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**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*)

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

3  
4 **BE IT ENACTED** by the Senate and General Assembly of the State  
5 of New Jersey:

- 6  
7 1. (New section) The Legislature finds and declares:  
8 a. There are an estimated 1.25 million residents of the State  
9 who have no health insurance coverage, of which over 240,000 are  
10 children, and the number of uninsured residents is increasing each  
11 year;  
12 b. While employer-sponsored health care coverage in the State  
13 is well above the national average and has been a major factor in  
14 keeping the number of uninsured lower than in many states, because  
15 of the rising cost of the coverage, increasing numbers of employers  
16 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:

<sup>1</sup>Senate SHH committee amendments adopted May 15, 2008.

<sup>2</sup>Senate SBA committee amendments adopted May 19, 2008.

<sup>3</sup>Senate SBA committee amendments adopted June 19, 2008.

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

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

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

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

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

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

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

37

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

45 b. As used in this section:

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

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

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

6  
7 3. Section 4 of P.L.2005, 156 (C.30:4J-11) is amended to read  
8 as follows:

9 4. As used in this act:

10 "Commissioner" means the Commissioner of Human Services.

11 "Department" means the Department of Human Services.

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

15 "NJ FamilyCare" or "program" means the NJ FamilyCare  
16 Program established pursuant to sections 3 through 5 of P.L.2005,  
17 156 (C.30:4J-10 through C.30:4J-12).

18 "Poverty level" means the official federal poverty level based on  
19 family size, established and adjusted under Section 673(2) of  
20 Subtitle B, the "Community Services Block Grant Act," Pub.L.97-  
21 35 (42 U.S.C. s.9902(2)).

22 "Qualified applicant" means:

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

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

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

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

46

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

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

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

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

17       c. The commissioner:

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

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

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

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

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

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

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

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

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

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

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

30 (4) Continuous enrollment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

45 <sup>3</sup>1. Subject to federal approval, the Commissioner of Human  
46 Services shall establish a hardship waiver for part or all of the  
47 premium for an eligible child under the NJ FamilyCare program. A  
48 parent or caretaker may apply to the commissioner for a hardship

1 waiver in a manner and form established by the commissioner. If  
2 the parent or caretaker can demonstrate to the satisfaction of the  
3 commissioner, pursuant to regulations adopted by the  
4 commissioner, that payment of all or part of the premium for the  
5 parent or caretaker's child presents a hardship, the commissioner  
6 shall grant the waiver for a prescribed period of time.<sup>3</sup>

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

8  
9 5. (New section) The Commissioner of Human Services shall  
10 apply for such waivers as may be necessary to implement the  
11 provisions of section 4 of P.L.2005, c.156 (C.30:4J-11) and to  
12 secure federal financial participation for NJ FamilyCare  
13 expenditures under the State Children's Health Insurance Program  
14 pursuant to 42 U.S.C.s.1397aa et seq.

15  
16 6. (New section) Notwithstanding the provisions of section 3 of  
17 P.L.2004, c.113 (C.26:2H-18.59i) to the contrary, a hospital shall  
18 not submit charity care claims to the Department of Health and  
19 Senior Services for health care services provided to a child under 19  
20 years of age who presents at a hospital for emergency care and who  
21 may be deemed presumptively eligible for NJ FamilyCare coverage  
22 pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) or Medicaid coverage  
23 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

24  
25 7. (New section) a. Beginning with the 2008 tax year and for  
26 each tax year thereafter, the Department of the Treasury shall  
27 require that each individual <sup>2</sup>**[taxpayer]** who files a resident New  
28 Jersey Gross Income Tax return<sup>2</sup> indicate on the taxpayer's income  
29 tax return whether the taxpayer and dependents, if applicable, has  
30 health insurance coverage on the date of filing of the return.

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

47 c. As used in this section:

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

4 "NJ FamilyCare" or "program" means the NJ FamilyCare  
5 Program established pursuant to P.L.2005, <sup>2</sup>[156] c.156<sup>2</sup> (C.30:4J-  
6 8 et al.).

7  
8 8. R.S.54:50-9 is amended to read as follows:

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

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

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

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

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

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

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

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

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

- 1 required to pay child support, upon request by the State agency and  
2 pursuant to procedures and in a form prescribed by the director;
- 3 i. The furnishing by the director to the Board of Public  
4 Utilities any information contained in tax information statements,  
5 reports or returns or any audit thereof or a report of any  
6 investigation made with respect thereto, as may be necessary for the  
7 administration of P.L.1991, c.184 (C.54:30A-18.6 et al.) and  
8 P.L.1997, c.162 (C.54:10A-5.25 et al.);
- 9 j. The furnishing by the director to the Director of the Division  
10 of Alcoholic Beverage Control in the Department of Law and  
11 Public Safety any information contained in tax information  
12 statements, reports or returns or any audit thereof or a report of any  
13 investigation made with respect thereto, as may be relevant, in the  
14 discretion of the director, in any proceeding conducted for the  
15 issuance, suspension or revocation of any license authorized  
16 pursuant to Title 33 of the Revised Statutes;
- 17 k. The inspection by the Attorney General or other legal  
18 representative of this State of the reports or files of any tobacco  
19 product manufacturer, as defined in section 2 of P.L.1999, c.148  
20 (C.52:4D-2), for any period in which that tobacco product  
21 manufacturer was not or is not in compliance with subsection a. of  
22 section 3 of P.L.1999, c.148 (C.52:4D-3), or of any licensed  
23 distributor as defined in section 102 of P.L.1948, c.65 (C.54:40A-  
24 2), for the purpose of facilitating the administration of the  
25 provisions of P.L.1999, c.148 (C.52:4D-1 et seq.);
- 26 l. The furnishing, at the discretion of the director, of  
27 information as to whether a contractor or subcontractor holds a  
28 valid business registration as defined in section 1 of P.L.2001, c.134  
29 (C.52:32-44);
- 30 m. The furnishing by the director to a State agency as defined in  
31 section 1 of P.L.1995, c.158 (C.54:50-24) the names of licensees  
32 subject to suspension for non-payment of State tax indebtedness  
33 pursuant to P.L.2004, c.58 (C.54:50-26.1 et al.);
- 34 n. The release to the United States Department of the Treasury,  
35 Bureau of Financial Management Service, or its successor of  
36 relevant taxpayer information for purposes of implementing a  
37 reciprocal collection and offset of indebtedness agreement entered  
38 into between the State of New Jersey and the federal government  
39 pursuant to section 1 of P.L.2006, c.32 (C.54:49-12.7);
- 40 o. The examination of said records and files by the  
41 Commissioner of Health and Senior Services, the Commissioner of  
42 Human Services, the Medicaid Inspector General, or their  
43 respective duly authorized agents, pursuant to section 5 of  
44 P.L.2007, c.217 (C.26:2H-18.60e)<sup>2</sup>, section 3 of P.L.1968, c.413  
45 (C.30:4D-3), or section 5 of P.L.2005, c.156 (C.30:4J-12)<sup>2</sup>;
- 46 p. The furnishing at the discretion of the director of employer  
47 provided wage and tax withholding information contained in tax  
48 reports or returns filed pursuant to N.J.S.54A:7-2, 54A:7-4 and

1 54A:7-7, to the designated municipal officer of a municipality  
2 authorized to impose an employer payroll tax pursuant to the  
3 provisions of Article 5 (Employer Payroll Tax) of the "Local Tax  
4 Authorization Act," P.L.1970, c.326 (C.40:48C-14 et seq.), for the  
5 limited purpose of verifying the payroll information reported by  
6 employers subject to the employer payroll tax.  
7 (cf: P.L.2007, c.294, s.2)

8  
9 9. Section 1 of P.L.1992, c.161 (C.17B:27A-2) is amended to  
10 read as follows:

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

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

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

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

26 "Commissioner" means the Commissioner of Banking and  
27 Insurance.

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

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

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

12       "Department" means the Department of Banking and Insurance.

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

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

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

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

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

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

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

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

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

1 (10 U.S.C. s.1071 et seq.); and similar supplemental coverage  
2 provided to coverage under a group health plan.

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

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

16 Individual health benefits plan shall not include a certificate  
17 issued under a policy or contract issued to a trust, or to the trustees  
18 of a fund, which trust or fund is an employee welfare benefit plan,  
19 to the extent the "Employee Retirement Income Security Act of  
20 1974" (29 U.S.C. s.1001 et seq.) preempts the application of  
21 P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

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

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



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

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

19 "Net earned premium" means the premiums earned in this State  
20 on health benefits plans, less return premiums thereon and  
21 dividends paid or credited to policy or contract holders on the  
22 health benefits plan business. Net earned premium shall include the  
23 aggregate premiums earned on the carrier's insured group and  
24 individual business and health maintenance organization business,  
25 including premiums from any Medicare, Medicaid, or NJ  
26 FamilyCare or **[NJ KidCare]** contracts with the State or federal  
27 government, but shall not include premiums earned from contracts  
28 funded pursuant to the "Federal Employee Health Benefits Act of  
29 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss  
30 insurance coverage issued by a carrier in connection with any self  
31 insured health benefits plan, or Medicare supplement policies or  
32 contracts.

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

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

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

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

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

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

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

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

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

20 "Two-year calculation period" means a two calendar year period,  
21 the first of which shall begin January 1, 1997 and end December 31,  
22 1998.

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

24  
25 10. Section 2 of P.L.1992, c.161 (C.17B:27A-3) is amended to  
26 read as follows:

27 2. a. An individual health benefits plan issued on or after  
28 **【August 1, 1993 shall be subject to the provisions of this act】** the  
29 effective date of <sup>1</sup>this section of<sup>1</sup> P.L. , c. (pending before the  
30 Legislature as this bill) shall be subject to the rating provisions  
31 established in P.L. , c. (pending before the Legislature as this bill)<sup>3</sup>;  
32 except that for the four years next following the effective date of  
33 this section, in the case of a person who is 55 years of age or older  
34 who purchases a health benefits plan on or after that effective date,  
35 the annual rate increase for that person shall be limited to the lower  
36 of 15% or the medical trend assumption used by the carrier to  
37 project claims<sup>3</sup>.

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

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

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

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

7 (3) A group conversion contract or policy issued prior to August  
8 1, 1993 that is not issued on a modified community rated basis or  
9 community rated basis, shall not be subject to the provisions of this  
10 act, except that the contract or policy shall be liable for assessments  
11 made pursuant to section 11 of this act.

12 (4) Notwithstanding any other provision of law to the contrary,  
13 an individual health benefits plan issued by a hospital service  
14 corporation or medical service corporation prior to the effective  
15 date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to  
16 the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that  
17 the plan shall guarantee renewal pursuant to subsection b. of section  
18 5 of P.L.1992, c.161 (C.17B:27A-6).

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

29 <sup>3</sup>[(Deleted by amendment, P.L. \_\_\_\_\_, c. \_\_\_\_\_) (pending before the  
30 Legislature as this bill).]

31 (1) An individual health benefits plan issued on an open  
32 enrollment, modified community rated basis or community rated  
33 basis prior to August 1, 1993 shall not be subject to sections 3  
34 through 8, inclusive, of P.L.1992, c.161 (C.17B:27A-4 through  
35 17B:27A-9), unless otherwise specified therein.

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

41 (3) A group conversion contract or policy issued prior to August  
42 1, 1993 that is not issued on a modified community rated basis or  
43 community rated basis, shall not be subject to the provisions of this  
44 act, except that the contract or policy shall be liable for assessments  
45 made pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-12).

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

1 date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to  
2 the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that  
3 the plan shall guarantee renewal pursuant to subsection b. of section  
4 5 of P.L.1992, c.161 (C.17B:27A-6).

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

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

27 After August 1, 1993, an individual who is eligible to participate  
28 in a group health benefits plan that provides coverage for hospital  
29 or medical expenses shall not be covered by an individual health  
30 benefits plan which provides benefits for hospital and medical  
31 expenses that are the same or similar to coverage provided in the  
32 group health benefits plan, except that an individual who is eligible  
33 to participate in a group health benefits plan but is currently  
34 covered by an individual health benefits plan may continue to be  
35 covered by that plan until the first anniversary date of the group  
36 health benefits plan occurring on or after January 1, 1994.<sup>1</sup>

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

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

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

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

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

20

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 f. In addition to the rider packages provided for in subsection  
14 c. of section 6 of P.L.1992, c.161 (C.17B:27A-7), every carrier may  
15 offer, in connection with the health benefits plans required to be  
16 offered by this section, any number of riders which may <sup>1</sup>【revise  
17 the coverage offered by the plans in any way, provided, however,  
18 that any form of such rider or amendment thereof which decreases  
19 benefits or decreases the actuarial value of one of the plans shall be  
20 filed for informational purposes with the board and for approval by  
21 the commissioner before such rider may be sold】 add benefits or  
22 increase the actuarial value of any of the plans<sup>1</sup>. Any <sup>1</sup>'such' rider  
23 or amendment thereof <sup>1</sup>【which adds benefits or increases the  
24 actuarial value of one of the plans】<sup>1</sup> shall be filed with the board for  
25 informational purposes before <sup>1</sup>【such】 the<sup>1</sup> rider may be sold. The  
26 added premium <sup>1</sup>【or reduction in premium】<sup>1</sup> for each rider <sup>1</sup>【, as  
27 applicable,】<sup>1</sup> shall be listed separately from the premium for the  
28 standard plan.

29 The commissioner shall disapprove any rider filed pursuant to  
30 this subsection that is unjust, unfair, inequitable, unreasonably  
31 discriminatory, misleading, contrary to law or the public policy of  
32 this State. <sup>1</sup>【The commissioner shall not approve any rider which  
33 reduces benefits below those required by sections 55, 57 and 59 of  
34 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and  
35 required to be sold pursuant to this section.】<sup>1</sup> The commissioner's  
36 determination shall be in writing and shall be appealable.

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

38

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

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

46 90 days hospital room and board - \$500 copayment per hospital  
47 stay;

1 Outpatient and ambulatory surgery- \$250 copayment per surgery;  
2 Physicians' fees connected with hospital care, including general  
3 acute care and surgery;  
4 Physicians' fees connected with outpatient and ambulatory surgery;  
5 Anesthesia and the administration of anesthesia;  
6 Coverage for newborns;  
7 Treatment for complications of pregnancy;  
8 Intravenous solutions, blood and blood plasma;  
9 Oxygen and the administration of oxygen;  
10 Radiation and x-ray therapy;  
11 Inpatient physical therapy and hydrotherapy;  
12 Outpatient physical therapy - 30 visits annually per covered person-  
13 \$20 copayment per treatment;  
14 Dialysis - inpatient or outpatient;  
15 Inpatient diagnostic tests and \$500 annual aggregate per covered  
16 person for out-of-hospital diagnostic tests;  
17 Laboratory fees for treatment in hospital;  
18 Delivery room fees;  
19 Operating room fees;  
20 Special care unit;  
21 Treatment room fees;  
22 Emergency room services for medically necessary treatment - \$100  
23 copayment per visit;  
24 Pharmaceuticals dispensed in hospital;  
25 Dressings;  
26 Splints;  
27 Treatment for biologically-based mental illness, as defined in  
28 subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90  
29 days inpatient with no coinsurance - \$500 copayment per inpatient  
30 stay, 30 days outpatient with 30% coinsurance;  
31 Alcohol and Substance Abuse Treatment - 30 days inpatient or  
32 outpatient - 30% coinsurance;  
33 Childhood immunizations in accordance with the provisions of  
34 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and  
35 adult immunizations;  
36 Wellness benefit - \$600 annual aggregate per covered person, \$50  
37 annual deductible, 20% coinsurance per service; and  
38 Physicians visits for diagnosed illness or injury - to a \$700 annual  
39 aggregate per covered person.

40 b. A carrier shall offer the benefits on an indemnity basis, with  
41 the option that: (1) coverage is restricted to health care providers in  
42 the carrier's network, including an exclusive provider organization,  
43 or the carrier's preferred provider organization; or (2) coverage is  
44 provided through health care providers in the carrier's network or  
45 preferred provider organization with an out-of-network option with  
46 30% coinsurance in addition to whatever other coinsurance may be  
47 applicable under the policy.



1 c. With respect to all policies or contracts issued pursuant to  
2 this section, the premium rate charged by a carrier to the highest  
3 rated individual or class of individuals shall not be greater than  
4 350% of the premium rate charged for the lowest rated individual or  
5 class of individuals purchasing this health benefits plan, provided,  
6 however, that the only factors upon which the rate differential may  
7 be based are age, gender, and geography. Rates applicable to  
8 policies or contracts issued pursuant to this section shall reflect past  
9 and prospective loss experience for benefits included in such  
10 policies or contracts, and shall be formulated in a manner that does  
11 not result in an unfair subsidization of rates applicable to policies  
12 issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2  
13 et seq.) as the result of differences in levels of benefits offered.

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

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

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

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

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

37

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

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

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

12 (cf: P.L.2001, c.368, s.4)

13

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

16 5. An individual health benefits plan issued pursuant to section  
17 3 of this act is subject to the following provisions:

18 a. The health benefits plan shall guarantee coverage for an  
19 eligible person and his dependents on a modified community rated  
20 basis.

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

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

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

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

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

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

39 (3) **[board]** approval by the commissioner of a request by  
40 the individual carrier to not renew a particular type of health  
41 benefits plan, in accordance with rules adopted by the **[board]**  
42 commissioner. After receiving **[board]** approval by the  
43 commissioner, a carrier may not renew a type of health benefits  
44 plan only if the carrier: (a) provides notice to each covered  
45 individual provided coverage of this type of the nonrenewal at least  
46 90 days prior to the date of the nonrenewal of the coverage; (b)  
47 offers to each individual provided coverage of this type the option  
48 to purchase any other individual health benefits plan currently being

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

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

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

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

26  
27 15. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to  
28 read as follows:

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

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

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

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

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

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

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

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

34 e. Effective immediately for an individual health benefits plan  
35 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
36 35.27 et al.) and effective on the first 12-month anniversary date of  
37 an individual health benefits plan in effect on the effective date of  
38 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health  
39 benefits plans required pursuant to section 3 of P.L.1992, c.161  
40 (C.17B:27A-4), including any plan offered by a federally qualified  
41 health maintenance organization, shall contain benefits for expenses  
42 incurred in the following:

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

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

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

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

19 The benefits provided pursuant to this subsection shall be  
20 provided to the same extent as for any other medical condition  
21 under the health benefits plan, except that a deductible shall not be  
22 applied for benefits provided pursuant to this subsection; however,  
23 with respect to a health benefits plan that qualifies as a high  
24 deductible health plan for which qualified medical expenses are  
25 paid using a health savings account established pursuant to section  
26 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),  
27 a deductible shall not be applied for any benefits provided pursuant  
28 to this subsection that represent preventive care as permitted by that  
29 federal law, and shall not be applied as provided pursuant to section  
30 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall  
31 apply to all individual health benefits plans in which the carrier has  
32 reserved the right to change the premium.

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

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

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

5 g. Effective immediately for an individual health benefits plan  
6 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
7 35.27 et al.) and effective on the first 12-month anniversary date of  
8 an individual health benefits plan in effect on the effective date of  
9 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans  
10 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)  
11 that qualify as high deductible health plans for which qualified  
12 medical expenses are paid using a health savings account  
13 established pursuant to section 223 of the federal Internal Revenue  
14 Code of 1986 (26 U.S.C. s.223), including any plan offered by a  
15 federally qualified health maintenance organization, shall contain  
16 benefits for expenses incurred in connection with any medically  
17 necessary benefits provided in-network which represent preventive  
18 care as permitted by that federal law.

19 The benefits provided pursuant to this subsection shall be  
20 provided to the same extent as for any other medical condition  
21 under the health benefits plan, except that a deductible shall not be  
22 applied for benefits provided pursuant to this subsection. This  
23 subsection shall apply to all individual health benefits plans in  
24 which the carrier has reserved the right to change the premium.  
25 (cf: P.L.2005, c.248, s.13)

26

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

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

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

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

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

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

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

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

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

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

12 f. **【Notwithstanding the provisions of P.L.1992, c.161**  
13 **(C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed**  
14 **pursuant to this section by a carrier which insured at least 50% of**  
15 **the community-rated individually insured persons on the effective**  
16 **date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required**  
17 **to produce a loss ratio which when combined with the carrier's**  
18 **administrative costs and investment income results in self-**  
19 **sustaining rates prior to January 1, 1996, for individual policies or**  
20 **contracts issued prior to August 1, 1993. The carrier shall, not later**  
21 **than 30 days after the effective date of P.L.1994, c.102**  
22 **(C.17B;27A-4 et al.), file with the board for approval, a plan to**  
23 **achieve this objective.】** (Deleted by amendment, P.L., c. )(pending  
24 before the Legislature as this bill).  
25 (cf: P.L.1994, c.102, s.2)  
26

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

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

35 The board shall have the specific authority to:

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

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

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



- 1 d. define the provisions of individual health benefits plans in  
2 accordance with the requirements of this act;
- 3 e. enter into contracts which are necessary or proper to carry  
4 out the provisions and purposes of this act;
- 5 f. establish a procedure for the joint distribution of information  
6 on individual health benefits plans issued pursuant to section 3 of  
7 this act;
- 8 g. establish, at the board's discretion, standards for the  
9 application of a means test for individual health benefits plans  
10 issued pursuant to section 3 of this act;
- 11 h. establish, at the board's discretion, reasonable guidelines for  
12 the purchase of new individual health benefits plans by persons who  
13 already are enrolled in or insured by another individual health  
14 benefits plan;
- 15 i. establish minimum requirements for performance standards  
16 for carriers that are reimbursed for losses submitted to the program  
17 and provide for performance audits from time to time;
- 18 j. sue or be sued, including taking any legal actions necessary  
19 or proper for recovery of an assessment for, on behalf of, or against  
20 the program or a member;
- 21 k. appoint from among its members appropriate legal, actuarial,  
22 and other committees as necessary to provide technical and other  
23 assistance in the operation of the program, in policy and other  
24 contract design, and any other function within the authority of the  
25 program;
- 26 l. borrow money to effect the purposes of the program. Any  
27 notes or other evidence of indebtedness of the program not in  
28 default shall be legal investments for carriers and may be carried as  
29 admitted assets; and
- 30 m. contract for an independent actuary and any other  
31 professional services the board deems necessary to carry out its  
32 duties under P.L.1992, c.161 (C.17B:27A-2 et al.).  
33 (cf: P.L.1993, c.164, s.6)

34  
35 18. Section 11 of P.L.1992, c.161 (C.17B:27A-12) is amended  
36 to read as follows:

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

- 40 a. (1) By March 1, 1999, and following the close of each two-  
41 year calculation period thereafter, or on a different date established  
42 by the board:
  - 43 (a) every carrier issuing health benefits plans in this State shall  
44 file with the board its net earned premium for the preceding two-  
45 year calculation period; and
  - 46 (b) every carrier issuing individual health benefits plans in the  
47 State shall file with the board the net earned premium on health  
48 benefits plans issued pursuant to paragraph (1) of subsection b. of

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

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

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

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

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

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

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

19 (2) Notwithstanding the provisions of paragraph (1) of this  
20 subsection to the contrary, a health maintenance organization  
21 qualified pursuant to the "Health Maintenance Organization Act of  
22 1973," Pub.L93-222 (42U.S.C. s.300e et seq.) and tax exempt  
23 pursuant to paragraph (3) of subsection (c) of section 501 of the  
24 federal Internal Revenue Code of 1986, 26U.S.C. s.501, may  
25 include up to one third Medicaid recipients and up to one third  
26 Medicare recipients in determining whether it meets its minimum  
27 number of non-group person life years.

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

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

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

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

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

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

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

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

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

26

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

29 5. A domestic mutual insurer which has converted from a  
30 health service corporation pursuant to the provisions of sections 2  
31 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48)  
32 shall not renew individual hospital or medical insurance policies or  
33 health service contracts originally issued prior to November 30,  
34 1992, until it has made an informational filing with the [New Jersey  
35 Individual Health Coverage Program Board, of a full schedule of  
36 rates which are to apply to those contracts. The New Jersey  
37 Individual Health Coverage Program Board shall forward a copy of  
38 such filing to the] commissioner. The rates shall be formulated so  
39 that the anticipated minimum loss ratio for such policy or contract  
40 form shall not be less than [75%] 80% of the premium. Such  
41 domestic mutual insurer shall submit with its rate filing supporting  
42 data and a certification that the insurer is in compliance with the  
43 anticipated loss ratio requirement. The content and form of the  
44 supporting data and certification required pursuant to subsection e.  
45 of section 8 of P.L.1992, c.161 (C.17B:27A-9) shall satisfy the  
46 requirements of this section. Any other insurer may irrevocably  
47 elect to become subject to the provisions of this section by written

1 notice to the commissioner[, except that such informational filing  
2 by any other insurer shall be] in a format specified by the  
3 commissioner [and shall be made directly to the commissioner and  
4 not to the New Jersey Individual Health Coverage Program Board].

5 (cf: P.L.1995, c.196, s.5)

6

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

9 1. As used in this act:

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

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

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

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

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

1 "Commissioner" means the Commissioner of Banking and  
2 Insurance.

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

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

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

35 "Department" means the Department of Banking and Insurance.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41 h. Notwithstanding the provisions of subsection a. of this  
42 section to the contrary, the board may modify the benefits provided  
43 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,  
44 17B:26B-2 and 26:2J-4.3).

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

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

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

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

26 j. (1) Notwithstanding the provisions of P.L.1992, c.162  
27 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued  
28 by or through a carrier, association, or multiple employer  
29 arrangement prior to January 1, 1994 or, if the requirements of  
30 subparagraph (c) of paragraph (6) of this subsection are met, issued  
31 by or through an out-of-State trust prior to January 1, 1994, at the  
32 option of a small employer policy or contract holder, may be  
33 renewed or continued after February 28, 1994, or in the case of such  
34 a health benefits plan whose anniversary date occurred between  
35 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-  
36 19.1 et al.), may be reinstated within 60 days of that anniversary  
37 date and renewed or continued if, beginning on the first 12-month  
38 anniversary date occurring on or after the sixtieth day after the  
39 board adopts regulations concerning the implementation of the  
40 rating factors permitted by section 9 of P.L.1992, c.162  
41 (C.17B:27A-25) and, regardless of the situs of delivery of the health  
42 benefits plan, the health benefits plan renewed, continued or  
43 reinstated pursuant to this subsection complies with the provisions  
44 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and  
45 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,  
46 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and  
47 section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

39

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

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

1 network of providers shall be subject to review and approval or  
2 disapproval by the Commissioner of Banking and Insurance, in  
3 consultation with the Commissioner of Health and Senior Services,  
4 pursuant to regulations promulgated by the Department of Banking  
5 and Insurance, including review and approval or disapproval before  
6 plans with benefits provided through a carrier's network of  
7 providers pursuant to this section may be offered by the carrier.  
8 Policies or contracts written on this basis shall be rated in a separate  
9 rating pool for the purposes of establishing a premium, but for the  
10 purpose of determining a carrier's losses, these policies or contracts  
11 shall be aggregated with the losses on the carrier's other business  
12 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-  
13 17 et seq.).

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

15

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42

43 <sup>1</sup>【25.】 24.<sup>1</sup> Section 9 of P.L.1992, c.162 (C.17B:27A-25) is  
44 amended to read as follows:

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

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

47 (3) <sup>1</sup>(a)<sup>1</sup> For all policies or contracts providing health benefits  
48 plans for small employers issued pursuant to section 3 of P.L.1992,

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

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

25 <sup>3</sup> <sup>1</sup>(c) The amount of the commission or other compensation paid  
26 to an insurance producer in connection with a policy or contract  
27 issued to a small employer shall be disclosed to the small employer,  
28 as provided in section 25 of P.L. , c. (pending before the  
29 Legislature as this bill). Rates charged to a small employer shall  
30 differ based on the actual compensation paid to an insurance  
31 producer, in a manner consistent with regulations adopted by the  
32 commissioner. Variations in rates attributable solely to differences  
33 in commissions or other compensation paid are not subject to the  
34 200% limitation provided in subparagraph (a) of this paragraph  
35 (3).]<sup>3</sup>

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

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

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

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

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

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

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

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

9 A carrier which provides a health benefits plan to one or more  
10 small employers through a policy issued to an association or trust of  
11 employers after the effective date of P.L.1992, c.162 (C.17B:27A-  
12 17 et seq.), shall be required to offer small employer health benefits  
13 plans to non-association or trust employers in the same manner as  
14 any other small employer carrier is required pursuant to P.L.1992,  
15 c.162 (C.17B:27A-17 et seq.).

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

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

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

47 (2) Each calendar year, a carrier shall return, in the form of  
48 aggregate benefits for all of the ~~【five】~~ standard policy forms

1 offered by the carrier pursuant to subsection a. of section 3 of  
2 P.L.1992, c.162 (C.17B:27A-19), at least ~~【75%】~~ 80% of the  
3 aggregate premiums collected for all of the standard policy forms,  
4 other than alliance policy forms, and at least ~~【75%】~~ 80% of the  
5 aggregate premiums collected for all of the non-standard policy  
6 forms during that calendar year. A carrier shall return at least  
7 ~~【75%】~~ 80% of the premiums collected for all of the alliances  
8 during that calendar year, which loss ratio may be calculated in the  
9 aggregate for all of the alliances or separately for each alliance.  
10 Carriers shall annually report, no later than August 1st of each year,  
11 the loss ratio calculated pursuant to this section for all of the  
12 standard, other than alliance policy forms, non-standard policy  
13 forms and alliance policy forms for the previous calendar year,  
14 provided that a carrier may annually report the loss ratio calculated  
15 pursuant to this section for all of the alliances in the aggregate or  
16 separately for each alliance. In each case where the loss ratio fails  
17 to substantially comply with the ~~【75%】~~ 80% loss ratio requirement,  
18 the carrier shall issue a dividend or credit against future premiums  
19 for all policyholders with the standard, other than alliance policy  
20 forms, nonstandard policy forms or alliance policy forms, as  
21 applicable, in an amount sufficient to assure that the aggregate  
22 benefits paid in the previous calendar year plus the amount of the  
23 dividends and credits shall equal ~~【75%】~~ 80% of the aggregate  
24 premiums collected for the respective policy forms in the previous  
25 calendar year. All dividends and credits must be distributed by  
26 December 31 of the year following the calendar year in which the  
27 loss ratio requirements were not satisfied. The annual report  
28 required by this paragraph shall include a carrier's calculation of the  
29 dividends and credits applicable to standard, other than alliance  
30 policy forms, non-standard policy forms and alliance policy forms,  
31 as well as an explanation of the carrier's plan to issue dividends or  
32 credits. The instructions and format for calculating and reporting  
33 loss ratios and issuing dividends or credits shall be specified by the  
34 commissioner by regulation. Such regulations shall include  
35 provisions for the distribution of a dividend or credit in the event of  
36 cancellation or termination by a policyholder. For purposes of this  
37 paragraph, "alliance policy forms" means policies purchased by  
38 small employers who are members of Small Employer Purchasing  
39 Alliances.

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

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

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

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

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

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

13  
14 <sup>1</sup>[26.] 25.<sup>1</sup> (New section) a. An insurance producer licensed  
15 pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.) who sells,  
16 solicits, or negotiates health insurance policies or contracts to  
17 residents of this State shall notify the purchaser of the insurance, in  
18 writing, of the amount of any commission, service fee, brokerage,  
19 or other valuable consideration that the producer will receive as a  
20 result of the sale, solicitation or negotiation of the health insurance  
21 policy or contract. If the commission, fee, brokerage, or other  
22 valuable consideration is based on a percentage of premium, the  
23 insurance producer shall include that information in the notification  
24 to the purchaser.

25 b. <sup>1</sup>[Upon seeking renewal of a license issued pursuant to  
26 P.L.2001, c.210 (C.17:22A-26 et seq.), an insurance producer shall  
27 report to the Commissioner of Banking and Insurance, in a form and  
28 manner specified by the commissioner, how the producer is  
29 compensated for the sale, solicitation, or negotiation of health  
30 insurance policies and contracts, including the basis for determining  
31 a commission, service fee, brokerage, or other valuable  
32 consideration for the sale, solicitation, or negotiation of a health  
33 insurance policy or contract. The insurance producer shall provide  
34 such other information regarding compensation as the commissioner  
35 deems appropriate.

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

41 d.] b.<sup>1</sup> The commissioner may specify, by regulation, the  
42 information that shall be provided by an insurance producer in the  
43 notification to a purchaser of health insurance and the procedure for  
44 providing the notification.

45  
46 <sup>1</sup>26. (New section) The Commissioner of Human Services shall  
47 establish an enhanced NJ FamilyCare outreach and enrollment  
48 initiative to increase public awareness about the availability of, and



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

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

8 The initiative shall also include the provision of training and  
9 support services, upon request, to community groups, legislative  
10 district offices, and community-based health care providers to  
11 enable these parties to assist in enrolling parents and children in the  
12 applicable programs.<sup>1</sup>

13

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

21 a. The members of the working group shall include:

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

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

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

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

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

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

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

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

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

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

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

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

34       f. The Department of Human Services shall provide staff  
35 support to the working group.<sup>1</sup>

36  
37       <sup>1</sup>28. There is appropriated to the Department of Human Services  
38 from the General Fund \$1 million for the purpose of carrying out  
39 the enhanced NJ FamilyCare outreach, enrollment, and retention  
40 initiative established pursuant to section 26 of this act.<sup>1</sup>

41  
42       <sup>3</sup>29. Section 1 of P.L.2005 c.375 (C.17:48-6.19) is amended to  
43 read as follows:

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

46           (1) is **【less than】** 30 years of age or younger;

47           (2) is unmarried;

1 (3) has no dependent of his own;

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

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

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

15 b. (1) A hospital service corporation contract that provides  
16 coverage for a subscriber's dependent under which coverage of the  
17 dependent terminates at a specific age on or before the dependent's  
18 30th birthday, and is delivered, issued, executed or renewed in this  
19 State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved  
20 for issuance or renewal in this State by the Commissioner of  
21 Banking and Insurance on or after the effective date of this section  
22 of P.L. , c. (pending before the Legislature as this bill), shall,  
23 upon application of the dependent as set forth in subsection c. of  
24 this section, provide coverage to the dependent after that specific  
25 age, until the dependent's **[30th]** 31st birthday.

26 (2) Nothing herein shall be construed to require:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (3) the date upon which the **【employer under whose】** contract <sub>2</sub>  
4 under which coverage is provided to a dependent<sub>2</sub> ceases to provide  
5 coverage to the subscriber.

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

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

15 (1) in the certificate of coverage or other equivalent document  
16 prepared for subscribers **【by the hospital service corporation】** and  
17 delivered on or about the date of commencement of the subscribers'  
18 coverage; and

19 (2) **【by the subscriber's employer:**

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

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

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

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

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

38 h. This section shall apply to those contracts in which the  
39 hospital service corporation has reserved the right to change the  
40 premium.<sup>3</sup>

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

42

43 <sup>3</sup>30. Section 2 of P.L.2005, c.375 (C.17:48A-7.13) is amended  
44 to read as follows:

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

47 (1) is **【less than】** 30 years of age or younger;

1 (2) is unmarried;

2 (3) has no dependent of his own;

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

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

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

16 b. (1) A medical service corporation contract that provides  
17 coverage for a subscriber's dependent under which coverage of the  
18 dependent terminates at a specific age on or before the dependent's  
19 30th birthday, and is delivered, issued, executed or renewed in this  
20 State pursuant to P.L.1940, c.74 (C.17:48A 1 et seq.), or approved  
21 for issuance or renewal in this State by the Commissioner of  
22 Banking and Insurance on or after the effective date of this section  
23 of P.L. , c. (pending before the Legislature as this bill), shall,  
24 upon application of the dependent as set forth in subsection c. of  
25 this section, provide coverage to the dependent after that specific  
26 age, until the dependent's ~~30th~~ 31st birthday.

27 (2) Nothing herein shall be construed to require:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 (3) the date upon which the **【employer under whose】** contract,  
 5 under which coverage is provided to a dependent, ceases to provide  
 6 coverage to the subscriber.

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

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

16 (1) in the certificate of coverage or other equivalent document  
 17 prepared for subscribers **【by the medical service corporation】** and  
 18 delivered on or about the date of commencement of the subscribers'  
 19 coverage; and

20 (2) **【by the subscriber's employer:**

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

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

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

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

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

39 h. This section shall apply to those contracts in which the  
 40 medical service corporation has reserved the right to change the  
 41 premium.<sup>3</sup>

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

43  
 44 <sup>3</sup>31. Section 3 of P.L.2005, c.375 (C.17:48E-30.1) is amended to  
 45 read as follows:

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



- 1 (1) is **less than** 30 years of age or younger;
- 2 (2) is unmarried;
- 3 (3) has no dependent of his own;
- 4 (4) is a resident of this State or is enrolled as a full-time student  
5 at an accredited public or private institution of higher education;  
6 and
- 7 (5) (a) is not actually provided coverage as a named subscriber,  
8 insured, enrollee, or covered person under any other group or  
9 individual health benefits plan, group health plan, church plan or  
10 health benefits plan, or entitled to benefits under Title XVIII of the  
11 Social Security Act, [Pub.L.89-97] Pub.L.74-271 (42 U.S.C.  
12 s.1395 et seq.) at the time the dependent coverage pursuant to this  
13 section begins or will begin; and
- 14 (b) there is evidence of prior, creditable coverage or receipt of  
15 benefits under a benefits plan or by law as set forth in subparagraph  
16 (a) of this paragraph.
- 17 b. (1) A health service corporation contract that provides  
18 coverage for a subscriber's dependent under which coverage of the  
19 dependent terminates at a specific age on or before the dependent's  
20 30th birthday, and is delivered, issued, executed or renewed in this  
21 State pursuant to P.L.1985, c.236 (C.17:48E 1 et seq.), or approved  
22 for issuance or renewal in this State by the Commissioner of  
23 Banking and Insurance on or after the effective date of this section  
24 of P.L. , c. (pending before the Legislature as this bill), shall,  
25 upon application of the dependent as set forth in subsection c. of  
26 this section, provide coverage to the dependent after that specific  
27 age, until the dependent's **30th** 31st birthday.
- 28 (2) Nothing herein shall be construed to require:
- 29 (a) coverage for services provided to a dependent before the  
30 effective date of this section of P.L. , c. (pending before the  
31 Legislature as this bill); or
- 32 (b) that an employer or other group policyholder pay all or part  
33 of the cost of coverage for a dependent as provided pursuant to this  
34 section.
- 35 c. (1) A dependent covered by a subscriber's contract, which  
36 coverage under the contract terminates at a specific age on or before  
37 the dependent's 30th birthday, may make a written election for  
38 coverage as a dependent pursuant to this section, until the  
39 dependent's 30th birthday:
- 40 (a) within 30 days prior to the termination of coverage at the  
41 specific age provided in the contract;
- 42 (b) within 30 days after meeting the requirements for dependent  
43 status as set forth in subsection a. of this section, when coverage for  
44 the dependent under the contract previously terminated; or
- 45 (c) during an open enrollment period, as provided pursuant to  
46 the contract, if the dependent meets the requirements for dependent  
47 status as set forth in subsection a. of this section during the open  
48 enrollment period.

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

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

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

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

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

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

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

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

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

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

4 (3) the date upon which the **【employer under whose】** contract,  
5 under which coverage is provided to a dependent, ceases to provide  
6 coverage to the subscriber.

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

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

16 (1) in the certificate of coverage or other equivalent document  
17 prepared for subscribers **【by the health service corporation】** and  
18 delivered on or about the date of commencement of the subscribers'  
19 coverage; and

20 (2) **【by the subscriber's employer:**

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

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

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

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

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

39 h. This section shall apply to those contracts in which the  
40 health service corporation has reserved the right to change the  
41 premium.<sup>3</sup>

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

43  
44 <sup>3</sup>32. Section 4 of P.L.2005, c.375 (C.17B:27-30.5) is amended  
45 to read as follows:

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

- 1 (1) is **less than** 30 years of age or younger;
- 2 (2) is unmarried;
- 3 (3) has no dependent of his own;
- 4 (4) is a resident of this State or is enrolled as a full-time student  
5 at an accredited public or private institution of higher education;  
6 and
- 7 (5) (a) is not actually provided coverage as a named subscriber,  
8 insured, enrollee, or covered person under any other group or  
9 individual health benefits plan, group health plan, church plan or  
10 health benefits plan, or entitled to benefits under Title XVIII of the  
11 Social Security Act, **Pub.L.89-97** Pub.L.74-271 (42 U.S.C.  
12 s.1395 et seq.) at the time dependent coverage pursuant to this  
13 section begins or will begin; and
- 14 (b) there is evidence of prior, creditable coverage or receipt of  
15 benefits under a benefits plan or by law as set forth in subparagraph  
16 (a) of this paragraph.
- 17 b. (1) A group health insurance policy that provides coverage for  
18 an insured's dependent under which coverage of the dependent  
19 terminates at a specific age on or before the dependent's 30th  
20 birthday, and is delivered, issued, executed or renewed in this State  
21 pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or  
22 approved for issuance or renewal in this State by the Commissioner  
23 of Banking and Insurance on or after the effective date of this  
24 section of P.L. , c. (pending before the Legislature as this bill),  
25 shall, upon application of the dependent as set forth in subsection c.  
26 of this section, provide coverage to the dependent after that specific  
27 age, until the dependent's **30th** 31st birthday.
- 28 (2) Nothing herein shall be construed to require:
- 29 (a) coverage for services provided to a dependent before the  
30 effective date of this section of P.L. , c. (pending before the  
31 Legislature as this bill); or
- 32 (b) that an employer or other group policyholder pay all or part  
33 of the cost of coverage for a dependent as provided pursuant to this  
34 section .
- 35 c. (1) A dependent covered by an insured's policy, which  
36 coverage under the policy terminates at a specific age on or before  
37 the dependent's 30th birthday, may make a written election for  
38 coverage as a dependent pursuant to this section, until the  
39 dependent's 30th birthday:
- 40 (a) within 30 days prior to the termination of coverage at the  
41 specific age provided in the policy;
- 42 (b) within 30 days after meeting the requirements for dependent  
43 status as set forth in subsection a. of this section, when coverage for  
44 the dependent under the policy previously terminated; or
- 45 (c) during an open enrollment period, as provided pursuant to  
46 the policy, if the dependent meets the requirements for dependent  
47 status as set forth in subsection a. of this section during the open  
48 enrollment period.

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

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

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

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

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

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

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

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

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

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

3 (3) the date upon which the **【employer under whose】** policy,  
4 under which coverage is provided to a dependent,<sup>2</sup> ceases to provide  
5 coverage to the insured.

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

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

15 (1) in the certificate of coverage or other equivalent document  
16 prepared for insureds **【by the insurer】** and delivered on or about the  
17 date of commencement of the insureds' coverage; and

18 (2) **【by the insured's employer:**

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

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

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

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

36 h. This section shall apply to those policies in which the insurer  
37 has reserved the right to change the premium.<sup>3</sup>

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

39

40 <sup>3</sup>33. Section 5 of P.L.2005, c.375 (C.17B:27A-19.16) is  
41 amended to read as follows:

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

44 (1) is **【less than】** 30 years of age or younger;

45 (2) is unmarried;

46 (3) has no dependent of his own;

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

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

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

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

25 (2) Nothing herein shall be construed to require:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

3 (3) the date upon which the **[employer under whose]** plan,  
4 under which coverage is provided to a dependent,<sup>2</sup> ceases to provide  
5 coverage to the covered person.

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

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

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

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

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

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

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

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

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

39 h. This section shall apply to those plans in which the carrier  
40 has reserved the right to change the premium.<sup>3</sup>

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

42

43 <sup>3</sup>34. Section 6 of P.L.2005, c.375 (C.26:2J-10.3) is amended to  
44 read as follows:

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

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

1 (2) is unmarried;

2 (3) has no dependent of his own;

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

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

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

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

26 (2) Nothing herein shall be construed to require:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (3) the date upon which the **【employer under whose】** contract,  
4 under which coverage is provided to a dependent,<sup>2</sup> ceases to provide  
5 coverage to the enrollee.

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

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

15 (1) in the certificate of coverage or other equivalent document  
16 prepared for enrollees **【by the health maintenance organization】**  
17 and delivered on or about the date of commencement of the  
18 enrollees' coverage; and

19 (2) **【by the enrollee's employer:**

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

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

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

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

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

38 h. This section shall apply to those contracts in which the  
39 health maintenance organization has reserved the right to change  
40 the schedule of charges.<sup>3</sup>

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

42

43 <sup>3</sup>35. Section 7 of P.L.2005, c.375 (C.52:14-17.29k) is amended  
44 to read as follows:

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

47 (1) is **【less than】** 30 years of age or younger;

1 (2) is unmarried;

2 (3) has no dependent of his own;

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

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

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

16 b. The State Health Benefits Commission shall ensure that  
17 every contract purchased or renewed by the commission on or after  
18 the effective date of P.L.2005, c.375 (C.17:48-6.19 et al.), prohibits  
19 the termination of coverage of a dependent before the dependent's  
20 23rd birthday by reason of age, and complies with the provisions of  
21 [P.L.2005, c.375 (C.17:48-6.19 et al.)] this section of P.L. , c.  
22 (pending before the Legislature as this bill) concerning the coverage  
23 of a dependent by written election, as set forth in subsection d. of  
24 this section, until the dependent's [30th] 31st birthday. [The cost of  
25 coverage pursuant to this section shall be reimbursed by the  
26 employee to the New Jersey State Health Benefits Program, in  
27 accordance with a rate to be determined by the commission.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 (2) in a notice delivered to covered persons on a quarterly  
 10 basis.<sup>3</sup>

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

12

13 <sup>1</sup>[27.] <sup>3</sup>[29.1] <sup>3</sup>36.<sup>3</sup> The Commissioner of Banking and  
 14 Insurance shall, pursuant to the "Administrative Procedure Act,"  
 15 P.L.1968, c.410 (C.52:14B-1 et seq.), adopt regulations necessary to  
 16 implement <sup>1</sup>[the provisions] sections 9 through 25<sup>1</sup> <sup>3</sup>and sections  
 17 29 through 34<sup>3</sup> of this act.

18

19 <sup>1</sup>[28.] <sup>3</sup>[30.1] <sup>3</sup>37.<sup>3</sup> Sections 1 through <sup>1</sup>[7 and 27] 8, 26  
 20 through 28, 36 and this section<sup>1</sup> of this act shall take effect  
 21 immediately and sections <sup>1</sup>[8] 9<sup>1</sup> through <sup>1</sup>[26] 25<sup>1</sup> <sup>3</sup>and 29  
 22 through 35<sup>3</sup> of this act shall take effect on the 180th day after  
 23 enactment <sup>1</sup>[and] , except that the 80% minimum loss ratio  
 24 requirements in sections 16, 19, and 24 of this bill shall take effect  
 25 on January 1 next following the date of enactment. Sections 9  
 26 through 25<sup>1</sup> <sup>3</sup>and 29 through 35<sup>3</sup> shall apply to all contracts and  
 27 policies that are delivered, issued, executed or renewed or approved  
 28 for issuance or renewal in this State on or after the effective date  
 29 <sup>1</sup>[provided herein,<sup>1</sup>] but the Commissioner of Banking and Insurance  
 30 may take such anticipatory administrative action in advance thereof  
 31 as shall be necessary for the implementation of this act.

32

33

34

35

36 Expands NJ FamilyCare, establishes mandate for health care  
 37 coverage of children, makes various reforms to individual and small  
 38 employer insurance markets and certain dependent coverage;  
 39 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)**



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

3

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

6

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

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

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

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

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

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

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

41 g. In order to ensure that more low income parents in the State  
42 have access to health care coverage and all children in the State are  
43 covered under a health plan, thus moving closer to providing  
44 universal coverage for all residents of this State, it is necessary to  
45 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 thus is new matter.

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

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

8

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

16 b. As used in this section:

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

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

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

25

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

28 4. As used in this act:

29 "Commissioner" means the Commissioner of Human Services.

30 "Department" means the Department of Human Services.

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

34 "NJ FamilyCare" or "program" means the NJ FamilyCare  
35 Program established pursuant to sections 3 through 5 of P.L.2005,  
36 156 (C.30:4J-10 through C.30:4J-12).

37 "Poverty level" means the official federal poverty level based on  
38 family size, established and adjusted under Section 673(2) of  
39 Subtitle B, the "Community Services Block Grant Act," Pub.L.97-  
40 35 (42 U.S.C. s.9902(2)).

41 "Qualified applicant" means:

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

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

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

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

17

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

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

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

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

36       c. The commissioner:

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

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

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

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

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

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

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

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

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

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

1 (4) Continuous enrollment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 k. The commissioner, in consultation with the Rutgers Center  
14 for State Health Policy, shall develop a streamlined application  
15 form for the NJ FamilyCare and Medicaid programs.  
16 (cf: P.L.2005, c.156, s.5).

17

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

24

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

33

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

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

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

3 c. As used in this section:

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

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

9

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

11 54:50-9. Nothing herein contained shall be construed to prevent:

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

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

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

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

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

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

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

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



- 1 of all absent parents who are certified by that agency as being  
2 required to pay child support, upon request by the State agency and  
3 pursuant to procedures and in a form prescribed by the director;
- 4 i. The furnishing by the director to the Board of Public  
5 Utilities any information contained in tax information statements,  
6 reports or returns or any audit thereof or a report of any  
7 investigation made with respect thereto, as may be necessary for the  
8 administration of P.L.1991, c.184 (C.54:30A-18.6 et al.) and  
9 P.L.1997, c.162 (C.54:10A-5.25 et al.);
- 10 j. The furnishing by the director to the Director of the Division  
11 of Alcoholic Beverage Control in the Department of Law and  
12 Public Safety any information contained in tax information  
13 statements, reports or returns or any audit thereof or a report of any  
14 investigation made with respect thereto, as may be relevant, in the  
15 discretion of the director, in any proceeding conducted for the  
16 issuance, suspension or revocation of any license authorized  
17 pursuant to Title 33 of the Revised Statutes;
- 18 k. The inspection by the Attorney General or other legal  
19 representative of this State of the reports or files of any tobacco  
20 product manufacturer, as defined in section 2 of P.L.1999, c.148  
21 (C.52:4D-2), for any period in which that tobacco product  
22 manufacturer was not or is not in compliance with subsection a. of  
23 section 3 of P.L.1999, c.148 (C.52:4D-3), or of any licensed  
24 distributor as defined in section 102 of P.L.1948, c.65 (C.54:40A-  
25 2), for the purpose of facilitating the administration of the  
26 provisions of P.L.1999, c.148 (C.52:4D-1 et seq.);
- 27 l. The furnishing, at the discretion of the director, of  
28 information as to whether a contractor or subcontractor holds a  
29 valid business registration as defined in section 1 of P.L.2001, c.134  
30 (C.52:32-44);
- 31 m. The furnishing by the director to a State agency as defined in  
32 section 1 of P.L.1995, c.158 (C.54:50-24) the names of licensees  
33 subject to suspension for non-payment of State tax indebtedness  
34 pursuant to P.L.2004, c.58 (C.54:50-26.1 et al.);
- 35 n. The release to the United States Department of the Treasury,  
36 Bureau of Financial Management Service, or its successor of  
37 relevant taxpayer information for purposes of implementing a  
38 reciprocal collection and offset of indebtedness agreement entered  
39 into between the State of New Jersey and the federal government  
40 pursuant to section 1 of P.L.2006, c.32 (C.54:49-12.7);
- 41 o. The examination of said records and files by the  
42 Commissioner of Health and Senior Services, the Commissioner of  
43 Human Services, the Medicaid Inspector General, or their  
44 respective duly authorized agents, pursuant to section 5 of  
45 P.L.2007, c.217 (C.26:2H-18.60e);
- 46 p. The furnishing at the discretion of the director of employer  
47 provided wage and tax withholding information contained in tax  
48 reports or returns filed pursuant to N.J.S.54A:7-2, 54A:7-4 and

1 54A:7-7, to the designated municipal officer of a municipality  
2 authorized to impose an employer payroll tax pursuant to the  
3 provisions of Article 5 (Employer Payroll Tax) of the "Local Tax  
4 Authorization Act," P.L.1970, c.326 (C.40:48C-14 et seq.), for the  
5 limited purpose of verifying the payroll information reported by  
6 employers subject to the employer payroll tax.  
7 (cf: P.L.2007, c.294, s.2)

8  
9 9. Section 1 of P.L.1992, c.161 (C.17B:27A-2) is amended to  
10 read as follows:

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

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

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

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

26 "Commissioner" means the Commissioner of Banking and  
27 Insurance.

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

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

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

12       "Department" means the Department of Banking and Insurance.

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

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

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

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

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

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

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

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

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

1 (10 U.S.C. s.1071 et seq.); and similar supplemental coverage  
2 provided to coverage under a group health plan.

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

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

16 Individual health benefits plan shall not include a certificate  
17 issued under a policy or contract issued to a trust, or to the trustees  
18 of a fund, which trust or fund is an employee welfare benefit plan,  
19 to the extent the "Employee Retirement Income Security Act of  
20 1974" (29 U.S.C. s.1001 et seq.) preempts the application of  
21 P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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

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

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

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

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

19 "Net earned premium" means the premiums earned in this State  
20 on health benefits plans, less return premiums thereon and  
21 dividends paid or credited to policy or contract holders on the  
22 health benefits plan business. Net earned premium shall include the  
23 aggregate premiums earned on the carrier's insured group and  
24 individual business and health maintenance organization business,  
25 including premiums from any Medicare, Medicaid, or NJ  
26 FamilyCare or **[NJ KidCare]** contracts with the State or federal  
27 government, but shall not include premiums earned from contracts  
28 funded pursuant to the "Federal Employee Health Benefits Act of  
29 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss  
30 insurance coverage issued by a carrier in connection with any self  
31 insured health benefits plan, or Medicare supplement policies or  
32 contracts.

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

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

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

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

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

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

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

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

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

20 "Two-year calculation period" means a two calendar year period,  
21 the first of which shall begin January 1, 1997 and end December 31,  
22 1998.

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

24  
25 10. Section 2 of P.L.1992, c.161 (C.17B:27A-3) is amended to  
26 read as follows:

27 2. a. An individual health benefits plan issued on or after  
28 **【August 1, 1993 shall be subject to the provisions of this act】** the  
29 effective date of P.L. , c. (pending before the Legislature as this  
30 bill) shall be subject to the rating provisions established in P.L. , c.  
31 (pending before the Legislature as this bill). In the case of an  
32 individual health benefits plan issued to a covered person prior to  
33 the effective date of P.L. , c. (pending before the Legislature as  
34 this bill) and renewed thereafter, for the five years next following  
35 enactment of P.L. , c. (pending before the Legislature as this  
36 bill), the annual rate increase filed for the plan shall be limited to  
37 the lower of 15% or the medical trend assumption used by the  
38 carrier to project claims.

39 b. **【(1) An individual health benefits plan issued on an open**  
40 **enrollment, modified community rated basis or community rated**  
41 **basis prior to August 1, 1993 shall not be subject to sections 3**  
42 **through 8, inclusive, of this act, unless otherwise specified therein.**

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

47 (3) A group conversion contract or policy issued prior to August  
48 1, 1993 that is not issued on a modified community rated basis or

1 community rated basis, shall not be subject to the provisions of this  
2 act, except that the contract or policy shall be liable for assessments  
3 made pursuant to section 11 of this act.

4 (4) Notwithstanding any other provision of law to the contrary,  
5 an individual health benefits plan issued by a hospital service  
6 corporation or medical service corporation prior to the effective  
7 date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to  
8 the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that  
9 the plan shall guarantee renewal pursuant to subsection b. of section  
10 5 of P.L.1992, c.161 (C.17B:27A-6).

11 (5) Notwithstanding any other provision of law to the contrary,  
12 an individual health benefits plan issued by a hospital service  
13 corporation or medical service corporation to an eligible person or  
14 federally defined eligible individual after the effective date of  
15 P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the  
16 provisions of subsections c. and d. of section 2, subsection b. of  
17 section 3, section 5, subsection b. of section 6, and subsections c.,  
18 d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3,  
19 C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall  
20 not be subject to the remaining provisions of P.L.1992, c. 161. ]  
21 (Deleted by amendment, P.L. , c. ) (pending before the  
22 Legislature as this bill).

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

35 d. [Except as otherwise provided in subsection c. of this  
36 section, after August 1, 1993, a person who is covered by an  
37 individual health benefits plan who is a participant in, or is eligible  
38 to participate in, a group health benefits plan that provides the same  
39 or similar coverages as the individual health benefits plan, and a  
40 person, including an employer or insurance producer, who causes  
41 another person to be covered by an individual health benefits plan  
42 which person is a participant in, or who is eligible to participate in a  
43 group health benefits plan that provides the same or similar  
44 coverages as the individual health benefits plan, shall be subject to  
45 a fine by the commissioner in an amount not less than twice the  
46 annual premium paid for the individual health benefits plan,



1 together with any other penalties permitted by law.】 (Deleted by  
2 amendment, P.L. , c. )(pending before the Legislature as this bill).

3 e. (Deleted by amendment, P.L.1997, c.146).  
4 (cf: P.L.1997, c.146, s.2)

5  
6 11. Section 3 of P.L.1992, c.161 (C.17B:27A-4) is amended to  
7 read as follows:

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

21 b. A carrier shall offer to an eligible person a choice of 【five】  
22 at least three individual health benefits plans 【any of which may  
23 contain provisions for managed care】 established by the board  
24 pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7). One plan  
25 shall be a basic health benefits plan【, one plan shall be a managed  
26 care plan and three plans shall include enhanced benefits of  
27 proportionally increasing actuarial value】. A carrier may elect to  
28 convert any individual contract or policy forms in force on the  
29 effective date of 【this act】 P.L. , c. (pending before the Legislature  
30 as this bill) to any of the 【five】 benefit plans, except that the carrier  
31 may not convert more than 25% of existing contracts or policies  
32 each year, and the replacement plan shall be of no less actuarial  
33 value than the policy or contract being replaced.

34 【Notwithstanding the provisions of this subsection to the  
35 contrary, at any time after three years after the effective date of this  
36 act, the board, by regulation, may reduce the number of plans  
37 required to be offered by a carrier.】

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

45 c. (1) A basic health benefits plan shall provide the benefits set  
46 forth in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section 57

1 of P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991, c.187  
2 (C.26:2J-4.3), as the case may be.

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

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

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

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

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

31 d. Every group conversion contract or policy issued after the  
32 effective date of this act shall be issued pursuant to this section;  
33 except that this requirement shall not apply to any group conversion  
34 contract or policy in which a portion of the premium is chargeable  
35 to, or subsidized by, the group policy from which the conversion is  
36 made.

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

46 f. In addition to the rider packages provided for in subsection  
47 c. of section 6 of P.L.1992, c.161 (C.17B:27A-7), every carrier may  
48 offer, in connection with the health benefits plans required to be

1 offered by this section, any number of riders which may revise the  
2 coverage offered by the plans in any way, provided, however, that  
3 any form of such rider or amendment thereof which decreases  
4 benefits or decreases the actuarial value of one of the plans shall be  
5 filed for informational purposes with the board and for approval by  
6 the commissioner before such rider may be sold. Any rider or  
7 amendment thereof which adds benefits or increases the actuarial  
8 value of one of the plans shall be filed with the board for  
9 informational purposes before such rider may be sold. The added  
10 premium or reduction in premium for each rider, as applicable, shall  
11 be listed separately from the premium for the standard plan.

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

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

21

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

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

29 90 days hospital room and board - \$500 copayment per hospital  
30 stay;

31 Outpatient and ambulatory surgery- \$250 copayment per surgery;

32 Physicians' fees connected with hospital care, including general  
33 acute care and surgery;

34 Physicians' fees connected with outpatient and ambulatory surgery;

35 Anesthesia and the administration of anesthesia;

36 Coverage for newborns;

37 Treatment for complications of pregnancy;

38 Intravenous solutions, blood and blood plasma;

39 Oxygen and the administration of oxygen;

40 Radiation and x-ray therapy;

41 Inpatient physical therapy and hydrotherapy;

42 Outpatient physical therapy - 30 visits annually per covered person-

43 \$20 copayment per treatment;

44 Dialysis - inpatient or outpatient;

45 Inpatient diagnostic tests and \$500 annual aggregate per covered  
46 person for out-of-hospital diagnostic tests;

47 Laboratory fees for treatment in hospital;

48 Delivery room fees;

1 Operating room fees;  
2 Special care unit;  
3 Treatment room fees;  
4 Emergency room services for medically necessary treatment - \$100  
5 copayment per visit;  
6 Pharmaceuticals dispensed in hospital;  
7 Dressings;  
8 Splints;  
9 Treatment for biologically-based mental illness, as defined in  
10 subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90  
11 days inpatient with no coinsurance - \$500 copayment per inpatient  
12 stay, 30 days outpatient with 30% coinsurance;  
13 Alcohol and Substance Abuse Treatment - 30 days inpatient or  
14 outpatient - 30% coinsurance;  
15 Childhood immunizations in accordance with the provisions of  
16 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and  
17 adult immunizations;  
18 Wellness benefit - \$600 annual aggregate per covered person, \$50  
19 annual deductible, 20% coinsurance per service; and  
20 Physicians visits for diagnosed illness or injury - to a \$700 annual  
21 aggregate per covered person.

22 b. A carrier shall offer the benefits on an indemnity basis, with  
23 the option that: (1) coverage is restricted to health care providers in  
24 the carrier's network, including an exclusive provider organization,  
25 or the carrier's preferred provider organization; or (2) coverage is  
26 provided through health care providers in the carrier's network or  
27 preferred provider organization with an out-of-network option with  
28 30% coinsurance in addition to whatever other coinsurance may be  
29 applicable under the policy.

30 c. With respect to all policies or contracts issued pursuant to  
31 this section, the premium rate charged by a carrier to the highest  
32 rated individual or class of individuals shall not be greater than  
33 350% of the premium rate charged for the lowest rated individual or  
34 class of individuals purchasing this health benefits plan, provided,  
35 however, that the only factors upon which the rate differential may  
36 be based are age, gender, and geography. Rates applicable to  
37 policies or contracts issued pursuant to this section shall reflect past  
38 and prospective loss experience for benefits included in such  
39 policies or contracts, and shall be formulated in a manner that does  
40 not result in an unfair subsidization of rates applicable to policies  
41 issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2  
42 et seq.) as the result of differences in levels of benefits offered.

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

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

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

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

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

19

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

22 4. In addition to the **[five]** health benefits plans offered by a  
23 carrier on the effective date of this act, a carrier that writes  
24 individual health benefits plans pursuant to P.L.1992, c.161  
25 (C.17B:27A-2 et seq.) may also offer one or more of the plans  
26 through the carrier's network of providers, with no reimbursement  
27 for any out-of-network benefits other than emergency care, urgent  
28 care, and continuity of care. A carrier's network of providers shall  
29 be subject to review and approval or disapproval by the  
30 Commissioner of Banking and Insurance, in consultation with the  
31 Commissioner of Health and Senior Services, pursuant to  
32 regulations promulgated by the Department of Banking and  
33 Insurance, including review and approval or disapproval before  
34 plans with benefits provided through a carrier's network of  
35 providers pursuant to this section may be offered by the carrier.  
36 Policies or contracts written on this basis shall be rated in a separate  
37 rating pool for the purposes of establishing a premium, but for the  
38 purpose of determining a carrier's losses, these policies or contracts  
39 shall be aggregated with the losses on the carrier's other business  
40 written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2  
41 et seq.).

42 (cf: P.L.2001, c.368, s.4)

43

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

46 5. An individual health benefits plan issued pursuant to section  
47 3 of this act is subject to the following provisions:

- 1 a. The health benefits plan shall guarantee coverage for an  
2 eligible person and his dependents on a modified community rated  
3 basis.
- 4 b. A health benefits plan shall be renewable with respect to an  
5 eligible person and his dependents at the option of the policy or  
6 contract holder. A carrier may terminate a health benefits plan  
7 under the following circumstances:
- 8 (1) the policy or contract holder has failed to pay premiums in  
9 accordance with the terms of the policy or contract or the carrier has  
10 not received timely premium payments;
- 11 (2) the policy or contract holder has performed an act or practice  
12 that constitutes fraud or made an intentional misrepresentation of  
13 material fact under the terms of the coverage;
- 14 c. A carrier may not renew a health benefits plan only under  
15 the following circumstances:
- 16 (1) termination of eligibility of the policy or contract holder if  
17 the person is no longer a resident or becomes eligible for a group  
18 health benefits plan, group health plan, governmental plan or church  
19 plan;
- 20 (2) cancellation or amendment by the board of the specific  
21 individual health benefits plan;
- 22 (3) **[board]** approval by the commissioner of a request by  
23 the individual carrier to not renew a particular type of health  
24 benefits plan, in accordance with rules adopted by the **[board]**  
25 commissioner. After receiving **[board]** approval by the  
26 commissioner, a carrier may not renew a type of health benefits  
27 plan only if the carrier: (a) provides notice to each covered  
28 individual provided coverage of this type of the nonrenewal at least  
29 90 days prior to the date of the nonrenewal of the coverage; (b)  
30 offers to each individual provided coverage of this type the option  
31 to purchase any other individual health benefits plan currently being  
32 offered by the carrier; and (c) in exercising the option to not renew  
33 coverage of this type and in offering coverage as required under (b)  
34 above, the carrier acts uniformly without regard to any health  
35 status-related factor of enrolled individuals or individuals who may  
36 become eligible for coverage;
- 37 (4) **[board]** approval by the commissioner of a request by the  
38 individual carrier to cease doing business in the individual health  
39 benefits market. A carrier may not renew all individual health  
40 benefits plans only if the carrier: (a) first receives approval from  
41 the **[board]** commissioner; and (b) provides notice to each  
42 individual of the nonrenewal at least 180 days prior to the date of  
43 the expiration of such coverage. A carrier ceasing to do business in  
44 the individual health benefits market may not provide for the  
45 issuance of any health benefits plan in the individual **[market]** or  
46 small employer markets during the five-year period beginning on

1 the date of the termination of the last health benefits plan not so  
2 renewed; and

3 (5) In the case of a health benefits plan made available by a  
4 health maintenance organization carrier, the carrier shall not be  
5 required to renew coverage to an eligible individual who no longer  
6 resides, lives, or works in the service area, or in an area for which  
7 the carrier is authorized to do business, but only if coverage is  
8 terminated under this paragraph uniformly without regard to any  
9 health status-related factor of covered individuals.  
10 (cf. P.L.1997, c.146, s.3)

11

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

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

27 a. The individual health benefits plans established by the board  
28 may include cost containment measures such as, but not limited to:  
29 utilization review of health care services, including review of  
30 medical necessity of hospital and physician services; case  
31 management benefit alternatives; selective contracting with  
32 hospitals, physicians, and other health care providers; and  
33 reasonable benefit differentials applicable to participating and  
34 nonparticipating providers; and other managed care provisions.

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

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

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

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

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

18 e. Effective immediately for an individual health benefits plan  
19 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
20 35.27 et al.) and effective on the first 12-month anniversary date of  
21 an individual health benefits plan in effect on the effective date of  
22 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health  
23 benefits plans required pursuant to section 3 of P.L.1992, c.161  
24 (C.17B:27A-4), including any plan offered by a federally qualified  
25 health maintenance organization, shall contain benefits for expenses  
26 incurred in the following:

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

33 (2) All childhood immunizations as recommended by the  
34 Advisory Committee on Immunization Practices of the United  
35 States Public Health Service and the Department of Health and  
36 Senior Services pursuant to section 7 of P.L.1995, c.316 (C.26:2-  
37 137.1). A carrier shall notify its insureds, in writing, of any change  
38 in the health care services provided with respect to childhood  
39 immunizations and any related changes in premium. Such  
40 notification shall be in a form and manner to be determined by the  
41 Commissioner of Banking and Insurance.

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



1 form of a newborn hearing screening fee as negotiated with the  
2 provider and facility.

3 The benefits provided pursuant to this subsection shall be  
4 provided to the same extent as for any other medical condition  
5 under the health benefits plan, except that a deductible shall not be  
6 applied for benefits provided pursuant to this subsection; however,  
7 with respect to a health benefits plan that qualifies as a high  
8 deductible health plan for which qualified medical expenses are  
9 paid using a health savings account established pursuant to section  
10 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),  
11 a deductible shall not be applied for any benefits provided pursuant  
12 to this subsection that represent preventive care as permitted by that  
13 federal law, and shall not be applied as provided pursuant to section  
14 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall  
15 apply to all individual health benefits plans in which the carrier has  
16 reserved the right to change the premium.

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

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

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

37 g. Effective immediately for an individual health benefits plan  
38 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
39 35.27 et al.) and effective on the first 12-month anniversary date of  
40 an individual health benefits plan in effect on the effective date of  
41 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans  
42 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)  
43 that qualify as high deductible health plans for which qualified  
44 medical expenses are paid using a health savings account  
45 established pursuant to section 223 of the federal Internal Revenue  
46 Code of 1986 (26 U.S.C. s.223), including any plan offered by a  
47 federally qualified health maintenance organization, shall contain  
48 benefits for expenses incurred in connection with any medically

1 necessary benefits provided in-network which represent preventive  
2 care as permitted by that federal law.

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

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

10

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

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

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

26 c. A carrier shall not issue individual health benefits plans on a  
27 new contract or policy form pursuant to this act until an  
28 informational filing of a full schedule of rates which applies to the  
29 contract or policy form has been filed with the ~~【board】~~  
30 commissioner. The ~~【board】~~ commissioner shall ~~【forward】~~ provide  
31 a copy of the informational filing to the ~~【commissioner and the】~~  
32 Attorney General and the board.

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

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

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

16 Each calendar year, a carrier shall return, in the form of  
17 aggregate benefits for all of the policy or contract forms offered by  
18 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161  
19 (C.17:B:27A-4), at least 80% of the aggregate premiums collected  
20 for all of the policy or contract forms during that calendar year.  
21 Carriers shall annually report, no later than August 1 of each year,  
22 the loss ratio calculated pursuant to this section for all of the policy  
23 or contract forms for the previous calendar year. In each case in  
24 which the loss ratio fails to comply with the 80% loss ratio  
25 requirement, the carrier shall issue a dividend or credit against  
26 future premiums for all policy or contract holders, as applicable, in  
27 an amount sufficient to assure that the aggregate benefits paid in the  
28 previous calendar year plus the amount of the dividends and credits  
29 equal 80% of the aggregate premiums collected for the policy or  
30 contract forms in the previous calendar year. All dividends and  
31 credits shall be distributed by December 31 of the year following  
32 the calendar year in which the loss ratio requirements were not  
33 satisfied. The annual report required by this subsection shall include  
34 a carrier's calculation of the dividends and credits applicable to all  
35 policy or contract forms, as well as an explanation of the carrier's  
36 plan to issue dividends or credits. The instructions and format for  
37 calculating and reporting loss ratios and issuing dividends or credits  
38 shall be specified by the commissioner by regulation. Those  
39 regulations shall include provisions for the distribution of a  
40 dividend or credit in the event of cancellation or termination by a  
41 policyholder.

42 f. ~~【Notwithstanding the provisions of P.L.1992, c.161~~  
43 ~~(C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed~~  
44 ~~pursuant to this section by a carrier which insured at least 50% of~~  
45 ~~the community-rated individually insured persons on the effective~~  
46 ~~date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required~~  
47 ~~to produce a loss ratio which when combined with the carrier's~~

1 administrative costs and investment income results in self-  
2 sustaining rates prior to January 1, 1996, for individual policies or  
3 contracts issued prior to August 1, 1993. The carrier shall, not later  
4 than 30 days after the effective date of P.L.1994, c.102  
5 (C.17B;27A-4 et al.), file with the board for approval, a plan to  
6 achieve this objective. **】** (Deleted by amendment, P.L., c. )(pending  
7 before the Legislature as this bill).  
8 (cf: P.L.1994, c.102, s.2)  
9

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

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

18 The board shall have the specific authority to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17

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

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

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

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

29 (b) every carrier issuing individual health benefits plans in the  
30 State shall file with the board the net earned premium on health  
31 benefits plans issued pursuant to paragraph (1) of subsection b. of  
32 section 2 and section 3 of this act and the claims paid. If the claims  
33 paid for all health benefits plans during the two-year calculation  
34 period exceed 115% of the net earned premium and any investment  
35 income thereon for the two-year calculation period, the amount of  
36 the excess shall be the net paid loss for the carrier that shall be  
37 reimbursable under this act.

38 (2) Every member shall be liable for an assessment to reimburse  
39 carriers issuing individual health benefits plans in this State which  
40 sustain net paid losses during the two-year calculation period,  
41 unless the member has received an exemption from the board  
42 pursuant to subsection d. of this section and has written a minimum  
43 number of non-group person life years as provided for in that  
44 subsection. The assessment of each member shall be in the  
45 proportion that the net earned premium of the member for the two-  
46 year calculation period preceding the assessment bears to the net  
47 earned premium of all members for the two-year calculation period  
48 preceding the assessment. Notwithstanding the provisions of this

1 subsection to the contrary, a medical service corporation or a  
2 hospital service corporation shall not be liable for an assessment to  
3 reimburse carriers which sustain net paid losses.

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

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

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

27 d. (1) Notwithstanding the provisions of this act to the  
28 contrary, a carrier may apply to the board, by a date established by  
29 the board, for an exemption from the assessment and reimbursement  
30 for losses provided for in this section. A carrier which applies for  
31 an exemption shall agree to cover a minimum number of non-group  
32 person life years on an open enrollment community rated basis,  
33 under a managed care or indemnity plan, as specified in this  
34 subsection, provided that any indemnity plan so issued conforms  
35 with sections 2 through 7, inclusive, of P.L.1992, c.161  
36 (C.17B:27A-3 through 17B:27A-8). For the purposes of this  
37 subsection, non-group persons include individually enrolled  
38 persons, conversion policies issued pursuant to this act, Medicare  
39 cost and risk lives and Medicaid recipients; except that in  
40 determining whether the carrier meets the minimum number of non-  
41 group person life years required to be covered pursuant to this  
42 subsection, the number of Medicaid recipients and Medicare cost  
43 and risk lives shall not exceed 50% of the total. Pursuant to  
44 regulations adopted by the board, the carrier shall determine the  
45 number of non-group person life years it has covered by adding the  
46 number of non-group persons covered on the last day of each  
47 calendar quarter of the two-year calculation period, taking into

1 account the limitations on counting Medicaid recipients and  
2 Medicare cost and risk lives, and dividing the total by eight.

3 (2) Notwithstanding the provisions of paragraph (1) of this  
4 subsection to the contrary, a health maintenance organization  
5 qualified pursuant to the "Health Maintenance Organization Act of  
6 1973," Pub.L 93-222 (42 U.S.C. s.300e et seq.) and tax exempt  
7 pursuant to paragraph (3) of subsection (c) of section 501 of the  
8 federal Internal Revenue Code of 1986, 26 U.S.C. s.501, may  
9 include up to one third Medicaid recipients and up to one third  
10 Medicare recipients in determining whether it meets its minimum  
11 number of non-group person life years.

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

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

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

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

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

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

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

47 f. The loss assessment for the two-year calculation period in  
48 which P.L. , c. (pending before the Legislature as this bill) takes

1 effect shall be the last loss assessment authorized under this section,  
2 and no further loss assessments shall be calculated or collected;  
3 provided, however, that nothing in this subsection shall relieve a  
4 carrier of its obligations for loss assessments authorized under this  
5 section prior to the effective date of P.L. , c. (pending before the  
6 Legislature as this bill).  
7 (cf: P.L.1997, c.146, s.6)

8  
9 19. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended  
10 to read as follows:

11 5. A domestic mutual insurer which has converted from a  
12 health service corporation pursuant to the provisions of sections 2  
13 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48)  
14 shall not renew individual hospital or medical insurance policies or  
15 health service contracts originally issued prior to November 30,  
16 1992, until it has made an informational filing with the [New Jersey  
17 Individual Health Coverage Program Board, of a full schedule of  
18 rates which are to apply to those contracts. The New Jersey  
19 Individual Health Coverage Program Board shall forward a copy of  
20 such filing to the] commissioner. The rates shall be formulated so  
21 that the anticipated minimum loss ratio for such policy or contract  
22 form shall not be less than [75%] 80% of the premium. Such  
23 domestic mutual insurer shall submit with its rate filing supporting  
24 data and a certification that the insurer is in compliance with the  
25 anticipated loss ratio requirement. The content and form of the  
26 supporting data and certification required pursuant to subsection e.  
27 of section 8 of P.L.1992, c.161 (C.17B:27A-9) shall satisfy the  
28 requirements of this section. Any other insurer may irrevocably  
29 elect to become subject to the provisions of this section by written  
30 notice to the commissioner[, except that such informational filing  
31 by any other insurer shall be] in a format specified by the  
32 commissioner [and shall be made directly to the commissioner and  
33 not to the New Jersey Individual Health Coverage Program Board].  
34 (cf: P.L.1995, c.196, s.5)

35  
36 20. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to  
37 read as follows:

38 1. As used in this act:

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



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

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

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

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

31 "Commissioner" means the Commissioner of Banking and  
32 Insurance.

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

39 "Creditable coverage" means, with respect to an individual,  
40 coverage of the individual under any of the following: a group  
41 health plan; a group or individual health benefits plan; Part A or  
42 part B of Title XVIII of the federal Social Security Act (42 U.S.C.  
43 s.1395 et seq.); Title XIX of the federal Social Security Act (42  
44 U.S.C. 1396 et seq.), other than coverage consisting solely of  
45 benefits under section 1928 of Title XIX of the federal Social  
46 Security Act (42 U.S.C.s.1396s); chapter 55 of Title 10, United  
47 States Code (10 U.S.C. 1071 et seq.); a medical care program of the  
48 Indian Health Service or of a tribal organization; a state health plan

1 offered under chapter 89 of Title 5, United States Code (5 U.S.C.  
2 s.8901 et seq.); a public health plan as defined by federal  
3 regulation; a health benefits plan under section 5(e) of the "Peace  
4 Corps Act" (22 U.S.C. s.2504(e)); or coverage under any other type  
5 of plan as set forth by the commissioner by regulation.

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

17 "Department" means the Department of Banking and Insurance.

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

23 "Eligible employee" means a full-time employee who works a  
24 normal work week of 25 or more hours. The term includes a sole  
25 proprietor, a partner of a partnership, or an independent contractor,  
26 if the sole proprietor, partner, or independent contractor is included  
27 as an employee under a health benefits plan of a small employer,  
28 but does not include employees who work less than 25 hours a  
29 week, work on a temporary or substitute basis or are participating in  
30 an employee welfare arrangement established pursuant to a  
31 collective bargaining agreement.

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

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

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

47 "Group health plan" means an employee welfare benefit plan, as  
48 defined in Title I of section 3 of Pub.L.93-406, the "Employee

1 Retirement Income Security Act of 1974" (29 U.S.C.s.1002(1)), to  
2 the extent that the plan provides medical care and including items  
3 and services paid for as medical care to employees or their  
4 dependents directly or through insurance, reimbursement or  
5 otherwise.

6 "Health benefits plan" means any hospital and medical expense  
7 insurance policy or certificate; health, hospital, or medical service  
8 corporation contract or certificate; or health maintenance  
9 organization subscriber contract or certificate delivered or issued  
10 for delivery in this State by any carrier to a small employer group  
11 pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For  
12 purposes of this act, "health benefits plan" shall not include one or  
13 more, or any combination of, the following: coverage only for  
14 accident or disability income insurance, or any combination thereof;  
15 coverage issued as a supplement to liability insurance; liability  
16 insurance, including general liability insurance and automobile  
17 liability insurance; workers' compensation or similar insurance;  
18 automobile medical payment insurance; credit-only insurance;  
19 coverage for on-site medical clinics; and other similar insurance  
20 coverage, as specified in federal regulations, under which benefits  
21 for medical care are secondary or incidental to other insurance  
22 benefits. Health benefits plans shall not include the following  
23 benefits if they are provided under a separate policy, certificate or  
24 contract of insurance or are otherwise not an integral part of the  
25 plan: limited scope dental or vision benefits; benefits for long-term  
26 care, nursing home care, home health care, community-based care,  
27 or any combination thereof; and such other similar, limited benefits  
28 as are specified in federal regulations. Health benefits plan shall  
29 not include hospital confinement indemnity coverage if the benefits  
30 are provided under a separate policy, certificate or contract of  
31 insurance, there is no coordination between the provision of the  
32 benefits and any exclusion of benefits under any group health  
33 benefits plan maintained by the same plan sponsor, and those  
34 benefits are paid with respect to an event without regard to whether  
35 benefits are provided with respect to such an event under any group  
36 health plan maintained by the same plan sponsor. Health benefits  
37 plan shall not include the following if it is offered as a separate  
38 policy, certificate or contract of insurance: Medicare supplemental  
39 health insurance as defined under section 1882(g)(1) of the federal  
40 Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage  
41 supplemental to the coverage provided under chapter 55 of Title 10,  
42 United States Code (10 U.S.C. s.1071 et seq.); and similar  
43 supplemental coverage provided to coverage under a group health  
44 plan.

45 "Health status-related factor" means any of the following factors:  
46 health status; medical condition, including both physical and mental  
47 illness; claims experience; receipt of health care; medical history;

1 genetic information; evidence of insurability, including conditions  
2 arising out of acts of domestic violence; and disability.

3 "Late enrollee" means an eligible employee or dependent who  
4 requests enrollment in a health benefits plan of a small employer  
5 following the initial minimum 30-day enrollment period provided  
6 under the terms of the health benefits plan. An eligible employee or  
7 dependent shall not be considered a late enrollee if the individual: a.  
8 was covered under another employer's health benefits plan at the  
9 time he was eligible to enroll and stated at the time of the initial  
10 enrollment that coverage under that other employer's health benefits  
11 plan was the reason for declining enrollment, but only if the plan  
12 sponsor or carrier required such a statement at that time and  
13 provided the employee with notice of that requirement and the  
14 consequences of that requirement at that time; b. has lost coverage  
15 under that other employer's health benefits plan as a result of  
16 termination of employment or eligibility, reduction in the number of  
17 hours of employment, involuntary termination, the termination of  
18 the other plan's coverage, death of a spouse, or divorce or legal  
19 separation; and c. requests enrollment within 90 days after  
20 termination of coverage provided under another employer's health  
21 benefits plan. An eligible employee or dependent also shall not be  
22 considered a late enrollee if the individual is employed by an  
23 employer which offers multiple health benefits plans and the  
24 individual elects a different plan during an open enrollment period;  
25 the individual had coverage under a COBRA continuation provision  
26 and the coverage under that provision was exhausted and the  
27 employee requests enrollment not later than 30 days after the date  
28 of exhaustion of COBRA coverage; or if a court of competent  
29 jurisdiction has ordered coverage to be provided for a spouse or  
30 minor child under a covered employee's health benefits plan and  
31 request for enrollment is made within 30 days after issuance of that  
32 court order.

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

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

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

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

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

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

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

18 "Small employer" means, in connection with a group health plan  
19 with respect to a calendar year and a plan year, any person, firm,  
20 corporation, partnership, or political subdivision that is actively  
21 engaged in business that employed an average of at least two but  
22 not more than 50 eligible employees on business days during the  
23 preceding calendar year and who employs at least two employees  
24 on the first day of the plan year, and the majority of the employees  
25 are employed in New Jersey. All persons treated as a single  
26 employer under subsection (b), (c), (m) or (o) of section 414 of the  
27 Internal Revenue Code of 1986 (26 U.S.C.s.414) shall be treated as  
28 one employer. Subsequent to the issuance of a health benefits plan  
29 to a small employer and for the purpose of determining continued  
30 eligibility, the size of a small employer shall be determined  
31 annually. Except as otherwise specifically provided, provisions of  
32 P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small  
33 employer shall continue to apply at least until the plan anniversary  
34 following the date the small employer no longer meets the  
35 requirements of this definition. In the case of an employer that was  
36 not in existence during the preceding calendar year, the  
37 determination of whether the employer is a small or large employer  
38 shall be based on the average number of employees that it is  
39 reasonably expected that the employer will employ on business  
40 days in the current calendar year. Any reference in P.L.1992, c.162  
41 (C.17B:27A-17 et seq.) to an employer shall include a reference to  
42 any predecessor of such employer.

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

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

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

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

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

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

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

20  
21 21. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to  
22 read as follows:

23 3. a. Except as provided in subsection f. of this section, every  
24 small employer carrier shall, as a condition of transacting business  
25 in this State, offer to every small employer at least three of the  
26 **【five】** health benefit plans established by the board, as provided in  
27 this section, and also offer and make a good faith effort to market  
28 individual health benefits plans as provided in section 3 of  
29 P.L.1992, c.161 (C.17B:27A-4). The board shall establish a  
30 standard policy form for each of the **【five】** plans, which except as  
31 otherwise provided in subsection j. of this section, shall be the only  
32 plans offered to small groups on or after January 1, 1994. One  
33 policy form shall contain the benefits provided for in sections 55,  
34 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and  
35 26:2J-4.3). In the case of indemnity carriers, one policy form shall  
36 be established which contains benefits and cost sharing levels which  
37 are equivalent to the health benefits plans of health maintenance  
38 organizations pursuant to the "Health Maintenance Organization  
39 Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.). The  
40 remaining policy forms shall contain basic hospital and medical-  
41 surgical benefits, including, but not limited to:

42 (1) Basic inpatient and outpatient hospital care;

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

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

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

46 and

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

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

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

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

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

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

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

46 f. Notwithstanding the provisions of this section to the  
47 contrary, a health maintenance organization which is a qualified  
48 health maintenance organization pursuant to the "Health

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

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

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

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

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

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



1 required to be sold pursuant to this section. The commissioner's  
2 determination shall be in writing and shall be appealable.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 applicable, and shall comply with the provisions of sections 2 and 9  
2 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7  
3 of P.L.1995, c.340 (C.17B:27A-19.3).

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

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

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

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

47 (10) In a case in which an association made available a health  
48 benefits plan on or before March 1, 1994 and subsequently changed

1 the issuing carrier between March 1, 1994 and the effective date of  
2 P.L.1995, c.340, the new issuing carrier shall be deemed to have  
3 been eligible to continue and renew the plan pursuant to paragraph  
4 (1) of this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

47 n. Effective immediately for a health benefits plan issued on or  
48 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)

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

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

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

20

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

23 5. In addition to the **[five]** standard health benefits plans  
24 offered by a carrier on the effective date of this act, a carrier that  
25 writes small employer health benefits plans pursuant to P.L.1992,  
26 c.162 (C.17B:27A-17 et seq.) may also offer one or more of the  
27 plans through the carrier's network of providers, with no  
28 reimbursement for any out-of-network benefits other than  
29 emergency care, urgent care, and continuity of care. A carrier's  
30 network of providers shall be subject to review and approval or  
31 disapproval by the Commissioner of Banking and Insurance, in  
32 consultation with the Commissioner of Health and Senior Services,  
33 pursuant to regulations promulgated by the Department of Banking  
34 and Insurance, including review and approval or disapproval before  
35 plans with benefits provided through a carrier's network of  
36 providers pursuant to this section may be offered by the carrier.  
37 Policies or contracts written on this basis shall be rated in a separate  
38 rating pool for the purposes of establishing a premium, but for the  
39 purpose of determining a carrier's losses, these policies or contracts  
40 shall be aggregated with the losses on the carrier's other business  
41 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-  
42 17 et seq.).

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

44

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

47 7. Every policy or contract issued to small employers in this  
48 State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be

1 renewable with respect to all eligible employees or dependents at  
2 the option of the policy or contract holder, or small employer except  
3 that a carrier may discontinue or not renew a health benefits plan in  
4 accordance with the provisions of this section:

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

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

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

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

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

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

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

24 (1) The carrier gives notice to cease doing business in the small  
25 employer market to the commissioner not later than eight months  
26 prior to the date of the planned withdrawal from the small **【group**  
27 **market】** employer market, during which time the carrier shall  
28 continue to be governed by this act with respect to business written  
29 pursuant to this act. For the purposes of this subsection, "date of  
30 withdrawal" means the date upon which the first notice to small  
31 employers is sent by the carrier pursuant to paragraph (2) of this  
32 subsection;

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

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

46 f. In the case of policies or contracts issued in connection with  
47 membership in an association or trust of employers, an employer  
48 ceases to maintain its membership in the association or trust, but

1 only if such coverage is terminated under this provision uniformly  
2 without regard to any health status-related factor relating to any  
3 covered individual.

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

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

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

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

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

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

23

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

26 8. Any small employer carrier may require a reasonable  
27 specified minimum participation with the same carrier of eligible  
28 employees, which shall not exceed 75%, or reasonable minimum  
29 employer contributions in determining whether to accept a small  
30 group pursuant to this act. The standards so established by the  
31 carrier shall be first approved by the board and shall be applied  
32 uniformly to all small groups, except that in no event shall a carrier  
33 require an employer to contribute more than 10% to the annual cost  
34 of the policy or contract, or an amount as otherwise provided by the  
35 board, and any minimum participation standards established by the  
36 carrier shall be reasonable. In establishing the percentage of  
37 employee participation, a one-to-one credit shall be given for each  
38 employee covered by a spouse's health benefits coverage, Medicare,  
39 Medicaid, NJ FamilyCare or another group health benefits plan. In  
40 calculating an employer's participation, the carrier shall include all  
41 insured employees, regardless of whether the employees chose an  
42 indemnity plan or a health maintenance organization, or a  
43 combination thereof.

44 (cf: P.L. 2005, c.166, s.1)

45

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



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

1 17 et seq.), shall be required to offer small employer health benefits  
2 plans to non-association or trust employers in the same manner as  
3 any other small employer carrier is required pursuant to P.L.1992,  
4 c.162 (C.17B:27A-17 et seq.).

5 e. Nothing contained herein shall prohibit the use of premium  
6 rate structures to establish different premium rates for individuals  
7 and family units.

8 f. No insurance contract or policy subject to this act, including  
9 a contract or policy entered into with a small employer who is a  
10 member of a Small Employer Purchasing Alliance pursuant to the  
11 provisions of P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be  
12 entered into unless and until the carrier has made an informational  
13 filing with the commissioner of a schedule of premiums, not to  
14 exceed 12 months in duration, to be paid pursuant to such contract  
15 or policy, of the carrier's rating plan and classification system in  
16 connection with such contract or policy, and of the actuarial  
17 assumptions and methods used by the carrier in establishing  
18 premium rates for such contract or policy.

19 g. (1) Beginning January 1, 1995, a carrier desiring to increase  
20 or decrease premiums for any policy form or benefit rider offered  
21 pursuant to subsection i. of section 3 of P.L.1992, c.162  
22 (C.17B:27A-19) subject to this act may implement such increase or  
23 decrease upon making an informational filing with the  
24 commissioner of such increase or decrease, along with the actuarial  
25 assumptions and methods used by the carrier in establishing such  
26 increase or decrease, provided that the anticipated minimum loss  
27 ratio for all policy forms shall not be less than ~~75%~~ 80% of the  
28 premium therefor as provided in paragraph (2) of this subsection.  
29 The commissioner may disapprove any informational filing on a  
30 finding that it is incomplete and not in substantial compliance with  
31 P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are  
32 inadequate or unfairly discriminatory. Until December 31, 1996,  
33 the informational filing shall also include the carrier's rating plan  
34 and classification system in connection with such increase or  
35 decrease.

36 (2) Each calendar year, a carrier shall return, in the form of  
37 aggregate benefits for all of the ~~five~~ standard policy forms  
38 offered by the carrier pursuant to subsection a. of section 3 of  
39 P.L.1992, c.162 (C.17B:27A-19), at least ~~75%~~ 80% of the  
40 aggregate premiums collected for all of the standard policy forms,  
41 other than alliance policy forms, and at least ~~75%~~ 80% of the  
42 aggregate premiums collected for all of the non-standard policy  
43 forms during that calendar year. A carrier shall return at least  
44 ~~75%~~ 80% of the premiums collected for all of the alliances  
45 during that calendar year, which loss ratio may be calculated in the  
46 aggregate for all of the alliances or separately for each alliance.  
47 Carriers shall annually report, no later than August 1st of each year,

1 the loss ratio calculated pursuant to this section for all of the  
2 standard, other than alliance policy forms, non-standard policy  
3 forms and alliance policy forms for the previous calendar year,  
4 provided that a carrier may annually report the loss ratio calculated  
5 pursuant to this section for all of the alliances in the aggregate or  
6 separately for each alliance. In each case where the loss ratio fails  
7 to substantially comply with the ~~【75%】~~ 80% loss ratio requirement,  
8 the carrier shall issue a dividend or credit against future premiums  
9 for all policyholders with the standard, other than alliance policy  
10 forms, nonstandard policy forms or alliance policy forms, as  
11 applicable, in an amount sufficient to assure that the aggregate  
12 benefits paid in the previous calendar year plus the amount of the  
13 dividends and credits shall equal ~~【75%】~~ 80% of the aggregate  
14 premiums collected for the respective policy forms in the previous  
15 calendar year. All dividends and credits must be distributed by  
16 December 31 of the year following the calendar year in which the  
17 loss ratio requirements were not satisfied. The annual report  
18 required by this paragraph shall include a carrier's calculation of the  
19 dividends and credits applicable to standard, other than alliance  
20 policy forms, non-standard policy forms and alliance policy forms,  
21 as well as an explanation of the carrier's plan to issue dividends or  
22 credits. The instructions and format for calculating and reporting  
23 loss ratios and issuing dividends or credits shall be specified by the  
24 commissioner by regulation. Such regulations shall include  
25 provisions for the distribution of a dividend or credit in the event of  
26 cancellation or termination by a policyholder. For purposes of this  
27 paragraph, "alliance policy forms" means policies purchased by  
28 small employers who are members of Small Employer Purchasing  
29 Alliances.

30 (3) The loss ratio of a health benefits plan issued pursuant to  
31 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall  
32 be calculated in accordance with the provisions of section 7 of  
33 P.L.1995, c.340 (C.17B:27A-19.3), for the purposes of meeting the  
34 requirements of this subsection.

35 h. (Deleted by amendment, P.L.1993, c.162).

36 i. The provisions of this act shall apply to health benefits plans  
37 which are delivered, issued for delivery, renewed or continued on or  
38 after January 1, 1994.

39 j. (Deleted by amendment, P.L.1995, c.340).

40 k. A carrier who negotiates a reduced premium rate with a  
41 Small Employer Purchasing Alliance for members of that alliance  
42 shall provide a reduction in the premium rate filed in accordance  
43 with paragraph (3) of subsection a. of this section, expressed as a  
44 percentage, which reduction shall be based on volume or other  
45 efficiencies or economies of scale and shall not be based on health  
46 status-related factors.

47 (cf: P.L.2003, c.163, s.1)

1       26. (New section) a. An insurance producer licensed pursuant to  
2 P.L.2001, c.210 (C.17:22A-26 et seq.) who sells, solicits, or  
3 negotiates health insurance policies or contracts to residents of this  
4 State shall notify the purchaser of the insurance, in writing, of the  
5 amount of any commission, service fee, brokerage, or other  
6 valuable consideration that the producer will receive as a result of  
7 the sale, solicitation or negotiation of the health insurance policy or  
8 contract. If the commission, fee, brokerage, or other valuable  
9 consideration is based on a percentage of premium, the insurance  
10 producer shall include that information in the notification to the  
11 purchaser.

12       b. Upon seeking renewal of a license issued pursuant to  
13 P.L.2001, c.210 (C.17:22A-26 et seq.), an insurance producer shall  
14 report to the Commissioner of Banking and Insurance, in a form and  
15 manner specified by the commissioner, how the producer is  
16 compensated for the sale, solicitation, or negotiation of health  
17 insurance policies and contracts, including the basis for determining  
18 a commission, service fee, brokerage, or other valuable  
19 consideration for the sale, solicitation, or negotiation of a health  
20 insurance policy or contract. The insurance producer shall provide  
21 such other information regarding compensation as the commissioner  
22 deems appropriate.

23       c. Notwithstanding the provisions of any law to the contrary,  
24 the commissioner shall not renew the license of an insurance  
25 producer who is subject to the provisions of this section unless the  
26 insurance producer provides the information required pursuant to  
27 this section.

28       d. The commissioner may specify, by regulation, the  
29 information that shall be provided by an insurance producer in the  
30 notification to a purchaser of health insurance and the procedure for  
31 providing the notification.

32

33       27. The Commissioner of Banking and Insurance shall, pursuant  
34 to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-  
35 1 et seq.), adopt regulations necessary to implement the provisions  
36 of this act.

37

38       28. Sections 1 through 7 and 27 of this act shall take effect  
39 immediately and sections 8 through 26 of this act shall take effect  
40 on the 180th day after enactment and shall apply to all contracts and  
41 policies that are delivered, issued, executed or renewed or approved  
42 for issuance or renewal in this State on or after the effective date,  
43 but the Commissioner of Banking and Insurance may take such  
44 anticipatory administrative action in advance thereof as shall be  
45 necessary for the implementation of this act.

## STATEMENT

1  
2  
3 The purpose of this bill is to ensure that more residents in this  
4 State have access to affordable health care coverage. The bill  
5 achieves this goal by expanding the NJ FamilyCare Program to  
6 more low income parents, mandating that all children in the State  
7 have health care coverage either through public programs or private  
8 coverage, and adopting various reform measures to the individual  
9 and small employer insurance markets to increase the affordability  
10 of, and stabilize enrollment in, health benefits plans for individuals  
11 and small businesses. The provisions of this bill represent the first  
12 phase of a comprehensive reform of the health care system in this  
13 State which, when fully implemented, will ensure universal health  
14 care coverage for all residents of this State.

**Health Care Coverage Reforms:**

- 17 • To ensure that all children in the State are able to access health  
18 care, the bill establishes a “Kids First” mandate that requires all  
19 children 18 years of age and younger in the State to have health  
20 insurance coverage, beginning one year after the date of  
21 enactment of the bill. This coverage may be provided through an  
22 employer-sponsored or individual health benefits plan, the  
23 Medicaid program, NJ FamilyCare Program, or the NJ  
24 FamilyCare Advantage buy-in program.
- 25 • To make health care coverage more accessible to low income  
26 parents, eligibility for the NJ FamilyCare Program is expanded to  
27 include parents whose income is up to 200% of the federal  
28 poverty level.
- 29 • In order to ensure that hospitals assess patients under 19 years of  
30 age who present at the hospital for emergency care as to whether  
31 they may be presumptively eligible for NJ FamilyCare or  
32 Medicaid, the bill prohibits hospitals from submitting charity care  
33 claims for these patients. The cost of emergency care for patients  
34 who are determined to be presumptively eligible for NJ  
35 FamilyCare or Medicaid is shared by the federal government and,  
36 therefore, this provision will ensure more effective use of the  
37 State’s limited charity care funds for patient care that is not  
38 reimbursed by the federal government.
- 39 • In order to identify, and provide increased State outreach to,  
40 residents of the State who are uninsured and may be eligible to  
41 enroll in the Medicaid or NJ FamilyCare program, the bill  
42 establishes an ongoing enrollment initiative through the  
43 Department of the Treasury, in consultation with the Department  
44 of Human Services. Under the initiative, beginning with the 2008  
45 tax year and for each tax year thereafter, the Department of the  
46 Treasury shall require that each individual taxpayer indicate on  
47 the taxpayer's income tax return whether the taxpayer and  
48 dependents, if applicable, has health insurance coverage on the

1 date of filing of the return. If a taxpayer reports that he or his  
2 dependents are uninsured, and the State Treasurer determines that  
3 based on the taxpayer's reported income the taxpayer or his  
4 dependents may be eligible for either Medicaid or NJ  
5 FamilyCare, the State Treasurer would to send the taxpayer an  
6 application for the Medicaid or NJ FamilyCare program, as  
7 applicable.

8

9 **Individual and Small Employer Health Insurance Reforms:**

10 The bill implements several reforms to the individual and small  
11 employer markets to make health benefits plans more affordable to  
12 individuals and small businesses in the State. Specifically, the bill:

- 13 • Seeks to make individual health benefits plans more affordable to  
14 younger persons, by revising the rating system for individual  
15 plans for new policies and contracts issued after the effective date  
16 of the bill, so that the premium rate differential can be up to  
17 350%, but the only factor that the rating differential may be based  
18 on is the age of the person covered under the plan and the factor  
19 must be applied in a manner consistent with regulations of the  
20 Commissioner of Banking and Insurance, which include age  
21 classifications in a minimum of five-year increments. The bill  
22 provides, however, that in order to protect consumers who  
23 currently have coverage under an individual health benefits plan,  
24 rate increases for these consumers would be limited for the next  
25 five years to an amount no more than the lower of 15% or the  
26 medical trend assumption used by the carrier to project claims.
- 27 • Requires that a carrier must offer and make a good faith effort to  
28 market individual policies as a condition of participation in the  
29 small employer market, in order to ensure greater participation by  
30 carriers in the individual market.
- 31 • Reduces the number of standard plans that a carrier must offer in  
32 the individual and small employer markets from five to at least  
33 three plans.
- 34 • Authorizes carriers in the individual market to offer any number  
35 of riders which may revise the coverage offered by the standard  
36 plans in any way, but any form of such rider which decreases the  
37 actuarial value of one of the plans shall be filed for informational  
38 purposes with the board and for approval by the commissioner  
39 before any such rider may be sold. Any rider which adds benefits  
40 or increases the actuarial value of one of the plans shall be filed  
41 with the board or informational purposes before the rider may be  
42 sold. The additional premium for a rider shall be listed separately  
43 from the premium for the standard plan.
- 44 • Transfers regulatory oversight regarding approval of policy and  
45 contract forms, and review of premium rate filings and other  
46 similar matters, from the Individual Health Coverage Program  
47 Board to the Commissioner of Banking and Insurance, as is

- 1 currently provided in the New Jersey Small Employer Health  
2 Benefits Program.
- 3 • Requires carriers in the individual market to make an  
4 informational filing to the Commissioner of Banking and  
5 Insurance in the event the carrier seeks to increase or decrease  
6 premiums for any contract or policy form.
  - 7 • Revises provisions concerning the minimum loss ratio for  
8 individual and small employer plans and provides that rates shall  
9 be formulated so that the anticipated minimum loss ratio is not  
10 less than 80% of the premium.
  - 11 • Provides that after the effective date of the bill, no further loss  
12 assessments shall be calculated or collected, although carriers are  
13 not relieved of their obligations for loss assessments authorized  
14 prior to the effective date of the bill.
  - 15 • Permits small employer carriers to require a reasonable specified  
16 minimum participation “with the same carrier” of eligible  
17 employees.
  - 18 • Establishes transparency with respect to insurance broker fees by  
19 requiring insurance producers to notify a purchaser of insurance,  
20 in writing, of the amount of any commission, service fee,  
21 brokerage, other valuable consideration that the producer will  
22 receive as a result of the sale, solicitation or negotiation of the  
23 health insurance policy or contract. The bill also requires  
24 producers, as a condition of licensure by the Department of  
25 Banking and Insurance, to notify the department how the  
26 producer is compensated by carriers for the sale, solicitation or  
27 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:

<b>Additional State Enrollment and *Costs if Parent Expansion plus Outreach Campaign</b>						
	<b>Children</b>		<b>Parents</b>		<b>Total</b>	
	<b>Enrolled</b>	<b>State Costs</b>	<b>Enrolled</b>	<b>State Costs</b>	<b>Enrolled</b>	<b>State Costs</b>
<b>SFY08</b>	-	-	-	-	-	\$ -
<b>SFY09</b>	11,111	\$ 2,838,969	17,844	\$ 9,104,352	28,954	\$ 11,943,321
<b>SFY10</b>	15,962	\$ 8,003,130	37,667	\$ 32,511,666	53,629	\$ 40,514,795
<b>SFY11</b>	19,806	\$ 11,096,106	57,668	\$ 56,944,850	77,474	\$ 68,040,956
<b>3-YEAR TOTAL</b>		<b>\$ 21,938,205</b>		<b>\$ 98,560,868</b>		<b>\$ 120,499,073</b>

\*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**

<b>Fiscal Impact</b>	<b><u>Years 1 - 3</u></b>
<b>State Cost</b>	<p><b>Parents.</b> 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).</p> <p><b>Presumptive Eligibility.</b> 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.</p>
<b>State Revenue</b>	<p><b>Federal Reimbursement</b> of either 50 percent or 65 percent will be available to offset gross program expenditures.</p>



- **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:

<b>Number of Additional Children Enrolled (Phased in)</b>	<b>Annual Gross Costs (\$000)</b>	<b>Federal Match of 50% and 65% (\$000)</b>	<b>State Costs at Federal Match of 50% and 65% (\$000)</b>
<b>10,000</b>	\$7,707	\$3,853 - \$5,009	\$3,853 - \$2,697
<b>25,000</b>	\$19,267	\$9,633 - \$12,523	\$9,633 - \$6,743
<b>50,000</b>	\$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:

<b>Number of Adults Enrolled (Phased In)</b>	<b>Annual Gross Costs (\$000)</b>	<b>Federal Match at 65% (\$000)</b>	<b>State Costs (\$000)</b>
<b>10,000</b>	\$14,450	\$9,3936	\$5,058
<b>25,000</b>	\$19,167	\$12,523	\$6,7434
<b>50,000</b>	\$38,533	\$25,0472	\$13,487
<b>75,000</b>	\$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)**

1 AN ACT concerning health care coverage and revising parts of  
2 statutory law.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State  
5 of New Jersey:

6

7 1. (New section) The Legislature finds and declares:

8 a. There are an estimated 1.25 million residents of the State  
9 who have no health insurance coverage, of which over 240,000 are  
10 children, and the number of uninsured residents is increasing each  
11 year;

12 b. While employer-sponsored health care coverage in the State  
13 is well above the national average and has been a major factor in  
14 keeping the number of uninsured lower than in many states, because  
15 of the rising cost of the coverage, increasing numbers of employers  
16 are considering dropping coverage for their employees and  
17 dependents, or are requiring employees to share in a greater  
18 percentage of premium costs and to bear larger copayments and  
19 coinsurance, which is making health care coverage increasingly  
20 unaffordable to low and moderate income working families;

21 c. Persons without health insurance coverage receive less  
22 preventive care, poorer treatment for both minor and serious  
23 chronic and acute illnesses, and in many cases live shorter lives  
24 than comparable insured populations;

25 d. Many uninsured are forced to seek health care in  
26 inappropriate settings such as hospital emergency rooms because  
27 they cannot obtain needed health care services in a convenient and  
28 more cost-effective setting such as a primary care provider's office  
29 or clinic, which contributes to higher health care costs;

30 e. The uninsured are commonly billed at higher rates than  
31 those who have health care coverage. Health care costs have  
32 become a leading cause of bankruptcy in this country, and those  
33 without insurance are most at risk;

34 f. The State has recognized the importance of increasing access  
35 to health care coverage and, over the last several years, has enacted  
36 several reforms to make health care coverage more affordable and  
37 accessible to residents of the State. Among these reforms are the  
38 expansions of coverage under the State Medicaid and NJ  
39 FamilyCare programs. Despite these efforts, too many low income  
40 parents and children lack access to health care coverage;

41 g. In order to ensure that more low income parents in the State  
42 have access to health care coverage and all children in the State are  
43 covered under a health plan, thus moving closer to providing  
44 universal coverage for all residents of this State, it is necessary to  
45 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 thus is new matter.

1 Program, and mandate that all children in the State have health care  
2 coverage, either through public programs or private coverage; and

3 h. In order to make insurance coverage more affordable to  
4 residents and small businesses in this State, and to stabilize  
5 enrollment in, and the costs of, individual and small employer  
6 health benefits plans, it is also necessary to adopt comprehensive  
7 reform measures to the insurance marketplace.

8

9 2. (New section) a. Beginning one year after the date of  
10 enactment of this act, all residents of this State 18 years of age and  
11 younger shall obtain and maintain health care coverage that  
12 provides hospital and medical benefits. The coverage may be  
13 provided through an employer-sponsored or individual health  
14 benefits plan, the Medicaid program, NJ FamilyCare Program, or  
15 the NJ FamilyCare Advantage buy-in program.

16 b. As used in this section:

17 "Medicaid" means the New Jersey Medical Assistance and  
18 Health Services Program established pursuant to P.L.1968, c.413  
19 (C.30:4D-1 et seq.).

20 "NJ FamilyCare" means the NJ FamilyCare Program established  
21 pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

22 "NJ FamilyCare Advantage" means the buy-in program  
23 established pursuant to subsection j. of section 5 of P.L.2005, c.156  
24 (C.30:4J-12).

25

26 3. Section 4 of P.L.2005, 156 (C.30:4J-11) is amended to read  
27 as follows:

28 4. As used in this act:

29 "Commissioner" means the Commissioner of Human Services.

30 "Department" means the Department of Human Services.

31 "Medicaid" means the New Jersey Medical Assistance and  
32 Health Services Program established pursuant to P.L.1968, c.413  
33 (C.30:4D-1 et seq.).

34 "NJ FamilyCare" or "program" means the NJ FamilyCare  
35 Program established pursuant to sections 3 through 5 of P.L.2005,  
36 156 (C.30:4J-10 through C.30:4J-12).

37 "Poverty level" means the official federal poverty level based on  
38 family size, established and adjusted under Section 673(2) of  
39 Subtitle B, the "Community Services Block Grant Act," Pub.L.97-  
40 35 (42 U.S.C. s.9902(2)).

41 "Qualified applicant" means:

42 a. a child under 19 years of age: (1) whose family gross income  
43 does not exceed 350% of the poverty level; (2) who has no health  
44 insurance, as determined by the commissioner, and is ineligible for  
45 Medicaid; (3) who is a resident of this State; and (4) who is a  
46 citizen of the United States, or has been lawfully admitted for  
47 permanent residence into and remains lawfully present in the United  
48 States;

1       b. a parent or caretaker: (1) whose gross family income does  
2 not exceed 200% of the poverty level; (2) **【**who is enrolled in NJ  
3 FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et  
4 al.); (3)**】** who has no health insurance, as determined by the  
5 commissioner, and is ineligible for Medicaid; **【(4)】** (3) who is a  
6 resident of this State; and **【(5)】** (4) who is a citizen of the United  
7 States, or has been lawfully admitted for permanent residence into  
8 and remains lawfully present in the United States; and

9       c. a single adult or couple without dependent children: (1)  
10 whose family gross income does not exceed 100% of the poverty  
11 level; (2) who is enrolled in NJ FamilyCare on the effective date of  
12 P.L.2005, c.156 (C.30:4J-8 et al.) and is ineligible for Medicaid; (3)  
13 who is a resident of this State; and (4) who is a citizen of the United  
14 States, or has been lawfully admitted for permanent residence into  
15 and remains lawfully present in the United States.

16 (cf: P.L.2005, c.156, s.4)

17  
18       4. Section 5 of P.L.2005, 156 (C.30:4J-12) is amended to read  
19 as follows:

20       5. a. The purpose of the program shall be to provide  
21 subsidized health insurance coverage, and other health care benefits  
22 as determined by the commissioner, to children under 19 years of  
23 age and their parents or caretakers and to adults without dependent  
24 children, within the limits of funds appropriated or otherwise made  
25 available for the program.

26       The program shall require families to pay copayments and make  
27 premium contributions, based upon a sliding income scale. The  
28 program shall include the provision of well-child and other  
29 preventive services, hospitalization, physician care, laboratory and  
30 x-ray services, prescription drugs, mental health services, and other  
31 services as determined by the commissioner.

32       b. The commissioner shall take such actions as are necessary to  
33 implement and operate the program in accordance with the State  
34 Children's Health Insurance Program established pursuant to 42  
35 U.S.C.s.1397aa et seq.

36       c. The commissioner:

37       (1) shall, by regulation, establish standards for determining  
38 eligibility and other program requirements, including, but not  
39 limited to, restrictions on voluntary disenrollments from existing  
40 health insurance coverage;

41       (2) shall require that a parent or caretaker who is a qualified  
42 applicant purchase coverage, if available, through an employer-  
43 sponsored health insurance plan which is determined to be cost-  
44 effective and is approved by the commissioner, and shall provide  
45 assistance to the qualified applicant to purchase that coverage,  
46 except that the provisions of this paragraph shall not be construed to  
47 require an employer to provide health insurance coverage for any  
48 employee or employee's spouse or dependent child;



1 (3) may, by regulation, establish plans of coverage and benefits  
2 to be covered under the program, except that the provisions of this  
3 section shall not apply to coverage for medications used exclusively  
4 to treat AIDS or HIV infection; and

5 (4) shall establish, by regulation, other requirements for the  
6 program, including, but not limited to, premium payments and  
7 copayments, and may contract with one or more appropriate  
8 entities, including managed care organizations, to assist in  
9 administering the program. The period for which eligibility for the  
10 program is determined shall be the maximum period permitted  
11 under federal law.

12 d. The commissioner shall establish procedures for determining  
13 eligibility, which shall include, at a minimum, the following  
14 enrollment simplification practices:

15 (1) A streamlined application form as established pursuant to  
16 subsection k. of this section;

17 (2) Require new applicants to submit no more than one recent  
18 pay stub from the applicant's employer, or, if the applicant has more  
19 than one employer, no more than one from each of the applicant's  
20 employers, to verify income. In the event the applicant cannot  
21 provide a recent pay stub, the applicant may submit another form of  
22 income verification as deemed appropriate by the commissioner. If  
23 an applicant does not submit income verification in a timely  
24 manner, before determining the applicant ineligible for the program,  
25 the commissioner shall seek to verify the applicant's income by  
26 reviewing available Department of the Treasury or Department of  
27 Labor and Workforce Development records concerning the  
28 applicant, or such other records as the commissioner determines  
29 appropriate.

30 The commissioner may establish such retrospective auditing or  
31 income verification procedures as he deems appropriate, such as  
32 sample auditing and matching reported income with records of the  
33 Department of the Treasury or the Department of Labor and  
34 Workforce Development or such other records as the commissioner  
35 determines appropriate.

36 If the commissioner elects to match reported income with  
37 confidential records of the Department of the Treasury, the  
38 commissioner shall require an applicant to provide written  
39 authorization for the Division of Taxation in the Department of the  
40 Treasury to release applicable tax information to the commissioner  
41 for the purposes of establishing income eligibility for the program.  
42 The authorization, which shall be included on the program  
43 application form, shall be developed by the commissioner, in  
44 consultation with the State Treasurer;

45 (3) Online enrollment and renewal, in addition to enrollment  
46 and renewal by mail. The online enrollment and renewal forms  
47 shall include electronic links to other State and federal health and  
48 social services programs;

1 (4) Continuous enrollment;

2 (5) Simplified renewal by sending an enrollee a preprinted  
3 renewal form and requiring the enrollee to sign and return the form,  
4 with any applicable changes in the information provided in the  
5 form, no later than 30 days after the date the enrollee's annual  
6 eligibility expires. The commissioner may establish such auditing or  
7 income verification procedures as he deems appropriate, as  
8 provided in paragraph (1) of this subsection; and

9 (6) Provision of program eligibility-identification cards that are  
10 issued no more frequently than once a year.

11 e. The commissioner shall take, or cause to be taken, any  
12 action necessary to secure for the State the maximum amount of  
13 federal financial participation available with respect to the program,  
14 subject to the constraints of fiscal responsibility and within the  
15 limits of available funding in any fiscal year. In this regard,  
16 notwithstanding the definition of "qualified applicant," the  
17 commissioner may enroll in the program such children or their  
18 parents or caretakers who may otherwise be eligible for the  
19 Medicaid program in order to maximize use of federal funds that  
20 may be available pursuant to 42 U.S.C. s.1397aa et seq.

21 f. Subject to federal approval, a child shall be determined  
22 ineligible for the program if the child was voluntarily disenrolled  
23 from employer-sponsored group insurance coverage within six  
24 months prior to application to the program.

25 g. The commissioner shall provide, by regulation, for  
26 presumptive eligibility for the program in accordance with the  
27 following provisions:

28 (1) A child who presents himself for treatment at a general  
29 hospital, federally qualified or community health center, local  
30 health department that provides primary care, or other State  
31 licensed community-based primary care provider shall be deemed  
32 presumptively eligible for the program if a preliminary  
33 determination by hospital, health center, local health department or  
34 licensed health care provider staff indicates that the child meets  
35 program eligibility standards and is a member of a household with  
36 an income that does not exceed 350% of the poverty level;

37 (2) The provisions of paragraph (1) of this subsection shall also  
38 apply to a child who is deemed presumptively eligible for Medicaid  
39 coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

40 (3) The parent or caretaker of a child deemed presumptively  
41 eligible pursuant to this subsection shall be required to submit a  
42 completed application for the program no later than the end of the  
43 month following the month in which presumptive eligibility is  
44 determined;

45 (4) A child shall be eligible to receive all services covered by  
46 the program during the period in which the child is presumptively  
47 eligible; and

1 (5) The commissioner may, by regulation, establish a limit on  
2 the number of times a child may be deemed presumptively eligible  
3 for NJ FamilyCare.

4 h. The commissioner, in consultation with the Commissioner of  
5 Education, shall administer an ongoing enrollment initiative to  
6 provide outreach to children throughout the State who may be  
7 eligible for the program.

8 (1) With respect to school-age children, the commissioner, in  
9 consultation with the Commissioner of Education and the Secretary  
10 of Agriculture, shall develop a form that provides information about  
11 the NJ FamilyCare and Medicaid programs and provides an  
12 opportunity for the parent or guardian who signs the school lunch  
13 application form to give consent for information to be shared with  
14 the Department of Human Services for the purpose of determining  
15 eligibility for the programs. The form shall be attached to, included  
16 with, or incorporated into, the school lunch application form.

17 The commissioner, in consultation with the Commissioner of  
18 Education, shall establish procedures for schools to transmit  
19 information attached to, included with, or provided on the school  
20 lunch application form regarding the NJ FamilyCare and Medicaid  
21 programs to the Department of Human Services, in order to enable  
22 the department to determine eligibility for the programs.

23 (2) The commissioner or the Commissioner of Education, as  
24 applicable, shall:

25 (a) make available to each elementary and secondary school,  
26 licensed child care center, registered family day care home, unified  
27 child care agency, local health department that provides primary  
28 care, and community-based primary care provider, informational  
29 materials about the program, including instructions for applying  
30 online or by mail, as well as copies of the program application  
31 form.

32 The entity shall make the informational and application materials  
33 available, upon request, to persons interested in the program; and

34 (b) request each entity to distribute a notice at least annually, as  
35 developed by the commissioner, to households of children attending  
36 or receiving its services or care, informing them about the program  
37 and the availability of informational and application materials. In  
38 the case of elementary and secondary schools, the information  
39 attached to, included with, or incorporated into, the school lunch  
40 application form for school-age children pursuant to this  
41 subparagraph shall be deemed to meet the requirements of this  
42 paragraph.

43 i. Subject to federal approval, the commissioner shall, by  
44 regulation, establish that in determining income eligibility for a  
45 child, any gross family income above 200% of the poverty level, up  
46 to a maximum of 350% of the poverty level, shall be disregarded.

47 j. The commissioner shall establish a NJ FamilyCare coverage  
48 buy-in program through which a parent or caretaker whose family

1 income exceeds 350% of the poverty level may purchase coverage  
2 under NJ FamilyCare for a child under the age of 19, who is  
3 uninsured and was not voluntarily disenrolled from employer-  
4 sponsored group insurance coverage within six months prior to  
5 application to the program. The program shall be known as NJ  
6 FamilyCare Advantage.

7 The commissioner shall establish the premium and cost sharing  
8 amounts required to purchase coverage, except that the premium  
9 shall not exceed the amount the program pays per month to a  
10 managed care organization under NJ FamilyCare for a child of  
11 comparable age whose family income is between 200% and 350%  
12 of the poverty level, plus a reasonable processing fee.

13 k. The commissioner, in consultation with the Rutgers Center  
14 for State Health Policy, shall develop a streamlined application  
15 form for the NJ FamilyCare and Medicaid programs.  
16 (cf: P.L.2005, c.156, s.5).

17

18 5. (New section) The Commissioner of Human Services shall  
19 apply for such waivers as may be necessary to implement the  
20 provisions of section 4 of P.L.2005, c.156 (C.30:4J-11) and to  
21 secure federal financial participation for NJ FamilyCare  
22 expenditures under the State Children's Health Insurance Program  
23 pursuant to 42 U.S.C.s.1397aa et seq.

24

25 6. (New section) Notwithstanding the provisions of section 3  
26 of P.L.2004, c.113 (C.26:2H-18.59i) to the contrary, a hospital shall  
27 not submit charity care claims to the Department of Health and  
28 Senior Services for health care services provided to a child under 19  
29 years of age who presents at a hospital for emergency care and who  
30 may be deemed presumptively eligible for NJ FamilyCare coverage  
31 pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) or Medicaid coverage  
32 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

33

34 7. (New section) a. Beginning with the 2008 tax year and for  
35 each tax year thereafter, the Department of the Treasury shall  
36 require that each individual taxpayer indicate on the taxpayer's  
37 income tax return whether the taxpayer and dependents, if  
38 applicable, has health insurance coverage on the date of filing of the  
39 return.

40 b. The department shall, in consultation with the Commissioner  
41 of Human Services, administer an ongoing enrollment initiative to  
42 identify and provide outreach to taxpayers who are uninsured and  
43 may be eligible to enroll in the Medicaid or NJ FamilyCare  
44 program. As part of the initiative, the department shall send an  
45 application for the Medicaid or NJ FamilyCare program, as  
46 applicable, to any taxpayer who reports on the tax return form that  
47 he or his dependents do not have health insurance coverage and  
48 who, based on the income reported on the tax return form and the

1 tax payer's family size, may be eligible for either of the State's  
2 health care coverage programs.

3 c. As used in this section:

4 "Medicaid" means the New Jersey Medical Assistance and  
5 Health Services Program established pursuant to P.L.1968, c.413  
6 (C.30:4D-1 et seq.).

7 "NJ FamilyCare" or "program" means the NJ FamilyCare  
8 Program established pursuant to P.L.2005, 156 (C.30:4J-8 et al.).

9

10 8. R.S.54:50-9 is amended to read as follows:

11 54:50-9. Nothing herein contained shall be construed to prevent:

12 a. The delivery to a taxpayer or the taxpayer's duly authorized  
13 representative of a copy of any report or any other paper filed by  
14 the taxpayer pursuant to the provisions of this subtitle or of any  
15 such State tax law;

16 b. The publication of statistics so classified as to prevent the  
17 identification of a particular report and the items thereof;

18 c. The director, in the director's discretion and subject to  
19 reasonable conditions imposed by the director, from disclosing the  
20 name and address of any licensee under any State tax law, unless  
21 expressly prohibited by such State tax law;

22 d. The inspection by the Attorney General or other legal  
23 representative of this State of the reports or files relating to the  
24 claim of any taxpayer who shall bring an action to review or set  
25 aside any tax imposed under any State tax law or against whom an  
26 action or proceeding has been instituted in accordance with the  
27 provisions thereof;

28 e. The examination of said records and files by the  
29 Comptroller, State Auditor or State Commissioner of Finance, or by  
30 their respective duly authorized agents;

31 f. The furnishing, at the discretion of the director, of any  
32 information contained in tax reports or returns or any audit thereof  
33 or the report of any investigation made with respect thereto, filed  
34 pursuant to the tax laws, to the taxing officials of any other state,  
35 the District of Columbia, the United States and the territories  
36 thereof, providing said jurisdictions grant like privileges to this  
37 State and providing such information is to be used for tax purposes  
38 only;

39 g. The furnishing, at the discretion of the director, of any  
40 material information disclosed by the records or files to any law  
41 enforcing authority of this State who shall be charged with the  
42 investigation or prosecution of any violation of the criminal  
43 provisions of this subtitle or of any State tax law;

44 h. The furnishing by the director to the State agency  
45 responsible for administering the Child Support Enforcement  
46 program pursuant to Title IV-D of the federal Social Security Act,  
47 Pub.L.93-647 (42 U.S.C. s.651 et seq.), with the names, home  
48 addresses, social security numbers and sources of income and assets

- 1 of all absent parents who are certified by that agency as being  
2 required to pay child support, upon request by the State agency and  
3 pursuant to procedures and in a form prescribed by the director;
- 4 i. The furnishing by the director to the Board of Public  
5 Utilities any information contained in tax information statements,  
6 reports or returns or any audit thereof or a report of any  
7 investigation made with respect thereto, as may be necessary for the  
8 administration of P.L.1991, c.184 (C.54:30A-18.6 et al.) and  
9 P.L.1997, c.162 (C.54:10A-5.25 et al.);
- 10 j. The furnishing by the director to the Director of the Division  
11 of Alcoholic Beverage Control in the Department of Law and  
12 Public Safety any information contained in tax information  
13 statements, reports or returns or any audit thereof or a report of any  
14 investigation made with respect thereto, as may be relevant, in the  
15 discretion of the director, in any proceeding conducted for the  
16 issuance, suspension or revocation of any license authorized  
17 pursuant to Title 33 of the Revised Statutes;
- 18 k. The inspection by the Attorney General or other legal  
19 representative of this State of the reports or files of any tobacco  
20 product manufacturer, as defined in section 2 of P.L.1999, c.148  
21 (C.52:4D-2), for any period in which that tobacco product  
22 manufacturer was not or is not in compliance with subsection a. of  
23 section 3 of P.L.1999, c.148 (C.52:4D-3), or of any licensed  
24 distributor as defined in section 102 of P.L.1948, c.65 (C.54:40A-  
25 2), for the purpose of facilitating the administration of the  
26 provisions of P.L.1999, c.148 (C.52:4D-1 et seq.);
- 27 l. The furnishing, at the discretion of the director, of  
28 information as to whether a contractor or subcontractor holds a  
29 valid business registration as defined in section 1 of P.L.2001, c.134  
30 (C.52:32-44);
- 31 m. The furnishing by the director to a State agency as defined in  
32 section 1 of P.L.1995, c.158 (C.54:50-24) the names of licensees  
33 subject to suspension for non-payment of State tax indebtedness  
34 pursuant to P.L.2004, c.58 (C.54:50-26.1 et al.);
- 35 n. The release to the United States Department of the Treasury,  
36 Bureau of Financial Management Service, or its successor of  
37 relevant taxpayer information for purposes of implementing a  
38 reciprocal collection and offset of indebtedness agreement entered  
39 into between the State of New Jersey and the federal government  
40 pursuant to section 1 of P.L.2006, c.32 (C.54:49-12.7);
- 41 o. The examination of said records and files by the  
42 Commissioner of Health and Senior Services, the Commissioner of  
43 Human Services, the Medicaid Inspector General, or their  
44 respective duly authorized agents, pursuant to section 5 of  
45 P.L.2007, c.217 (C.26:2H-18.60e);
- 46 p. The furnishing at the discretion of the director of employer  
47 provided wage and tax withholding information contained in tax  
48 reports or returns filed pursuant to N.J.S.54A:7-2, 54A:7-4 and

1 54A:7-7, to the designated municipal officer of a municipality  
2 authorized to impose an employer payroll tax pursuant to the  
3 provisions of Article 5 (Employer Payroll Tax) of the "Local Tax  
4 Authorization Act," P.L.1970, c.326 (C.40:48C-14 et seq.), for the  
5 limited purpose of verifying the payroll information reported by  
6 employers subject to the employer payroll tax.  
7 (cf: P.L.2007, c.294, s.2)

8  
9 9. Section 1 of P.L.1992, c.161 (C.17B:27A-2) is amended to  
10 read as follows:

11 1. As used in sections 1 through 15, inclusive, of this act:

12 "Board" means the board of directors of the program.

13 "Carrier" means any entity subject to the insurance laws and  
14 regulations of this State, or subject to the jurisdiction of the  
15 commissioner, that contracts or offers to contract to provide,  
16 deliver, arrange for, pay for, or reimburse any of the costs of health  
17 care services, including a sickness and accident insurance company,  
18 a health maintenance organization, a nonprofit hospital or health  
19 service corporation, or any other entity providing a plan of health  
20 insurance, health benefits or health services. For purposes of this  
21 act, carriers that are affiliated companies shall be treated as one  
22 carrier.

23 "Church plan" has the same meaning given that term under Title  
24 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
25 Security Act of 1974" (29 U.S.C.s.1002(33)).

26 "Commissioner" means the Commissioner of Banking and  
27 Insurance.

28 "Community rating" means a rating system in which the  
29 premium for all persons covered by a contract is the same, based on  
30 the experience of all persons covered by that contract, without  
31 regard to age, sex, health status, occupation and geographical  
32 location

33 "Creditable coverage" means, with respect to an individual,  
34 coverage of the individual under any of the following: a group  
35 health plan; a group or individual health benefits plan; Part A or  
36 Part B of Title XVIII of the federal Social Security Act (42 U.S.C.  
37 s.1395 et seq.); Title XIX of the federal Social Security Act (42  
38 U.S.C. s.1396 et seq.), other than coverage consisting solely of  
39 benefits under section 1928 of Title XIX of the federal Social  
40 Security Act (42 U.S.C.s.1396s); Chapter 55 of Title 10, United  
41 States Code (10 U.S.C. s.1071 et seq.); a medical care program of  
42 the Indian Health Service or of a tribal organization; a State health  
43 plan offered under chapter 89 of Title 5, United States Code (5  
44 U.S.C. 8901 et seq.); a public health plan as defined by federal  
45 regulation; and a health benefits plan under section 5(e) of the  
46 "Peace Corps Act" (22 U.S.C. s.2504(e)); or coverage under any  
47 other type of plan as set forth by the commissioner by regulation.

1       Creditable coverage shall not include coverage consisting solely  
2 of the following: coverage only for accident or disability income  
3 insurance, or any combination thereof; coverage issued as a  
4 supplement to liability insurance; liability insurance, including  
5 general liability insurance and automobile liability insurance;  
6 workers' compensation or similar insurance; automobile medical  
7 payment insurance; credit only insurance; coverage for on-site  
8 medical clinics; coverage, as specified in federal regulation, under  
9 which benefits for medical care are secondary or incidental to the  
10 insurance benefits; and other coverage expressly excluded from the  
11 definition of health benefits plan.

12       "Department" means the Department of Banking and Insurance.

13       "Dependent" means the spouse, domestic partner as defined in  
14 section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as  
15 defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an  
16 eligible person, subject to applicable terms of the individual health  
17 benefits plan.

18       "Eligible person" means a person who is a resident who is not  
19 eligible to be covered under a group health benefits plan, group  
20 health plan, governmental plan, church plan, or Part A or Part B of  
21 Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.).

22       "Federally defined eligible individual" means an eligible person:  
23 (1) for whom, as of the date on which the individual seeks coverage  
24 under P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the  
25 periods of creditable coverage is 18 or more months; (2) whose  
26 most recent prior creditable coverage was under a group health  
27 plan, governmental plan, church plan, or health insurance coverage  
28 offered in connection with any such plan; (3) who is not eligible for  
29 coverage under a group health plan, Part A or Part B of Title XVIII  
30 of the Social Security Act (42 U.S.C.s.1395 et seq.), or a State plan  
31 under Title XIX of the Social Security Act (42 U.S.C.s.1396 et seq.)  
32 or any successor program, and who does not have another health  
33 benefits plan, or hospital or medical service plan; (4) with respect to  
34 whom the most recent coverage within the period of aggregate  
35 creditable coverage was not terminated based on a factor relating to  
36 nonpayment of premiums or fraud; (5) who, if offered the option of  
37 continuation coverage under the COBRA continuation provision or  
38 a similar State program, elected that coverage; and (6) who has  
39 elected continuation coverage described in (5) above and has  
40 exhausted that continuation coverage.

41       "Financially impaired" means a carrier which, after the effective  
42 date of this act, is not insolvent, but is deemed by the commissioner  
43 to be potentially unable to fulfill its contractual obligations, or a  
44 carrier which is placed under an order of rehabilitation or  
45 conservation by a court of competent jurisdiction.

46       "Governmental plan" has the meaning given that term under Title  
47 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
48 Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental



1 plan established or maintained for its employees by the Government  
2 of the United States or by any agency or instrumentality of that  
3 government.

4 "Group health benefits plan" means a health benefits plan for  
5 groups of two or more persons.

6 "Group health plan" means an employee welfare benefit plan, as  
7 defined in Title I, section 3 of Pub.L.93-406, the "Employee  
8 Retirement Income Security Act of 1974" (29 U.S.C. s.1002(1)), to  
9 the extent that the plan provides medical care, and including items  
10 and services paid for as medical care to employees or their  
11 dependents directly or through insurance, reimbursement, or  
12 otherwise.

13 "Health benefits plan" means a hospital and medical expense  
14 insurance policy; health service corporation contract; hospital  
15 service corporation contract; medical service corporation contract;  
16 health maintenance organization subscriber contract; or other plan  
17 for medical care delivered or issued for delivery in this State. For  
18 purposes of this act, health benefits plan shall not include one or  
19 more, or any combination of, the following: coverage only for  
20 accident, or disability income insurance, or any combination  
21 thereof; coverage issued as a supplement to liability insurance;  
22 liability insurance, including general liability insurance and  
23 automobile liability insurance; stop loss or excess risk insurance;  
24 workers' compensation or similar insurance; automobile medical  
25 payment insurance; credit-only insurance; coverage for on-site  
26 medical clinics; and other similar insurance coverage, as specified  
27 in federal regulations, under which benefits for medical care are  
28 secondary or incidental to other insurance benefits. Health benefits  
29 plans shall not include the following benefits if they are provided  
30 under a separate policy, certificate or contract of insurance or are  
31 otherwise not an integral part of the plan: limited scope dental or  
32 vision benefits; benefits for long-term care, nursing home care,  
33 home health care, community-based care, or any combination  
34 thereof; and such other similar, limited benefits as are specified in  
35 federal regulations. Health benefits plan shall not include hospital  
36 confinement indemnity coverage if the benefits are provided under  
37 a separate policy, certificate or contract of insurance, there is no  
38 coordination between the provision of the benefits and any  
39 exclusion of benefits under any group health benefits plan  
40 maintained by the same plan sponsor, and those benefits are paid  
41 with respect to an event without regard to whether benefits are  
42 provided with respect to such an event under any group health plan  
43 maintained by the same plan sponsor. Health benefits plan shall not  
44 include the following if it is offered as a separate policy, certificate  
45 or contract of insurance: Medicare supplemental health insurance  
46 as defined under section 1882(g)(1) of the federal Social Security  
47 Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the  
48 coverage provided under chapter 55 of Title 10, United States Code

1 (10 U.S.C. s.1071 et seq.); and similar supplemental coverage  
2 provided to coverage under a group health plan.

3 "Health status-related factor" means any of the following factors:  
4 health status; medical condition, including both physical and mental  
5 illness; claims experience; receipt of health care; medical history;  
6 genetic information; evidence of insurability, including conditions  
7 arising out of acts of domestic violence; and disability.

8 "Individual health benefits plan" means: a. a health benefits plan  
9 for eligible persons and their dependents; and b. a certificate issued  
10 to an eligible person which evidences coverage under a policy or  
11 contract issued to a trust or association, regardless of the situs of  
12 delivery of the policy or contract, if the eligible person pays the  
13 premium and is not being covered under the policy or contract  
14 pursuant to continuation of benefits provisions applicable under  
15 federal or State law.

16 Individual health benefits plan shall not include a certificate  
17 issued under a policy or contract issued to a trust, or to the trustees  
18 of a fund, which trust or fund is an employee welfare benefit plan,  
19 to the extent the "Employee Retirement Income Security Act of  
20 1974" (29 U.S.C. s.1001 et seq.) preempts the application of  
21 P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

22 "Medicaid" means the Medicaid program established pursuant to  
23 P.L.1968, c.413 (C.30:4D-1 et seq.).

24 "Medical care" means amounts paid: (1) for the diagnosis, care,  
25 mitigation, treatment, or prevention of disease, or for the purpose of  
26 affecting any structure or function of the body; and (2)  
27 transportation primarily for and essential to medical care referred to  
28 in (1) above.

29 "Member" means a carrier that issues or has in force health  
30 benefits plans in New Jersey. Member shall not include a carrier  
31 whose combined average Medicare, Medicaid, and NJ FamilyCare  
32 **[and NJ KidCare]** enrollment represents more than 75% of its  
33 average total enrollment for all health benefits plans or whose  
34 combined Medicare, Medicaid, and NJ FamilyCare **[and NJ**  
35 **KidCare]** net earned premium for the two-year calculation period  
36 represents more than 75% of its total net earned premium for the  
37 two-year calculation period.

38 "Modified community rating" means a rating system in which the  
39 premium for all persons covered **[by a contract is formulated based**  
40 **on the experience of all persons covered by that contract, without**  
41 **regard to age, sex, occupation and geographical location, but which**  
42 **may differ by health status. The term modified community rating**  
43 **shall apply to contracts and policies issued prior to the effective**  
44 **date of this act which are subject to the provisions of subsection e.**  
45 **of section 2 of this act.] under a policy or contract for a specific**  
46 **health benefits plan and a specific date of issue of that plan is the**  
47 **same without regard to sex, health status, occupation, geographical**

1 location or any other factor or characteristic of covered persons,  
2 other than age.

3 The rating system shall provide that the premium rate charged by  
4 the carrier for the highest rated individual or class of individuals  
5 shall not be greater than 350% of the premium rate charged for the  
6 lowest rated individual or class of individuals purchasing the same  
7 individual health benefits plan. The rate differential among the  
8 premium rates charged to individuals covered under the same  
9 individual health benefits plans shall be based on the actual or  
10 expected experience of persons covered under that plan; provided,  
11 however, that the rate differential may also be based upon age. The  
12 factors upon which the rate differential is applied shall be consistent  
13 with regulations promulgated by the commissioner, which shall  
14 include age classifications established, at a minimum, in five year  
15 increments. There may be a reasonable differential among the  
16 premium rates charged for different family structure rating tiers  
17 within an individual health benefits plan or for different health  
18 benefits plans offered by the carrier.

19 "Net earned premium" means the premiums earned in this State  
20 on health benefits plans, less return premiums thereon and  
21 dividends paid or credited to policy or contract holders on the  
22 health benefits plan business. Net earned premium shall include the  
23 aggregate premiums earned on the carrier's insured group and  
24 individual business and health maintenance organization business,  
25 including premiums from any Medicare, Medicaid, or NJ  
26 FamilyCare or **[NJ KidCare]** contracts with the State or federal  
27 government, but shall not include premiums earned from contracts  
28 funded pursuant to the "Federal Employee Health Benefits Act of  
29 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss  
30 insurance coverage issued by a carrier in connection with any self  
31 insured health benefits plan, or Medicare supplement policies or  
32 contracts.

33 "NJ FamilyCare" means the NJ FamilyCare **[Health Coverage]**  
34 Program established pursuant to **[P.L.2000, c.71 (C.30:4J-1 et**  
35 seq.) **]** **P.L.2005, c.156 (C.30:4J-8 et al.)**.

36 **["NJ KidCare" means the Children's Health Care Coverage**  
37 **Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et**  
38 **seq.)**]****

39 "Non-group person life year" means coverage of a person for 12  
40 months by an individual health benefits plan or conversion policy or  
41 contract subject to P.L.1992, c.161 (C.17B:27A-2 et seq.), Medicare  
42 cost or risk contract or Medicaid contract.

43 "Open enrollment" means the offering of an individual health  
44 benefits plan to any eligible person on a guaranteed issue basis,  
45 pursuant to procedures established by the board.

46 "Plan of operation" means the plan of operation of the program  
47 adopted by the board pursuant to this act.

1 "Plan sponsor" shall have the meaning given that term under  
2 Title I, section 3 of Pub.L.93-406, the "Employee Retirement  
3 Income Security Act of 1974" (29 U.S.C. s.1002(16)(B)).

4 "Preexisting condition" means a condition that, during a  
5 specified period of not more than six months immediately preceding  
6 the effective date of coverage, had manifested itself in such a  
7 manner as would cause an ordinarily prudent person to seek medical  
8 advice, diagnosis, care or treatment, or for which medical advice,  
9 diagnosis, care or treatment was recommended or received as to that  
10 condition or as to a pregnancy existing on the effective date of  
11 coverage.

12 "Program" means the New Jersey Individual Health Coverage  
13 Program established pursuant to this act.

14 "Resident" means a person whose primary residence is in New  
15 Jersey and who is present in New Jersey for at least six months of  
16 the calendar year, or, in the case of a person who has moved to New  
17 Jersey less than six months before applying for individual health  
18 coverage, who intends to be present in New Jersey for at least six  
19 months of the calendar year.

20 "Two-year calculation period" means a two calendar year period,  
21 the first of which shall begin January 1, 1997 and end December 31,  
22 1998.

23 (cf: P.L.2001, c.349, s.1)

24  
25 10. Section 2 of P.L.1992, c.161 (C.17B:27A-3) is amended to  
26 read as follows:

27 2. a. An individual health benefits plan issued on or after  
28 **【August 1, 1993 shall be subject to the provisions of this act】** the  
29 effective date of P.L. , c. (pending before the Legislature as this  
30 bill) shall be subject to the rating provisions established in P.L. , c.  
31 (pending before the Legislature as this bill). In the case of an  
32 individual health benefits plan issued to a covered person prior to  
33 the effective date of P.L. , c. (pending before the Legislature as  
34 this bill) and renewed thereafter, for the five years next following  
35 enactment of P.L. , c. (pending before the Legislature as this  
36 bill), the annual rate increase filed for the plan shall be limited to  
37 the lower of 15% or the medical trend assumption used by the  
38 carrier to project claims.

39 b. **【(1) An individual health benefits plan issued on an open**  
40 **enrollment, modified community rated basis or community rated**  
41 **basis prior to August 1, 1993 shall not be subject to sections 3**  
42 **through 8, inclusive, of this act, unless otherwise specified therein.**

43 **(2) An individual health benefits plan issued other than on an**  
44 **open enrollment basis prior to August 1, 1993 shall not be subject**  
45 **to the provisions of this act, except that the plan shall be liable for**  
46 **assessments made pursuant to section 11 of this act.**

47 **(3) A group conversion contract or policy issued prior to August**  
48 **1, 1993 that is not issued on a modified community rated basis or**

1 community rated basis, shall not be subject to the provisions of this  
2 act, except that the contract or policy shall be liable for assessments  
3 made pursuant to section 11 of this act.

4 (4) Notwithstanding any other provision of law to the contrary,  
5 an individual health benefits plan issued by a hospital service  
6 corporation or medical service corporation prior to the effective  
7 date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to  
8 the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that  
9 the plan shall guarantee renewal pursuant to subsection b. of section  
10 5 of P.L.1992, c.161 (C.17B:27A-6).

11 (5) Notwithstanding any other provision of law to the contrary,  
12 an individual health benefits plan issued by a hospital service  
13 corporation or medical service corporation to an eligible person or  
14 federally defined eligible individual after the effective date of  
15 P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the  
16 provisions of subsections c. and d. of section 2, subsection b. of  
17 section 3, section 5, subsection b. of section 6, and subsections c.,  
18 d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3,  
19 C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall  
20 not be subject to the remaining provisions of P.L.1992, c. 161. ]  
21 (Deleted by amendment, P.L. , c. ) (pending before the  
22 Legislature as this bill).

23 c. [After August 1, 1993, an individual who is eligible to  
24 participate in a group health benefits plan that provides coverage for  
25 hospital or medical expenses shall not be covered by an individual  
26 health benefits plan which provides benefits for hospital and  
27 medical expenses that are the same or similar to coverage provided  
28 in the group health benefits plan, except that an individual who is  
29 eligible to participate in a group health benefits plan but is currently  
30 covered by an individual health benefits plan may continue to be  
31 covered by that plan until the first anniversary date of the group  
32 health benefits plan occurring on or after January 1, 1994. ]  
33 (Deleted by amendment, P.L. , c. ) (pending before the  
34 Legislature as this bill).

35 d. [Except as otherwise provided in subsection c. of this  
36 section, after August 1, 1993, a person who is covered by an  
37 individual health benefits plan who is a participant in, or is eligible  
38 to participate in, a group health benefits plan that provides the same  
39 or similar coverages as the individual health benefits plan, and a  
40 person, including an employer or insurance producer, who causes  
41 another person to be covered by an individual health benefits plan  
42 which person is a participant in, or who is eligible to participate in a  
43 group health benefits plan that provides the same or similar  
44 coverages as the individual health benefits plan, shall be subject to  
45 a fine by the commissioner in an amount not less than twice the  
46 annual premium paid for the individual health benefits plan,

1 together with any other penalties permitted by law.】 (Deleted by  
2 amendment, P.L. , c. )(pending before the Legislature as this bill).

3 e. (Deleted by amendment, P.L.1997, c.146).  
4 (cf: P.L.1997, c.146, s.2)

5  
6 11. Section 3 of P.L.1992, c.161 (C.17B:27A-4) is amended to  
7 read as follows:

8 3. a. No later than 180 days after the effective date of 【this  
9 act】 P.L. , c. (pending before the Legislature as this bill), a  
10 carrier shall, as a condition of issuing small employer health  
11 benefits plans in this State, also offer individual health benefits  
12 plans. The plans shall be offered on an open enrollment, modified  
13 community rated basis, pursuant to the provisions of this act【;  
14 except that a carrier shall be deemed to have satisfied its obligation  
15 to provide the individual health benefits plans by paying an  
16 assessment or receiving an exemption pursuant to section 11 of this  
17 act】 and P.L. , c. (pending before the Legislature as this bill).  
18 Every carrier that issues small employer health benefits plans  
19 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall make a  
20 good faith effort to market individual health benefits plans.

21 b. A carrier shall offer to an eligible person a choice of 【five】  
22 at least three individual health benefits plans 【any of which may  
23 contain provisions for managed care】 established by the board  
24 pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7). One plan  
25 shall be a basic health benefits plan【, one plan shall be a managed  
26 care plan and three plans shall include enhanced benefits of  
27 proportionally increasing actuarial value】. A carrier may elect to  
28 convert any individual contract or policy forms in force on the  
29 effective date of 【this act】 P.L. , c. (pending before the Legislature  
30 as this bill) to any of the 【five】 benefit plans, except that the carrier  
31 may not convert more than 25% of existing contracts or policies  
32 each year, and the replacement plan shall be of no less actuarial  
33 value than the policy or contract being replaced.

34 【Notwithstanding the provisions of this subsection to the  
35 contrary, at any time after three years after the effective date of this  
36 act, the board, by regulation, may reduce the number of plans  
37 required to be offered by a carrier.】

38 Notwithstanding the provisions of this subsection to the contrary,  
39 a health maintenance organization which is a qualified health  
40 maintenance organization pursuant to the "Health Maintenance  
41 Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.)  
42 shall be permitted to offer a basic health benefits plan in accordance  
43 with the provisions of that law in lieu of the 【five】 plans required  
44 pursuant to this subsection.

45 c. (1) A basic health benefits plan shall provide the benefits set  
46 forth in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section 57

1 of P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991, c.187  
2 (C.26:2J-4.3), as the case may be.

3 (2) Notwithstanding the provisions of this subsection or any  
4 other law to the contrary, a carrier may, with the approval of the  
5 board, modify the coverage provided for in sections 55, 57, and 59  
6 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3,  
7 respectively) or provide alternative benefits or services from those  
8 required by this subsection if they are within the intent of this act or  
9 if the board changes the benefits included in the basic health  
10 benefits plan.

11 (3) A contract or policy for a basic health benefits plan provided  
12 for in this section may contain or provide for coinsurance or  
13 deductibles, or both, except that no deductible shall be payable in  
14 excess of a total of \$250 by an individual or \$500 by a family unit  
15 during any benefit year; and no coinsurance shall be payable in  
16 excess of a total of \$500 by an individual or by a family unit during  
17 any benefit year.

18 (4) Notwithstanding the provisions of paragraph (3) of this  
19 subsection or any other law to the contrary, a carrier may provide  
20 for increased deductibles or coinsurance for a basic health benefits  
21 plan if approved by the board or if the board increases deductibles  
22 or coinsurance included in the basic health benefits plan.

23 (5) The provisions of section 13 of P.L.1985, c.236 (C.17:48E-  
24 13), N.J.S.17B:26-1, and section 8 of P.L.1973, c.337 (C.26:2J-8)  
25 with respect to the filing of policy forms shall not apply to health  
26 plans issued on or after the effective date of this act.

27 (6) The provisions of section 27 of P.L.1985, c.236 (C.17:48E-  
28 27) and section 7 of P.L.1988, c.71 (C.17:48E-27.1) with respect to  
29 rate filings shall not apply to individual health plans issued on or  
30 after the effective date of this act.

31 d. Every group conversion contract or policy issued after the  
32 effective date of this act shall be issued pursuant to this section;  
33 except that this requirement shall not apply to any group conversion  
34 contract or policy in which a portion of the premium is chargeable  
35 to, or subsidized by, the group policy from which the conversion is  
36 made.

37 e. **[If all five of the individual health benefits plans are not**  
38 **established by the board by the effective date of P.L.1993, c.164**  
39 **(C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the**  
40 **five health benefits plans by offering each health benefits plan as it**  
41 **is established by the board; however, once the board establishes all**  
42 **five plans, the carrier shall be required to offer the five plans in**  
43 **accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et**  
44 **al.).]** (Deleted by amendment, P.L. , c. )(pending before the  
45 Legislature as this bill).

46 f. In addition to the rider packages provided for in subsection  
47 c. of section 6 of P.L.1992, c.161 (C.17B:27A-7), every carrier may  
48 offer, in connection with the health benefits plans required to be

1 offered by this section, any number of riders which may revise the  
2 coverage offered by the plans in any way, provided, however, that  
3 any form of such rider or amendment thereof which decreases  
4 benefits or decreases the actuarial value of one of the plans shall be  
5 filed for informational purposes with the board and for approval by  
6 the commissioner before such rider may be sold. Any rider or  
7 amendment thereof which adds benefits or increases the actuarial  
8 value of one of the plans shall be filed with the board for  
9 informational purposes before such rider may be sold. The added  
10 premium or reduction in premium for each rider, as applicable, shall  
11 be listed separately from the premium for the standard plan.

12 The commissioner shall disapprove any rider filed pursuant to  
13 this subsection that is unjust, unfair, inequitable, unreasonably  
14 discriminatory, misleading, contrary to law or the public policy of  
15 this State. The commissioner shall not approve any rider which  
16 reduces benefits below those required by sections 55, 57 and 59 of  
17 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and  
18 required to be sold pursuant to this section. The commissioner's  
19 determination shall be in writing and shall be appealable.

20 (cf: P.L.1994, c.102, s.1)

21

22 12. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to  
23 read as follows:

24 2. a. Notwithstanding the provisions of P.L.1992, c.161  
25 (C.17B:27A-2 et seq.), every carrier that writes individual health  
26 benefits plans pursuant to P.L.1992, c.161 shall offer a health  
27 benefits plan in the individual health insurance market that includes  
28 only the coverages enumerated in this section, as follows:

29 90 days hospital room and board - \$500 copayment per hospital  
30 stay;

31 Outpatient and ambulatory surgery- \$250 copayment per surgery;

32 Physicians' fees connected with hospital care, including general  
33 acute care and surgery;

34 Physicians' fees connected with outpatient and ambulatory surgery;

35 Anesthesia and the administration of anesthesia;

36 Coverage for newborns;

37 Treatment for complications of pregnancy;

38 Intravenous solutions, blood and blood plasma;

39 Oxygen and the administration of oxygen;

40 Radiation and x-ray therapy;

41 Inpatient physical therapy and hydrotherapy;

42 Outpatient physical therapy - 30 visits annually per covered person-

43 \$20 copayment per treatment;

44 Dialysis - inpatient or outpatient;

45 Inpatient diagnostic tests and \$500 annual aggregate per covered  
46 person for out-of-hospital diagnostic tests;

47 Laboratory fees for treatment in hospital;

48 Delivery room fees;



- 1 Operating room fees;
  - 2 Special care unit;
  - 3 Treatment room fees;
  - 4 Emergency room services for medically necessary treatment - \$100
  - 5 copayment per visit;
  - 6 Pharmaceuticals dispensed in hospital;
  - 7 Dressings;
  - 8 Splints;
  - 9 Treatment for biologically-based mental illness, as defined in
  - 10 subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90
  - 11 days inpatient with no coinsurance - \$500 copayment per inpatient
  - 12 stay, 30 days outpatient with 30% coinsurance;
  - 13 Alcohol and Substance Abuse Treatment - 30 days inpatient or
  - 14 outpatient - 30% coinsurance;
  - 15 Childhood immunizations in accordance with the provisions of
  - 16 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
  - 17 adult immunizations;
  - 18 Wellness benefit - \$600 annual aggregate per covered person, \$50
  - 19 annual deductible, 20% coinsurance per service; and
  - 20 Physicians visits for diagnosed illness or injury - to a \$700 annual
  - 21 aggregate per covered person.
- 22 b. A carrier shall offer the benefits on an indemnity basis, with
- 23 the option that: (1) coverage is restricted to health care providers in
- 24 the carrier's network, including an exclusive provider organization,
- 25 or the carrier's preferred provider organization; or (2) coverage is
- 26 provided through health care providers in the carrier's network or
- 27 preferred provider organization with an out-of-network option with
- 28 30% coinsurance in addition to whatever other coinsurance may be
- 29 applicable under the policy.
- 30 c. With respect to all policies or contracts issued pursuant to
- 31 this section, the premium rate charged by a carrier to the highest
- 32 rated individual or class of individuals shall not be greater than
- 33 350% of the premium rate charged for the lowest rated individual or
- 34 class of individuals purchasing this health benefits plan, provided,
- 35 however, that the only factors upon which the rate differential may
- 36 be based are age, gender, and geography. Rates applicable to
- 37 policies or contracts issued pursuant to this section shall reflect past
- 38 and prospective loss experience for benefits included in such
- 39 policies or contracts, and shall be formulated in a manner that does
- 40 not result in an unfair subsidization of rates applicable to policies
- 41 issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2
- 42 et seq.) as the result of differences in levels of benefits offered.
- 43 d. Carriers may offer enhanced or additional benefits for an
- 44 additional premium amount in the form of a rider or riders, each of
- 45 which shall be comprised of a combination of enhanced or
- 46 additional benefits, in a manner which will avoid adverse selection
- 47 to the extent possible.

1 e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.)  
2 shall apply to this section to the extent that they are not contrary to  
3 the provisions of this section, including but not limited to,  
4 provisions relating to preexisting conditions, guaranteed issue, and  
5 calculation of loss ratio.

6 f. No later than one year following enactment of this act, every  
7 carrier shall make an informational filing with the **[board]**  
8 commissioner, which shall include the policy form, the premiums to  
9 be charged for the coverage, and the anticipated loss ratio. If the  
10 **[board]** commissioner has not disapproved the form within 30  
11 days, the form shall be deemed approved.

12 g. Every carrier that writes individual health benefits plans  
13 pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make  
14 available and shall make a good faith effort to market the contract  
15 or policy established pursuant to this section. A carrier who is in  
16 violation of this section shall be subject to the provisions of  
17 N.J.S.17B:30-1.

18 (cf: P.L.2001, c.368, s.2)

19

20 13. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to  
21 read as follows:

22 4. In addition to the **[five]** health benefits plans offered by a  
23 carrier on the effective date of this act, a carrier that writes  
24 individual health benefits plans pursuant to P.L.1992, c.161  
25 (C.17B:27A-2 et seq.) may also offer one or more of the plans  
26 through the carrier's network of providers, with no reimbursement  
27 for any out-of-network benefits other than emergency care, urgent  
28 care, and continuity of care. A carrier's network of providers shall  
29 be subject to review and approval or disapproval by the  
30 Commissioner of Banking and Insurance, in consultation with the  
31 Commissioner of Health and Senior Services, pursuant to  
32 regulations promulgated by the Department of Banking and  
33 Insurance, including review and approval or disapproval before  
34 plans with benefits provided through a carrier's network of  
35 providers pursuant to this section may be offered by the carrier.  
36 Policies or contracts written on this basis shall be rated in a separate  
37 rating pool for the purposes of establishing a premium, but for the  
38 purpose of determining a carrier's losses, these policies or contracts  
39 shall be aggregated with the losses on the carrier's other business  
40 written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2  
41 et seq.).

42 (cf: P.L.2001, c.368, s.4)

43

44 14. Section 5 of P.L.1992, c.161 (C.17B:27A-6) is amended to  
45 read as follows:

46 5. An individual health benefits plan issued pursuant to section  
47 3 of this act is subject to the following provisions:

- 1 a. The health benefits plan shall guarantee coverage for an  
2 eligible person and his dependents on a modified community rated  
3 basis.
- 4 b. A health benefits plan shall be renewable with respect to an  
5 eligible person and his dependents at the option of the policy or  
6 contract holder. A carrier may terminate a health benefits plan  
7 under the following circumstances:
- 8 (1) the policy or contract holder has failed to pay premiums in  
9 accordance with the terms of the policy or contract or the carrier has  
10 not received timely premium payments;
- 11 (2) the policy or contract holder has performed an act or practice  
12 that constitutes fraud or made an intentional misrepresentation of  
13 material fact under the terms of the coverage;
- 14 c. A carrier may not renew a health benefits plan only under  
15 the following circumstances:
- 16 (1) termination of eligibility of the policy or contract holder if  
17 the person is no longer a resident or becomes eligible for a group  
18 health benefits plan, group health plan, governmental plan or church  
19 plan;
- 20 (2) cancellation or amendment by the board of the specific  
21 individual health benefits plan;
- 22 (3) **[board]** approval by the commissioner of a request by  
23 the individual carrier to not renew a particular type of health  
24 benefits plan, in accordance with rules adopted by the **[board]**  
25 commissioner. After receiving **[board]** approval by the  
26 commissioner, a carrier may not renew a type of health benefits  
27 plan only if the carrier: (a) provides notice to each covered  
28 individual provided coverage of this type of the nonrenewal at least  
29 90 days prior to the date of the nonrenewal of the coverage; (b)  
30 offers to each individual provided coverage of this type the option  
31 to purchase any other individual health benefits plan currently being  
32 offered by the carrier; and (c) in exercising the option to not renew  
33 coverage of this type and in offering coverage as required under (b)  
34 above, the carrier acts uniformly without regard to any health  
35 status-related factor of enrolled individuals or individuals who may  
36 become eligible for coverage;
- 37 (4) **[board]** approval by the commissioner of a request by the  
38 individual carrier to cease doing business in the individual health  
39 benefits market. A carrier may not renew all individual health  
40 benefits plans only if the carrier: (a) first receives approval from  
41 the **[board]** commissioner; and (b) provides notice to each  
42 individual of the nonrenewal at least 180 days prior to the date of  
43 the expiration of such coverage. A carrier ceasing to do business in  
44 the individual health benefits market may not provide for the  
45 issuance of any health benefits plan in the individual **[market]** or  
46 small employer markets during the five-year period beginning on

1 the date of the termination of the last health benefits plan not so  
2 renewed; and

3 (5) In the case of a health benefits plan made available by a  
4 health maintenance organization carrier, the carrier shall not be  
5 required to renew coverage to an eligible individual who no longer  
6 resides, lives, or works in the service area, or in an area for which  
7 the carrier is authorized to do business, but only if coverage is  
8 terminated under this paragraph uniformly without regard to any  
9 health status-related factor of covered individuals.  
10 (cf. P.L.1997, c.146, s.3)

11  
12 15. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to  
13 read as follows:

14 6. The **board** commissioner shall **establish** approve the  
15 policy and contract forms and benefit levels to be made available by  
16 all carriers for the health benefits plans required to be issued  
17 pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall  
18 adopt such modifications to one or more plans as the board  
19 determines are necessary to make available a "high deductible  
20 health plan" or plans consistent with section 301 of Title III of the  
21 "Health Insurance Portability and Accountability Act of 1996,"  
22 Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical  
23 savings accounts, within 60 days after the enactment of P.L.1997,  
24 c.414 (C.54A:3-4 et al.). The **board** commissioner shall provide  
25 the **commissioner** board with an informational filing of the policy  
26 and contract forms and benefit levels it **establishes** approves.

27 a. The individual health benefits plans established by the board  
28 may include cost containment measures such as, but not limited to:  
29 utilization review of health care services, including review of  
30 medical necessity of hospital and physician services; case  
31 management benefit alternatives; selective contracting with  
32 hospitals, physicians, and other health care providers; and  
33 reasonable benefit differentials applicable to participating and  
34 nonparticipating providers; and other managed care provisions.

35 b. An individual health benefits plan offered pursuant to  
36 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a  
37 limitation of no more than 12 months on coverage for preexisting  
38 conditions. An individual health benefits plan offered pursuant to  
39 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a  
40 preexisting condition limitation of any period under the following  
41 circumstances:

42 (1) to an individual who has, under creditable coverage, with no  
43 intervening lapse in coverage of more than 31 days, been treated or  
44 diagnosed by a physician for a condition under that plan or satisfied  
45 a 12-month preexisting condition limitation; or

46 (2) to a federally defined eligible individual who applies for an  
47 individual health benefits plan within 63 days of termination of the  
48 prior coverage.

1 c. In addition to the **[five]** standard individual health benefits  
2 plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4),  
3 the board may develop up to five rider packages. Premium rates for  
4 the rider packages shall be determined in accordance with section 8  
5 of P.L.1992, c.161 (C.17B:27A-9).

6 d. After the board's establishment of the individual health  
7 benefits plans required pursuant to section 3 of P.L.1992, c.161  
8 (C.17B:27A-4), and notwithstanding any law to the contrary, a  
9 carrier shall file the policy or contract forms with the **[board]**  
10 commissioner and certify to the **[board]** commissioner that the  
11 health benefits plans to be used by the carrier are in substantial  
12 compliance with the provisions in the corresponding **[board]**  
13 approved plans. The certification shall be signed by the chief  
14 executive officer of the carrier. Upon receipt by the **[board]**  
15 commissioner of the certification, the certified plans may be used  
16 until the **[board]** commissioner, after notice and hearing,  
17 disapproves their continued use.

18 e. Effective immediately for an individual health benefits plan  
19 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
20 35.27 et al.) and effective on the first 12-month anniversary date of  
21 an individual health benefits plan in effect on the effective date of  
22 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health  
23 benefits plans required pursuant to section 3 of P.L.1992, c.161  
24 (C.17B:27A-4), including any plan offered by a federally qualified  
25 health maintenance organization, shall contain benefits for expenses  
26 incurred in the following:

27 (1) Screening by blood lead measurement for lead poisoning for  
28 children, including confirmatory blood lead testing as specified by  
29 the Department of Health and Senior Services pursuant to section 7  
30 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any  
31 necessary medical follow-up and treatment for lead poisoned  
32 children.

33 (2) All childhood immunizations as recommended by the  
34 Advisory Committee on Immunization Practices of the United  
35 States Public Health Service and the Department of Health and  
36 Senior Services pursuant to section 7 of P.L.1995, c.316 (C.26:2-  
37 137.1). A carrier shall notify its insureds, in writing, of any change  
38 in the health care services provided with respect to childhood  
39 immunizations and any related changes in premium. Such  
40 notification shall be in a form and manner to be determined by the  
41 Commissioner of Banking and Insurance.

42 (3) Screening for newborn hearing loss by appropriate  
43 electrophysiologic screening measures and periodic monitoring of  
44 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
45 (C.26:2-103.1 et al.). Payment for this screening service shall be  
46 separate and distinct from payment for routine new baby care in the

1 form of a newborn hearing screening fee as negotiated with the  
2 provider and facility.

3 The benefits provided pursuant to this subsection shall be  
4 provided to the same extent as for any other medical condition  
5 under the health benefits plan, except that a deductible shall not be  
6 applied for benefits provided pursuant to this subsection; however,  
7 with respect to a health benefits plan that qualifies as a high  
8 deductible health plan for which qualified medical expenses are  
9 paid using a health savings account established pursuant to section  
10 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),  
11 a deductible shall not be applied for any benefits provided pursuant  
12 to this subsection that represent preventive care as permitted by that  
13 federal law, and shall not be applied as provided pursuant to section  
14 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall  
15 apply to all individual health benefits plans in which the carrier has  
16 reserved the right to change the premium.

17 f. Effective immediately for a health benefits plan issued on or  
18 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and  
19 effective on the first 12-month anniversary date of a health benefits  
20 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z  
21 et al.), the health benefits plans required pursuant to section 3 of  
22 P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses  
23 incurred in the purchase of prescription drugs shall provide benefits  
24 for expenses incurred in the purchase of specialized non-standard  
25 infant formulas, when the covered infant's physician has diagnosed  
26 the infant as having multiple food protein intolerance and has  
27 determined such formula to be medically necessary, and when the  
28 covered infant has not been responsive to trials of standard non-cow  
29 milk-based formulas, including soybean and goat milk. The  
30 coverage may be subject to utilization review, including periodic  
31 review, of the continued medical necessity of the specialized infant  
32 formula.

33 The benefits shall be provided to the same extent as for any other  
34 prescribed items under the health benefits plan.

35 This subsection shall apply to all individual health benefits plans  
36 in which the carrier has reserved the right to change the premium.

37 g. Effective immediately for an individual health benefits plan  
38 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
39 35.27 et al.) and effective on the first 12-month anniversary date of  
40 an individual health benefits plan in effect on the effective date of  
41 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans  
42 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)  
43 that qualify as high deductible health plans for which qualified  
44 medical expenses are paid using a health savings account  
45 established pursuant to section 223 of the federal Internal Revenue  
46 Code of 1986 (26 U.S.C. s.223), including any plan offered by a  
47 federally qualified health maintenance organization, shall contain  
48 benefits for expenses incurred in connection with any medically

1 necessary benefits provided in-network which represent preventive  
2 care as permitted by that federal law.

3 The benefits provided pursuant to this subsection shall be  
4 provided to the same extent as for any other medical condition  
5 under the health benefits plan, except that a deductible shall not be  
6 applied for benefits provided pursuant to this subsection. This  
7 subsection shall apply to all individual health benefits plans in  
8 which the carrier has reserved the right to change the premium.

9 (cf: P.L.2005, c.248, s.13)

10

11 16. Section 8 of P.L.1992, c.161 (C.17B:27A-9) is amended to  
12 read as follows:

13 8. a. **【**The board shall make application to the Hospital Rate  
14 Setting Commission on behalf of all carriers for approval of  
15 discounted or reduced rates of payment to hospitals for health care  
16 services provided under an individual health benefits plan provided  
17 pursuant to this act.**】** (Deleted by amendment, P.L. , c. )(pending  
18 before the Legislature as this bill).

19 b. **【**In addition to discounted or reduced rates of hospital  
20 payment, the**】** The board shall make application on behalf of all  
21 carriers for any other subsidies, discounts, or funds that may be  
22 provided for under State or federal law or regulation. A carrier may  
23 include **【**discounted or reduced rates of hospital payment and other**】**  
24 subsidies or funds granted to the board to reduce its premium rates  
25 for individual health benefits plans subject to this act.

26 c. A carrier shall not issue individual health benefits plans on a  
27 new contract or policy form pursuant to this act until an  
28 informational filing of a full schedule of rates which applies to the  
29 contract or policy form has been filed with the **【**board**】**  
30 commissioner. The **【**board**】** commissioner shall **【**forward**】** provide  
31 a copy of the informational filing to the **【**commissioner and the**】**  
32 Attorney General and the board.

33 d. **【**A carrier shall make an informational filing with the board  
34 of any change in its rates for individual health benefits plans  
35 pursuant to section 3 of this act prior to the date the rates become  
36 effective. The board shall file the informational filing with the  
37 commissioner and the Attorney General. If the carrier has filed all  
38 information required by the board, the filing shall be deemed to be  
39 complete.**】** A carrier desiring to increase or decrease premiums for  
40 any contract or policy form may implement that increase or  
41 decrease upon making an informational filing with the  
42 commissioner of that increase or decrease, along with the actuarial  
43 assumptions and methods used by the carrier in establishing that  
44 increase or decrease. The commissioner may disapprove any  
45 informational filing on a finding that it is incomplete and not in  
46 substantial compliance with P.L.1992, c.161 (C.17B:27A-2 et seq.),  
47 or that the rates are inadequate or unfairly discriminatory.

1 e. (1) Rates shall be formulated on contracts or policies  
2 required pursuant to section 3 of this act so that the anticipated  
3 minimum loss ratio for a contract or policy form shall not be less  
4 than ~~【75%】~~ 80% of the premium. The carrier shall submit with its  
5 rate filing supporting data, as determined by the ~~【board】~~  
6 commissioner, and a certification by a member of the American  
7 Academy of Actuaries, or other individuals in a format acceptable  
8 to the ~~【board and to the】~~ commissioner, that the carrier is in  
9 compliance with the provisions of this subsection.

10 (2) ~~【Following the close of each calendar year, if the board~~  
11 ~~determines that a carrier's loss ratio was less than 75% for that~~  
12 ~~calendar year, the carrier shall be required to refund to policy or~~  
13 ~~contract holders the difference between the amount of net earned~~  
14 ~~premium it received that year and the amount that would have been~~  
15 ~~necessary to achieve the 75% loss ratio.】~~

16 Each calendar year, a carrier shall return, in the form of  
17 aggregate benefits for all of the policy or contract forms offered by  
18 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161  
19 (C.17:B:27A-4), at least 80% of the aggregate premiums collected  
20 for all of the policy or contract forms during that calendar year.  
21 Carriers shall annually report, no later than August 1 of each year,  
22 the loss ratio calculated pursuant to this section for all of the policy  
23 or contract forms for the previous calendar year. In each case in  
24 which the loss ratio fails to comply with the 80% loss ratio  
25 requirement, the carrier shall issue a dividend or credit against  
26 future premiums for all policy or contract holders, as applicable, in  
27 an amount sufficient to assure that the aggregate benefits paid in the  
28 previous calendar year plus the amount of the dividends and credits  
29 equal 80% of the aggregate premiums collected for the policy or  
30 contract forms in the previous calendar year. All dividends and  
31 credits shall be distributed by December 31 of the year following  
32 the calendar year in which the loss ratio requirements were not  
33 satisfied. The annual report required by this subsection shall include  
34 a carrier's calculation of the dividends and credits applicable to all  
35 policy or contract forms, as well as an explanation of the carrier's  
36 plan to issue dividends or credits. The instructions and format for  
37 calculating and reporting loss ratios and issuing dividends or credits  
38 shall be specified by the commissioner by regulation. Those  
39 regulations shall include provisions for the distribution of a  
40 dividend or credit in the event of cancellation or termination by a  
41 policyholder.

42 f. ~~【Notwithstanding the provisions of P.L.1992, c.161~~  
43 ~~(C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed~~  
44 ~~pursuant to this section by a carrier which insured at least 50% of~~  
45 ~~the community-rated individually insured persons on the effective~~  
46 ~~date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required~~  
47 ~~to produce a loss ratio which when combined with the carrier's~~



1 administrative costs and investment income results in self-  
2 sustaining rates prior to January 1, 1996, for individual policies or  
3 contracts issued prior to August 1, 1993. The carrier shall, not later  
4 than 30 days after the effective date of P.L.1994, c.102  
5 (C.17B;27A-4 et al.), file with the board for approval, a plan to  
6 achieve this objective. **】** (Deleted by amendment, P.L., c. )(pending  
7 before the Legislature as this bill).  
8 (cf: P.L.1994, c.102, s.2)  
9

10 17. Section 10 of P.L.1992, c.161 (C.17B:27A-11) is amended  
11 to read as follows:

12 10. The program shall have the general powers and authority  
13 granted under the laws of New Jersey to insurance companies,  
14 health service corporations and health maintenance organizations  
15 licensed or approved to transact business in this State, except that  
16 the program shall not have the power to issue health benefits plans  
17 directly to either groups or individuals.

18 The board shall have the specific authority to:

19 a. assess members their proportionate share of program losses  
20 and administrative expenses in accordance with the provisions of  
21 section 11 of this act, and make advance interim assessments, as  
22 may be reasonable and necessary for organizational and reasonable  
23 operating expenses and estimated losses. An interim assessment  
24 shall be credited as an offset against any regular assessment due  
25 following the close of the fiscal year;

26 b. establish rules, conditions, and procedures pertaining to the  
27 sharing of program losses and administrative expenses among the  
28 members of the program;

29 c. **【**review rate applications and form filings submitted by  
30 carriers in accordance with this act;**】** (Deleted by amendment,  
31 P.L. , c. )(pending before the Legislature as this bill).

32 d. define the provisions of individual health benefits plans in  
33 accordance with the requirements of this act;

34 e. enter into contracts which are necessary or proper to carry  
35 out the provisions and purposes of this act;

36 f. establish a procedure for the joint distribution of information  
37 on individual health benefits plans issued pursuant to section 3 of  
38 this act;

39 g. establish, at the board's discretion, standards for the  
40 application of a means test for individual health benefits plans  
41 issued pursuant to section 3 of this act;

42 h. establish, at the board's discretion, reasonable guidelines for  
43 the purchase of new individual health benefits plans by persons who  
44 already are enrolled in or insured by another individual health  
45 benefits plan;

46 i. establish minimum requirements for performance standards  
47 for carriers that are reimbursed for losses submitted to the program  
48 and provide for performance audits from time to time;

1 j. sue or be sued, including taking any legal actions necessary  
2 or proper for recovery of an assessment for, on behalf of, or against  
3 the program or a member;

4 k. appoint from among its members appropriate legal, actuarial,  
5 and other committees as necessary to provide technical and other  
6 assistance in the operation of the program, in policy and other  
7 contract design, and any other function within the authority of the  
8 program;

9 l. borrow money to effect the purposes of the program. Any  
10 notes or other evidence of indebtedness of the program not in  
11 default shall be legal investments for carriers and may be carried as  
12 admitted assets; and

13 m. contract for an independent actuary and any other  
14 professional services the board deems necessary to carry out its  
15 duties under P.L.1992, c.161 (C.17B:27A-2 et al.).

16 (cf: P.L.1993, c.164, s.6)

17

18 18. Section 11 of P.L.1992, c.161 (C.17B:27A-12) is amended  
19 to read as follows:

20 11. The board shall establish procedures for the equitable  
21 sharing of program losses among all members in accordance with  
22 their total market share as follows:

23 a. (1) By March 1, 1999, and following the close of each two-  
24 year calculation period thereafter, or on a different date established  
25 by the board:

26 (a) every carrier issuing health benefits plans in this State shall  
27 file with the board its net earned premium for the preceding two-  
28 year calculation period; and

29 (b) every carrier issuing individual health benefits plans in the  
30 State shall file with the board the net earned premium on health  
31 benefits plans issued pursuant to paragraph (1) of subsection b. of  
32 section 2 and section 3 of this act and the claims paid. If the claims  
33 paid for all health benefits plans during the two-year calculation  
34 period exceed 115% of the net earned premium and any investment  
35 income thereon for the two-year calculation period, the amount of  
36 the excess shall be the net paid loss for the carrier that shall be  
37 reimbursable under this act.

38 (2) Every member shall be liable for an assessment to reimburse  
39 carriers issuing individual health benefits plans in this State which  
40 sustain net paid losses during the two-year calculation period,  
41 unless the member has received an exemption from the board  
42 pursuant to subsection d. of this section and has written a minimum  
43 number of non-group person life years as provided for in that  
44 subsection. The assessment of each member shall be in the  
45 proportion that the net earned premium of the member for the two-  
46 year calculation period preceding the assessment bears to the net  
47 earned premium of all members for the two-year calculation period  
48 preceding the assessment. Notwithstanding the provisions of this

1 subsection to the contrary, a medical service corporation or a  
2 hospital service corporation shall not be liable for an assessment to  
3 reimburse carriers which sustain net paid losses.

4 (3) A member that is financially impaired may seek from the  
5 commissioner a deferment in whole or in part from any assessment  
6 issued by the board. The commissioner may defer, in whole or in  
7 part, the assessment of the member if, in the opinion of the  
8 commissioner, the payment of the assessment would endanger the  
9 ability of the member to fulfill its contractual obligations. If an  
10 assessment against a member is deferred in whole or in part, the  
11 amount by which the assessment is deferred may be assessed  
12 against the other members in a manner consistent with the basis for  
13 assessment set forth in this section. The member receiving the  
14 deferment shall remain liable to the program for the amount  
15 deferred.

16 b. The participation in the program as a member, the  
17 establishment of rates, forms or procedures, or any other joint or  
18 collective action required by this act shall not be the basis of any  
19 legal action, criminal or civil liability, or penalty against the  
20 program, a member of the board or a member of the program either  
21 jointly or separately except as otherwise provided in this act.

22 c. Payment of an assessment made under this section shall be a  
23 condition of issuing health benefits plans in the State for a carrier.  
24 Failure to pay the assessment shall be grounds for forfeiture of a  
25 carrier's authorization to issue health benefits plans of any kind in  
26 the State, as well as any other penalties permitted by law.

27 d. (1) Notwithstanding the provisions of this act to the  
28 contrary, a carrier may apply to the board, by a date established by  
29 the board, for an exemption from the assessment and reimbursement  
30 for losses provided for in this section. A carrier which applies for  
31 an exemption shall agree to cover a minimum number of non-group  
32 person life years on an open enrollment community rated basis,  
33 under a managed care or indemnity plan, as specified in this  
34 subsection, provided that any indemnity plan so issued conforms  
35 with sections 2 through 7, inclusive, of P.L.1992, c.161  
36 (C.17B:27A-3 through 17B:27A-8). For the purposes of this  
37 subsection, non-group persons include individually enrolled  
38 persons, conversion policies issued pursuant to this act, Medicare  
39 cost and risk lives and Medicaid recipients; except that in  
40 determining whether the carrier meets the minimum number of non-  
41 group person life years required to be covered pursuant to this  
42 subsection, the number of Medicaid recipients and Medicare cost  
43 and risk lives shall not exceed 50% of the total. Pursuant to  
44 regulations adopted by the board, the carrier shall determine the  
45 number of non-group person life years it has covered by adding the  
46 number of non-group persons covered on the last day of each  
47 calendar quarter of the two-year calculation period, taking into

1 account the limitations on counting Medicaid recipients and  
2 Medicare cost and risk lives, and dividing the total by eight.

3 (2) Notwithstanding the provisions of paragraph (1) of this  
4 subsection to the contrary, a health maintenance organization  
5 qualified pursuant to the "Health Maintenance Organization Act of  
6 1973," Pub.L 93-222 (42 U.S.C. s.300e et seq.) and tax exempt  
7 pursuant to paragraph (3) of subsection (c) of section 501 of the  
8 federal Internal Revenue Code of 1986, 26 U.S.C. s.501, may  
9 include up to one third Medicaid recipients and up to one third  
10 Medicare recipients in determining whether it meets its minimum  
11 number of non-group person life years.

12 (3) The minimum number of non-group person life years  
13 required to be covered, as determined by the board, shall equal the  
14 total number of non-group person life years of community rated,  
15 individually enrolled or insured persons, including Medicare cost  
16 and risk lives and enrolled Medicaid lives, of all carriers subject to  
17 this act for the two-year calculation period, multiplied by the  
18 proportion that that carrier's net earned premium bears to the net  
19 earned premium of all carriers for that two-year calculation period,  
20 including those carriers that are exempt from the assessment.

21 (4) On or before March 1 of the first year of each two-year  
22 calculation period, every carrier seeking an exemption pursuant to  
23 this subsection shall file with the board a statement of its net earned  
24 premium for the two-year calculation period. The board shall  
25 determine each carrier's minimum number of non-group person life  
26 years in accordance with this subsection.

27 (5) On or before March 1 of each year immediately following  
28 the close of a two-year calculation period, every carrier that was  
29 granted an exemption for the preceding two-year calculation period  
30 shall file with the board the number of non-group person life years,  
31 by category, covered for the two-year calculation period.

32 To the extent that the carrier has failed to cover the minimum  
33 number of non-group person life years established by the board, the  
34 carrier shall be assessed by the board on a pro rata basis for any  
35 differential between the minimum number established by the board  
36 and the actual number covered by the carrier.

37 (6) A carrier that applies for the exemption shall be deemed to  
38 be in compliance with the requirements of this subsection if it has  
39 covered 100% of the minimum number of non-group person life  
40 years required.

41 (7) Any carrier that writes both managed care and indemnity  
42 business that is granted an exemption pursuant to this subsection  
43 may satisfy its obligation to cover a minimum number of non-group  
44 person life years by issuing either managed care or indemnity  
45 business, or both.

46 e. (Deleted by amendment, P.L.1997, c.146).

47 f. The loss assessment for the two-year calculation period in  
48 which P.L. , c. (pending before the Legislature as this bill) takes

1 effect shall be the last loss assessment authorized under this section,  
2 and no further loss assessments shall be calculated or collected;  
3 provided, however, that nothing in this subsection shall relieve a  
4 carrier of its obligations for loss assessments authorized under this  
5 section prior to the effective date of P.L. , c. (pending before the  
6 Legislature as this bill).  
7 (cf: P.L.1997, c.146, s.6)

8  
9 19. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended  
10 to read as follows:

11 5. A domestic mutual insurer which has converted from a  
12 health service corporation pursuant to the provisions of sections 2  
13 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48)  
14 shall not renew individual hospital or medical insurance policies or  
15 health service contracts originally issued prior to November 30,  
16 1992, until it has made an informational filing with the [New Jersey  
17 Individual Health Coverage Program Board, of a full schedule of  
18 rates which are to apply to those contracts. The New Jersey  
19 Individual Health Coverage Program Board shall forward a copy of  
20 such filing to the] commissioner. The rates shall be formulated so  
21 that the anticipated minimum loss ratio for such policy or contract  
22 form shall not be less than [75%] 80% of the premium. Such  
23 domestic mutual insurer shall submit with its rate filing supporting  
24 data and a certification that the insurer is in compliance with the  
25 anticipated loss ratio requirement. The content and form of the  
26 supporting data and certification required pursuant to subsection e.  
27 of section 8 of P.L.1992, c.161 (C.17B:27A-9) shall satisfy the  
28 requirements of this section. Any other insurer may irrevocably  
29 elect to become subject to the provisions of this section by written  
30 notice to the commissioner[, except that such informational filing  
31 by any other insurer shall be] in a format specified by the  
32 commissioner [and shall be made directly to the commissioner and  
33 not to the New Jersey Individual Health Coverage Program Board].  
34 (cf: P.L.1995, c.196, s.5)

35  
36 20. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to  
37 read as follows:

38 1. As used in this act:

39 "Actuarial certification" means a written statement by a member  
40 of the American Academy of Actuaries or other individual  
41 acceptable to the commissioner that a small employer carrier is in  
42 compliance with the provisions of section 9 of P.L.1992, c.162  
43 (C.17B:27A-25), based upon examination, including a review of the  
44 appropriate records and actuarial assumptions and methods used by  
45 the small employer carrier in establishing premium rates for  
46 applicable health benefits plans.

1 "Anticipated loss ratio" means the ratio of the present value of  
2 the expected benefits, not including dividends, to the present value  
3 of the expected premiums, not reduced by dividends, over the entire  
4 period for which rates are computed to provide coverage. For  
5 purposes of this ratio, the present values must incorporate realistic  
6 rates of interest which are determined before federal taxes but after  
7 investment expenses.

8 "Board" means the board of directors of the program.

9 "Carrier" means any entity subject to the insurance laws and  
10 regulations of this State, or subject to the jurisdiction of the  
11 commissioner, that contracts or offers to contract to provide,  
12 deliver, arrange for, pay for, or reimburse any of the costs of health  
13 care services, including an insurance company authorized to issue  
14 health insurance, a health maintenance organization, a hospital  
15 service corporation, medical service corporation and health service  
16 corporation, or any other entity providing a plan of health  
17 insurance, health benefits or health services. The term "carrier"  
18 shall not include a joint insurance fund established pursuant to State  
19 law. For purposes of this act, carriers that are affiliated companies  
20 shall be treated as one carrier, except that any insurance company,  
21 health service corporation, hospital service corporation, or medical  
22 service corporation that is an affiliate of a health maintenance  
23 organization located in New Jersey or any health maintenance  
24 organization located in New Jersey that is affiliated with an  
25 insurance company, health service corporation, hospital service  
26 corporation, or medical service corporation shall treat the health  
27 maintenance organization as a separate carrier.

28 "Church plan" has the same meaning given that term under Title  
29 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
30 Security Act of 1974" (29 U.S.C.s.1002(33)).

31 "Commissioner" means the Commissioner of Banking and  
32 Insurance.

33 "Community rating" or "community rated" means a rating  
34 methodology in which the premium charged by a carrier for all  
35 persons covered by a policy or contract form is the same based upon  
36 the experience of the entire pool of risks covered by that policy or  
37 contract form without regard to age, gender, health status, residence  
38 or occupation.

39 "Creditable coverage" means, with respect to an individual,  
40 coverage of the individual under any of the following: a group  
41 health plan; a group or individual health benefits plan; Part A or  
42 part B of Title XVIII of the federal Social Security Act (42 U.S.C.  
43 s.1395 et seq.); Title XIX of the federal Social Security Act (42  
44 U.S.C. 1396 et seq.), other than coverage consisting solely of  
45 benefits under section 1928 of Title XIX of the federal Social  
46 Security Act (42 U.S.C.s.1396s); chapter 55 of Title 10, United  
47 States Code (10 U.S.C. 1071 et seq.); a medical care program of the  
48 Indian Health Service or of a tribal organization; a state health plan

1 offered under chapter 89 of Title 5, United States Code (5 U.S.C.  
2 s.8901 et seq.); a public health plan as defined by federal  
3 regulation; a health benefits plan under section 5(e) of the "Peace  
4 Corps Act" (22 U.S.C. s.2504(e)); or coverage under any other type  
5 of plan as set forth by the commissioner by regulation.

6 Creditable coverage shall not include coverage consisting solely  
7 of the following: coverage only for accident or disability income  
8 insurance, or any combination thereof; coverage issued as a  
9 supplement to liability insurance; liability insurance, including  
10 general liability insurance and automobile liability insurance;  
11 workers' compensation or similar insurance; automobile medical  
12 payment insurance; credit only insurance; coverage for on-site  
13 medical clinics; coverage, as specified in federal regulation, under  
14 which benefits for medical care are secondary or incidental to the  
15 insurance benefits; and other coverage expressly excluded from the  
16 definition of health benefits plan.

17 "Department" means the Department of Banking and Insurance.

18 "Dependent" means the spouse, domestic partner as defined in  
19 section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as  
20 defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an  
21 eligible employee, subject to applicable terms of the health benefits  
22 plan covering the employee.

23 "Eligible employee" means a full-time employee who works a  
24 normal work week of 25 or more hours. The term includes a sole  
25 proprietor, a partner of a partnership, or an independent contractor,  
26 if the sole proprietor, partner, or independent contractor is included  
27 as an employee under a health benefits plan of a small employer,  
28 but does not include employees who work less than 25 hours a  
29 week, work on a temporary or substitute basis or are participating in  
30 an employee welfare arrangement established pursuant to a  
31 collective bargaining agreement.

32 "Enrollment date" means, with respect to a person covered under  
33 a health benefits plan, the date of enrollment of the person in the  
34 health benefits plan or, if earlier, the first day of the waiting period  
35 for such enrollment.

36 "Financially impaired" means a carrier which, after the effective  
37 date of this act, is not insolvent, but is deemed by the commissioner  
38 to be potentially unable to fulfill its contractual obligations or a  
39 carrier which is placed under an order of rehabilitation or  
40 conservation by a court of competent jurisdiction.

41 "Governmental plan" has the meaning given that term under Title  
42 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
43 Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental  
44 plan established or maintained for its employees by the Government  
45 of the United States or by any agency or instrumentality of that  
46 government.

47 "Group health plan" means an employee welfare benefit plan, as  
48 defined in Title I of section 3 of Pub.L.93-406, the "Employee

1 Retirement Income Security Act of 1974" (29 U.S.C.s.1002(1)), to  
2 the extent that the plan provides medical care and including items  
3 and services paid for as medical care to employees or their  
4 dependents directly or through insurance, reimbursement or  
5 otherwise.

6 "Health benefits plan" means any hospital and medical expense  
7 insurance policy or certificate; health, hospital, or medical service  
8 corporation contract or certificate; or health maintenance  
9 organization subscriber contract or certificate delivered or issued  
10 for delivery in this State by any carrier to a small employer group  
11 pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For  
12 purposes of this act, "health benefits plan" shall not include one or  
13 more, or any combination of, the following: coverage only for  
14 accident or disability income insurance, or any combination thereof;  
15 coverage issued as a supplement to liability insurance; liability  
16 insurance, including general liability insurance and automobile  
17 liability insurance; workers' compensation or similar insurance;  
18 automobile medical payment insurance; credit-only insurance;  
19 coverage for on-site medical clinics; and other similar insurance  
20 coverage, as specified in federal regulations, under which benefits  
21 for medical care are secondary or incidental to other insurance  
22 benefits. Health benefits plans shall not include the following  
23 benefits if they are provided under a separate policy, certificate or  
24 contract of insurance or are otherwise not an integral part of the  
25 plan: limited scope dental or vision benefits; benefits for long-term  
26 care, nursing home care, home health care, community-based care,  
27 or any combination thereof; and such other similar, limited benefits  
28 as are specified in federal regulations. Health benefits plan shall  
29 not include hospital confinement indemnity coverage if the benefits  
30 are provided under a separate policy, certificate or contract of  
31 insurance, there is no coordination between the provision of the  
32 benefits and any exclusion of benefits under any group health  
33 benefits plan maintained by the same plan sponsor, and those  
34 benefits are paid with respect to an event without regard to whether  
35 benefits are provided with respect to such an event under any group  
36 health plan maintained by the same plan sponsor. Health benefits  
37 plan shall not include the following if it is offered as a separate  
38 policy, certificate or contract of insurance: Medicare supplemental  
39 health insurance as defined under section 1882(g)(1) of the federal  
40 Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage  
41 supplemental to the coverage provided under chapter 55 of Title 10,  
42 United States Code (10 U.S.C. s.1071 et seq.); and similar  
43 supplemental coverage provided to coverage under a group health  
44 plan.

45 "Health status-related factor" means any of the following factors:  
46 health status; medical condition, including both physical and mental  
47 illness; claims experience; receipt of health care; medical history;



1 genetic information; evidence of insurability, including conditions  
2 arising out of acts of domestic violence; and disability.

3 "Late enrollee" means an eligible employee or dependent who  
4 requests enrollment in a health benefits plan of a small employer  
5 following the initial minimum 30-day enrollment period provided  
6 under the terms of the health benefits plan. An eligible employee or  
7 dependent shall not be considered a late enrollee if the individual: a.  
8 was covered under another employer's health benefits plan at the  
9 time he was eligible to enroll and stated at the time of the initial  
10 enrollment that coverage under that other employer's health benefits  
11 plan was the reason for declining enrollment, but only if the plan  
12 sponsor or carrier required such a statement at that time and  
13 provided the employee with notice of that requirement and the  
14 consequences of that requirement at that time; b. has lost coverage  
15 under that other employer's health benefits plan as a result of  
16 termination of employment or eligibility, reduction in the number of  
17 hours of employment, involuntary termination, the termination of  
18 the other plan's coverage, death of a spouse, or divorce or legal  
19 separation; and c. requests enrollment within 90 days after  
20 termination of coverage provided under another employer's health  
21 benefits plan. An eligible employee or dependent also shall not be  
22 considered a late enrollee if the individual is employed by an  
23 employer which offers multiple health benefits plans and the  
24 individual elects a different plan during an open enrollment period;  
25 the individual had coverage under a COBRA continuation provision  
26 and the coverage under that provision was exhausted and the  
27 employee requests enrollment not later than 30 days after the date  
28 of exhaustion of COBRA coverage; or if a court of competent  
29 jurisdiction has ordered coverage to be provided for a spouse or  
30 minor child under a covered employee's health benefits plan and  
31 request for enrollment is made within 30 days after issuance of that  
32 court order.

33 "Medical care" means amounts paid: (1) for the diagnosis, care,  
34 mitigation, treatment, or prevention of disease, or for the purpose of  
35 affecting any structure or function of the body; and (2)  
36 transportation primarily for and essential to medical care referred to  
37 in (1) above.

38 "Member" means all carriers issuing health benefits plans in this  
39 State on or after the effective date of this act.

40 "Multiple employer arrangement" means an arrangement  
41 established or maintained to provide health benefits to employees  
42 and their dependents of two or more employers, under an insured  
43 plan purchased from a carrier in which the carrier assumes all or a  
44 substantial portion of the risk, as determined by the commissioner,  
45 and shall include, but is not limited to, a multiple employer welfare  
46 arrangement, or MEWA, multiple employer trust or other form of  
47 benefit trust.

1 "Plan of operation" means the plan of operation of the program  
2 including articles, bylaws and operating rules approved pursuant to  
3 section 14 of P.L.1992, c.162 (C.17B:27A-30).

4 "Plan sponsor" has the meaning given that term under Title I of  
5 section 3 of Pub.L.93-406, the "Employee Retirement Income  
6 Security Act of 1974" (29 U.S.C.s.1002(16)(B)).

7 "Preexisting condition exclusion" means, with respect to  
8 coverage, a limitation or exclusion of benefits relating to a  
9 condition based on the fact that the condition was present before the  
10 date of enrollment for that coverage, whether or not any medical  
11 advice, diagnosis, care, or treatment was recommended or received  
12 before that date. Genetic information shall not be treated as a  
13 preexisting condition in the absence of a diagnosis of the condition  
14 related to that information.

15 "Program" means the New Jersey Small Employer Health  
16 Benefits Program established pursuant to section 12 of P.L.1992,  
17 c.162 (C.17B:27A-28).

18 "Small employer" means, in connection with a group health plan  
19 with respect to a calendar year and a plan year, any person, firm,  
20 corporation, partnership, or political subdivision that is actively  
21 engaged in business that employed an average of at least two but  
22 not more than 50 eligible employees on business days during the  
23 preceding calendar year and who employs at least two employees  
24 on the first day of the plan year, and the majority of the employees  
25 are employed in New Jersey. All persons treated as a single  
26 employer under subsection (b), (c), (m) or (o) of section 414 of the  
27 Internal Revenue Code of 1986 (26 U.S.C.s.414) shall be treated as  
28 one employer. Subsequent to the issuance of a health benefits plan  
29 to a small employer and for the purpose of determining continued  
30 eligibility, the size of a small employer shall be determined  
31 annually. Except as otherwise specifically provided, provisions of  
32 P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small  
33 employer shall continue to apply at least until the plan anniversary  
34 following the date the small employer no longer meets the  
35 requirements of this definition. In the case of an employer that was  
36 not in existence during the preceding calendar year, the  
37 determination of whether the employer is a small or large employer  
38 shall be based on the average number of employees that it is  
39 reasonably expected that the employer will employ on business  
40 days in the current calendar year. Any reference in P.L.1992, c.162  
41 (C.17B:27A-17 et seq.) to an employer shall include a reference to  
42 any predecessor of such employer.

43 "Small employer carrier" means any carrier that offers health  
44 benefits plans covering eligible employees of one or more small  
45 employers.

46 "Small employer health benefits plan" means a health benefits  
47 plan for small employers approved by the commissioner pursuant to  
48 section 17 of P.L.1992, c.162 (C.17B:27A-33).

1 "Stop loss" or "excess risk insurance" means an insurance policy  
2 designed to reimburse a self-funded arrangement of one or more  
3 small employers for catastrophic, excess or unexpected expenses,  
4 wherein neither the employees nor other individuals are third party  
5 beneficiaries under the insurance policy. In order to be considered  
6 stop loss or excess risk insurance for the purposes of P.L.1992,  
7 c.162 (C.17B:27A-17 et seq.), the policy shall establish a per person  
8 attachment point or retention or aggregate attachment point or  
9 retention, or both, which meet the following requirements:

10 a. If the policy establishes a per person attachment point or  
11 retention, that specific attachment point or retention shall not be  
12 less than \$20,000 per covered person per plan year; and

13 b. If the policy establishes an aggregate attachment point or  
14 retention, that aggregate attachment point or retention shall not be  
15 less than 125% of expected claims per plan year.

16 "Supplemental limited benefit insurance" means insurance that is  
17 provided in addition to a health benefits plan on an indemnity non-  
18 expense incurred basis.

19 (cf: P.L.1997, c.146, s.7)

20  
21 21. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to  
22 read as follows:

23 3. a. Except as provided in subsection f. of this section, every  
24 small employer carrier shall, as a condition of transacting business  
25 in this State, offer to every small employer at least three of the  
26 **【five】** health benefit plans established by the board, as provided in  
27 this section, and also offer and make a good faith effort to market  
28 individual health benefits plans as provided in section 3 of  
29 P.L.1992, c.161 (C.17B:27A-4). The board shall establish a  
30 standard policy form for each of the **【five】** plans, which except as  
31 otherwise provided in subsection j. of this section, shall be the only  
32 plans offered to small groups on or after January 1, 1994. One  
33 policy form shall contain the benefits provided for in sections 55,  
34 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and  
35 26:2J-4.3). In the case of indemnity carriers, one policy form shall  
36 be established which contains benefits and cost sharing levels which  
37 are equivalent to the health benefits plans of health maintenance  
38 organizations pursuant to the "Health Maintenance Organization  
39 Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.). The  
40 remaining policy forms shall contain basic hospital and medical-  
41 surgical benefits, including, but not limited to:

42 (1) Basic inpatient and outpatient hospital care;

43 (2) Basic and extended medical-surgical benefits;

44 (3) Diagnostic tests, including X-rays;

45 (4) Maternity benefits, including prenatal and postnatal care;

46 and

47 (5) Preventive medicine, including periodic physical  
48 examinations and inoculations.

1 At least three of the forms shall provide for major medical  
2 benefits in varying lifetime aggregates, one of which shall provide  
3 at least \$1,000,000 in lifetime aggregate benefits. The policy forms  
4 provided pursuant to this section shall contain benefits representing  
5 progressively greater actuarial values.

6 Notwithstanding the provisions of this subsection to the contrary,  
7 the board also may establish additional policy forms by which a  
8 small employer carrier, other than a health maintenance  
9 organization, may provide indemnity benefits for health  
10 maintenance organization enrollees by direct contract with the  
11 enrollees' small employer through a dual arrangement with the  
12 health maintenance organization. The dual arrangement shall be  
13 filed with the commissioner for approval. The additional policy  
14 forms shall be consistent with the general requirements of P.L.1992,  
15 c.162 (C.17B:27A-17 et seq.).

16 b. Initially, a carrier shall offer a plan within 90 days of the  
17 approval of such plan by the commissioner. Thereafter, the plans  
18 shall be available to all small employers on a continuing basis.  
19 Every small employer which elects to be covered under any health  
20 benefits plan who pays the premium therefor and who satisfies the  
21 participation requirements of the plan shall be issued a policy or  
22 contract by the carrier.

23 c. The carrier may establish a premium payment plan which  
24 provides installment payments and which may contain reasonable  
25 provisions to ensure payment security, provided that provisions to  
26 ensure payment security are uniformly applied.

27 d. In addition to the **[five]** standard policies described in  
28 subsection a. of this section, the board may develop up to five rider  
29 packages. Any such package which a carrier chooses to offer shall  
30 be issued to a small employer who pays the premium therefor, and  
31 shall be subject to the rating methodology set forth in section 9 of  
32 P.L.1992, c.162 (C.17B:27A-25).

33 e. **[Notwithstanding the provisions of subsection a. of this**  
34 **section to the contrary, the board may approve a health benefits**  
35 **plan containing only medical-surgical benefits or major medical**  
36 **expense benefits, or a combination thereof, which is issued as a**  
37 **separate policy in conjunction with a contract of insurance for**  
38 **hospital expense benefits issued by a hospital service corporation, if**  
39 **the health benefits plan and hospital service corporation contract**  
40 **combined otherwise comply with the provisions of P.L.1992, c.162**  
41 **(C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the**  
42 **contract combined may be allocated between the separate contracts**  
43 **at the discretion of the carrier and the hospital service corporation.]**  
44 (Deleted by amendment, P.L. , c. ) (pending before the  
45 Legislature as this bill).

46 f. Notwithstanding the provisions of this section to the  
47 contrary, a health maintenance organization which is a qualified  
48 health maintenance organization pursuant to the "Health

1 Maintenance Organization Act of 1973," Pub.L.93-222 (42  
2 U.S.C.s.300e et seq.) shall be permitted to offer health benefits  
3 plans formulated by the board and approved by the commissioner  
4 which are in accordance with the provisions of that law in lieu of  
5 the [five] plans required pursuant to this section.

6 Notwithstanding the provisions of this section to the contrary, a  
7 health maintenance organization which is approved pursuant to  
8 P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health  
9 benefits plans formulated by the board and approved by the  
10 commissioner which are in accordance with the provisions of that  
11 law in lieu of the [five] plans required pursuant to this section,  
12 except that the plans shall provide the same level of benefits as  
13 required for a federally qualified health maintenance organization,  
14 including any requirements concerning copayments by enrollees.

15 g. A carrier shall not be required to own or control a health  
16 maintenance organization or otherwise affiliate with a health  
17 maintenance organization in order to comply with the provisions of  
18 this section, but the carrier shall be required to offer [the five] at  
19 least three of the health benefits plans which are formulated by the  
20 board and approved by the commissioner, including one plan which  
21 contains benefits and cost sharing levels that are equivalent to those  
22 required for health maintenance organizations.

23 h. Notwithstanding the provisions of subsection a. of this  
24 section to the contrary, the board may modify the benefits provided  
25 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,  
26 17B:26B-2 and 26:2J-4.3).

27 i. (1) In addition to the rider packages provided for in  
28 subsection d. of this section, every carrier may offer, in connection  
29 with the [five] health benefits plans required to be offered by this  
30 section, any number of riders which may revise the coverage  
31 offered by the [five] plans in any way, provided, however, that any  
32 form of such rider or amendment thereof which decreases benefits  
33 or decreases the actuarial value of [one of the five plans] a plan  
34 shall be filed for informational purposes with the board and for  
35 approval by the commissioner before such rider may be sold. Any  
36 rider or amendment thereof which adds benefits or increases the  
37 actuarial value of [one of the five plans] a plan shall be filed with  
38 the board for informational purposes before such rider may be sold.  
39 The added premium or reduction in premium for each rider, as  
40 applicable, shall be listed separately from the premium for the  
41 standard plan.

42 The commissioner shall disapprove any rider filed pursuant to  
43 this subsection that is unjust, unfair, inequitable, unreasonably  
44 discriminatory, misleading, contrary to law or the public policy of  
45 this State. The commissioner shall not approve any rider which  
46 reduces benefits below those required by sections 55, 57 and 59 of  
47 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and

1 required to be sold pursuant to this section. The commissioner's  
2 determination shall be in writing and shall be appealable.

3 (2) The benefit riders provided for in paragraph (1) of this  
4 subsection shall be subject to the provisions of section 2, subsection  
5 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162  
6 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-  
7 24, 17B:27A-25, and 17B:27A-27).

8 j. (1) Notwithstanding the provisions of P.L.1992, c.162  
9 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued  
10 by or through a carrier, association, or multiple employer  
11 arrangement prior to January 1, 1994 or, if the requirements of  
12 subparagraph (c) of paragraph (6) of this subsection are met, issued  
13 by or through an out-of-State trust prior to January 1, 1994, at the  
14 option of a small employer policy or contract holder, may be  
15 renewed or continued after February 28, 1994, or in the case of such  
16 a health benefits plan whose anniversary date occurred between  
17 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-  
18 19.1 et al.), may be reinstated within 60 days of that anniversary  
19 date and renewed or continued if, beginning on the first 12-month  
20 anniversary date occurring on or after the sixtieth day after the  
21 board adopts regulations concerning the implementation of the  
22 rating factors permitted by section 9 of P.L.1992, c.162  
23 (C.17B:27A-25) and, regardless of the situs of delivery of the health  
24 benefits plan, the health benefits plan renewed, continued or  
25 reinstated pursuant to this subsection complies with the provisions  
26 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and  
27 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,  
28 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and  
29 section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

30 Nothing in this subsection shall be construed to require an  
31 association, multiple employer arrangement or out-of-State trust to  
32 provide health benefits coverage to small employers that are not  
33 contemplated by the organizational documents, bylaws, or other  
34 regulations governing the purpose and operation of the association,  
35 multiple employer arrangement or out-of-State trust.  
36 Notwithstanding the foregoing provision to the contrary, an  
37 association, multiple employer arrangement or out-of-State trust  
38 that offers health benefits coverage to its members' employees and  
39 dependents:

40 (a) shall offer coverage to all eligible employees and their  
41 dependents within the membership of the association, multiple  
42 employer arrangement or out-of-State trust;

43 (b) shall not use actual or expected health status in determining  
44 its membership; and

45 (c) shall make available to its small employer members at least  
46 one of the standard benefits plans, as determined by the  
47 commissioner, in addition to any health benefits plan permitted to  
48 be renewed or continued pursuant to this subsection.

1 (2) Notwithstanding the provisions of this subsection to the  
2 contrary, a carrier or out-of-State trust which writes the health  
3 benefits plans required pursuant to subsection a. of this section shall  
4 be required to offer those plans to any small employer, association  
5 or multiple employer arrangement.

6 (3) (a) A carrier, association, multiple employer arrangement or  
7 out-of-State trust may withdraw a health benefits plan marketed to  
8 small employers that was in effect on December 31, 1993 with the  
9 approval of the commissioner. The commissioner shall approve a  
10 request to withdraw a plan, consistent with regulations adopted by  
11 the commissioner, only on the grounds that retention of the plan  
12 would cause an unreasonable financial burden to the issuing carrier,  
13 taking into account the rating provisions of section 9 of P.L.1992,  
14 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340  
15 (C.17B:27A-19.3).

16 (b) A carrier which has renewed, continued or reinstated a  
17 health benefits plan pursuant to this subsection that has not been  
18 newly issued to a new small employer group since January 1, 1994,  
19 may, upon approval of the commissioner, continue to establish its  
20 rates for that plan based on the loss experience of that plan if the  
21 carrier does not issue that health benefits plan to any new small  
22 employer groups.

23 (4) (Deleted by amendment, P.L.1995, c.340).

24 (5) A health benefits plan that otherwise conforms to the  
25 requirements of this subsection shall be deemed to be in compliance  
26 with this subsection, notwithstanding any change in the plan's  
27 deductible or copayment.

28 (6) (a) Except as otherwise provided in subparagraphs (b) and  
29 (c) of this paragraph, a health benefits plan renewed, continued or  
30 reinstated pursuant to this subsection shall be filed with the  
31 commissioner for informational purposes within 30 days after its  
32 renewal date. No later than 60 days after the board adopts  
33 regulations concerning the implementation of the rating factors  
34 permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing  
35 shall be amended to show any modifications in the plan that are  
36 necessary to comply with the provisions of this subsection. The  
37 commissioner shall monitor compliance of any such plan with the  
38 requirements of this subsection, except that the board shall enforce  
39 the loss ratio requirements.

40 (b) A health benefits plan filed with the commissioner pursuant  
41 to subparagraph (a) of this paragraph may be amended as to its  
42 benefit structure if the amendment does not reduce the actuarial  
43 value and benefits coverage of the health benefits plan below that of  
44 the lowest standard health benefits plan established by the board  
45 pursuant to subsection a. of this section. The amendment shall be  
46 filed with the commissioner for approval pursuant to the terms of  
47 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,  
48 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as

1 applicable, and shall comply with the provisions of sections 2 and 9  
2 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7  
3 of P.L.1995, c.340 (C.17B:27A-19.3).

4 (c) A health benefits plan issued by a carrier through an out-of-  
5 State trust shall be permitted to be renewed or continued pursuant to  
6 paragraph (1) of this subsection upon approval by the commissioner  
7 and only if the benefits offered under the plan are at least equal to  
8 the actuarial value and benefits coverage of the lowest standard  
9 health benefits plan established by the board pursuant to subsection  
10 a. of this section. For the purposes of meeting the requirements of  
11 this subparagraph, carriers shall be required to file with the  
12 commissioner the health benefits plans issued through an out-of-  
13 State trust no later than 180 days after the date of enactment of  
14 P.L.1995, c.340. A health benefits plan issued by a carrier through  
15 an out-of-State trust that is not filed with the commissioner pursuant  
16 to this subparagraph, shall not be permitted to be continued or  
17 renewed after the 180-day period.

18 (7) Notwithstanding the provisions of P.L.1992, c.162  
19 (C.17B:27A-17 et seq.) to the contrary, an association, multiple  
20 employer arrangement or out-of-State trust may offer a health  
21 benefits plan authorized to be renewed, continued or reinstated  
22 pursuant to this subsection to small employer groups that are  
23 otherwise eligible pursuant to paragraph (1) of subsection j. of this  
24 section during the period for which such health benefits plan is  
25 otherwise authorized to be renewed, continued or reinstated.

26 (8) Notwithstanding the provisions of P.L.1992, c.162  
27 (C.17B:27A-17 et seq.) to the contrary, a carrier, association,  
28 multiple employer arrangement or out-of-State trust may offer  
29 coverage under a health benefits plan authorized to be renewed,  
30 continued or reinstated pursuant to this subsection to new  
31 employees of small employer groups covered by the health benefits  
32 plan in accordance with the provisions of paragraph (1) of this  
33 subsection.

34 (9) Notwithstanding the provisions of P.L.1992, c.162  
35 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to  
36 the contrary, any individual, who is eligible for small employer  
37 coverage under a policy issued, renewed, continued or reinstated  
38 pursuant to this subsection, but who would be subject to a  
39 preexisting condition exclusion under the small employer health  
40 benefits plan, or who is a member of a small employer group who  
41 has been denied coverage under the small employer group health  
42 benefits plan for health reasons, may elect to purchase or continue  
43 coverage under an individual health benefits plan until such time as  
44 the group health benefits plan covering the small employer group of  
45 which the individual is a member complies with the provisions of  
46 P.L.1992, c.162 (C.17B:27A-17 et seq.).

47 (10) In a case in which an association made available a health  
48 benefits plan on or before March 1, 1994 and subsequently changed



1 the issuing carrier between March 1, 1994 and the effective date of  
2 P.L.1995, c.340, the new issuing carrier shall be deemed to have  
3 been eligible to continue and renew the plan pursuant to paragraph  
4 (1) of this subsection.

5 (11) In a case in which an association, multiple employer  
6 arrangement or out-of-State trust made available a health benefits  
7 plan on or before March 1, 1994 and subsequently changes the  
8 issuing carrier for that plan after the effective date of P.L.1995,  
9 c.340, the new issuing carrier shall file the health benefits plan with  
10 the commissioner for approval in order to be deemed eligible to  
11 continue and renew that plan pursuant to paragraph (1) of this  
12 subsection.

13 (12) In a case in which a small employer purchased a health  
14 benefits plan directly from a carrier on or before March 1, 1994 and  
15 subsequently changes the issuing carrier for that plan after the  
16 effective date of P.L.1995, c.340, the new issuing carrier shall file  
17 the health benefits plan with the commissioner for approval in order  
18 to be deemed eligible to continue and renew that plan pursuant to  
19 paragraph (1) of this subsection.

20 Notwithstanding the provisions of subparagraph (b) of paragraph  
21 (6) of this subsection to the contrary, a small employer who changes  
22 its health benefits plan's issuing carrier pursuant to the provisions of  
23 this paragraph, shall not, upon changing carriers, modify the benefit  
24 structure of that health benefits plan within six months of the date  
25 the issuing carrier was changed.

26 k. Effective immediately for a health benefits plan issued on or  
27 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)  
28 and effective on the first 12-month anniversary date of a health  
29 benefits plan in effect on the effective date of P.L.2005, c.248  
30 (C.17:48E-35.27 et al.), the health benefits plans required pursuant  
31 to this section, including any plans offered by a State approved or  
32 federally qualified health maintenance organization, shall contain  
33 benefits for expenses incurred in the following:

34 (1) Screening by blood lead measurement for lead poisoning for  
35 children, including confirmatory blood lead testing as specified by  
36 the Department of Health and Senior Services pursuant to section 7  
37 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any  
38 necessary medical follow-up and treatment for lead poisoned  
39 children.

40 (2) All childhood immunization as recommended by the  
41 Advisory Committee on Immunization Practices of the United  
42 **[State]** States Public Health Service and the Department of Health  
43 and Senior Services pursuant to section 7 of P.L.1995, c.316  
44 (C.26:2-137.1). A carrier shall notify its insureds, in writing, of any  
45 change in the health care services provided with respect to  
46 childhood immunizations and any related changes in premium.  
47 Such notification shall be in a form and manner to be determined by  
48 the Commissioner of Banking and Insurance.

1 (3) Screening for newborn hearing loss by appropriate  
2 electrophysiologic screening measures and periodic monitoring of  
3 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
4 (C.26:2-103.1 et al.). Payment for this screening service shall be  
5 separate and distinct from payment for routine new baby care in the  
6 form of a newborn hearing screening fee as negotiated with the  
7 provider and facility.

8 The benefits provided pursuant to this subsection shall be  
9 provided to the same extent as for any other medical condition  
10 under the health benefits plan, except that a deductible shall not be  
11 applied for benefits provided pursuant to this subsection; however,  
12 with respect to a small employer health benefits plan that qualifies  
13 as a high deductible health plan for which qualified medical  
14 expenses are paid using a health savings account established  
15 pursuant to section 223 of the federal Internal Revenue Code of  
16 1986 (26 U.S.C. s.223), a deductible shall not be applied for any  
17 benefits that represent preventive care as permitted by that federal  
18 law, and shall not be applied as provided pursuant to section 16 of  
19 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to  
20 all small employer health benefits plans in which the carrier has  
21 reserved the right to change the premium.

22 l. The board shall consider including benefits for speech-  
23 language pathology and audiology services, as rendered by speech-  
24 language pathologists and audiologists within the scope of their  
25 practices, in at least one of the **[five]** standard policies and in at  
26 least one of the five riders to be developed under this section.

27 m. Effective immediately for a health benefits plan issued on or  
28 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and  
29 effective on the first 12-month anniversary date of a health benefits  
30 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z  
31 et al.), the health benefits plans required pursuant to this section  
32 that provide benefits for expenses incurred in the purchase of  
33 prescription drugs shall provide benefits for expenses incurred in  
34 the purchase of specialized non-standard infant formulas, when the  
35 covered infant's physician has diagnosed the infant as having  
36 multiple food protein intolerance and has determined such formula  
37 to be medically necessary, and when the covered infant has not been  
38 responsive to trials of standard non-cow milk-based formulas,  
39 including soybean and goat milk. The coverage may be subject to  
40 utilization review, including periodic review, of the continued  
41 medical necessity of the specialized infant formula.

42 The benefits shall be provided to the same extent as for any other  
43 prescribed items under the health benefits plan.

44 This subsection shall apply to all small employer health benefits  
45 plans in which the carrier has reserved the right to change the  
46 premium.

47 n. Effective immediately for a health benefits plan issued on or  
48 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)

1 and effective on the first 12-month anniversary date of a small  
2 employer health benefits plan in effect on the effective date of  
3 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans  
4 required pursuant to this section that qualify as high deductible  
5 health plans for which qualified medical expenses are paid using a  
6 health savings account established pursuant to section 223 of the  
7 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including  
8 any plans offered by a State approved or federally qualified health  
9 maintenance organization, shall contain benefits for expenses  
10 incurred in connection with any medically necessary benefits  
11 provided in-network that represent preventive care as permitted by  
12 that federal law.

13 The benefits provided pursuant to this subsection shall be  
14 provided to the same extent as for any other medical condition  
15 under the health benefits plan, except that no deductible shall be  
16 applied for benefits provided pursuant to this subsection. This  
17 subsection shall apply to all small employer health benefits plans in  
18 which the carrier has reserved the right to change the premium.  
19 (cf: P.L.2005, c.248, s.15)

20

21 22. Section 5 of P.L.2001, c.368 (C.17B:27A-19.11) is amended  
22 to read as follows:

23 5. In addition to the **[five]** standard health benefits plans  
24 offered by a carrier on the effective date of this act, a carrier that  
25 writes small employer health benefits plans pursuant to P.L.1992,  
26 c.162 (C.17B:27A-17 et seq.) may also offer one or more of the  
27 plans through the carrier's network of providers, with no  
28 reimbursement for any out-of-network benefits other than  
29 emergency care, urgent care, and continuity of care. A carrier's  
30 network of providers shall be subject to review and approval or  
31 disapproval by the Commissioner of Banking and Insurance, in  
32 consultation with the Commissioner of Health and Senior Services,  
33 pursuant to regulations promulgated by the Department of Banking  
34 and Insurance, including review and approval or disapproval before  
35 plans with benefits provided through a carrier's network of  
36 providers pursuant to this section may be offered by the carrier.  
37 Policies or contracts written on this basis shall be rated in a separate  
38 rating pool for the purposes of establishing a premium, but for the  
39 purpose of determining a carrier's losses, these policies or contracts  
40 shall be aggregated with the losses on the carrier's other business  
41 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-  
42 17 et seq.).

43 (cf: P.L.2001, c.368, s.5)

44

45 23. Section 7 of P.L.1992, c.162 (C.17B:27A-23) is amended to  
46 read as follows:

47 7. Every policy or contract issued to small employers in this  
48 State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be

1 renewable with respect to all eligible employees or dependents at  
2 the option of the policy or contract holder, or small employer except  
3 that a carrier may discontinue or not renew a health benefits plan in  
4 accordance with the provisions of this section:

5 a. A carrier may discontinue such coverage only if:

6 (1) The policyholder, contract holder, or employer has failed to  
7 pay premiums or contributions in accordance with the terms of the  
8 health benefits plan or the carrier has not received timely premium  
9 payments; or

10 (2) The policyholder, contract holder, or employer has  
11 performed an act or practice that constitutes fraud or made an  
12 intentional misrepresentation of material fact under the terms of the  
13 coverage;

14 b. (Deleted by amendment, P.L.1997, c.146).

15 c. The number of employees covered under the health benefits  
16 plan is less than the number or percentage of employees required by  
17 participation requirements under the health benefits policy or  
18 contract;

19 d. Noncompliance with a carrier's employment contribution  
20 requirements;

21 e. Any carrier doing business pursuant to the provisions of this  
22 act ceases doing business in the small employer market, if the  
23 following conditions are satisfied:

24 (1) The carrier gives notice to cease doing business in the small  
25 employer market to the commissioner not later than eight months  
26 prior to the date of the planned withdrawal from the small **[group**  
27 **market]** employer market, during which time the carrier shall  
28 continue to be governed by this act with respect to business written  
29 pursuant to this act. For the purposes of this subsection, "date of  
30 withdrawal" means the date upon which the first notice to small  
31 employers is sent by the carrier pursuant to paragraph (2) of this  
32 subsection;

33 (2) No later than two months following the date of the  
34 notification to the commissioner that the carrier intends to cease  
35 doing business in the small employer market, the carrier shall mail a  
36 notice to every small business employer insured by the carrier, and  
37 all covered persons, that the policy or contract of insurance will not  
38 be renewed. This notice shall be sent by certified mail to the small  
39 business employer not less than six months in advance of the  
40 effective date of the nonrenewal date of the policy or contract;

41 (3) Any carrier that ceases to do business pursuant to this act  
42 shall be prohibited from writing new business in the small employer  
43 **[market]** and individual health benefits plan markets for a period of  
44 five years from the date of termination of the last health insurance  
45 coverage not so renewed;

46 f. In the case of policies or contracts issued in connection with  
47 membership in an association or trust of employers, an employer  
48 ceases to maintain its membership in the association or trust, but

1 only if such coverage is terminated under this provision uniformly  
2 without regard to any health status-related factor relating to any  
3 covered individual.

4 g. (Deleted by amendment, P.L.1995, c.50).

5 h. A decision by the small employer carrier to cease offering  
6 and not renew a particular type of group health benefits plan in the  
7 small employer market, if the board discontinues a standard health  
8 benefits plan or as permitted or required pursuant to subsection j. of  
9 section 3 of P.L.1992, 162 (C.17B:27A-19), and pursuant to  
10 regulations adopted by the commissioner;

11 i. In the case of a health maintenance organization plan issued  
12 to a small employer:

13 (1) an eligible person who no longer resides, lives, or works in  
14 the carrier's approved service area, but only if coverage is  
15 terminated under this paragraph uniformly without regard to any  
16 health status-related factor of covered individuals; or

17 (2) a small employer that no longer has any enrollee in  
18 connection with such plan who lives, resides, or works in the  
19 service area of the carrier and the carrier would deny enrollment  
20 with respect to such plan pursuant to subsection a. of section 10 of  
21 P.L.1992, c.162 (C.17B:27A-26).

22 (cf: P.L.1997, c.146, s.10)

23

24 24. Section 8 of P.L.1992, c.162 (C.17B:27A-24) is amended to  
25 read as follows:

26 8. Any small employer carrier may require a reasonable  
27 specified minimum participation with the same carrier of eligible  
28 employees, which shall not exceed 75%, or reasonable minimum  
29 employer contributions in determining whether to accept a small  
30 group pursuant to this act. The standards so established by the  
31 carrier shall be first approved by the board and shall be applied  
32 uniformly to all small groups, except that in no event shall a carrier  
33 require an employer to contribute more than 10% to the annual cost  
34 of the policy or contract, or an amount as otherwise provided by the  
35 board, and any minimum participation standards established by the  
36 carrier shall be reasonable. In establishing the percentage of  
37 employee participation, a one-to-one credit shall be given for each  
38 employee covered by a spouse's health benefits coverage, Medicare,  
39 Medicaid, NJ FamilyCare or another group health benefits plan. In  
40 calculating an employer's participation, the carrier shall include all  
41 insured employees, regardless of whether the employees chose an  
42 indemnity plan or a health maintenance organization, or a  
43 combination thereof.

44 (cf: P.L. 2005, c.166, s.1)

45

46 25. Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to  
47 read as follows:

- 1       9. a. (1) (Deleted by amendment, P.L.1997, c.146).
- 2       (2) (Deleted by amendment, P.L.1997, c.146).
- 3       (3) For all policies or contracts providing health benefits plans  
4 for small employers issued pursuant to section 3 of P.L.1992, c.162  
5 (C.17B:27A-19), and including policies or contracts offered by a  
6 carrier to a small employer who is a member of a Small Employer  
7 Purchasing Alliance pursuant to the provisions of P.L.2001, c.225  
8 (C.17B:27A-25.1 et al.) the premium rate charged by a carrier to the  
9 highest rated small group purchasing a small employer health  
10 benefits plan issued pursuant to section 3 of P.L.1992, c.162  
11 (C.17B:27A-19) shall not be greater than 200% of the premium rate  
12 charged for the lowest rated small group purchasing that same  
13 health benefits plan; provided, however, that the only factors upon  
14 which the rate differential may be based are age, gender and  
15 geography, and provided further, that such factors are applied in a  
16 manner consistent with regulations adopted by the board. For the  
17 purposes of this paragraph (3), policies or contracts offered by a  
18 carrier to a small employer who is a member of a Small Employer  
19 Purchasing Alliance shall be rated separately from the carrier's  
20 other small employer health benefits policies or contracts.
- 21       A health benefits plan issued pursuant to subsection j. of section  
22 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in accordance  
23 with the provisions of section 7 of P.L.1995, c.340 (C.17B:27A-  
24 19.3), for the purposes of meeting the requirements of this  
25 paragraph.
- 26       (4) (Deleted by amendment, P.L.1994, c.11).
- 27       (5) Any policy or contract issued after January 1, 1994 to a  
28 small employer who was not previously covered by a health  
29 benefits plan issued by the issuing small employer carrier, shall be  
30 subject to the same premium rate restrictions as provided in  
31 paragraph (3) of this subsection, which rate restrictions shall be  
32 effective on the date the policy or contract is issued.
- 33       (6) The board shall establish, pursuant to section 17 of  
34 P.L.1993, c.162 (C.17B:27A-51):
- 35       (a) up to six geographic territories, none of which is smaller  
36 than a county; and
- 37       (b) age classifications which, at a minimum, shall be in five-  
38 year increments.
- 39       b. (Deleted by amendment, P.L.1993, c.162).
- 40       c. (Deleted by amendment, P.L.1995, c.298).
- 41       d. Notwithstanding any other provision of law to the contrary,  
42 this act shall apply to a carrier which provides a health benefits plan  
43 to one or more small employers through a policy issued to an  
44 association or trust of employers.
- 45       A carrier which provides a health benefits plan to one or more  
46 small employers through a policy issued to an association or trust of  
47 employers after the effective date of P.L.1992, c.162 (C.17B:27A-

1 17 et seq.), shall be required to offer small employer health benefits  
2 plans to non-association or trust employers in the same manner as  
3 any other small employer carrier is required pursuant to P.L.1992,  
4 c.162 (C.17B:27A-17 et seq.).

5 e. Nothing contained herein shall prohibit the use of premium  
6 rate structures to establish different premium rates for individuals  
7 and family units.

8 f. No insurance contract or policy subject to this act, including  
9 a contract or policy entered into with a small employer who is a  
10 member of a Small Employer Purchasing Alliance pursuant to the  
11 provisions of P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be  
12 entered into unless and until the carrier has made an informational  
13 filing with the commissioner of a schedule of premiums, not to  
14 exceed 12 months in duration, to be paid pursuant to such contract  
15 or policy, of the carrier's rating plan and classification system in  
16 connection with such contract or policy, and of the actuarial  
17 assumptions and methods used by the carrier in establishing  
18 premium rates for such contract or policy.

19 g. (1) Beginning January 1, 1995, a carrier desiring to increase  
20 or decrease premiums for any policy form or benefit rider offered  
21 pursuant to subsection i. of section 3 of P.L.1992, c.162  
22 (C.17B:27A-19) subject to this act may implement such increase or  
23 decrease upon making an informational filing with the  
24 commissioner of such increase or decrease, along with the actuarial  
25 assumptions and methods used by the carrier in establishing such  
26 increase or decrease, provided that the anticipated minimum loss  
27 ratio for all policy forms shall not be less than ~~75%~~ 80% of the  
28 premium therefor as provided in paragraph (2) of this subsection.  
29 The commissioner may disapprove any informational filing on a  
30 finding that it is incomplete and not in substantial compliance with  
31 P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are  
32 inadequate or unfairly discriminatory. Until December 31, 1996,  
33 the informational filing shall also include the carrier's rating plan  
34 and classification system in connection with such increase or  
35 decrease.

36 (2) Each calendar year, a carrier shall return, in the form of  
37 aggregate benefits for all of the ~~five~~ standard policy forms  
38 offered by the carrier pursuant to subsection a. of section 3 of  
39 P.L.1992, c.162 (C.17B:27A-19), at least ~~75%~~ 80% of the  
40 aggregate premiums collected for all of the standard policy forms,  
41 other than alliance policy forms, and at least ~~75%~~ 80% of the  
42 aggregate premiums collected for all of the non-standard policy  
43 forms during that calendar year. A carrier shall return at least  
44 ~~75%~~ 80% of the premiums collected for all of the alliances  
45 during that calendar year, which loss ratio may be calculated in the  
46 aggregate for all of the alliances or separately for each alliance.  
47 Carriers shall annually report, no later than August 1st of each year,

1 the loss ratio calculated pursuant to this section for all of the  
2 standard, other than alliance policy forms, non-standard policy  
3 forms and alliance policy forms for the previous calendar year,  
4 provided that a carrier may annually report the loss ratio calculated  
5 pursuant to this section for all of the alliances in the aggregate or  
6 separately for each alliance. In each case where the loss ratio fails  
7 to substantially comply with the ~~【75%】~~ 80% loss ratio requirement,  
8 the carrier shall issue a dividend or credit against future premiums  
9 for all policyholders with the standard, other than alliance policy  
10 forms, nonstandard policy forms or alliance policy forms, as  
11 applicable, in an amount sufficient to assure that the aggregate  
12 benefits paid in the previous calendar year plus the amount of the  
13 dividends and credits shall equal ~~【75%】~~ 80% of the aggregate  
14 premiums collected for the respective policy forms in the previous  
15 calendar year. All dividends and credits must be distributed by  
16 December 31 of the year following the calendar year in which the  
17 loss ratio requirements were not satisfied. The annual report  
18 required by this paragraph shall include a carrier's calculation of the  
19 dividends and credits applicable to standard, other than alliance  
20 policy forms, non-standard policy forms and alliance policy forms,  
21 as well as an explanation of the carrier's plan to issue dividends or  
22 credits. The instructions and format for calculating and reporting  
23 loss ratios and issuing dividends or credits shall be specified by the  
24 commissioner by regulation. Such regulations shall include  
25 provisions for the distribution of a dividend or credit in the event of  
26 cancellation or termination by a policyholder. For purposes of this  
27 paragraph, "alliance policy forms" means policies purchased by  
28 small employers who are members of Small Employer Purchasing  
29 Alliances.

30 (3) The loss ratio of a health benefits plan issued pursuant to  
31 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall  
32 be calculated in accordance with the provisions of section 7 of  
33 P.L.1995, c.340 (C.17B:27A-19.3), for the purposes of meeting the  
34 requirements of this subsection.

35 h. (Deleted by amendment, P.L.1993, c.162).

36 i. The provisions of this act shall apply to health benefits plans  
37 which are delivered, issued for delivery, renewed or continued on or  
38 after January 1, 1994.

39 j. (Deleted by amendment, P.L.1995, c.340).

40 k. A carrier who negotiates a reduced premium rate with a  
41 Small Employer Purchasing Alliance for members of that alliance  
42 shall provide a reduction in the premium rate filed in accordance  
43 with paragraph (3) of subsection a. of this section, expressed as a  
44 percentage, which reduction shall be based on volume or other  
45 efficiencies or economies of scale and shall not be based on health  
46 status-related factors.

47 (cf: P.L.2003, c.163, s.1)



1       26. (New section) a. An insurance producer licensed pursuant  
2 to P.L.2001, c.210 (C.17:22A-26 et seq.) who sells, solicits, or  
3 negotiates health insurance policies or contracts to residents of this  
4 State shall notify the purchaser of the insurance, in writing, of the  
5 amount of any commission, service fee, brokerage, or other  
6 valuable consideration that the producer will receive as a result of  
7 the sale, solicitation or negotiation of the health insurance policy or  
8 contract. If the commission, fee, brokerage, or other valuable  
9 consideration is based on a percentage of premium, the insurance  
10 producer shall include that information in the notification to the  
11 purchaser.

12       b. Upon seeking renewal of a license issued pursuant to  
13 P.L.2001, c.210 (C.17:22A-26 et seq.), an insurance producer shall  
14 report to the Commissioner of Banking and Insurance, in a form and  
15 manner specified by the commissioner, how the producer is  
16 compensated for the sale, solicitation, or negotiation of health  
17 insurance policies and contracts, including the basis for determining  
18 a commission, service fee, brokerage, or other valuable  
19 consideration for the sale, solicitation, or negotiation of a health  
20 insurance policy or contract. The insurance producer shall provide  
21 such other information regarding compensation as the commissioner  
22 deems appropriate.

23       c. Notwithstanding the provisions of any law to the contrary,  
24 the commissioner shall not renew the license of an insurance  
25 producer who is subject to the provisions of this section unless the  
26 insurance producer provides the information required pursuant to  
27 this section.

28       d. The commissioner may specify, by regulation, the  
29 information that shall be provided by an insurance producer in the  
30 notification to a purchaser of health insurance and the procedure for  
31 providing the notification.

32

33       27. The Commissioner of Banking and Insurance shall, pursuant  
34 to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-  
35 1 et seq.), adopt regulations necessary to implement the provisions  
36 of this act.

37

38       28. Sections 1 through 7 and 27 of this act shall take effect  
39 immediately and sections 8 through 26 of this act shall take effect  
40 on the 180th day after enactment and shall apply to all contracts and  
41 policies that are delivered, issued, executed or renewed or approved  
42 for issuance or renewal in this State on or after the effective date,  
43 but the Commissioner of Banking and Insurance may take such  
44 anticipatory administrative action in advance thereof as shall be  
45 necessary for the implementation of this act.

## STATEMENT

1  
2  
3 The purpose of this bill is to ensure that more residents in this  
4 State have access to affordable health care coverage. The bill  
5 achieves this goal by expanding the NJ FamilyCare Program to  
6 more low income parents, mandating that all children in the State  
7 have health care coverage either through public programs or private  
8 coverage, and adopting various reform measures to the individual  
9 and small employer insurance markets to increase the affordability  
10 of, and stabilize enrollment in, health benefits plans for individuals  
11 and small businesses. The provisions of this bill represent the first  
12 phase of a comprehensive reform of the health care system in this  
13 State which, when fully implemented, will ensure universal health  
14 care coverage for all residents of this State.

**Health Care Coverage Reforms:**

- 17 • To ensure that all children in the State are able to access health  
18 care, the bill establishes a “Kids First” mandate that requires all  
19 children 18 years of age and younger in the State to have health  
20 insurance coverage, beginning one year after the date of  
21 enactment of the bill. This coverage may be provided through an  
22 employer-sponsored or individual health benefits plan, the  
23 Medicaid program, NJ FamilyCare Program, or the NJ  
24 FamilyCare Advantage buy-in program.
- 25 • To make health care coverage more accessible to low income  
26 parents, eligibility for the NJ FamilyCare Program is expanded to  
27 include parents whose income is up to 200% of the federal  
28 poverty level.
- 29 • In order to ensure that hospitals assess patients under 19 years of  
30 age who present at the hospital for emergency care as to whether  
31 they may be presumptively eligible for NJ FamilyCare or  
32 Medicaid, the bill prohibits hospitals from submitting charity care  
33 claims for these patients. The cost of emergency care for patients  
34 who are determined to be presumptively eligible for NJ  
35 FamilyCare or Medicaid is shared by the federal government and,  
36 therefore, this provision will ensure more effective use of the  
37 State’s limited charity care funds for patient care that is not  
38 reimbursed by the federal government.
- 39 • In order to identify, and provide increased State outreach to,  
40 residents of the State who are uninsured and may be eligible to  
41 enroll in the Medicaid or NJ FamilyCare program, the bill  
42 establishes an ongoing enrollment initiative through the  
43 Department of the Treasury, in consultation with the Department  
44 of Human Services. Under the initiative, beginning with the 2008  
45 tax year and for each tax year thereafter, the Department of the  
46 Treasury shall require that each individual taxpayer indicate on  
47 the taxpayer's income tax return whether the taxpayer and  
48 dependents, if applicable, has health insurance coverage on the

1 date of filing of the return. If a taxpayer reports that he or his  
2 dependents are uninsured, and the State Treasurer determines that  
3 based on the taxpayer's reported income the taxpayer or his  
4 dependents may be eligible for either Medicaid or NJ  
5 FamilyCare, the State Treasurer would to send the taxpayer an  
6 application for the Medicaid or NJ FamilyCare program, as  
7 applicable.

8

9 **Individual and Small Employer Health Insurance Reforms:**

10 The bill implements several reforms to the individual and small  
11 employer markets to make health benefits plans more affordable to  
12 individuals and small businesses in the State. Specifically, the bill:

- 13 • Seeks to make individual health benefits plans more affordable to  
14 younger persons, by revising the rating system for individual  
15 plans for new policies and contracts issued after the effective date  
16 of the bill, so that the premium rate differential can be up to  
17 350%, but the only factor that the rating differential may be based  
18 on is the age of the person covered under the plan and the factor  
19 must be applied in a manner consistent with regulations of the  
20 Commissioner of Banking and Insurance, which include age  
21 classifications in a minimum of five-year increments. The bill  
22 provides, however, that in order to protect consumers who  
23 currently have coverage under an individual health benefits plan,  
24 rate increases for these consumers would be limited for the next  
25 five years to an amount no more than the lower of 15% or the  
26 medical trend assumption used by the carrier to project claims.
- 27 • Requires that a carrier must offer and make a good faith effort to  
28 market individual policies as a condition of participation in the  
29 small employer market, in order to ensure greater participation by  
30 carriers in the individual market.
- 31 • Reduces the number of standard plans that a carrier must offer in  
32 the individual and small employer markets from five to at least  
33 three plans.
- 34 • Authorizes carriers in the individual market to offer any number  
35 of riders which may revise the coverage offered by the standard  
36 plans in any way, but any form of such rider which decreases the  
37 actuarial value of one of the plans shall be filed for informational  
38 purposes with the board and for approval by the commissioner  
39 before any such rider may be sold. Any rider which adds benefits  
40 or increases the actuarial value of one of the plans shall be filed  
41 with the board or informational purposes before the rider may be  
42 sold. The additional premium for a rider shall be listed separately  
43 from the premium for the standard plan.
- 44 • Transfers regulatory oversight regarding approval of policy and  
45 contract forms, and review of premium rate filings and other  
46 similar matters, from the Individual Health Coverage Program  
47 Board to the Commissioner of Banking and Insurance, as is

- 1 currently provided in the New Jersey Small Employer Health  
2 Benefits Program.
- 3 • Requires carriers in the individual market to make an  
4 informational filing to the Commissioner of Banking and  
5 Insurance in the event the carrier seeks to increase or decrease  
6 premiums for any contract or policy form.
  - 7 • Revises provisions concerning the minimum loss ratio for  
8 individual and small employer plans and provides that rates shall  
9 be formulated so that the anticipated minimum loss ratio is not  
10 less than 80% of the premium.
  - 11 • Provides that after the effective date of the bill, no further loss  
12 assessments shall be calculated or collected, although carriers are  
13 not relieved of their obligations for loss assessments authorized  
14 prior to the effective date of the bill.
  - 15 • Permits small employer carriers to require a reasonable specified  
16 minimum participation “with the same carrier” of eligible  
17 employees.
  - 18 • Establishes transparency with respect to insurance broker fees by  
19 requiring insurance producers to notify a purchaser of insurance,  
20 in writing, of the amount of any commission, service fee,  
21 brokerage, other valuable consideration that the producer will  
22 receive as a result of the sale, solicitation or negotiation of the  
23 health insurance policy or contract. The bill also requires  
24 producers, as a condition of licensure by the Department of  
25 Banking and Insurance, to notify the department how the  
26 producer is compensated by carriers for the sale, solicitation or  
27 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.

- 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.).

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
<b>State Cost</b>	<p><b>Parents.</b> 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).</p>
<b>State Revenue</b>	<p><b>Presumptive Eligibility.</b> 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.</p> <p><b>Federal Reimbursement</b> of either 50 percent or 65 percent will be available to offset gross program expenditures.</p>

- **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:

<b>Number of Additional Children Enrolled (Phased in)</b>	<b>Annual Gross Costs (\$000)</b>	<b>Federal Match of 50% and 65% (\$000)</b>	<b>State Costs at Federal Match of 50% and 65% (\$000)</b>
<b>10,000</b>	\$7,707	\$3,853 - \$5,009	\$3,853 - \$2,697
<b>25,000</b>	\$19,267	\$9,633 - \$12,523	\$9,633 - \$6,743
<b>50,000</b>	\$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:

<b>Number of Adults Enrolled (Phased In)</b>	<b>Annual Gross Costs (\$000)</b>	<b>Federal Match at 65% (\$000)</b>	<b>State Costs (\$000)</b>
<b>10,000</b>	\$14,450	\$9,3936	\$5,058
<b>25,000</b>	\$19,167	\$12,523	\$6,7434
<b>50,000</b>	\$38,533	\$25,0472	\$13,487
<b>75,000</b>	\$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.).





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JON S. CORZINE  
*Governor*

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**For Immediate Release:**

[For Kids](#)

**Effective:** July 07, 2008

**For More Information:**

Sean Darcy  
Jim Gardner

**Phone:** 609-777-2600

## 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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