17:48-6.17

LEGISLATIVE HISTORY CHECKLIST
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(Health insurance reform)

NJSA: 17:48-6.17

LAWS OF: 1995 **CHAPTER:** 291

BILL NO: S2349

SPONSOR(S): Bassano

DATE INTRODUCED: November 9, 1995

COMMITTEE: **ASSEMBLY** Insurance

SENATE: Human Services

AMENDED DURING PASSAGE: No

DATE OF PASSAGE: **ASSEMBLY:** December 18, 1995

SENATE: December 11, 1995

DATE OF APPROVAL: December 22, 1995

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT: Yes

COMMITTEE STATEMENT: **ASSEMBLY:** Yes

SENATE: Yes

FISCAL NOTE: No

VETO MESSAGE: No

MESSAGE ON SIGNING: No

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

KBP:pp

§1-C.17:48-6.17
§2-C.17:48A-6.10
§3-C.17:48E-15.1
§4-C.17B:27A-4.3
§5-C.17B:27A-21.1
§6-C.17B:27-36.1
§10-Note to §7

P.L.1995, CHAPTER 291, *approved December 22, 1995*

1995 Senate No. 2349

AN ACT concerning health insurance for Medicaid-eligible persons, supplementing P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985, c.236 (C.17:48E-1 et seq.), P.L.1992, c.162 (C.17B:27A-17 et seq.) and chapter 27 of Title 17B of the New Jersey Statutes, supplementing and amending P.L.1992, c.161, and amending P.L.1973, c.337.

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

1. (New section) Notwithstanding any other provision of law to the contrary, a hospital service corporation shall not consider a person's eligibility for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or the equivalent statute in another state, when determining the person's eligibility for enrollment in, or the provision of benefits under, a hospital service corporation contract providing hospital or medical expense benefits delivered, issued or executed in this State, or approved for issuance in this State by the Commissioner of Insurance.

2. (New section) Notwithstanding any other provision of law to the contrary, a medical service corporation shall not consider a person's eligibility for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or the equivalent statute in another state, when determining the person's eligibility for enrollment in, or the provision of benefits under, a medical service corporation contract providing hospital or medical expense benefits delivered, issued or executed in this State, or approved for issuance in this State by the Commissioner of Insurance.

3. (New section) Notwithstanding any other provision of law to the contrary, a health service corporation shall not consider a person's eligibility for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or the equivalent statute in another state, when determining the person's eligibility for enrollment in, or the provision of benefits under, a health service corporation contract providing hospital or medical expense benefits delivered, issued or executed in this State, or approved for issuance in this State by the Commissioner of Insurance.

4. (New section) Notwithstanding any other provision of law to the contrary, a carrier shall not consider a person's eligibility for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or the equivalent statute in another state, when determining the person's eligibility for enrollment in, or the

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.

provision of benefits under, an individual health benefits plan delivered, issued or executed in this State.

5. (New section) Notwithstanding any other provision of law to the contrary, a carrier shall not consider a person's eligibility for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or the equivalent statute in another state, when determining the person's eligibility for enrollment in, or the provision of benefits under, a small employer health benefits plan delivered, issued or executed in this State.

6. (New section) Notwithstanding any other provision of law to the contrary, an insurer shall not consider a person's eligibility for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or the equivalent statute in another state, when determining the person's eligibility for enrollment in, or the provision of benefits under, a policy providing hospital or medical expense benefits delivered, issued or executed in this State, or approved for issuance in this State by the Commissioner of Insurance.

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

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

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

"Carrier" means an insurance company, health service corporation or health maintenance organization authorized to issue health benefits plans in this State. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier.

"Commissioner" means the Commissioner of Insurance.

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

"Department" means the Department of Insurance.

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

"Eligible person" means a person who is a resident of the State who is not eligible to be insured under a group health insurance policy[.] or Medicare[, or Medicaid].

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

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

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; or health maintenance organization subscriber contract delivered or issued for delivery in this State. For purposes of this act, health benefits plan does not include the following plans, policies, or contracts: accident only, credit, disability, long-term care, Medicare supplement coverage, CHAMPUS supplement coverage,

coverage for Medicare services pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity coverage.

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

Individual health benefits plan shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is established or adopted by two or more employers, by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, to insure employees of the employers or members of the unions or organizations.

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

"Member" means a carrier that is a member of the program pursuant to this act.

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

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid or HealthStart Plus contracts with the State or federal government, but shall not include any excess or stop loss coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

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

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

"Preexisting condition" means a condition that, during a specified period of not more than six months immediately preceding the effective date of coverage, had manifested itself in

such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the effective date of coverage.

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

(cf: P.L.1993, c.164, s.1)

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

6. The board shall establish the policy and contract forms and benefit levels to be made available by all carriers for the policies required to be issued pursuant to section 3 of [this act] P.L.1992, c.161 (C.17B:27A-4). The board shall provide the commissioner with an informational filing of the policy and contract forms and benefit levels it establishes.

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

b. An individual health benefits plan offered pursuant to section 3 of [this act] P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no more than 12 months on coverage for preexisting conditions, except that the limitation shall not apply to an individual who has, under a prior group or individual health benefits plan or Medicaid, with no intervening lapse in coverage of more than 30 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation.

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

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

(cf: P.L.1993, c.164, s.4)

9. Section 15 of P.L.1973, c.337 (C.26:2J-15) is amended to read as follows:

15. a. No health maintenance organization, or representative

thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purpose of this act:

(1) a statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

(2) a statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;

(3) an evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefore, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

b. The unfair trade practice provisions of the New Jersey insurance law (N.J.S. 17B:30-1 through 22) shall be construed to apply to health maintenance organizations, health care plans and evidences of coverage except to the extent that the commissioner determines that the nature of health maintenance organizations, health care plans and evidence of coverage render such sections clearly inappropriate.

c. An enrollee may not be canceled or nonrenewed except for the failure to pay the charge for such coverage, or for such other reasons as may be promulgated by the commissioner.

d. No health maintenance organization, unless licensed as an insurer, may use in its name, evidence of coverage, or literature any of the words "insurance," "assurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance, or surety corporation doing business in this State.

e. A health maintenance organization shall not consider a person's eligibility for medical assistance pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or the equivalent statute in another state, when determining the person's eligibility for enrollment in, or the provision of health care services under, a contract or certificate for health care services.

The provisions of this section shall be enforced by the State Director of the Division of Consumer Affairs and, where

applicable, the commissioner or the Commissioner of Insurance. Nothing in this act shall limit the powers of the Attorney General and the procedures with respect to consumer fraud in N.J.S. 56:8-1 et seq.

(cf: P.L.1973, c.337, s.15)

10. This act shall take effect immediately and section 7 shall be retroactive to April 1, 1995.

STATEMENT

This bill prohibits a hospital service corporation, medical service corporation, health service corporation, commercial insurer or a health maintenance organization from considering a person's eligibility for Medicaid benefits in this or another state when determining the person's eligibility for enrollment or health care coverage.

The bill also amends P.L.1992, c.161 (C.17B:27A-2 et seq.), the law which established the New Jersey Individual Health Coverage Program, to provide that Medicaid coverage shall be considered valid insurance coverage for the purpose of satisfying a preexisting condition waiting period under an individual health benefits plan.

This bill is designed to meet a requirement for legislative enactment by all states under the federal "Omnibus Budget Reconciliation Act of 1993," Pub.L.103-66.

Prohibits health insurer from taking into account a person's Medicaid eligibility in the enrollment or claim payment process.

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SPONSOR'S STATEMENT

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ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

SENATE, No. 2349

STATE OF NEW JERSEY

DATED: DECEMBER 14, 1995

The Assembly Insurance Committee reports favorably Senate Bill No. 2349.

This bill prohibits a hospital service corporation, medical service corporation, health service corporation, commercial insurer or a health maintenance organization from considering a person's eligibility for Medicaid benefits in this or another state when determining the person's eligibility for enrollment or health care coverage.

The bill also amends P.L.1992, c.161 (C.17B:27A-2 et seq.), the law which established the New Jersey Individual Health Coverage Program, to provide that Medicaid coverage shall be considered valid insurance coverage for the purpose of satisfying a preexisting condition waiting period under an individual health benefits plan.

This bill is designed to meet a requirement for legislative enactment by all states under the federal "Omnibus Budget Reconciliation Act of 1993," Pub.L.103-66.

SENATE HUMAN SERVICES COMMITTEE

STATEMENT TO

SENATE, No. 2349

STATE OF NEW JERSEY

DATED: NOVEMBER 27, 1995

The Senate Human Services Committee favorably reports Senate Bill No. 2349.

This bill prohibits a hospital service corporation, medical service corporation, health service corporation, commercial insurer or a health maintenance organization from considering a person's eligibility for Medicaid benefits in this or another state when determining the person's eligibility for enrollment or health care coverage.

The bill also amends P.L.1992, c.161 (C.17B:27A-2 et seq.), the law which established the New Jersey Individual Health Coverage Program, to provide that Medicaid coverage shall be considered valid insurance coverage for the purpose of satisfying a preexisting condition waiting period under an individual health benefits plan.

This bill is designed to meet a requirement for legislative enactment by all states under the federal "Omnibus Budget Reconciliation Act of 1993," Pub.L.103-66.