates $1,000,000.

Type of Impact: Increase in costs to the Department of Human Services due to the expansion of NJ FamilyCare to parents with income up to 200 percent of the federal poverty level (FPL).

Agencies Affected: The Departments of Health and Senior Services, Human Services, and Treasury.

Office of Legislative Services Estimate

Fiscal Impact	Years 1 - 3
State Cost	**Parents**. Expanding NJ FamilyCare to parents with income of between 133 percent and 200 percent FPL will increase program costs. As the number of parents that will enroll in the program is not known, costs cannot be determined. However, based on current costs associated with parents in NJ FamilyCare, for every 10,000 additional parents that are phased-into NJ FamilyCare, program costs will total about $14.5 million (gross) or $5.1 million (State). **Presumptive Eligibility**. Mandating presumptive eligibility under Medicaid or NJ FamilyCare for emergency care provided by hospitals to children under the age of 19 may transfer approximately $29.5 million in Charity Care costs to the Medicaid/NJ FamilyCare program. In subsequent years, the amount of Charity Care provided to children under the age of 19 should be reduced, as many of these children may be eligible for Medicaid, NJ FamilyCare or other private health insurance, as provided in this bill.
State Revenue	**Federal Reimbursement** of either 50 percent or 65 percent will be available to offset gross program expenditures.

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- **Kids First Mandate**. There is no direct fiscal impact on the Medicaid/NJ FamilyCare programs as these programs already cover children with household income up to 350 percent FPL. The recommended FY 2009 budget provides $187.6 million (gross) for costs associated with children in the NJ FamilyCare program. To the extent that program costs of children in NJ FamilyCare exceed $187.6 million, additional State funds would be required.

- **Charity Care:** Establishing Medicaid and NJ FamilyCare presumptive eligibility for children under the age of 19 who receive emergency care in hospitals, expanding NJ FamilyCare eligibility to parents with income between 133 percent and 200 percent FPL, and making health insurance more affordable to individuals, families, and small businesses, should reduce the amount of documented Charity Care provided by hospitals. To the extent that State Charity Care appropriations are reallocated to support an increase in Medicaid and NJ FamilyCare costs, overall program costs would be reduced.

- **Premiums:** Households with income greater than 150 percent FPL would be required to pay a monthly premium based on household income. Any premiums that are collected would reduce overall program costs.

- New Jersey could experience developments similar to those in Massachusetts where State costs are significantly greater than initially estimated due to higher program enrollment.

- The various health insurance reforms in the bill affecting the individual and small insurance markets and dependent coverage up to age 30 will not have an impact on State costs.

BILL DESCRIPTION

Senate Bill No. 1557 (3R) of 2008:

- Establishes a “Kids First” mandate that requires all children 18 years of age and younger to have health insurance coverage, beginning one year after the date of enactment of the bill. This coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid program, NJ FamilyCare Program, or the NJ FamilyCare Advantage buy-in program (administered by Horizon Blue Cross Blue Shield of New Jersey).
- Expands eligibility for the NJ FamilyCare Program to include parents whose income is between 133 percent and 200 percent FPL.
- Prohibits hospitals from submitting charity care claims for emergency services provided to patients under the age of 19 and provides that .presumptive eligibility for NJ FamilyCare or Medicaid would be extended to these patients, and hospitals would be required to bill those programs for the cost of emergency care provided to such patients.
- Establishes an ongoing enrollment initiative with the Department of the Treasury and the Department of Human Services (DHS), and an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about enrollment in Medicaid, NJ FamilyCare, and the NJ FamilyCare Advantage buy-in programs, and appropriates $1.0 million to DHS to carry out the initiatives.

- Adopts various health insurance reforms affecting the individual and small insurance markets, and dependent coverage up to age 30, which will not have an impact on State costs.

FISCAL ANALYSIS

EXECUTIVE BRANCH

Although no formal fiscal information was provided to the Office of Legislative Services, DHS submitted fiscal information to the Senate Budget and Appropriations Committee related to the expansion of NJ FamilyCare to parents with income up to 200 percent FPL, and the expansion of NJ FamilyCare with an enhanced outreach campaign, as summarized below:

Expansion to parents with income up to 200% FPL

An additional 8,200, 10,700 and 12,100 children would be enrolled in NJ FamilyCare over current estimates if the program is expanded to parents with income up to 200 percent FPL in FY 2009, 2010 and 2011, respectively. State costs would increase by about $1.9 million, $5.2 million and $6.3 million in each year, respectively.

An additional 13,700, 27,600 and 40,200 adults with income up to 200 percent FPL would be enrolled in NJ FamilyCare in FY 2009, 2010 and 2011, respectively. State costs would increase by about $6.9 million, $24.1 million and $40.0 million in each year, respectively.

Expansion to parents with income up to 200% FPL plus outreach campaign

An additional 11,100, 16,000 and 19,800 children would be enrolled in NJ FamilyCare over current estimates in FY 2009, 2010 and 2011, respectively. State costs would increase by about $2.8 million, $8.0 million and $11.1 million in each year, respectively.

An additional 17,800, 37,700 and 57,700 adults with income up to under 200 percent FPL would be enrolled in NJ FamilyCare over current estimates in FY 2009, 2010 and 2011, respectively. State costs would increase by about $9.1 million, $32.5 million and $56.9 million in each year, respectively.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services can neither confirm or refute fiscal information provided by DHS to the Senate Budget and Appropriations Committee. It is noted, however, that prior DHS estimates as to the number of children and adults enrolled in NJ FamilyCare have not been realized even with marketing and outreach initiatives intended to increase enrollment.

Many of the provisions of the legislation affect the individual and small employer health insurance markets. Such changes have no impact on State costs and will not be considered in this analysis.

Kids First Mandate

The **Medicaid and NJ FamilyCare** programs already provide coverage to children with household income of up to 350 percent FPL. As such, there is no additional cost to the Medicaid/NJ FamilyCare programs as a result of the mandate that all children be covered by health insurance. The FY 2009 recommended budget includes $187.6 million (gross) to provide coverage to children under NJ FamilyCare.

To the extent that either the FY 2009 recommended budget is not adequate due to either an increase in the number of children eligible for NJ FamilyCare or an increase in program costs, additional funds would be required. Based on the average cost of $136 per child (July 2007 - March 2008), a range of possible State costs can be calculated should the number of children enrolled in NJ FamilyCare exceed FY 2009 budget estimates. Actual State costs will depend on whether a federal match of 50% or 65 percent is available:

Number of Additional Children Enrolled (Phased in)	Annual Gross Costs ($000)	Federal Match of 50% and 65% ($000)	State Costs at Federal Match of 50% and 65% ($000)
10,000	$7,707	$3,853 - $5,009	$3,853 - $2,697
25,000	$19,267	$9,633 - $12,523	$9,633 - $6,743
50,000	$38,533	$19,267 – 25,047	$19,267 - $13,487

The above costs will be reduced through the collection of premiums from families with income greater than 150 percent FPL and through third party liability recoveries from other health insurance coverage a family may have. The amount of premiums that may be collected and the amount of third party liability recoveries that may be realized will not be known until such children enroll in NJ FamilyCare.

NJ FamilyCare Advantage: At present, there are no State costs associated with the program that is available to children in households with income greater than 350 percent FPL, as Horizon Blue Cross Blue Shield of New Jersey subsidizes program costs in excess of the amount of premiums collected. At present, there are fewer than 50 families participating in the program.

NJ FamilyCare Parent Expansion from 133% to 200% FPL

At present, there are about 44,000 children in the NJ FamilyCare program with family income between 133 percent and 200 percent FPL. Although information is not readily available as to the number of parents associated with the 44,000 children, the average cost to cover parents in the NJ FamilyCare program is $255 per person (July 2007 - March 2008). Based on this cost information, a range of possible costs can be calculated:

Number of Adults Enrolled (Phased In)	Annual Gross Costs ($000)	Federal Match at 65% ($000)	State Costs ($000)
10,000	$14,450	$9,3936	$5,058
25,000	$19,167	$12,523	$6,7434
50,000	$38,533	$25,0472	$13,487
75,000	$57,800	$37,570	$20,230

The above costs will be reduced due to the collection of premiums from adults and through third party liability recoveries from other health insurance coverage an adult may have. The amount of premiums and the amount of third party liability recoveries that may be realized cannot be determined.

Charity Care

Presumptive Eligibility: The legislation would extend presumptive eligibility to all children under the age of 19 for emergency care provided at hospitals, and prohibit hospitals from submitting claims for Charity Care for these patients.

Hospitals provide upwards of $950 million in Charity Care (at Medicaid reimbursement amounts). Approximately 3.1 percent of Charity Care expenditures are incurred by patients under the age of 19 (DeLia, Evaluation of the Hospital Charity Care Program in New Jersey, Table 3. Rutgers Center for State Health Policy, January 2007). Thus, upwards of $29.5 million in Charity Care costs would be shifted to and paid by the Medicaid and NJ FamilyCare programs. At a federal matching rate of either 50 percent or 65 percent, State costs would range from about $10.3 million to $14.8 million.

To the extent that additional children and adults obtain health insurance through either Medicaid, NJ FamilyCare, NJ FamilyCare Advantage, or other health insurance and do not have to rely on the Charity Care program, the amount of documented Charity Care provided by hospitals would be reduced. The amount of this reduction cannot be determined.

Section:	*Human Services*
Analyst:	*Jay A. Hershberg* *Principal Fiscal Analyst*
Approved:	*David J. Rosen* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L. 1980, c.67 (C. 52:13B-1 et seq.).

ASSEMBLY, No. 2624

STATE OF NEW JERSEY

213th LEGISLATURE

INTRODUCED MAY 12, 2008

Sponsored by:
Assemblyman NEIL M. COHEN
District 20 (Union)
Assemblyman LOUIS D. GREENWALD
District 6 (Camden)
Assemblyman RUBEN J. RAMOS, JR.
District 33 (Hudson)

SYNOPSIS

Expands NJ FamilyCare, establishes mandate for health care coverage of children, and makes various reforms to individual and small employer insurance markets.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 6/13/2008)

AN ACT concerning health care coverage and revising parts of statutory law.

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

1. (New section) The Legislature finds and declares:

a. There are an estimated 1.25 million residents of the State who have no health insurance coverage, of which over 240,000 are children, and the number of uninsured residents is increasing each year;

b. While employer-sponsored health care coverage in the State is well above the national average and has been a major factor in keeping the number of uninsured lower than in many states, because of the rising cost of the coverage, increasing numbers of employers are considering dropping coverage for their employees and dependents, or are requiring employees to share in a greater percentage of premium costs and to bear larger copayments and coinsurance, which is making health care coverage increasingly unaffordable to low and moderate income working families;

c. Persons without health insurance coverage receive less preventive care, poorer treatment for both minor and serious chronic and acute illnesses, and in many cases live shorter lives than comparable insured populations;

d. Many uninsured are forced to seek health care in inappropriate settings such as hospital emergency rooms because they cannot obtain needed health care services in a convenient and more cost-effective setting such as a primary care provider's office or clinic, which contributes to higher health care costs;

e. The uninsured are commonly billed at higher rates than those who have health care coverage. Health care costs have become a leading cause of bankruptcy in this country, and those without insurance are most at risk;

f. The State has recognized the importance of increasing access to health care coverage and, over the last several years, has enacted several reforms to make health care coverage more affordable and accessible to residents of the State. Among these reforms are the expansions of coverage under the State Medicaid and NJ FamilyCare programs. Despite these efforts, too many low income parents and children lack access to health care coverage;

g. In order to ensure that more low income parents in the State have access to health care coverage and all children in the State are covered under a health plan, thus moving closer to providing universal coverage for all residents of this State, it is necessary to further expand coverage for parents under the NJ FamilyCare

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 <u>thus</u> is new matter.

Program, and mandate that all children in the State have health care coverage, either through public programs or private coverage; and

h. In order to make insurance coverage more affordable to residents and small businesses in this State, and to stabilize enrollment in, and the costs of, individual and small employer health benefits plans, it is also necessary to adopt comprehensive reform measures to the insurance marketplace.

2. (New section) a. Beginning one year after the date of enactment of this act, all residents of this State 18 years of age and younger shall obtain and maintain health care coverage that provides hospital and medical benefits. The coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid program, NJ FamilyCare Program, or the NJ FamilyCare Advantage buy-in program.

b. As used in this section:

“Medicaid” means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

“NJ FamilyCare” means the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

“NJ FamilyCare Advantage” means the buy-in program established pursuant to subsection j. of section 5 of P.L.2005, c.156 (C.30:4J-12).

3. Section 4 of P.L.2005, 156 (C.30:4J-11) is amended to read as follows:

4. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" or "program" means the NJ FamilyCare Program established pursuant to sections 3 through 5 of P.L.2005, 156 (C.30:4J-10 though C.30:4J-12).

"Poverty level" means the official federal poverty level based on family size, established and adjusted under Section 673(2) of Subtitle B, the "Community Services Block Grant Act," Pub.L.97-35 (42 U.S.C. s.9902(2)).

"Qualified applicant" means:

a. a child under 19 years of age: (1) whose family gross income does not exceed 350% of the poverty level; (2) who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States;

b. a parent or caretaker: (1) whose gross family income does not exceed 200% of the poverty level; (2) [who is enrolled in NJ FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et al.); (3)] who has no health insurance, as determined by the commissioner, and is ineligible for Medicaid; [(4)] (3) who is a resident of this State; and [(5)] (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States; and

c. a single adult or couple without dependent children: (1) whose family gross income does not exceed 100% of the poverty level; (2) who is enrolled in NJ FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et al.) and is ineligible for Medicaid; (3) who is a resident of this State; and (4) who is a citizen of the United States, or has been lawfully admitted for permanent residence into and remains lawfully present in the United States.

(cf: P.L.2005, c.156, s.4)

4. Section 5 of P.L.2005, 156 (C.30:4J-12) is amended to read as follows:

5. a. The purpose of the program shall be to provide subsidized health insurance coverage, and other health care benefits as determined by the commissioner, to children under 19 years of age and their parents or caretakers and to adults without dependent children, within the limits of funds appropriated or otherwise made available for the program.

The program shall require families to pay copayments and make premium contributions, based upon a sliding income scale. The program shall include the provision of well-child and other preventive services, hospitalization, physician care, laboratory and x-ray services, prescription drugs, mental health services, and other services as determined by the commissioner.

b. The commissioner shall take such actions as are necessary to implement and operate the program in accordance with the State Children's Health Insurance Program established pursuant to 42 U.S.C.s.1397aa et seq.

c. The commissioner:

(1) shall, by regulation, establish standards for determining eligibility and other program requirements, including, but not limited to, restrictions on voluntary disenrollments from existing health insurance coverage;

(2) shall require that a parent or caretaker who is a qualified applicant purchase coverage, if available, through an employer-sponsored health insurance plan which is determined to be cost-effective and is approved by the commissioner, and shall provide assistance to the qualified applicant to purchase that coverage, except that the provisions of this paragraph shall not be construed to require an employer to provide health insurance coverage for any employee or employee's spouse or dependent child;

(3) may, by regulation, establish plans of coverage and benefits to be covered under the program, except that the provisions of this section shall not apply to coverage for medications used exclusively to treat AIDS or HIV infection; and

(4) shall establish, by regulation, other requirements for the program, including, but not limited to, premium payments and copayments, and may contract with one or more appropriate entities, including managed care organizations, to assist in administering the program. The period for which eligibility for the program is determined shall be the maximum period permitted under federal law.

d. The commissioner shall establish procedures for determining eligibility, which shall include, at a minimum, the following enrollment simplification practices:

(1) A streamlined application form as established pursuant to subsection k. of this section;

(2) Require new applicants to submit no more than one recent pay stub from the applicant's employer, or, if the applicant has more than one employer, no more than one from each of the applicant's employers, to verify income. In the event the applicant cannot provide a recent pay stub, the applicant may submit another form of income verification as deemed appropriate by the commissioner. If an applicant does not submit income verification in a timely manner, before determining the applicant ineligible for the program, the commissioner shall seek to verify the applicant's income by reviewing available Department of the Treasury or Department of Labor and Workforce Development records concerning the applicant, or such other records as the commissioner determines appropriate.

The commissioner may establish such retrospective auditing or income verification procedures as he deems appropriate, such as sample auditing and matching reported income with records of the Department of the Treasury or the Department of Labor and Workforce Development or such other records as the commissioner determines appropriate.

If the commissioner elects to match reported income with confidential records of the Department of the Treasury, the commissioner shall require an applicant to provide written authorization for the Division of Taxation in the Department of the Treasury to release applicable tax information to the commissioner for the purposes of establishing income eligibility for the program. The authorization, which shall be included on the program application form, shall be developed by the commissioner, in consultation with the State Treasurer;

(3) Online enrollment and renewal, in addition to enrollment and renewal by mail. The online enrollment and renewal forms shall include electronic links to other State and federal health and social services programs;

(4) Continuous enrollment;

(5) Simplified renewal by sending an enrollee a preprinted renewal form and requiring the enrollee to sign and return the form, with any applicable changes in the information provided in the form, no later than 30 days after the date the enrollee's annual eligibility expires. The commissioner may establish such auditing or income verification procedures as he deems appropriate, as provided in paragraph (1) of this subsection; and

(6) Provision of program eligibility-identification cards that are issued no more frequently than once a year.

e. The commissioner shall take, or cause to be taken, any action necessary to secure for the State the maximum amount of federal financial participation available with respect to the program, subject to the constraints of fiscal responsibility and within the limits of available funding in any fiscal year. In this regard, notwithstanding the definition of "qualified applicant," the commissioner may enroll in the program such children or their parents or caretakers who may otherwise be eligible for the Medicaid program in order to maximize use of federal funds that may be available pursuant to 42 U.S.C. s.1397aa et seq.

f. Subject to federal approval, a child shall be determined ineligible for the program if the child was voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program.

g. The commissioner shall provide, by regulation, for presumptive eligibility for the program in accordance with the following provisions:

(1) A child who presents himself for treatment at a general hospital, federally qualified or community health center, local health department that provides primary care, or other State licensed community-based primary care provider shall be deemed presumptively eligible for the program if a preliminary determination by hospital, health center, local health department or licensed health care provider staff indicates that the child meets program eligibility standards and is a member of a household with an income that does not exceed 350% of the poverty level;

(2) The provisions of paragraph (1) of this subsection shall also apply to a child who is deemed presumptively eligible for Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) The parent or caretaker of a child deemed presumptively eligible pursuant to this subsection shall be required to submit a completed application for the program no later than the end of the month following the month in which presumptive eligibility is determined;

(4) A child shall be eligible to receive all services covered by the program during the period in which the child is presumptively eligible; and

(5) The commissioner may, by regulation, establish a limit on the number of times a child may be deemed presumptively eligible for NJ FamilyCare.

h. The commissioner, in consultation with the Commissioner of Education, shall administer an ongoing enrollment initiative to provide outreach to children throughout the State who may be eligible for the program.

(1) With respect to school-age children, the commissioner, in consultation with the Commissioner of Education and the Secretary of Agriculture, shall develop a form that provides information about the NJ FamilyCare and Medicaid programs and provides an opportunity for the parent or guardian who signs the school lunch application form to give consent for information to be shared with the Department of Human Services for the purpose of determining eligibility for the programs. The form shall be attached to, included with, or incorporated into, the school lunch application form.

The commissioner, in consultation with the Commissioner of Education, shall establish procedures for schools to transmit information attached to, included with, or provided on the school lunch application form regarding the NJ FamilyCare and Medicaid programs to the Department of Human Services, in order to enable the department to determine eligibility for the programs.

(2) The commissioner or the Commissioner of Education, as applicable, shall:

(a) make available to each elementary and secondary school, licensed child care center, registered family day care home, unified child care agency, local health department that provides primary care, and community-based primary care provider, informational materials about the program, including instructions for applying online or by mail, as well as copies of the program application form.

The entity shall make the informational and application materials available, upon request, to persons interested in the program; and

(b) request each entity to distribute a notice at least annually, as developed by the commissioner, to households of children attending or receiving its services or care, informing them about the program and the availability of informational and application materials. In the case of elementary and secondary schools, the information attached to, included with, or incorporated into, the school lunch application form for school-age children pursuant to this subparagraph shall be deemed to meet the requirements of this paragraph.

i. Subject to federal approval, the commissioner shall, by regulation, establish that in determining income eligibility for a child, any gross family income above 200% of the poverty level, up to a maximum of 350% of the poverty level, shall be disregarded.

j. The commissioner shall establish a NJ FamilyCare coverage buy-in program through which a parent or caretaker whose family

income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. <u>The program shall be known as NJ FamilyCare Advantage.</u>

The commissioner shall establish the premium and cost sharing amounts required to purchase coverage, except that the premium shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the poverty level, plus a reasonable processing fee.

k. The commissioner, in consultation with the Rutgers Center for State Health Policy, shall develop a streamlined application form for the NJ FamilyCare and Medicaid programs.

(cf: P.L.2005, c.156, s.5).

5. (New section) The Commissioner of Human Services shall apply for such waivers as may be necessary to implement the provisions of section 4 of P.L.2005, c.156 (C.30:4J-11) and to secure federal financial participation for NJ FamilyCare expenditures under the State Children's Health Insurance Program pursuant to 42 U.S.C.s.1397aa et seq.

6. (New section) Notwithstanding the provisions of section 3 of P.L.2004, c.113 (C.26:2H-18.59i) to the contrary, a hospital shall not submit charity care claims to the Department of Health and Senior Services for health care services provided to a child under 19 years of age who presents at a hospital for emergency care and who may be deemed presumptively eligible for NJ FamilyCare coverage pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) or Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

7. (New section) a. Beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual taxpayer indicate on the taxpayer's income tax return whether the taxpayer and dependents, if applicable, has health insurance coverage on the date of filing of the return.

b. The department shall, in consultation with the Commissioner of Human Services, administer an ongoing enrollment initiative to identify and provide outreach to taxpayers who are uninsured and may be eligible to enroll in the Medicaid or NJ FamilyCare program. As part of the initiative, the department shall send an application for the Medicaid or NJ FamilyCare program, as applicable, to any taxpayer who reports on the tax return form that he or his dependents do not have health insurance coverage and who, based on the income reported on the tax return form and the

tax payer’s family size, may be eligible for either of the State’s health care coverage programs.

c. As used in this section:

"Medicaid" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"NJ FamilyCare" or "program" means the NJ FamilyCare Program established pursuant to P.L.2005, 156 (C.30:4J-8 et al.).

8. R.S.54:50-9 is amended to read as follows:

54:50-9. Nothing herein contained shall be construed to prevent:

a. The delivery to a taxpayer or the taxpayer's duly authorized representative of a copy of any report or any other paper filed by the taxpayer pursuant to the provisions of this subtitle or of any such State tax law;

b. The publication of statistics so classified as to prevent the identification of a particular report and the items thereof;

c. The director, in the director's discretion and subject to reasonable conditions imposed by the director, from disclosing the name and address of any licensee under any State tax law, unless expressly prohibited by such State tax law;

d. The inspection by the Attorney General or other legal representative of this State of the reports or files relating to the claim of any taxpayer who shall bring an action to review or set aside any tax imposed under any State tax law or against whom an action or proceeding has been instituted in accordance with the provisions thereof;

e. The examination of said records and files by the Comptroller, State Auditor or State Commissioner of Finance, or by their respective duly authorized agents;

f. The furnishing, at the discretion of the director, of any information contained in tax reports or returns or any audit thereof or the report of any investigation made with respect thereto, filed pursuant to the tax laws, to the taxing officials of any other state, the District of Columbia, the United States and the territories thereof, providing said jurisdictions grant like privileges to this State and providing such information is to be used for tax purposes only;

g. The furnishing, at the discretion of the director, of any material information disclosed by the records or files to any law enforcing authority of this State who shall be charged with the investigation or prosecution of any violation of the criminal provisions of this subtitle or of any State tax law;

h. The furnishing by the director to the State agency responsible for administering the Child Support Enforcement program pursuant to Title IV-D of the federal Social Security Act, Pub.L.93-647 (42 U.S.C. s.651 et seq.), with the names, home addresses, social security numbers and sources of income and assets

of all absent parents who are certified by that agency as being required to pay child support, upon request by the State agency and pursuant to procedures and in a form prescribed by the director;

i. The furnishing by the director to the Board of Public Utilities any information contained in tax information statements, reports or returns or any audit thereof or a report of any investigation made with respect thereto, as may be necessary for the administration of P.L.1991, c.184 (C.54:30A-18.6 et al.) and P.L.1997, c.162 (C.54:10A-5.25 et al.);

j. The furnishing by the director to the Director of the Division of Alcoholic Beverage Control in the Department of Law and Public Safety any information contained in tax information statements, reports or returns or any audit thereof or a report of any investigation made with respect thereto, as may be relevant, in the discretion of the director, in any proceeding conducted for the issuance, suspension or revocation of any license authorized pursuant to Title 33 of the Revised Statutes;

k. The inspection by the Attorney General or other legal representative of this State of the reports or files of any tobacco product manufacturer, as defined in section 2 of P.L.1999, c.148 (C.52:4D-2), for any period in which that tobacco product manufacturer was not or is not in compliance with subsection a. of section 3 of P.L.1999, c.148 (C.52:4D-3), or of any licensed distributor as defined in section 102 of P.L.1948, c.65 (C.54:40A-2), for the purpose of facilitating the administration of the provisions of P.L.1999, c.148 (C.52:4D-1 et seq.);

l. The furnishing, at the discretion of the director, of information as to whether a contractor or subcontractor holds a valid business registration as defined in section 1 of P.L.2001, c.134 (C.52:32-44);

m. The furnishing by the director to a State agency as defined in section 1 of P.L.1995, c.158 (C.54:50-24) the names of licensees subject to suspension for non-payment of State tax indebtedness pursuant to P.L.2004, c.58 (C.54:50-26.1 et al.);

n. The release to the United States Department of the Treasury, Bureau of Financial Management Service, or its successor of relevant taxpayer information for purposes of implementing a reciprocal collection and offset of indebtedness agreement entered into between the State of New Jersey and the federal government pursuant to section 1 of P.L.2006, c.32 (C.54:49-12.7);

o. The examination of said records and files by the Commissioner of Health and Senior Services, <u>the Commissioner of Human Services,</u> the Medicaid Inspector General, or their respective duly authorized agents, pursuant to section 5 of P.L.2007, c.217 (C.26:2H-18.60e);

p. The furnishing at the discretion of the director of employer provided wage and tax withholding information contained in tax reports or returns filed pursuant to N.J.S.54A:7-2, 54A:7-4 and

54A:7-7, to the designated municipal officer of a municipality authorized to impose an employer payroll tax pursuant to the provisions of Article 5 (Employer Payroll Tax) of the "Local Tax Authorization Act," P.L.1970, c.326 (C.40:48C-14 et seq.), for the limited purpose of verifying the payroll information reported by employers subject to the employer payroll tax.
(cf: P.L.2007, c.294, s.2)

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

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

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier.

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

"Department" means the Department of Banking and Insurance.

"Dependent" means the spouse, domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an eligible person, subject to applicable terms of the individual health benefits plan.

"Eligible person" means a person who is a resident who is not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan, or Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.).

"Federally defined eligible individual" means an eligible person: (1) for whom, as of the date on which the individual seeks coverage under P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months; (2) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan; (3) who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C.s.1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan; (4) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; (5) who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and (6) who has elected continuation coverage described in (5) above and has exhausted that continuation coverage.

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

"Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental

plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

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

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

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this act, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code

(10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

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

Individual health benefits plan shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan, to the extent the "Employee Retirement Income Security Act of 1974" (29 U.S.C. s.1001 et seq.) preempts the application of P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. Member shall not include a carrier whose combined average Medicare, Medicaid, and NJ FamilyCare **[**and NJ KidCare**]** enrollment represents more than 75% of its average total enrollment for all health benefits plans or whose combined Medicare, Medicaid, and NJ FamilyCare **[**and NJ KidCare**]** net earned premium for the two-year calculation period represents more than 75% of its total net earned premium for the two-year calculation period.

"Modified community rating" means a rating system in which the premium for all persons covered **[**by a contract is formulated based on the experience of all persons covered by that contract, without regard to age, sex, occupation and geographical location, but which may differ by health status. The term modified community rating shall apply to contracts and policies issued prior to the effective date of this act which are subject to the provisions of subsection e. of section 2 of this act.**]** under a policy or contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical

location or any other factor or characteristic of covered persons, other than age.

The rating system shall provide that the premium rate charged by the carrier for the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits plans shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with regulations promulgated by the commissioner, which shall include age classifications established, at a minimum, in five year increments. There may be a reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or for different health benefits plans offered by the carrier.

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid, or NJ FamilyCare or **[**NJ KidCare**]** contracts with the State or federal government, but shall not include premiums earned from contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

"NJ FamilyCare" means the NJ FamilyCare **[**Health Coverage**]** Program established pursuant to **[**P.L.2000, c.71 (C.30:4J-1 et seq.)**]** P.L.2005, c.156 (C.30:4J-8 et al.).

["NJ KidCare" means the Children's Health Care Coverage Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et seq.).**]**

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

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

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

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

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

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

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

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

(cf: P.L.2001, c.349, s.1)

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

2. a. An individual health benefits plan issued on or after [August 1, 1993 shall be subject to the provisions of this act] the effective date of P.L. , c. (pending before the Legislature as this bill) shall be subject to the rating provisions established in P.L. , c. (pending before the Legislature as this bill). In the case of an individual health benefits plan issued to a covered person prior to the effective date of P.L. , c. (pending before the Legislature as this bill) and renewed thereafter, for the five years next following enactment of P.L. , c. (pending before the Legislature as this bill), the annual rate increase filed for the plan shall be limited to the lower of 15% or the medical trend assumption used by the carrier to project claims.

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

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

(3) A group conversion contract or policy issued prior to August 1, 1993 that is not issued on a modified community rated basis or

community rated basis, shall not be subject to the provisions of this act, except that the contract or policy shall be liable for assessments made pursuant to section 11 of this act.

(4) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation prior to the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that the plan shall guarantee renewal pursuant to subsection b. of section 5 of P.L.1992, c.161 (C.17B:27A-6).

(5) Notwithstanding any other provision of law to the contrary, an individual health benefits plan issued by a hospital service corporation or medical service corporation to an eligible person or federally defined eligible individual after the effective date of P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the provisions of subsections c. and d. of section 2, subsection b. of section 3, section 5, subsection b. of section 6, and subsections c., d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3, C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall not be subject to the remaining provisions of P.L.1992, c. 161.**]** (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).

c. **[**After August 1, 1993, an individual who is eligible to participate in a group health benefits plan that provides coverage for hospital or medical expenses shall not be covered by an individual health benefits plan which provides benefits for hospital and medical expenses that are the same or similar to coverage provided in the group health benefits plan, except that an individual who is eligible to participate in a group health benefits plan but is currently covered by an individual health benefits plan may continue to be covered by that plan until the first anniversary date of the group health benefits plan occurring on or after January 1, 1994. **]** (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).

d. **[**Except as otherwise provided in subsection c. of this section, after August 1, 1993, a person who is covered by an individual health benefits plan who is a participant in, or is eligible to participate in, a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, and a person, including an employer or insurance producer, who causes another person to be covered by an individual health benefits plan which person is a participant in, or who is eligible to participate in a group health benefits plan that provides the same or similar coverages as the individual health benefits plan, shall be subject to a fine by the commissioner in an amount not less than twice the annual premium paid for the individual health benefits plan,

together with any other penalties permitted by law.] (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

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

(cf: P.L.1997, c.146, s.2)

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

3. a. No later than 180 days after the effective date of [this act] P.L. , c. (pending before the Legislature as this bill), a carrier shall, as a condition of issuing small employer health benefits plans in this State, also offer individual health benefits plans. The plans shall be offered on an open enrollment, modified community rated basis, pursuant to the provisions of this act[; except that a carrier shall be deemed to have satisfied its obligation to provide the individual health benefits plans by paying an assessment or receiving an exemption pursuant to section 11 of this act] and P.L. , c. (pending before the Legislature as this bill). Every carrier that issues small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall make a good faith effort to market individual health benefits plans.

b. A carrier shall offer to an eligible person a choice of [five] at least three individual health benefits plans [any of which may contain provisions for managed care] established by the board pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7). One plan shall be a basic health benefits plan[, one plan shall be a managed care plan and three plans shall include enhanced benefits of proportionally increasing actuarial value]. A carrier may elect to convert any individual contract or policy forms in force on the effective date of [this act] P.L. , c. (pending before the Legislature as this bill) to any of the [five] benefit plans, except that the carrier may not convert more than 25% of existing contracts or policies each year, and the replacement plan shall be of no less actuarial value than the policy or contract being replaced.

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

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

c. (1) A basic health benefits plan shall provide the benefits set forth in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section 57

of P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991, c.187 (C.26:2J-4.3), as the case may be.

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

(3) A contract or policy for a basic health benefits plan provided for in this section may contain or provide for coinsurance or deductibles, or both, except that no deductible shall be payable in excess of a total of $250 by an individual or $500 by a family unit during any benefit year; and no coinsurance shall be payable in excess of a total of $500 by an individual or by a family unit during any benefit year.

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

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

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

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

e. **[**If all five of the individual health benefits plans are not established by the board by the effective date of P.L.1993, c.164 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the five health benefits plans by offering each health benefits plan as it is established by the board; however, once the board establishes all five plans, the carrier shall be required to offer the five plans in accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et al.).**]** (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

f. In addition to the rider packages provided for in subsection c. of section 6 of P.L.1992, c.161 (C.17B:27A-7), every carrier may offer, in connection with the health benefits plans required to be

offered by this section, any number of riders which may revise the coverage offered by the plans in any way, provided, however, that any form of such rider or amendment thereof which decreases benefits or decreases the actuarial value of one of the plans shall be filed for informational purposes with the board and for approval by the commissioner before such rider may be sold. Any rider or amendment thereof which adds benefits or increases the actuarial value of one of the plans shall be filed with the board for informational purposes before such rider may be sold. The added premium or reduction in premium for each rider, as applicable, shall be listed separately from the premium for the standard plan.

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

(cf: P.L.1994, c.102, s.1)

12. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to read as follows:

2. a. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits plan in the individual health insurance market that includes only the coverages enumerated in this section, as follows:

90 days hospital room and board - $500 copayment per hospital stay;

Outpatient and ambulatory surgery- $250 copayment per surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Physicians' fees connected with outpatient and ambulatory surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

Intravenous solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Inpatient physical therapy and hydrotherapy;

Outpatient physical therapy - 30 visits annually per covered person- $20 copayment per treatment;

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and $500 annual aggregate per covered person for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;

Operating room fees;
Special care unit;
Treatment room fees;
Emergency room services for medically necessary treatment - $100 copayment per visit;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for biologically-based mental illness, as defined in subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - $500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;
Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;
Wellness benefit - $600 annual aggregate per covered person, $50 annual deductible, 20% coinsurance per service; and
Physicians visits for diagnosed illness or injury - to a $700 annual aggregate per covered person.

b. A carrier shall offer the benefits on an indemnity basis, with the option that: (1) coverage is restricted to health care providers in the carrier's network, including an exclusive provider organization, or the carrier's preferred provider organization; or (2) coverage is provided through health care providers in the carrier's network or preferred provider organization with an out-of-network option with 30% coinsurance in addition to whatever other coinsurance may be applicable under the policy.

c. With respect to all policies or contracts issued pursuant to this section, the premium rate charged by a carrier to the highest rated individual or class of individuals shall not be greater than 350% of the premium rate charged for the lowest rated individual or class of individuals purchasing this health benefits plan, provided, however, that the only factors upon which the rate differential may be based are age, gender, and geography. Rates applicable to policies or contracts issued pursuant to this section shall reflect past and prospective loss experience for benefits included in such policies or contracts, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to policies issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the result of differences in levels of benefits offered.

d. Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible.

e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall apply to this section to the extent that they are not contrary to the provisions of this section, including but not limited to, provisions relating to preexisting conditions, guaranteed issue, and calculation of loss ratio.

f. No later than one year following enactment of this act, every carrier shall make an informational filing with the [board] commissioner, which shall include the policy form, the premiums to be charged for the coverage, and the anticipated loss ratio. If the [board] commissioner has not disapproved the form within 30 days, the form shall be deemed approved.

g. Every carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make available and shall make a good faith effort to market the contract or policy established pursuant to this section. A carrier who is in violation of this section shall be subject to the provisions of N.J.S.17B:30-1.

(cf: P.L.2001, c.368, s.2)

13. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to read as follows:

4. In addition to the [five] health benefits plans offered by a carrier on the effective date of this act, a carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).

(cf: P.L.2001, c.368, s.4)

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

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

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

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

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

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

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

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

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

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

(4) **[**board**]** approval by the commissioner of a request by the individual carrier to cease doing business in the individual health benefits market. A carrier may not renew all individual health benefits plans only if the carrier: (a) first receives approval from the **[**board**]** commissioner; and (b) provides notice to each individual of the nonrenewal at least 180 days prior to the date of the expiration of such coverage. A carrier ceasing to do business in the individual health benefits market may not provide for the issuance of any health benefits plan in the individual **[**market**]** or small employer markets during the five-year period beginning on

the date of the termination of the last health benefits plan not so renewed; and

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

(cf. P.L.1997, c.146, s.3)

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

6. The **[**board**]** commissioner shall **[**establish**]** approve the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications to one or more plans as the board determines are necessary to make available a "high deductible health plan" or plans consistent with section 301 of Title III of the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical savings accounts, within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The **[**board**]** commissioner shall provide the **[**commissioner**]** board with an informational filing of the policy and contract forms and benefit levels it **[**establishes**]** approves.

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

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

(1) to an individual who has, under creditable coverage, with no intervening lapse in coverage of more than 31 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12-month preexisting condition limitation; or

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

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

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

e. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

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

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

(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the

form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a health benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this subsection that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

f. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

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

This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

g. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically

necessary benefits provided in-network which represent preventive care as permitted by that federal law.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection. This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2005, c.248, s.13)

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

8. a. **[**The board shall make application to the Hospital Rate Setting Commission on behalf of all carriers for approval of discounted or reduced rates of payment to hospitals for health care services provided under an individual health benefits plan provided pursuant to this act.**]** (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

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

c. A carrier shall not issue individual health benefits plans on a new contract or policy form pursuant to this act until an informational filing of a full schedule of rates which applies to the contract or policy form has been filed with the **[**board**]** commissioner. The **[**board**]** commissioner shall **[**forward**]** provide a copy of the informational filing to the **[**commissioner and the**]** Attorney General and the board.

d. **[**A carrier shall make an informational filing with the board of any change in its rates for individual health benefits plans pursuant to section 3 of this act prior to the date the rates become effective. The board shall file the informational filing with the commissioner and the Attorney General. If the carrier has filed all information required by the board, the filing shall be deemed to be complete.**]** A carrier desiring to increase or decrease premiums for any contract or policy form may implement that increase or decrease upon making an informational filing with the commissioner of that increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing that increase or decrease. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.161 (C.17B:27A-2 et seq.), or that the rates are inadequate or unfairly discriminatory.

e. (1) Rates shall be formulated on contracts or policies required pursuant to section 3 of this act so that the anticipated minimum loss ratio for a contract or policy form shall not be less than **[**75%**]** 80% of the premium. The carrier shall submit with its rate filing supporting data, as determined by the **[**board**]** commissioner, and a certification by a member of the American Academy of Actuaries, or other individuals in a format acceptable to the **[**board and to the**]** commissioner, that the carrier is in compliance with the provisions of this subsection.

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

Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the policy or contract forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161 (C.17:B:27A-4), at least 80% of the aggregate premiums collected for all of the policy or contract forms during that calendar year. Carriers shall annually report, no later than August 1 of each year, the loss ratio calculated pursuant to this section for all of the policy or contract forms for the previous calendar year. In each case in which the loss ratio fails to comply with the 80% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policy or contract holders, as applicable, in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits equal 80% of the aggregate premiums collected for the policy or contract forms in the previous calendar year. All dividends and credits shall be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this subsection shall include a carrier's calculation of the dividends and credits applicable to all policy or contract forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Those regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder.

f. **[**Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed pursuant to this section by a carrier which insured at least 50% of the community-rated individually insured persons on the effective date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required to produce a loss ratio which when combined with the carrier's

administrative costs and investment income results in self-sustaining rates prior to January 1, 1996, for individual policies or contracts issued prior to August 1, 1993. The carrier shall, not later than 30 days after the effective date of P.L.1994, c.102 (C.17B;27A-4 et al.), file with the board for approval, a plan to achieve this objective.**]** (Deleted by amendment, P.L., c. }(pending before the Legislature as this bill).

(cf: P.L.1994, c.102, s.2)

17. Section 10 of P.L.1992, c.161 (C.17B:27A-11) is amended to read as follows:

10. The program shall have the general powers and authority granted under the laws of New Jersey to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the program shall not have the power to issue health benefits plans directly to either groups or individuals.

The board shall have the specific authority to:

a. assess members their proportionate share of program losses and administrative expenses in accordance with the provisions of section 11 of this act, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

b. establish rules, conditions, and procedures pertaining to the sharing of program losses and administrative expenses among the members of the program;

c. **[**review rate applications and form filings submitted by carriers in accordance with this act;**]** (Deleted by amendment, P.L. , c.)(pending before the Legislature as this bill).

d. define the provisions of individual health benefits plans in accordance with the requirements of this act;

e. enter into contracts which are necessary or proper to carry out the provisions and purposes of this act;

f. establish a procedure for the joint distribution of information on individual health benefits plans issued pursuant to section 3 of this act;

g. establish, at the board's discretion, standards for the application of a means test for individual health benefits plans issued pursuant to section 3 of this act;

h. establish, at the board's discretion, reasonable guidelines for the purchase of new individual health benefits plans by persons who already are enrolled in or insured by another individual health benefits plan;

i. establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the program and provide for performance audits from time to time;

j. sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the program or a member;

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

l. borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets; and

m. contract for an independent actuary and any other professional services the board deems necessary to carry out its duties under P.L.1992, c.161 (C.17B:27A-2 et al.).

(cf: P.L.1993, c.164, s.6)

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

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

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

(a) every carrier issuing health benefits plans in this State shall file with the board its net earned premium for the preceding two-year calculation period; and

(b) every carrier issuing individual health benefits plans in the State shall file with the board the net earned premium on health benefits plans issued pursuant to paragraph (1) of subsection b. of section 2 and section 3 of this act and the claims paid. If the claims paid for all health benefits plans during the two-year calculation period exceed 115% of the net earned premium and any investment income thereon for the two-year calculation period, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this act.

(2) Every member shall be liable for an assessment to reimburse carriers issuing individual health benefits plans in this State which sustain net paid losses during the two-year calculation period, unless the member has received an exemption from the board pursuant to subsection d. of this section and has written a minimum number of non-group person life years as provided for in that subsection. The assessment of each member shall be in the proportion that the net earned premium of the member for the two-year calculation period preceding the assessment bears to the net earned premium of all members for the two-year calculation period preceding the assessment. Notwithstanding the provisions of this

subsection to the contrary, a medical service corporation or a hospital service corporation shall not be liable for an assessment to reimburse carriers which sustain net paid losses.

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

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

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

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

account the limitations on counting Medicaid recipients and Medicare cost and risk lives, and dividing the total by eight.

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

(3) The minimum number of non-group person life years required to be covered, as determined by the board, shall equal the total number of non-group person life years of community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives, of all carriers subject to this act for the two-year calculation period, multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for that two-year calculation period, including those carriers that are exempt from the assessment.

(4) On or before March 1 of the first year of each two-year calculation period, every carrier seeking an exemption pursuant to this subsection shall file with the board a statement of its net earned premium for the two-year calculation period. The board shall determine each carrier's minimum number of non-group person life years in accordance with this subsection.

(5) On or before March 1 of each year immediately following the close of a two-year calculation period, every carrier that was granted an exemption for the preceding two-year calculation period shall file with the board the number of non-group person life years, by category, covered for the two-year calculation period.

To the extent that the carrier has failed to cover the minimum number of non-group person life years established by the board, the carrier shall be assessed by the board on a pro rata basis for any differential between the minimum number established by the board and the actual number covered by the carrier.

(6) A carrier that applies for the exemption shall be deemed to be in compliance with the requirements of this subsection if it has covered 100% of the minimum number of non-group person life years required.

(7) Any carrier that writes both managed care and indemnity business that is granted an exemption pursuant to this subsection may satisfy its obligation to cover a minimum number of non-group person life years by issuing either managed care or indemnity business, or both.

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

f. The loss assessment for the two-year calculation period in which P.L. , c. (pending before the Legislature as this bill) takes

effect shall be the last loss assessment authorized under this section, and no further loss assessments shall be calculated or collected; provided, however, that nothing in this subsection shall relieve a carrier of its obligations for loss assessments authorized under this section prior to the effective date of P.L. , c. (pending before the Legislature as this bill).

(cf: P.L.1997, c.146, s.6)

19. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended to read as follows:

5. A domestic mutual insurer which has converted from a health service corporation pursuant to the provisions of sections 2 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48) shall not renew individual hospital or medical insurance policies or health service contracts originally issued prior to November 30, 1992, until it has made an informational filing with the **[**New Jersey Individual Health Coverage Program Board, of a full schedule of rates which are to apply to those contracts. The New Jersey Individual Health Coverage Program Board shall forward a copy of such filing to the**]** commissioner. The rates shall be formulated so that the anticipated minimum loss ratio for such policy or contract form shall not be less than **[**75%**]** 80% of the premium. Such domestic mutual insurer shall submit with its rate filing supporting data and a certification that the insurer is in compliance with the anticipated loss ratio requirement. The content and form of the supporting data and certification required pursuant to subsection e. of section 8 of P.L.1992, c.161 (C.17B:27A-9) shall satisfy the requirements of this section. Any other insurer may irrevocably elect to become subject to the provisions of this section by written notice to the commissioner**[**, except that such informational filing by any other insurer shall be**]** in a format specified by the commissioner **[**and shall be made directly to the commissioner and not to the New Jersey Individual Health Coverage Program Board**]**.

(cf: P.L.1995, c.196, s.5)

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

1. As used in this act:

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

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

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or part B of Title XVIII of the federal Social Security Act (42 U.S.C. s.1395 et seq.); Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (42 U.S.C.s.1396s); chapter 55 of Title 10, United States Code (10 U.S.C. 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health plan

offered under chapter 89 of Title 5, United States Code (5 U.S.C. s.8901 et seq.); a public health plan as defined by federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e)); or coverage under any other type of plan as set forth by the commissioner by regulation.

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

"Department" means the Department of Banking and Insurance.

"Dependent" means the spouse, domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

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

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

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

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

"Group health plan" means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee

Retirement Income Security Act of 1974" (29 U.S.C.s.1002(1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For purposes of this act, "health benefits plan" shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

"Health status-related factor" means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history;

genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

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

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

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

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

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

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

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

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

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, and the majority of the employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C.s.414) shall be treated as one employer. Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L.1992, c.162 (C.17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such employer.

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

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

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

a. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $20,000 per covered person per plan year; and

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

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

(cf: P.L.1997, c.146, s.7)

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

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

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

(3) Diagnostic tests, including X-rays;

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

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

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

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

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

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

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

e. **[**Notwithstanding the provisions of subsection a. of this section to the contrary, the board may approve a health benefits plan containing only medical-surgical benefits or major medical expense benefits, or a combination thereof, which is issued as a separate policy in conjunction with a contract of insurance for hospital expense benefits issued by a hospital service corporation, if the health benefits plan and hospital service corporation contract combined otherwise comply with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the contract combined may be allocated between the separate contracts at the discretion of the carrier and the hospital service corporation.**]** (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill).

f. Notwithstanding the provisions of this section to the contrary, a health maintenance organization which is a qualified health maintenance organization pursuant to the "Health

Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.s.300e et seq.) shall be permitted to offer health benefits plans formulated by the board and approved by the commissioner which are in accordance with the provisions of that law in lieu of the [five] plans required pursuant to this section.

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

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

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

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

The commissioner shall disapprove any rider filed pursuant to this subsection that is unjust, unfair, inequitable, unreasonably discriminatory, misleading, contrary to law or the public policy of this State. The commissioner shall not approve any rider which reduces benefits below those required by sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and

required to be sold pursuant to this section. The commissioner's determination shall be in writing and shall be appealable.

(2) The benefit riders provided for in paragraph (1) of this subsection shall be subject to the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).

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

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

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

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

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

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

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

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

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

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

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

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

applicable, and shall comply with the provisions of sections 2 and 9 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

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

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

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

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

(10)In a case in which an association made available a health benefits plan on or before March 1, 1994 and subsequently changed

the issuing carrier between March 1, 1994 and the effective date of P.L.1995, c.340, the new issuing carrier shall be deemed to have been eligible to continue and renew the plan pursuant to paragraph (1) of this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

n. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)

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

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

(cf: P.L.2005, c.248, s.15)

22. Section 5 of P.L.2001, c.368 (C.17B:27A-19.11) is amended to read as follows:

5. In addition to the **[**five**]** standard health benefits plans offered by a carrier on the effective date of this act, a carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

(cf: P.L.2001, c.368, s.5)

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

7. Every policy or contract issued to small employers in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be

renewable with respect to all eligible employees or dependents at the option of the policy or contract holder, or small employer except that a carrier may discontinue or not renew a health benefits plan in accordance with the provisions of this section:

a. A carrier may discontinue such coverage only if:

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

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

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

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

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

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

(1) The carrier gives notice to cease doing business in the small employer market to the commissioner not later than eight months prior to the date of the planned withdrawal from the small **[**group market**]** <u>employer</u> market, during which time the carrier shall continue to be governed by this act with respect to business written pursuant to this act. For the purposes of this subsection, "date of withdrawal" means the date upon which the first notice to small employers is sent by the carrier pursuant to paragraph (2) of this subsection;

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

(3) Any carrier that ceases to do business pursuant to this act shall be prohibited from writing new business in the small employer **[**market**]** <u>and individual health benefits plan markets</u> for a period of five years from the date of termination of the last health insurance coverage not so renewed;

f. In the case of policies or contracts issued in connection with membership in an association or trust of employers, an employer ceases to maintain its membership in the association or trust, but

only if such coverage is terminated under this provision uniformly without regard to any health status-related factor relating to any covered individual.

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

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

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

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

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

(cf: P.L.1997, c.146, s.10)

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

8. Any small employer carrier may require a reasonable specified minimum participation <u>with the same carrier</u> of eligible employees, which shall not exceed 75%, or reasonable minimum employer contributions in determining whether to accept a small group pursuant to this act. The standards so established by the carrier shall be first approved by the board and shall be applied uniformly to all small groups, except that in no event shall a carrier require an employer to contribute more than 10% to the annual cost of the policy or contract, or an amount as otherwise provided by the board, and any minimum participation standards established by the carrier shall be reasonable. In establishing the percentage of employee participation, a one-to-one credit shall be given for each employee covered by a spouse's health benefits coverage, Medicare, Medicaid, NJ FamilyCare or another group health benefits plan. In calculating an employer's participation, the carrier shall include all insured employees, regardless of whether the employees chose an indemnity plan or a health maintenance organization, or a combination thereof.

(cf: P.L. 2005, c.166, s.1)

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

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

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

(3) For all policies or contracts providing health benefits plans for small employers issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19), and including policies or contracts offered by a carrier to a small employer who is a member of a Small Employer Purchasing Alliance pursuant to the provisions of P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged by a carrier to the highest rated small group purchasing a small employer health benefits plan issued pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19) shall not be greater than 200% 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, gender and geography, and provided further, that such factors are applied in a manner consistent with regulations adopted by the board. For the purposes of this paragraph (3), policies or contracts offered by a carrier to a small employer who is a member of a Small Employer Purchasing Alliance shall be rated separately from the carrier's other small employer health benefits policies or contracts.

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

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

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

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

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

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

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

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

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

A carrier which provides a health benefits plan to one or more small employers through a policy issued to an association or trust of employers after the effective date of P.L.1992, c.162 (C.17B:27A-

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

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

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

g. (1) Beginning January 1, 1995, a carrier desiring to increase or decrease premiums for any policy form or benefit rider offered pursuant to subsection i. of section 3 of P.L.1992, c.162 (C.17B:27A-19) subject to this act may implement such increase or decrease upon making an informational filing with the commissioner of such increase or decrease, along with the actuarial assumptions and methods used by the carrier in establishing such increase or decrease, provided that the anticipated minimum loss ratio for all policy forms shall not be less than **[**75%**]** 80% of the premium therefor as provided in paragraph (2) of this subsection. The commissioner may disapprove any informational filing on a finding that it is incomplete and not in substantial compliance with P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are inadequate or unfairly discriminatory. Until December 31, 1996, the informational filing shall also include the carrier's rating plan and classification system in connection with such increase or decrease.

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the **[**five**]** standard policy forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19), at least **[**75%**]** 80% of the aggregate premiums collected for all of the standard policy forms, other than alliance policy forms, and at least **[**75%**]** 80% of the aggregate premiums collected for all of the non-standard policy forms during that calendar year. A carrier shall return at least **[**75%**]** 80% of the premiums collected for all of the alliances during that calendar year, which loss ratio may be calculated in the aggregate for all of the alliances or separately for each alliance. Carriers shall annually report, no later than August 1st of each year,

the loss ratio calculated pursuant to this section for all of the standard, other than alliance policy forms, non-standard policy forms and alliance policy forms for the previous calendar year, provided that a carrier may annually report the loss ratio calculated pursuant to this section for all of the alliances in the aggregate or separately for each alliance. In each case where the loss ratio fails to substantially comply with the [75%] 80% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with the standard, other than alliance policy forms, nonstandard policy forms or alliance policy forms, as applicable, in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal [75%] 80% of the aggregate premiums collected for the respective policy forms in the previous calendar year. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits applicable to standard, other than alliance policy forms, non-standard policy forms and alliance policy forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder. For purposes of this paragraph, "alliance policy forms" means policies purchased by small employers who are members of Small Employer Purchasing Alliances.

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

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

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

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

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

(cf: P.L.2003, c.163, s.1)

26. (New section) a. An insurance producer licensed pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.) who sells, solicits, or negotiates health insurance policies or contracts to residents of this State shall notify the purchaser of the insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. If the commission, fee, brokerage, or other valuable consideration is based on a percentage of premium, the insurance producer shall include that information in the notification to the purchaser.

b. Upon seeking renewal of a license issued pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.), an insurance producer shall report to the Commissioner of Banking and Insurance, in a form and manner specified by the commissioner, how the producer is compensated for the sale, solicitation, or negotiation of health insurance policies and contracts, including the basis for determining a commission, service fee, brokerage, or other valuable consideration for the sale, solicitation, or negotiation of a health insurance policy or contract. The insurance producer shall provide such other information regarding compensation as the commissioner deems appropriate.

c. Notwithstanding the provisions of any law to the contrary, the commissioner shall not renew the license of an insurance producer who is subject to the provisions of this section unless the insurance producer provides the information required pursuant to this section.

d. The commissioner may specify, by regulation, the information that shall be provided by an insurance producer in the notification to a purchaser of health insurance and the procedure for providing the notification.

27. The Commissioner of Banking and Insurance shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt regulations necessary to implement the provisions of this act.

28. Sections 1 through 7 and 27 of this act shall take effect immediately and sections 8 through 26 of this act shall take effect on the 180th day after enactment and shall apply to all contracts and policies that are delivered, issued, executed or renewed or approved for issuance or renewal in this State on or after the effective date, but the Commissioner of Banking and Insurance may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

STATEMENT

The purpose of this bill is to ensure that more residents in this State have access to affordable health care coverage. The bill achieves this goal by expanding the NJ FamilyCare Program to more low income parents, mandating that all children in the State have health care coverage either through public programs or private coverage, and adopting various reform measures to the individual and small employer insurance markets to increase the affordability of, and stabilize enrollment in, health benefits plans for individuals and small businesses. The provisions of this bill represent the first phase of a comprehensive reform of the health care system in this State which, when fully implemented, will ensure universal health care coverage for all residents of this State.

Health Care Coverage Reforms:

- To ensure that all children in the State are able to access health care, the bill establishes a "Kids First" mandate that requires all children 18 years of age and younger in the State to have health insurance coverage, beginning one year after the date of enactment of the bill. This coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid program, NJ FamilyCare Program, or the NJ FamilyCare Advantage buy-in program.
- To make health care coverage more accessible to low income parents, eligibility for the NJ FamilyCare Program is expanded to include parents whose income is up to 200% of the federal poverty level.
- In order to ensure that hospitals assess patients under 19 years of age who present at the hospital for emergency care as to whether they may be presumptively eligible for NJ FamilyCare or Medicaid, the bill prohibits hospitals from submitting charity care claims for these patients. The cost of emergency care for patients who are determined to be presumptively eligible for NJ FamilyCare or Medicaid is shared by the federal government and, therefore, this provision will ensure more effective use of the State's limited charity care funds for patient care that is not reimbursed by the federal government.
- In order to identify, and provide increased State outreach to, residents of the State who are uninsured and may be eligible to enroll in the Medicaid or NJ FamilyCare program, the bill establishes an ongoing enrollment initiative through the Department of the Treasury, in consultation with the Department of Human Services. Under the initiative, beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual taxpayer indicate on the taxpayer's income tax return whether the taxpayer and dependents, if applicable, has health insurance coverage on the

date of filing of the return. If a taxpayer reports that he or his dependents are uninsured, and the State Treasurer determines that based on the taxpayer's reported income the taxpayer or his dependents may be eligible for either Medicaid or NJ FamilyCare, the State Treasurer would to send the taxpayer an application for the Medicaid or NJ FamilyCare program, as applicable.

Individual and Small Employer Health Insurance Reforms:

The bill implements several reforms to the individual and small employer markets to make health benefits plans more affordable to individuals and small businesses in the State. Specifically, the bill:

- Seeks to make individual health benefits plans more affordable to younger persons, by revising the rating system for individual plans for new policies and contracts issued after the effective date of the bill, so that the premium rate differential can be up to 350%, but the only factor that the rating differential may be based on is the age of the person covered under the plan and the factor must be applied in a manner consistent with regulations of the Commissioner of Banking and Insurance, which include age classifications in a minimum of five-year increments. The bill provides, however, that in order to protect consumers who currently have coverage under an individual health benefits plan, rate increases for these consumers would be limited for the next five years to an amount no more than the lower of 15% or the medical trend assumption used by the carrier to project claims.
- Requires that a carrier must offer and make a good faith effort to market individual policies as a condition of participation in the small employer market, in order to ensure greater participation by carriers in the individual market.
- Reduces the number of standard plans that a carrier must offer in the individual and small employer markets from five to at least three plans.
- Authorizes carriers in the individual market to offer any number of riders which may revise the coverage offered by the standard plans in any way, but any form of such rider which decreases the actuarial value of one of the plans shall be filed for informational purposes with the board and for approval by the commissioner before any such rider may be sold. Any rider which adds benefits or increases the actuarial value of one of the plans shall be filed with the board or informational purposes before the rider may be sold. The additional premium for a rider shall be listed separately from the premium for the standard plan.
- Transfers regulatory oversight regarding approval of policy and contract forms, and review of premium rate filings and other similar matters, from the Individual Health Coverage Program Board to the Commissioner of Banking and Insurance, as is

currently provided in the New Jersey Small Employer Health Benefits Program.

- Requires carriers in the individual market to make an informational filing to the Commissioner of Banking and Insurance in the event the carrier seeks to increase or decrease premiums for any contract or policy form.
- Revises provisions concerning the minimum loss ratio for individual and small employer plans and provides that rates shall be formulated so that the anticipated minimum loss ratio is not less than 80% of the premium.
- Provides that after the effective date of the bill, no further loss assessments shall be calculated or collected, although carriers are not relieved of their obligations for loss assessments authorized prior to the effective date of the bill.
- Permits small employer carriers to require a reasonable specified minimum participation “with the same carrier” of eligible employees.
- Establishes transparency with respect to insurance broker fees by requiring insurance producers to notify a purchaser of insurance, in writing, of the amount of any commission, service fee, brokerage, other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract. The bill also requires producers, as a condition of licensure by the Department of Banking and Insurance, to notify the department how the producer is compensated by carriers for the sale, solicitation or negotiation of the health insurance policy or contract.

ASSEMBLY BUDGET COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2624

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 19, 2008

The Assembly Budget Committee reports favorably Assembly Bill No. 2624, with committee amendments.

The bill, as amended, ensures that more residents in this State have access to affordable health care coverage. The bill achieves this goal by: expanding the NJ FamilyCare Program to more low income parents; mandating that all children in the State have health care coverage either through public programs or private coverage; adopting various reform measures to the individual and small employer insurance markets to increase the affordability of, and stabilize enrollment in, health benefits plans for individuals and small businesses; and making various changes to the eligibility criteria, terms, and administration of continued dependent coverage for dependents 30 years of age or younger, initially mandated pursuant to P.L.2005, c.375 (C.17:48-6.19 et al.).

The provisions of this bill represent the first phase of a comprehensive reform of the health care system in this State which, when fully implemented, will ensure universal health care coverage for all residents of this State.

Health Care Coverage Reforms:

- To ensure that all children in the State are able to access health care, the bill establishes a “Kids First” mandate that requires all children 18 years of age and younger in the State to have health insurance coverage, beginning one year after the date of enactment of the bill. This coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid or NJ FamilyCare programs, or the NJ FamilyCare Advantage buy-in program.
- To make health care coverage more accessible to low income parents, the bill expands eligibility for the NJ FamilyCare Program to include parents whose income is up to 200% of the federal poverty level.
- To ensure that the cost of the premium for coverage of a child in the NJ FamilyCare program does not present a hardship for the child’s parent or caretaker, the bill directs the Commissioner of Human

Services to establish a hardship waiver for part or all of the premium for an eligible child under the NJ FamilyCare program.

- Tto ensure that hospitals assess patients under 19 years of age who present at the hospital for emergency care as to whether they may be presumptively eligible for NJ FamilyCare or Medicaid, the bill prohibits hospitals from submitting charity care claims for these patients. The cost of emergency care for patients who are determined to be presumptively eligible for NJ FamilyCare or Medicaid is shared by the federal government and, therefore, this provision will ensure more effective use of the State's limited charity care funds for patient care that is not reimbursed by the federal government.
- In order to identify, and provide increased State outreach to, residents of the State who are uninsured and may be eligible to enroll in the Medicaid, NJ FamilyCare, or NJ FamilyCare Advantage buy-in programs, the bill establishes various enrollment and retention initiatives:

(1) The bill provides for an ongoing enrollment initiative with the Department of the Treasury and the Department of Human Services (DHS). Under the initiative, beginning with the 2008 tax year and for each tax year thereafter, the Department of the Treasury shall require that each individual who files a resident New Jersey Gross Income Tax return indicate on the return whether the taxpayer and dependents, if applicable, has health insurance coverage on the date of filing of the return. The State Treasurer would transmit to DHS information permitting DHS to identify taxpayers who are uninsured and may be eligible to enroll in the Medicaid or NJ FamilyCare program. DHS would use this information in furtherance of its Medicaid and NJ FamilyCare outreach and enrollment initiative established pursuant to section 26 of the bill, and described below.

(2) The bill directs the Commissioner of Human Services to establish an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about the availability of, and benefits to enrolling in, Medicaid, NJ FamilyCare, and the NJ FamilyCare Advantage buy-in programs. The initiative shall include culturally sensitive, Statewide and local media public awareness campaigns addressing the availability of health care coverage for parents and children under the Medicaid and NJ FamilyCare programs and health care coverage for children under the NJ FamilyCare Advantage buy-in program. The initiative shall also include the provision of training and support services, upon request, to community groups, legislative district offices, and community-based health care providers to enable these parties to assist in enrolling parents and children in the applicable programs. The bill provides an appropriation of $1 million to the department for this purpose; and

(3) The bill directs the Commissioner of Human Services to establish an Outreach, Enrollment, and Retention Working Group to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare, or NJ Family Care Advantage, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs. The members of the working group shall include: the Commissioners of Human Services, Health and Senior Services, Banking and Insurance, Labor and Workforce Development, Education, and Community Affairs, the Secretary of Agriculture, and the Child Advocate, or their designees, who shall serve ex officio; and six public members appointed by the Commissioner of Human Services who include one person each who represents racial and ethnic minorities in this State, managed care organizations that participate in the Medicaid and NJ FamilyCare programs, the vendor under contract with the Division of Medical Assistance and Health Services to provide NJ FamilyCare eligibility, enrollment, and health benefit coordinator services to the division, New Jersey Policy Perspective, the Association for Children of New Jersey, and Legal Services of New Jersey.

Individual and Small Employer Health Insurance Reforms:

The bill implements several reforms to the individual and small employer markets to make health benefits plans more affordable to individuals and small businesses in the State. Specifically, the bill:

- Seeks to make individual health benefits plans more affordable to younger persons, by revising the rating system for individual plans for new policies and contracts issued after the effective date of the bill, so that the premium rate differential can be up to 350%, but the only factor that the rating differential may be based on is the age of the person covered under the plan and the factor must be applied in a manner consistent with regulations of the Commissioner of Banking and Insurance, which shall include age classifications established, at a minimum, in five-year increments. The bill provides, however, that in order to protect consumers who currently have coverage under an individual health benefits plan, or who are 55 years of age or older and newly purchase an individual health benefits plan, rate increases for these consumers would be limited for the next four years to an amount no more than the lower of 15% or the medical trend assumption used by the carrier to project claims.
- Requires that a carrier must offer and make a good faith effort to market individual policies as a condition of participation in the small employer market, in order to ensure greater participation by carriers in the individual market.

- Reduces the number of standard plans that a carrier must offer in the individual and small employer markets from five to at least three plans.
- Authorizes carriers in the individual market to offer any number of riders which may add benefits or increase the actuarial value of any of the standard plans. Any such rider shall be filed with the board for informational purposes before the rider may be sold. The additional premium for a rider shall be listed separately from the premium for the standard plan.
- Transfers regulatory oversight regarding approval of policy and contract forms, and review of premium rate filings and other similar matters, from the Individual Health Coverage Program Board to the Commissioner of Banking and Insurance, as is currently provided in the New Jersey Small Employer Health Benefits Program.
- Requires carriers in the individual market to make an informational filing to the Commissioner of Banking and Insurance in the event the carrier seeks to increase or decrease premiums for any contract or policy form.
- Revises provisions concerning the minimum loss ratio for individual and small employer plans and provides that rates shall be formulated so that the anticipated minimum loss ratio is not less than 80% of the premium.
- Provides that after the 2007-08 calculation period, no further loss assessments shall be calculated or collected in the Individual Health Coverage Program, although carriers are not relieved of their obligations for loss assessments authorized prior to the effective date of the bill.
- Establishes transparency with respect to insurance broker fees by requiring insurance producers (brokers and agents) to notify a purchaser of insurance, in writing, of the amount of any commission, service fee, brokerage, or other valuable consideration that the producer will receive as a result of the sale, solicitation or negotiation of the health insurance policy or contract.

The "Kids First" initiative and expansion of NJ FamilyCare take effect immediately upon enactment of the bill, and the insurance reforms take effect 180 days after the date of enactment of the bill, except that the changes to the minimum loss ratio will take effect on January 1 next following enactment of the bill.

Dependent Coverage for Dependents 30 Years of Age or Younger Reforms:

The bill makes various changes to the eligibility criteria, terms, and administration of continued dependent coverage for dependents 30 years of age or younger, initially mandated pursuant to P.L.2005, c.375 (C.17:48-6.19 et al.). Specifically, the bill:

- Requires proof of prior, creditable health benefits coverage or receipt of benefits from another group or individual benefits

coverage source to be eligible to elect or subsequently reinstate continued dependent coverage.

- Provides that once an individual elects dependent coverage, that coverage shall not terminate before the individual reaches age 31. The cut off for electing coverage, as with the current law, remains 30 years of age, but the bill clarifies that the dependent coverage shall remain in effect while the individual is 30 years of age.
- To increase awareness of continued dependent coverage, requires health insurers and the State Health Benefits Program (SHBP) to provide notice to the parents of dependents (as covered persons under the insurance contracts) in the certificates of coverage or other equivalent documents prepared and delivered on or about the date parents' coverage commences, and on a quarterly basis thereafter. Provisions requiring employers to provide notices of coverage are eliminated in recognition that employers may have no obligation to comply with the notice requirements due to federal preemption concerning such matters provided by the "Employee Retirement Income Security Act of 1974," Pub.L.93-406 (29 U.S.C. s.1001 et seq.).
- With respect to the SHBP only, establishes that the State Health Benefits Commission may require payment of a premium by dependents or their parents, which shall be capped, for any period of continued dependent coverage under one of its contracts. The premium cannot exceed 102% of the applicable "dependent portion" of the premium previously paid for a dependent's coverage under a contract prior to the dependent initially aging out of coverage under the contract. The calculation of this premium cap is identical to the calculation of the 102% premium cap on continued dependent coverage already established for health insurers pursuant to P.L.2005, c.375 (C.17:48-6.19 et al.).

As reported and amended by committee, this bill is identical to Senate Bill No. 1557 (2R) Sca.

FISCAL IMPACT:

This bill appropriates of $1 million to the Department of Human Services for the enrollment and retention initiative.

Assembly Bill No. 2800 (the FY 2009 appropriations bill) appropriates $8 million to fund the first year costs of the increase in coverage provided by this bill.

COMMITTEE AMENDMENTS:

The amendments:

-- establish a hardship waiver for all or part of the premium for a child under the NJ FamilyCare program;

--coordinate the Department of the Treasury/Department of Human Services (DHS) Medicaid and NJ FamilyCare enrollment initiative established in section 7 of the bill with the enrollment initiative

established in section 26 of the bill, by providing that the Department of the Treasury would transmit to DHS information permitting DHS to identify taxpayers who are uninsured and may be eligible for Medicaid or NJ FamilyCare, rather than requiring the Department of the Treasury to administer a separate enrollment initiative;

-- adopt technical amendments to clarify which tax returns the State Treasurer should review with respect to the ongoing enrollment initiative, and to specify in R.S.54:50-9 that authority for examination of certain tax records and files by the Commissioner of Human Services is for the purpose of eligibility determination in the Medicaid and NJ FamilyCare programs;

-- establish the Medicaid, NJ FamilyCare, and NJ FamilyCare Advantage outreach and enrollment initiative in the Department of Human Services;

-- add an appropriation of $1 million to the Department of Human Services for the enrollment and retention initiative;

-- establish the Outreach, Enrollment, and Retention Working Group in the Department of Human Services;

-- restore language in section 2 of P.L.1992, c.161 (C.17B:27A-3) (that had been deleted in the bill) concerning health benefits plans issued prior to August 1, 1993, and providing restrictions on persons who are eligible to participate in group health benefits plans who seek coverage under an individual health benefits plan;

-- extend the limitation on rate increases provided to current policyholders under section 10 of the bill (for a four-year period, increases are limited to an amount no more than the lower of 15% or the medical trend assumption used by the carrier to project claims) to include persons who are 55 years of age or older and newly purchase an individual health benefits plan rate, and reduce the period for the rate increase limitation from five years to four years;

-- delete language in the bill that would have permitted carriers in the Individual Health Coverage Program to offer riders that would decrease benefits or decrease the actuarial value of a standard plan;

-- provide that the loss assessment in the Individual Health Coverage Program for the 2007-08 two-year calculation period will be the last loss assessment under the program;

-- specify that the increase in the minimum loss ratio to 80% in both the Individual Health Coverage Program and Small Employer Health Benefits Program would take effect on January 1 next following the date of enactment of the bill;

-- delete section 24 of the bill which amended section 8 of P.L.1992, c.162 (C.17B:27A-24) to change provisions governing carrier participation rates in small employer health benefits plans, so that the current provisions concerning participation rates remain in effect;

-- delete the requirement that an insurance producer report to the Commissioner of Banking and Insurance how the producer is

compensated for the sale, solicitation, or negotiation of health insurance policies and contracts; and

-- amend the provisions of P.L.2005, c.375 concerning dependent coverage for dependents 30 years of age or younger, for health insurers and the State Health Benefits Program to alter the eligibility criteria, terms and administration of the coverage.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

ASSEMBLY, No. 2624

STATE OF NEW JERSEY
213th LEGISLATURE

DATED: JUNE 30, 2008

SUMMARY

Synopsis: Expands NJ FamilyCare, establishes mandate for health care coverage of children, and makes various reforms to individual and small employer insurance markets; appropriates $1,000,000.

Type of Impact: Increase in costs to the Department of Human Services due to the expansion of NJ FamilyCare to parents with income up to 200 percent of the federal poverty level (FPL).

Agencies Affected: The Departments of Health and Senior Services, Human Services, and Treasury.

Office of Legislative Services Estimate

Fiscal Impact	Years 1 - 3
State Cost	**Parents**. Expanding NJ FamilyCare to parents with income of between 133 percent and 200 percent FPL will increase program costs. As the number of parents that will enroll in the program is not known, costs cannot be determined. However, based on current costs associated with parents in NJ FamilyCare, for every 10,000 additional parents that are phased-into NJ FamilyCare, program costs will total about $14.5 million (gross) or $5.1 million (State). **Presumptive Eligibility**. Mandating presumptive eligibility under Medicaid or NJ FamilyCare for emergency care provided by hospitals to children under the age of 19 may transfer approximately $29.5 million in Charity Care costs to the Medicaid/NJ FamilyCare program. In subsequent years, the amount of Charity Care provided to children under the age of 19 should be reduced, as many of these children may be eligible for Medicaid, NJ FamilyCare or other private health insurance, as provided in this bill.
State Revenue	**Federal Reimbursement** of either 50 percent or 65 percent will be available to offset gross program expenditures.

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- **Kids First Mandate**. There is no direct fiscal impact on the Medicaid/NJ FamilyCare programs as these programs already cover children with household income up to 350 percent FPL. The recommended FY 2009 budget provides $187.6 million (gross) for costs associated with children in the NJ FamilyCare program. To the extent that program costs of children in NJ FamilyCare exceed $187.6 million, additional State funds would be required.

- **Charity Care:** Establishing Medicaid and NJ FamilyCare presumptive eligibility for children under the age of 19 who receive emergency care in hospitals, expanding NJ FamilyCare eligibility to parents with income between 133 percent and 200 percent FPL, and making health insurance more affordable to individuals, families, and small businesses, should reduce the amount of documented Charity Care provided by hospitals. To the extent that State Charity Care appropriations are reallocated to support an increase in Medicaid and NJ FamilyCare costs, overall program costs would be reduced.

- **Premiums:** Households with income greater than 150 percent FPL would be required to pay a monthly premium based on household income. Any premiums that are collected would reduce overall program costs.

- New Jersey could experience developments similar to those in Massachusetts where State costs are significantly greater than initially estimated due to higher program enrollment.

- The various health insurance reforms in the bill affecting the individual and small insurance markets and dependent coverage up to age 30 will not have an impact on State costs.

BILL DESCRIPTION

Assembly Bill No. 2624 (1R) of 2008:

- Establishes a “Kids First” mandate that requires all children 18 years of age and younger to have health insurance coverage, beginning one year after the date of enactment of the bill. This coverage may be provided through an employer-sponsored or individual health benefits plan, the Medicaid program, NJ FamilyCare Program, or the NJ FamilyCare Advantage buy-in program (administered by Horizon Blue Cross Blue Shield of New Jersey).
- Expands eligibility for the NJ FamilyCare Program to include parents whose income is between 133 percent and 200 percent FPL.
- Prohibits hospitals from submitting charity care claims for emergency services provided to patients under the age of 19 and provides that .presumptive eligibility for NJ FamilyCare or Medicaid would be extended to these patients, and hospitals would be required to bill those programs for the cost of emergency care provided to such patients.
- Establishes an ongoing enrollment initiative with the Department of the Treasury and the Department of Human Services (DHS), and an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about enrollment in Medicaid, NJ FamilyCare, and the NJ FamilyCare Advantage buy-in programs, and appropriates $1.0 million to DHS to carry out the initiatives.

- Adopts various health insurance reforms affecting the individual and small insurance markets, and dependent coverage up to age 30, which will not have an impact on State costs.

FISCAL ANALYSIS

EXECUTIVE BRANCH

Although no formal fiscal information was provided to the Office of Legislative Services, DHS submitted fiscal information to the Senate Budget and Appropriations Committee related to the expansion of NJ FamilyCare to parents with income up to 200 percent FPL, and the expansion of NJ FamilyCare with an enhanced outreach campaign, as summarized below:

Expansion to parents with income up to 200% FPL

An additional 8,200, 10,700 and 12,100 children would be enrolled in NJ FamilyCare over current estimates if the program is expanded to parents with income up to 200 percent FPL in FY 2009, 2010 and 2011, respectively. State costs would increase by about $1.9 million, $5.2 million and $6.3 million in each year, respectively.

An additional 13,700, 27,600 and 40,200 adults with income up to 200 percent FPL would be enrolled in NJ FamilyCare in FY 2009, 2010 and 2011, respectively. State costs would increase by about $6.9 million, $24.1 million and $40.0 million in each year, respectively.

Expansion to parents with income up to 200% FPL plus outreach campaign

An additional 11,100, 16,000 and 19,800 children would be enrolled in NJ FamilyCare over current estimates in FY 2009, 2010 and 2011, respectively. State costs would increase by about $2.8 million, $8.0 million and $11.1 million in each year, respectively.

An additional 17,800, 37,700 and 57,700 adults with income up to under 200 percent FPL would be enrolled in NJ FamilyCare over current estimates in FY 2009, 2010 and 2011, respectively. State costs would increase by about $9.1 million, $32.5 million and $56.9 million in each year, respectively.

OFFICE OF LEGISLATIVE SERVICES

The Office of Legislative Services can neither confirm or refute fiscal information provided by DHS to the Senate Budget and Appropriations Committee. It is noted, however, that prior DHS estimates as to the number of children and adults enrolled in NJ FamilyCare have not been realized even with marketing and outreach initiatives intended to increase enrollment.

Many of the provisions of the legislation affect the individual and small employer health insurance markets. Such changes have no impact on State costs and will not be considered in this analysis.

Kids First Mandate

The **Medicaid and NJ FamilyCare** programs already provide coverage to children with household income of up to 350 percent FPL. As such, there is no additional cost to the Medicaid/NJ FamilyCare programs as a result of the mandate that all children be covered by health insurance. The FY 2009 recommended budget includes $187.6 million (gross) to provide coverage to children under NJ FamilyCare.

To the extent that either the FY 2009 recommended budget is not adequate due to either an increase in the number of children eligible for NJ FamilyCare or an increase in program costs, additional funds would be required. Based on the average cost of $136 per child (July 2007 - March 2008), a range of possible State costs can be calculated should the number of children enrolled in NJ FamilyCare exceed FY 2009 budget estimates. Actual State costs will depend on whether a federal match of 50 percent or 65 percent is available:

Number of Additional Children Enrolled (Phased in)	Annual Gross Costs ($000)	Federal Match of 50% and 65% ($000)	State Costs at Federal Match of 50% and 65% ($000)
10,000	$7,707	$3,853 - $5,009	$3,853 - $2,697
25,000	$19,267	$9,633 - $12,523	$9,633 - $6,743
50,000	$38,533	$19,267 – 25,047	$19,267 - $13,487

The above costs will be reduced through the collection of premiums from families with income greater than 150 percent FPL and through third party liability recoveries from other health insurance coverage a family may have. The amount of premiums that may be collected and the amount of third party liability recoveries that may be realized will not be known until such children enroll in NJ FamilyCare.

NJ FamilyCare Advantage. At present, there are no State costs associated with the program that is available to children in households with income greater than 350 percent FPL, as Horizon Blue Cross Blue Shield of New Jersey subsidizes program costs in excess of the amount of premiums collected. At present, there are fewer than 50 families participating in the program.

NJ FamilyCare Parent Expansion from 133% to 200% FPL

At present, there are about 44,000 children in the NJ FamilyCare program with family income between 133 percent and 200 percent FPL. Although information is not readily available as to the number of parents associated with the 44,000 children, the average cost to cover parents in the NJ FamilyCare program is $255 per person (July 2007 - March 2008). Based on this cost information, a range of possible costs can be calculated:

Number of Adults Enrolled (Phased In)	Annual Gross Costs ($000)	Federal Match at 65% ($000)	State Costs ($000)
10,000	$14,450	$9,3936	$5,058
25,000	$19,167	$12,523	$6,7434
50,000	$38,533	$25,0472	$13,487
75,000	$57,800	$37,570	$20,230

The above costs will be reduced due to the collection of premiums from adults and through third party liability recoveries from other health insurance coverage an adult may have. The amount of premiums and the amount of third party liability recoveries that may be realized cannot be determined.

Charity Care

Presumptive Eligibility: The legislation would extend presumptive eligibility to all children under the age of 19 for emergency care provided at hospitals, and prohibit hospitals from submitting claims for Charity Care for these patients.

Hospitals provide upwards of $950 million in Charity Care (at Medicaid reimbursement amounts). Approximately 3.1 percent of Charity Care expenditures are incurred by patients under the age of 19 (DeLia, Evaluation of the Hospital Charity Care Program in New Jersey, Table 3. Rutgers Center for State Health Policy, January 2007). Thus, upwards of $29.5 million in Charity Care costs would be shifted to and paid by the Medicaid and NJ FamilyCare programs. At a federal matching rate of either 50 percent or 65 percent, State costs would range from about $10.3 million to $14.8 million.

To the extent that additional children and adults obtain health insurance through either Medicaid, NJ FamilyCare, NJ FamilyCare Advantage, or other health insurance and do not have to rely on the Charity Care program, the amount of documented Charity Care provided by hospitals would be reduced. The amount of this reduction cannot be determined.

Section:	*Human Services*
Analyst:	*Jay A. Hershberg* *Principal Fiscal Analyst*
Approved:	*David J. Rosen* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C. 52:13B-1 et seq.).

THE STATE OF NEW JERSEY
OFFICE OF THE GOVERNOR

JON S. CORZINE
Governor

En Español

For Immediate Release:
Date: July 07, 2008

For More Information:
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Governor Signs Progressive Familycare Legislation

Perth Amboy – Governor Jon S. Corzine today signed progressive legislation expanding NJ FamilyCare and establishing mandates for health care coverage of all children. The bill, S1557/A2624, also initiates a number of reforms to individual and small employer insurance markets.

"This is an historic day for health care in New Jersey," said Governor Corzine. "While there has been much national dialogue about universal health care, here in New Jersey, we're actually doing something about it.

"We're expanding our best-in-the-nation FamilyCare program to cover more working-class families and requiring health

coverage for all children in New Jersey. To do this, we will be phasing-in mandatory health care coverage to some 250,000 additional children and strengthening the FamilyCare buy-in option we recently offered for families earning up to 350 percent of the federal poverty level. Today is truly a giant leap on the road to universal healthcare coverage in New Jersey."

Overall, the bill achieves several broad goals. First, it expands NJ FamilyCare to include more low income parents. Second, it mandates that all children in the State have health care coverage through public or private means. Third, it increases affordability and stabilizes enrollment by individuals and small businesses. Fourth, it changes eligibility criteria, terms, and administration of continued dependent coverage for dependents 30 years of age or younger.

"With today's bill signing, New Jersey is taking a dramatic step forward in ensuring that quality health care is a fundamental right – not a privilege – for all State residents," said Senator Joseph F. Vitale, (D-Middlesex), the author of the plan to guarantee affordable health care coverage for all New Jerseyans. "The system of forcing the uninsured to seek costly emergency care, rather than see a doctor for regular medical checkups and preventive health care, is dysfunctional and unsustainable. We need to spend health care dollars smarter, and this new law puts us on track to get better health results cheaper for the 1.5 million New Jerseyans who are one major illness or injury away from bankruptcy."

New Jersey's FamilyCare program began as NJ KidCare in 1998. It was expanded and renamed NJ FamilyCare in 2000. Presently, parents in families of four must have incomes below 133 percent of the Federal Poverty Level to qualify or $28,196. There are more than 221,000 New Jersey children and adults covered, including 124,000 children and 97,000 adults. By expanding the program, it is anticipated that an additional 56,768 parents will be covered by the end of fiscal year 2011. During the same timeframe, it is anticipated that an additional 17, 149 children will become enrolled in the program.

"For too long families in New Jersey have been forced to rely on a healthcare plan that consists of not getting sick," said Assemblyman Neil M.Cohen (D-Union). "Expanding access to FamilyCare and ensuring universal health coverage for children means that more individuals will have their small health problems treated before they can grow into life-threatening illnesses. This new policy is a huge step forward that not only will save the state money, but more importantly, will save lives."

"Today, New Jersey continues down the road toward the goal of providing access to health care for all residents regardless of where they live or their economic condition," said Assemblyman Louis D. Greenwald (D-Camden). "It is inexcusable that

any child could be shut-out of a doctor's office. It is inexcusable that a working parent cannot have access to an affordable health care plan. Through this investment in FamilyCare and the push for comprehensive market reform, we can ensure there will be no more excuses."

Primary sponsors of the legislation in the Senate were Senators Joseph F. Vitale (D-Middlesex) and Robert W. Singer (R –Burlington, Mercer, Monmouth, Ocean). Assemblymen Neil M. Cohen (D-Union), Louis D. Greenwald (D-Camden), Ruben J. Ramos, Jr. (D-Hudson), John J. Burzichelli (D-Salem, Cumberland, Gloucester) and Paul D. Moriarity (D-Camden, Gloucester) were primary sponsors in the Assembly.

KEY REFORMS ESTABLISHED BY THE BILL:

Health Care Coverage

- Provides a "Kids First" mandate requiring all children 18 years of age and younger to have health insurance coverage through an employer-sponsored or individual health benefits plan, the Medicaid program, NJ FamilyCare Program, or the NJ FamilyCare Advantage buy-in program. This coverage begins one year after the bill is enacted.
- Makes health care coverage more accessible by expanding eligibility for the NJ FamilyCare Program to include parents whose income is between 133 percent and 200 percent of the Federal Poverty Level.
- Prohibits hospitals from submitting charity care claims for emergency services provided to patients under the age of 19 and presumes eligibility for NJ FamilyCare or Medicaid would be extended to these patients. Hospitals would be required to bill those programs for the cost of emergency care provided to the patient.
- An ongoing enrollment initiative with the Department of the Treasury and the Department of Human Services (DHS) will be established as well as an enhanced NJ FamilyCare outreach and enrollment initiative to increase public awareness about enrollment.

Individual and Small Employer Health Insurance Reforms

- Implements health insurance reforms to make health benefit more affordable to individuals and small businesses in the State.
- Makes individual health benefits plans more affordable to younger persons, by revising the rating system for individual plans

for new policies and contracts issued after the effective date of the bill.

- Requires carriers to offer and make a good faith effort to market individual policies as a condition of participation in the small employer market, in order to ensure greater participation by carriers in the individual market.
- Reduces the number of standard plans that a carrier must offer in the individual and small employer markets from five to at least three plans.

Dependent Coverage for Dependents 30 Years of Age or Younger Reforms:

- Makes changes to eligibility criteria, terms, and administration of continued dependent coverage for dependents 30 years of age or younger.
- Requires proof of prior, creditable health benefits coverage or receipt of benefits from another group or individual benefits coverage source to be eligible to elect or reinstate continued dependent coverage.

- Once an individual elects dependent coverage, that coverage is not ended until the individual reaches age 31. The cut off for electing coverage remains 30 years of age; the bill clarifies that the dependent coverage remains in effect while the individual is 30 years of age.
- Health insurers and the State Health Benefits Program (SHBP) must provide notice to the parents of dependents to increase awareness of continued dependent coverage

NJ FAMILYCARE BACKGROUND

- New Jersey's FamilyCare program began as NJ KidCare in 1998. It was expanded and renamed NJ FamilyCare in 2000.
- The goal of the original legislation was to provide health insurance for low-income children whose family incomes were too high for them to be eligible for traditional Medicaid but also too low for them to be able to participate in a private or employer-sponsored health insurance program. The program is funded with State and Federal monies.
- By mid-2001, an all-time enrollment high of 180,000 adults enrollments was reached. With that NJ faced the challenge of running out of federal funding to support the parent piece of the program and as a result jeopardize the enrollment of children.

- In June of 2002, forced by budget concerns, New Jersey made the extremely difficult decision to stop enrolling parents and adults.
- On July 13, 2005 – five years to the date that the program first was expanded to include adults – the bill to reopen NJ FamilyCare to parents was signed.
- Presently, parents in families must have incomes below 133 percent of the Federal Poverty Level to qualify. This is $28,196 of the Federal Poverty Level and there are 97,563 adults covered.
- Jan. 1, 2008, we instituted NJ FamilyCare ADVANTAGE, the low-cost full buy-in program for uninsured qualified children of any income.
- In the SCHIP program, there are more than 221,000 New Jersey children and adults covered, including 124,000 children and 97,000 adults.
- Today, Medicaid insures approximately 1.05 million New Jersey children and adults. That includes more than 598,000 children and 453,000 adults.

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Photos from Governor Corzine's public events are available in the Governor's Newsroom section on the State of New Jersey web page.

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