17B:27A-17

LEGISLATIVE HISTORY CHECKLIST
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(Small employee health benefits)

NJSA: 17B:27A-17

LAWS OF: 1995 **CHAPTER:** 340

BILL NO: S2380

SPONSOR(S): Cardinale and Sinagra

DATE INTRODUCED: November 27, 1995

COMMITTEE: **ASSEMBLY** Insurance

SENATE: Health

AMENDED DURING PASSAGE: Yes Amendments during passage denoted by superscript numbers

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

SENATE: December 11, 1995

DATE OF APPROVAL: January 5, 1996

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
See newspaper clippings-attached:
"Law gives insurance reprieve," 1-11-96, State Ledger.

KBP:pp

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[FIRST REPRINT]

SENATE, No. 2380

STATE OF NEW JERSEY

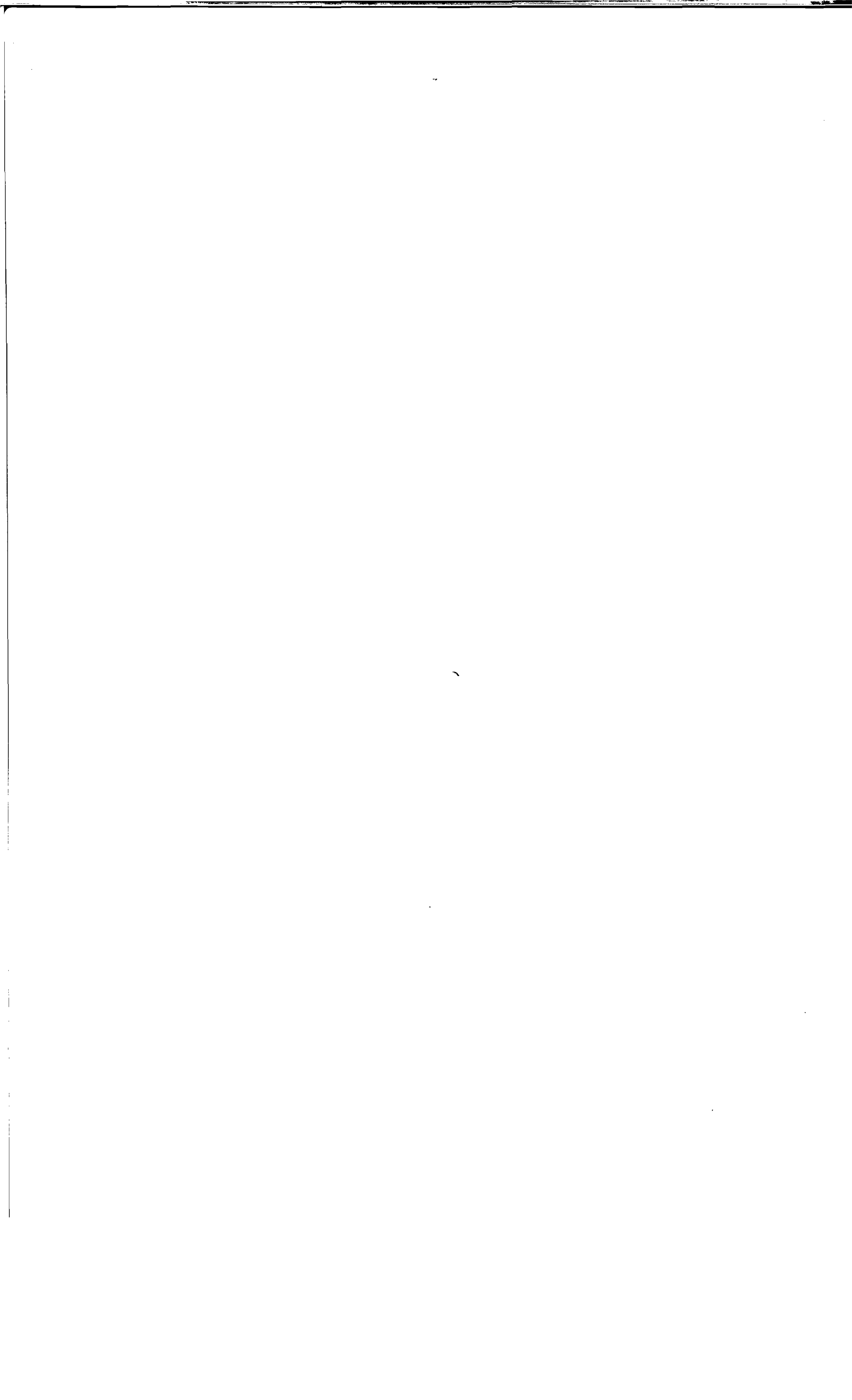
INTRODUCED NOVEMBER 27, 1995

By Senators CARDINALE and SINAGRA

1 *AN ACT* concerning small employer health benefits plans and
2 amending and supplementing P.L.1992, c.162.
3
4 BE IT ENACTED *by the Senate and General Assembly of the*
5 *State of New Jersey:*
6 1. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to
7 read as follows:
8 1. As used in this act:
9 "Actuarial certification" means a written statement by a
10 member of the American Academy of Actuaries or other
11 individual acceptable to the commissioner that a small employer
12 carrier is in compliance with the provisions of section 9 of
13 P.L.1992, c.162 (C.17B:27A-25), based upon examination,
14 including a review of the appropriate records and actuarial
15 assumptions and methods used by the small employer carrier in
16 establishing premium rates for applicable health benefits plans.
17 "Anticipated loss ratio" means the ratio of the present value of
18 the expected benefits, not including dividends, to the present
19 value of the expected premiums, not reduced by dividends, over
20 the entire period for which rates are computed to provide
21 coverage. For purposes of this ratio, the present values must
22 incorporate realistic rates of interest which are determined
23 before federal taxes but after investment expenses.
24 "Board" means the board of directors of the program.
25 "Carrier" means any insurance company, health service
26 corporation, hospital service corporation, medical service
27 corporation or health maintenance organization authorized to
28 issue health benefits plans in this State. For purposes of this act,
29 carriers that are affiliated companies shall be treated as one
30 carrier, except that any insurance company, health service
31 corporation, hospital service corporation, or medical service
32 corporation that is an affiliate of a health maintenance
33 organization located in New Jersey or any health maintenance
34 organization located in New Jersey that is affiliated with an
35 insurance company, health service corporation, hospital service
36 corporation, or medical service corporation shall treat the health
37 maintenance organization as a separate carrier.
38 "Commissioner" means the Commissioner of Insurance.
39 "Community rating" means a rating methodology in which the
40 premium for all persons covered by a policy or contract form is
41 the same based upon the experience of the entire pool of risks
42 covered by that policy or contract form without regard to age,
43 gender, health status, residence or occupation.
44 "Department" means the Department of Insurance.

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted December 7, 1995.



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1 *AN ACT* concerning small employer health benefits plans and
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3
4 BE IT ENACTED *by the Senate and General Assembly of the*
5 *State of New Jersey:*
6 1. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to
7 read as follows:
8 1. As used in this act:
9 "Actuarial certification" means a written statement by a
10 member of the American Academy of Actuaries or other
11 individual acceptable to the commissioner that a small employer
12 carrier is in compliance with the provisions of section 9 of
13 P.L.1992, c.162 (C.17B:27A-25), based upon examination,
14 including a review of the appropriate records and actuarial
15 assumptions and methods used by the small employer carrier in
16 establishing premium rates for applicable health benefits plans.
17 "Anticipated loss ratio" means the ratio of the present value of
18 the expected benefits, not including dividends, to the present
19 value of the expected premiums, not reduced by dividends, over
20 the entire period for which rates are computed to provide
21 coverage. For purposes of this ratio, the present values must
22 incorporate realistic rates of interest which are determined
23 before federal taxes but after investment expenses.
24 "Board" means the board of directors of the program.
25 "Carrier" means any insurance company, health service
26 corporation, hospital service corporation, medical service
27 corporation or health maintenance organization authorized to
28 issue health benefits plans in this State. For purposes of this act,
29 carriers that are affiliated companies shall be treated as one
30 carrier, except that any insurance company, health service
31 corporation, hospital service corporation, or medical service
32 corporation that is an affiliate of a health maintenance
33 organization located in New Jersey or any health maintenance
34 organization located in New Jersey that is affiliated with an
35 insurance company, health service corporation, hospital service
36 corporation, or medical service corporation shall treat the health
37 maintenance organization as a separate carrier.
38 "Commissioner" means the Commissioner of Insurance.
39 "Community rating" means a rating methodology in which the
40 premium for all persons covered by a policy or contract form is
41 the same based upon the experience of the entire pool of risks
42 covered by that policy or contract form without regard to age,
43 gender, health status, residence or occupation.
44 "Department" means the Department of Insurance.

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

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SHH committee amendments adopted December 7, 1995.

1 "Dependent" means the spouse or child of an eligible employee,
2 subject to applicable terms of the health benefits plan covering
3 the employee.
4 "Eligible employee" means a full-time employee who works a
5 normal work week of 25 or more hours. The term includes a sole
6 proprietor, a partner of a partnership, or an independent
7 contractor, if the sole proprietor, partner, or independent
8 contractor is included as an employee under a health benefits
9 plan of a small employer, but does not include employees who
10 work less than 25 hours a week, work on a temporary or
11 substitute basis or are participating in an employee welfare
12 arrangement established pursuant to a collective bargaining
13 agreement.
14 "Financially impaired" means a carrier which, after the
15 effective date of this act, is not insolvent, but is deemed by the
16 commissioner to be potentially unable to fulfill its contractual
17 obligations or a carrier which is placed under an order of
18 rehabilitation or conservation by a court of competent
19 jurisdiction.
20 "Health benefits plan" means any hospital and medical expense
21 insurance policy or certificate; health, hospital, or medical
22 service corporation contract or certificate; or health
23 maintenance organization subscriber contract or certificate
24 delivered or issued for delivery in this State by any carrier to a
25 small employer group pursuant to section 3 of P.L.1992, c.162
26 (C.17B:27A-19). For purposes of this act, "health benefits plan"
27 excludes the following plans, policies, or contracts: accident
28 only, credit, disability, long-term care, coverage for Medicare
29 services pursuant to a contract with the United States
30 government, Medicare supplement, dental only, prescription only
31 or vision only, insurance issued as a supplement to liability
32 insurance, coverage arising out of a workers' compensation or
33 similar law, hospital confinement or other supplemental limited
34 benefit insurance coverage, automobile medical payment
35 insurance, or personal injury protection coverage issued pursuant
36 to P.L.1972, c.70 (C.39:6A-1 et seq.).
37 "Late enrollee" means an eligible employee or dependent who
38 requests enrollment in a health benefits plan of a small employer
39 following the initial minimum 30-day enrollment period provided
40 under the terms of the health benefits plan. An eligible employee
41 or dependent shall not be considered a late enrollee if the
42 individual: a. was covered under another employer's health
43 benefits plan at the time he was eligible to enroll and stated at
44 the time of the initial enrollment that coverage under that other
45 employer's health benefits plan was the reason for declining
46 enrollment; b. has lost coverage under that other employer's
47 health benefits plan as a result of termination of employment,
48 the termination of the other plan's coverage, death of a spouse,
49 or divorce; and c. requests enrollment within 90 days after
50 termination of coverage provided under another employer's
51 health benefits plan. An eligible employee or dependent also
52 shall not be considered a late enrollee if the individual is
53 employed by an employer which offers multiple health benefits
54 plans and the individual elects a different plan during an open

1 enrollment period; or if a court of competent jurisdiction has
2 ordered coverage to be provided for a spouse or minor child under
3 a covered employee's health benefits plan and request for
4 enrollment is made within 30 days after issuance of that court
5 order.
6 "Member" means all carriers issuing health benefits plans in
7 this State on or after the effective date of this act.
8 "Multiple employer arrangement" means an arrangement
9 established or maintained to provide health benefits to employees
10 and their dependents of two or more employers, under an insured
11 plan purchased from a carrier in which the carrier assumes all or
12 a substantial portion of the risk, as determined by the
13 commissioner, and shall include, but is not limited to, a multiple
14 employer welfare arrangement, or MEWA, multiple employer
15 trust or other form of benefit trust.
16 "Plan of operation" means the plan of operation of the program
17 including articles, bylaws and operating rules approved pursuant
18 to section 14 of P.L.1992, c.162 (C.17B:27A-30).
19 "Preexisting condition provision" means a policy or contract
20 provision that excludes coverage under that policy or contract for
21 charges or expenses incurred during a specified period following
22 the insured's effective date of coverage, for a condition that,
23 during a specified period immediately preceding the effective
24 date of coverage, had manifested itself in such a manner as would
25 cause an ordinarily prudent person to seek medical advice,
26 diagnosis, care or treatment, or for which medical advice,
27 diagnosis, care or treatment was recommended or received as to
28 that condition or as to pregnancy existing on the effective date
29 of coverage.
30 "Program" means the New Jersey Small Employer Health
31 Benefits Program established pursuant to section 12 of P.L.1992,
32 c.162 (C.17B:27A-28).
33 "Qualifying previous coverage" means benefits or coverage
34 provided under:
35 a. Medicare or Medicaid or any other federally funded health
36 benefits program;
37 b. a group health insurance policy or contract, including
38 coverage by an insurance company, a health, hospital or medical
39 service corporation, or a health maintenance organization, or an
40 employer-based, self-funded or other health benefit
41 arrangement; or
42 c. an individual health insurance policy or contract, including
43 coverage by an insurance company, a health, hospital or medical
44 service corporation, or a health maintenance organization.
45 Qualifying previous coverage shall not include the following
46 policies, contracts or arrangements, whether issued on an
47 individual or group basis: specified disease only, accident only,
48 credit, disability, long-term care, Medicare supplement, dental
49 only, prescription only or vision only, insurance issued as a
50 supplement to liability insurance, stop loss or excess risk
51 insurance, coverage arising out of a workers' compensation or
52 similar law, hospital confinement or other supplemental limited
53 benefit coverage, automobile medical payment insurance, or
54 personal injury protection coverage issued pursuant to

1 P.L.1972, c.70 (C.39:6A-1 et seq.).
2 "Reinsuring carrier" means a small employer carrier electing
3 to receive reimbursement from the program in accordance with
4 section 19 of P.L.1992, c.162 (C.17B:27A-35).
5 "Risk-assuming carrier" means a small employer carrier
6 electing to assume risks pursuant to section 18 of P.L.1992, c.162
7 (C.17B:27A-34).
8 "Small employer" means any person, firm, corporation,
9 partnership, or association actively engaged in business which, on
10 at least 50 percent of its working days during the preceding
11 calendar year quarter, employed at least two but no more than 49
12 eligible employees, the majority of whom are employed within
13 the State of New Jersey. In determining the number of eligible
14 employees, companies which are affiliated companies shall be
15 considered one employer. Subsequent to the issuance of a health
16 benefits plan to a small employer pursuant to the provisions of
17 this act, and for the purpose of determining eligibility, the size of
18 a small employer shall be determined annually. Except as
19 otherwise specifically provided, provisions of this act which apply
20 to a small employer shall continue to apply until the anniversary
21 date of the health benefits plan next following the date the
22 employer no longer meets the definition of a small employer. For
23 the purposes of P.L.1992, c.162 (C.17B:27A-17 et seq.), a State,
24 county or municipal body, agency, board or department shall not
25 be considered a small [1][employee] employer[1].
26 "Small employer carrier" means any carrier that offers health
27 benefits plans covering eligible employees of one or more small
28 employers.
29 "Small employer health benefits plan" means a health benefits
30 plan for small employers approved by the commissioner pursuant
31 to section 17 of P.L.1992, c.162 (C.17B:27A-33).
32 [1]"Stop loss" or "excess risk insurance" means an insurance
33 policy designed to reimburse a self-funded arrangement of one or
34 more small employers for catastrophic, excess or unexpected
35 expenses, wherein neither the employees nor other individuals are
36 third party beneficiaries under the insurance policy. In order to
37 be considered stop loss or excess risk insurance for the purposes
38 of P.L.1992, c.162 (C.17B:27A-17 et seq.), the policy shall
39 establish a per person attachment point or retention or aggregate
40 attachment point or retention, or both, which meet the following
41 requirements:
42 a. If the policy establishes a per person attachment point or
43 retention, that specific attachment point or retention shall not be
44 less than $20,000 per covered person per plan year; and
45 b. If the policy establishes an aggregate attachment point or
46 retention, that aggregate attachment point or retention shall not
47 be less than 125% of expected claims per plan year.[1]
48 "Supplemental limited benefit insurance" means insurance that
49 is provided in addition to a health benefits plan on an indemnity
50 non-expense incurred basis.
51 (cf: P.L.1994, c.11. s.1)
52 2. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to
53 read as follows:
54 3. a. Except as provided in subsection f. of this section, every

1 small employer carrier shall, as a condition of transacting
2 business in this State, offer to every small employer the five
3 health benefit plans as provided in this section. The board shall
4 establish a standard policy form for each of the five plans, which
5 except as otherwise provided in subsection j. of this section, shall
6 be the only plans offered to small groups on or after January 1,
7 1994. One policy form shall contain the benefits provided for in
8 sections 55, 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2,
9 17B:26B-2 and 26:2J-4.3). In the case of indemnity carriers, one
10 policy form shall be established which contains benefits and cost
11 sharing levels which are equivalent to the health benefits plans of
12 health maintenance organizations pursuant to the "Health
13 Maintenance Organization Act of 1973," Pub.L.93-222 (42
14 U.S.C.§300e et seq.). The remaining policy forms shall contain
15 basic hospital and medical-surgical benefits, including, but not
16 limited to:
17 (1) Basic inpatient and outpatient hospital care;
18 (2) Basic and extended medical-surgical benefits;
19 (3) Diagnostic tests, including X-rays;
20 (4) Maternity benefits, including prenatal and postnatal care;
21 and
22 (5) Preventive medicine, including periodic physical
23 examinations and inoculations.
24 At least three of the forms shall provide for major medical
25 benefits in varying lifetime aggregates, one of which shall
26 provide at least $1,000,000 in lifetime aggregate benefits. The
27 policy forms provided pursuant to this section shall contain
28 benefits representing progressively greater actuarial values.
29 Notwithstanding the provisions of this subsection to the
30 contrary, the board also may establish additional policy forms by
31 which a [1][health maintenance organization] small employer
32 carrier, other than a health maintenance organization,[1] may
33 provide indemnity benefits [1][in accordance with the provisions of
34 P.L.1973, c.337 (C.26:2J-1 et seq.)] for health maintenance
35 organization enrollees by direct contract with the enrollees'
36 small employer through a dual arrangement with the health
37 maintenance organization. The dual arrangement shall be filed
38 with the commissioner for approval[1]. The additional policy forms
39 shall be consistent with the general requirements of P.L.1992,
40 c.162 (C.17B:27A-17 et seq.).
41 b. Initially, a carrier shall offer a plan within 90 days of the
42 approval of such plan by the commissioner. Thereafter, the plans
43 shall be available to all small employers on a continuing basis.
44 Every small employer which elects to be covered under any
45 health benefits plan who pays the premium therefor and who
46 satisfies the participation requirements of the plan shall be issued
47 a policy or contract by the carrier.
48 c. The carrier may establish a premium payment plan which
49 provides installment payments and which may contain reasonable
50 provisions to ensure payment security, provided that provisions to
51 ensure payment security are uniformly applied.
52 d. In addition to the five standard policies described in
53 subsection a. of this section, the board may develop up to five
54 rider packages. Any such package which a carrier chooses to

offer shall be issued to a small employer who pays the premium therefor, and shall be subject to the rating methodology set forth in section 9 of P.L.1992, c.162 (C.17B:27A-25).

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

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

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

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

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

i. (1) In addition to the rider packages provided for in subsection d. of this section, every carrier may offer, in connection with the five health benefits plans required to be offered by this section, any number of riders which may revise the coverage offered by the five plans in any way, provided, however, that any form of such rider or amendment thereof which decreases benefits or decreases the actuarial value of one of the five plans shall be filed for informational purposes with the board and for approval by the commissioner before such rider

1 may be sold. Any rider or amendment thereof which adds
2 benefits or increases the actuarial value of one of the five plans
3 shall be filed with the board for informational purposes before
4 such rider may be sold.
5 The commissioner shall disapprove any rider filed pursuant to
6 this subsection that is unjust, unfair, inequitable, unreasonably
7 discriminatory, misleading, contrary to law or the public policy of
8 this State. The commissioner shall not approve any rider which
9 reduces benefits below those required by sections 55, 57 and 59 of
10 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and
11 required to be sold pursuant to this section. The commissioner's
12 determination shall be in writing and shall be appealable.
13 (2) The benefit riders provided for in paragraph (1) of this
14 subsection shall be subject to the provisions of section 2,
15 subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of
16 P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19b., 17B:27A-22,
17 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).
18 j. (1) Notwithstanding the provisions of P.L.1992, c.162
19 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan
20 issued by or through a carrier, association, multiple employer
21 arrangement prior to January 1, 1994 or, if the requirements of
22 subparagraph (c) of paragraph (6) of this subsection are met,
23 issued by or through an out-of-State trust prior to January 1,
24 1994, at the option of a small employer policy or contract holder,
25 may be renewed or continued after February 28, 1994, or in the
26 case of such a health benefits plan whose anniversary date
27 occurred between March 1, 1994 and the effective date of
28 P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated within
29 60 days of that anniversary date[, for two successive 12-month
30 periods commencing with the first 12-month anniversary date
31 occurring after February 28, 1994, notwithstanding the provisions
32 of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary,] and
33 renewed or continued if, beginning on the first 12-month
34 anniversary date occurring on or after the sixtieth day after the
35 board adopts regulations concerning the implementation of the
36 rating factors permitted by section 9 of P.L.1992, c.162
37 (C.17B:27A-25) and, regardless of the situs of delivery of the
38 health benefits plan, the health benefits plan renewed, continued
39 or reinstated pursuant to this subsection complies with the
40 provisions of section 2, subsection b. of section 3, and sections 6,
41 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19b.,
42 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and
43 17B:27A-27) and section 7 of P.L. , c. (C.)(pending before the
44 Legislature as this bill).
45 Nothing in this subsection shall be construed to require an
46 association, multiple employer arrangement or out-of-State trust
47 to provide health benefits coverage to small employers that are
48 not contemplated by the organizational documents, bylaws, or
49 other regulations governing the purpose and operation of the
50 association, multiple employer arrangement or out-of-State
51 trust. Notwithstanding the foregoing provision to the contrary, an
52 association, multiple employer arrangement or out-of-State trust
53 that offers health benefits coverage to its members' employees
54 and dependents :

1 (a) shall offer coverage to all eligible employees and their
2 dependents within the membership of the association, multiple
3 employer arrangement or out-of-State trust [and an association,
4 multiple employer arrangement or out-of-State trust];
5 (b) shall not use actual or expected health status in
6 determining its membership; and
7 (c) shall make available to its small employer members at least
8 one of the standard benefits plans, as determined by the
9 commissioner, in addition to any health benefits plan permitted
10 to be renewed or continued pursuant to this subsection.
11 (2) [Notwithstanding the provisions of this subsection to the
12 contrary, a carrier or out-of-State trust which writes the health
13 benefits plans required pursuant to subsection a. of this section,
14 shall be required to offer those plans to any small employer,
15 association or multiple employer arrangement.] (Deleted by
16 amendment, P.L. , c.)(pending before the Legislature as this
17 bill).
18 [1]Notwithstanding the provisions of this subsection to the
19 contrary, a carrier or out-of-State trust which writes the health
20 benefits plans required pursuant to subsection a. of this section,
21 shall be required to offer those plans to any small employer,
22 association or multiple employer arrangement.[1]
23 (3) (a) A carrier, association, multiple employer arrangement
24 or out-of-State trust [1][shall not] may[1] withdraw a health
25 benefits plan marketed to small employers that was in effect on
26 December 31, 1993 [1][without] with[1] the approval of the
27 commissioner. The commissioner shall approve a request to
28 withdraw a plan[1], consistent with regulations adopted by the
29 commissioner,[1] only on the grounds that retention of the plan
30 would [1][present a substantial threat to the financial condition of
31 the carrier] cause an unreasonable financial burden to the issuing
32 carrier, taking into account the rating provisions of section 9 of
33 P.L.1992, c.162 (C.17B:27A-25) and section 7 of
34 P.L. , c. (C.)(pending before the Legislature as this bill)[1].
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,
38 1994, may, upon approval of the commissioner, continue to
39 establish its rates for that plan based on the loss experience of
40 that plan if the carrier does not issue that health benefits plan to
41 any new small employer groups.
42 (4) [Notwithstanding the provisions of P.L.1992, c.162
43 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan in
44 effect on the effective date of P.L.1994, c.11 (C.17B:27A-19.1 et
45 al.) shall remain in effect until the third 12-month anniversary
46 date occurring after February 28, 1994 of that policy or contract
47 and may, at the option of the policy or contract holder, be
48 renewed or continued until the second 12-month anniversary date
49 of that policy or contract occurring after February 28, 1994.]
50 (Deleted by amendment, P.L. , c.)(pending before the
51 Legislature as this bill)
52 (5) A health benefits plan that otherwise conforms to the
53 requirements of this subsection shall be deemed to be in
54 compliance with this subsection, notwithstanding any change in

1 the plan's deductible or copayment.
2 (6) [A] (a) Except as otherwise provided in subparagraphs (b)
3 and (c) of this paragraph, a health benefits plan renewed,
4 continued or reinstated pursuant to this subsection shall be filed
5 with the commissioner for informational purposes within 30 days
6 after its renewal date. No later than 60 days after the board
7 adopts regulations concerning the implementation of the rating
8 factors permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25)
9 the filing shall be amended to show any modifications in the plan
10 that are necessary to comply with the provisions of this
11 subsection. The commissioner shall monitor compliance of any
12 such plan with the requirements of this subsection, except that
13 the board shall enforce the loss ratio requirements.
14 (b) A health benefits plan filed with the commissioner pursuant
15 to subparagraph (a) of this paragraph may be amended as to its
16 benefit structure if the amendment does not reduce the actuarial
17 value [1]and benefits coverage[1] of the health benefits plan below
18 that of the lowest standard health benefits plan established by
19 the board pursuant to subsection a. of this section. The
20 amendment shall be filed with the commissioner for approval
21 pursuant to the terms of sections 4, 8, 12 and 25 of P.L.1995, c.73
22 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and 26:2J-43),
23 N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and shall
24 comply with the provisions of sections 2 and 9 of P.L.1992, c.162
25 (C.17B:27A-18 and 17B:27A-25) and section 7 of
26 P.L. , c. (C.)(pending before the Legislature as this bill).
27 (c) A health benefits plan issued by a carrier through an
28 out-of-State trust shall be permitted to be renewed or continued
29 pursuant to paragraph (1) of this subsection upon approval by the
30 commissioner and only if the benefits offered under the plan are
31 at least equal to the actuarial value and benefits coverage of the
32 lowest standard health benefits plan established by the board
33 pursuant to subsection a. of this section. For the purposes of
34 meeting the requirements of this subparagraph, carriers shall be
35 required to file with the commissioner the health benefits plans
36 issued through an out-of-State trust no later than 180 days after
37 the date of enactment of P.L. , c. (pending before the
38 Legislature as this bill). A health benefits plan issued by a
39 carrier through an out-of-State trust that is not filed with the
40 commissioner pursuant to this subparagraph, shall not be
41 permitted to be continued or renewed after the 180 day period.
42 (7) Notwithstanding the provisions of P.L.1992, c.162
43 (C.17B:27A-17 et seq.) to the contrary, an association, multiple
44 employer arrangement or out-of-State trust may offer a health
45 benefits plan authorized to be renewed, continued or reinstated
46 pursuant to this subsection to small employer groups that are
47 otherwise eligible pursuant to paragraph (1) of subsection j. of
48 this section during the period for which such health benefits plan
49 is otherwise authorized to be renewed, continued or reinstated.
50 (8) Notwithstanding the provisions of P.L.1992, c.162
51 (C.17B:27A-17 et seq.) to the contrary, a carrier, association,
52 multiple employer arrangement or out-of-State trust may offer
53 coverage under a health benefits plan authorized to be renewed,
54 continued or reinstated pursuant to this subsection to new

1 employees of small employer groups [that were] covered by the
2 health benefits plan [on December 31, 1993, during the period for
3 which such health benefits plan is otherwise authorized to be
4 renewed, continued or reinstated] in accordance with the
5 provisions of paragraph (1) of this subsection.
6 (9) Notwithstanding the provisions of P.L.1992, c.162
7 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.)
8 to the contrary, any individual, who is eligible for small employer
9 coverage under a policy issued, renewed, continued or reinstated
10 pursuant to this subsection, but who would be subject to a
11 preexisting condition exclusion under the small employer health
12 benefits plan, or who is a member of a small employer group who
13 has been denied coverage under the small employer group health
14 benefits plan for health reasons, may elect to purchase or
15 continue coverage under an individual health benefits plan until
16 such time as the group health benefits plan covering the small
17 employer group of which the individual is a member complies
18 with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).
19 (10) In a case in which an association made available a health
20 benefits plan on or before March 1, 1994 and subsequently
21 changed the issuing carrier between March 1, 1994 and the
22 effective date of P.L. , c. (pending before the Legislature as
23 this bill), the new issuing carrier shall be deemed to have been
24 eligible to continue and renew the plan pursuant to paragraph (1)
25 of this subsection.
26 [1](11) In a case in which an association, multiple employer
27 arrangement or out-of-State trust made available a health
28 benefits plan on or before March 1, 1994 and subsequently
29 changes the issuing carrier for that plan after the effective date
30 of P.L. , c. (pending before the Legislature as this bill), the
31 new issuing carrier shall file the health benefits plan with the
32 commissioner for approval in order to be deemed eligible to
33 continue and renew that plan pursuant to paragraph (1) of this
34 subsection.
35 (12) In a case in which a small employer purchased a health
36 benefits plan directly from a carrier on or before March 1, 1994
37 and subsequently changes the issuing carrier for that plan after
38 the effective date of P.L. , c. (pending before the Legislature
39 as this bill), the new issuing carrier shall file the health benefits
40 plan with the commissioner for approval in order to be deemed
41 eligible to continue and renew that plan pursuant to paragraph (1)
42 of this subsection.
43 Notwithstanding the provisions of subparagraph (b) of
44 paragraph (6) of this subsection to the contrary, a small employer
45 who changes its health benefits plan's issuing carrier pursuant to
46 the provisions of this paragraph, shall not, upon changing carriers,
47 modify the benefit structure of that health benefits plan within
48 six months of the date the issuing carrier was changed.[1]
49 (cf: P.L.1994, c.11, s.2)
50 3. Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to
51 read as follows:
52 9. a. (1) Beginning on the [1][third] fourth[1] 12-month
53 anniversary date of any policy or contract issued in 1994, no
54 small employer health benefits plan shall be issued in this State

1 unless the plan is community rated.
2 (2) Beginning January 1, 1994 and upon the first 12-month
3 anniversary date thereafter of the policy or contract, the
4 premium rate charged by a carrier to the highest rated small
5 group purchasing a small employer health benefits plan issued
6 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall not be
7 greater than 300% of the premium rate charged to the lowest
8 rated small group purchasing that same health benefits plan;
9 provided, however, that the only factors upon which the rate
10 differential may be based are age, gender and geography, and
11 provided further, that such factors are applied in a manner
12 consistent with regulations adopted by the board.
13 (3) Beginning on the second 12-month anniversary after the
14 date established in paragraph (2) of this subsection of the policy
15 or contract, the premium rate charged by a carrier to the highest
16 rated small group purchasing a small employer health benefits
17 plan issued pursuant to subsection a. of section 3 of P.L.1992,
18 c.162 [(C.17B:27A-17 et seq.)] (C.17B:27A-19) shall not be
19 greater than 200% of the premium rate charged for the lowest
20 rated small group purchasing that same health benefits plan;
21 provided, however, that the only factors upon which the rate
22 differential may be based are age, gender and geography, and
23 provided further, that such factors are applied in a manner
24 consistent with regulations adopted by the board.
25 A health benefits plan issued pursuant to subsection j. of
26 section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in
27 accordance with the provisions of section 7 of P.L. , c.
28 (C.)(pending before the Legislature as this bill), for the purposes
29 of meeting the requirements of this paragraph.
30 (4) (Deleted by amendment, P.L.1994, c.11).
31 (5) Any policy or contract issued after January 1, 1994 to a
32 small employer who was not previously covered by a health
33 benefits plan issued by the issuing small employer carrier, shall
34 be subject to the same premium rate restrictions as provided in
35 paragraphs (1), (2) and (3) of this subsection, which rate
36 restrictions shall be effective on the date the policy or contract
37 is issued.
38 (6) The board shall establish, pursuant to section 17 of
39 P.L.1993, c.162 (C.17B:27A-51):
40 (a) up to six geographic territories, none of which is smaller
41 than a county; and
42 (b) age classifications which, at a minimum, shall be in
43 five-year increments.
44 b. (Deleted by amendment, P.L.1993, c.162).
45 c. Notwithstanding any other provision of law to the contrary,
46 no carrier offering any health benefits plan pursuant to the
47 provisions of this act shall act to circumvent the intent of this
48 act by acting as a third party administrator for groups of small
49 employers, any one of whom was insured as of September 1, 1992;
50 provided, however, that this provision shall not act to limit a
51 bona fide group of small employers who voluntarily act together
52 to provide health benefits to their employees.
53 d. Notwithstanding any other provision of law to the contrary,
54 this act shall apply to a carrier which issues a policy to an

1 association or trust of employers, if the group includes one or
2 more member employers or other member groups which have at
3 least two but no more than 49 employees or members exclusive of
4 spouses and dependents; except that, this act shall not apply to a
5 carrier which issued a policy exclusively to the members of an
6 association, on or before the effective date of P.L.1992, c.162
7 (C.17B:27A-17 et seq.), if the policy was written in the name of
8 the association, the carrier writes no other group health
9 insurance policy in this State and the aggregate number of
10 insured association members exceeds 49.
11 A carrier which is not exempt from the provisions of this act
12 pursuant to this subsection and which issues a policy to an
13 association or trust of employers after the effective date of
14 P.L.1992, c.162 (C.17B:27A-17 et seq.), shall be required to offer
15 small employer health benefits plans to non-association or trust
16 employers in the same manner as any other small employer
17 carrier is required pursuant to P.L.1992, c.162 (C.17B:27A-17 et
18 seq.).
19 e. Nothing contained herein shall prohibit the use of premium
20 rate structures to establish different premium rates for
21 individuals and family units.
22 f. No insurance contract or policy subject to this act may be
23 entered into unless and until the carrier has made an
24 informational filing with the commissioner of a schedule of
25 premiums, not to exceed 12 months in duration, to be paid
26 pursuant to such contract or policy, of the carrier's rating plan
27 and classification system in connection with such contract or
28 policy, and of the actuarial assumptions and methods used by the
29 carrier in establishing 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
34 or decrease upon making an informational filing with the
35 commissioner of such increase or decrease, along with the
36 actuarial assumptions and methods used by the carrier in
37 establishing such increase or decrease, provided that the
38 anticipated minimum loss ratio for a policy form shall not be less
39 than 75% of the premium therefor. Until December 31, 1996, the
40 informational filing shall also include the carrier's rating plan
41 and classification system in connection with such increase or
42 decrease.
43 (2) Each calendar year, a carrier shall return, in the form of
44 aggregate benefits for each of the five standard policy forms
45 offered by the carrier pursuant to <u>subsection a. of</u> section 3 of
46 P.L.1992, c.162 (C.17B:27A-19), at least 75% of the aggregate
47 premiums collected for the policy form during that calendar
48 year. Carriers shall annually report, no later than August 1st of
49 each year, the loss ratio calculated pursuant to this section for
50 each such policy form for the previous calendar year. In each
51 case where the loss ratio for a policy fails to substantially comply
52 with the 75% loss ratio requirement, the carrier shall issue a
53 dividend or credit against future premiums for all policyholders
54 with that policy form in an amount sufficient to assure that the

1 aggregate benefits paid in the previous calendar year plus the
2 amount of the dividends and credits shall equal 75% of the
3 aggregate premiums collected for the policy form in the previous
4 calendar year. [The dividend or credit shall be issued to each
5 policy which was in effect as of March 30th of the applicable
6 year and remains in effect as of the date the dividend or credit is
7 issued.] All dividends and credits must be distributed by
8 December 31 of the year following the calendar year in which the
9 loss ratio requirements were not satisfied. The annual report
10 required by this paragraph shall include a carrier's calculation of
11 the dividends and credits, as well as an explanation of the
12 carrier's plan to issue dividends or credits. The instructions and
13 format for calculating and reporting loss ratios and issuing
14 dividends or credits shall be specified by the commissioner by
15 regulation. Such regulations shall include provisions for the
16 distribution of a dividend or credit in the event of cancellation or
17 termination by a policyholder.
18 (3) The loss ratio of a health benefits plan issued pursuant to
19 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall
20 be calculated in accordance with the provisions of section 7 of
21 P.L. , c. (C.)(pending before the Legislature as this bill), for
22 the purposes of meeting the requirements of this subsection.
23 h. (Deleted by amendment, P.L.1993, c.162).
24 i. The provisions of this act shall apply to health benefits plans
25 which are delivered, issued for delivery, renewed or continued on
26 or after January 1, 1994.
27 j. [Except as provided in subsection j. of section 3 of P.L.1992,
28 c.162 (C.17B:27A-19), a policy or contract covering two or more
29 employees of a small employer issued by a carrier prior to
30 January 1, 1994 shall remain in effect until the first 12-month
31 anniversary date after February 28, 1994 of that policy or
32 contract, but at least 60 days before the first 12-month
33 anniversary date thereof the carrier shall be required to offer the
34 small employer a policy or contract pursuant to section 3 of
35 P.L.1992, c.162 (C.17B:27A-19).] (Deleted by amendment P.L.
36 c.)(pending before the Legislature as this bill)
37 (cf: P.L.1994, c.11, s.4)
38 4. (New section) The board shall, in combination with its
39 carrier members, conduct a study to determine the effect of the
40 transition to community rating on a representative number of the
41 existing small employer groups to whom policies are issued in the
42 State. The study shall include, but not be limited to, an
43 assessment of the estimated percentage increase or decrease in
44 premiums which is attributable to community rating on groups of
45 varying demographic characteristics. The study shall be
46 submitted to the Governor and the Legislature no later than
47 [1][March 1, 1996] June 30, 1997[1], at which time the Legislature
48 shall determine whether community rating shall go into effect on
49 January 1, [1][1997] 1998[1], or whether the impact of community
50 rating on small employer health benefits plans is sufficiently
51 adverse to warrant the elimination of that provision as enacted in
52 paragraph (1) of subsection a. of section 9 of P.L.1992, c.162
53 (C.17B:27A-25).
54 5. (New section) The board shall, in conjunction with the

1 Individual Health Insurance Program Board and the department,
2 conduct a study to determine the impact on the individual and
3 small employer insurance markets of permitting individuals to
4 purchase a small employer health benefits plan. The study shall
5 include, but not be limited to, a consideration of the benefit
6 structure of the standard plans in the individual insurance
7 market, the effect of the rating differentials between the
8 individual and small employer markets on purchasers of health
9 benefits plans and the impact on rates of the assessments on
10 carriers for losses in the individual market. The study shall
11 include such other issues as the Legislature and Governor may
12 determine after the effective date of this act. The board shall
13 report its findings to the Governor and the Legislature six months
14 from the effective date of this act.
15 6. (New section) If a small employer is no longer eligible for
16 coverage under a health benefits plan pursuant to P.L.1992, c.162
17 (C.17B:27A-17 et seq.), the carrier shall so notify the small
18 employer at least 60 days prior to the termination of the policy
19 or contract. This 60-day notification requirement shall not apply
20 in cases of nonpayment of required premiums by the policy or
21 contract holder or employer, or fraud or misrepresentation of the
22 policy or contract holder or employer or, with respect to
23 coverage of eligible employees or dependents, fraud or
24 misrepresentation of the enrollees or their representatives.
25 7. (New section) The commissioner, in consultation with the
26 board, shall establish regulations governing the applicable rating
27 methodology and manner in which loss ratios shall be calculated
28 for health benefits plans permitted to be renewed or continued
29 pursuant to the provisions of subsection j. of section 3 of
30 P.L.1992, c.162 (C.17B:27A-19). In establishing these
31 regulations, the commissioner may consider, but shall not be
32 limited to, the impact of allowing these health benefits plans to
33 continue to be rated separately from the standard health benefits
34 plans established pursuant to subsection a. of section 3 of
35 P.L.1992, c.162 (C.17B:27A-19) and on their own claims
36 experience. If the commissioner determines that the
37 continuation of separate rating pools adversely affects the small
38 employer insurance market and serves to counter the public
39 policy goals which lead to the enactment of P.L.1992, c.162
40 (C.17B:27A-17 et seq.), the commissioner shall develop a
41 [1][rating][1] methodology which creates a linkage between the
42 standard health benefits plans established pursuant to subsection
43 a. of section 3 of P.L.1992, c.162 (C.17B:27A-19) and the plans
44 permitted to be continued or renewed pursuant to the provisions
45 of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19)
46 [1]<u>for the purpose of rating and loss ratio calculation</u>[1].
47 Regulations established under the provisions of this section
48 shall detail all additional obligations of carriers continuing or
49 renewing health benefits plans pursuant to the provisions of
50 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19)
51 which are necessary to meet the general requirements of
52 P.L.1992, c.162 (C.17B:27A-17 et seq.).
53 The regulations shall be adopted pursuant to the
54 "Administrative Procedure Act," P.L.1968, c.410

1 (C.52:14B-1 et seq.)no later than 180 days following the effective
2 date of this act. Until such time as the regulations are adopted,
3 the health benefits plans shall continue to be rated and subject to
4 the loss ratio calculations in accordance with applicable law in
5 effect on the effective date of P.L. , c. (pending before the
6 Legislature as this bill).
7 8. This act shall take effect immediately.
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11
12 Makes various changes to small employer health benefits program
13 law.

no later than 180 days following the effective date of this act. Until such time as the regulations are adopted, the health benefits plans shall continue to be rated and subject to the loss ratio calculations in accordance with applicable law in effect on the effective date of P.L. , c. (pending before the Legislature as this bill).

8. This act shall take effect immediately.

STATEMENT

This bill makes various changes to the small employer health insurance law, P.L.1992, c.162 (C.17B:27A-17 et seq.).

The bill permanently "grandfathers" small employer health benefits plans that were in existence prior to January 1, 1994 and permits these nonstandard plans to be continued or renewed subject to the following conditions. (The law currently provides that these nonstandard plans must convert to one of the five standard plans by 1997.)

The plans must comply with regulations adopted by the commissioner in consultation with the board governing the rating methodology and manner in which loss ratios shall be calculated; however, the bill permits carriers with a closed book of business (a health benefits plan that has not been issued to a new small employer group since January 1, 1994) to continue to rate that plan based on the loss experience of that plan. Also, a health benefits plan issued through an out-of-State trust may be continued or renewed only upon the approval of the commissioner and if the benefits are at least equal to the actuarial value and benefits of the lowest rated standard health benefits plan adopted by the board, known as Plan A. The out-of-State trust must file the plan with the commissioner within 180 days of the effective date of the bill in order to be able to continue or renew the plan.

Also, the bill requires associations, multiple employer arrangements and out-of-State trusts that offer health benefits coverage through a nonstandard plan to also make available to its small employer members at least one of the standard plans. In addition, the bill provides that the benefit structure of a nonstandard plan may be amended but the amendments cannot reduce the actuarial value of the health benefits plan below that of the lowest rated standard health benefits plan adopted by the board.

The bill provides that in the case of an association that made available a health benefits plan on or before March 1, 1994 and subsequently changed the issuing carrier between March 1, 1994 and the effective date of the bill, the new issuing carrier would be deemed to have been eligible to continue and renew the plan pursuant to paragraph (1) of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19).

The bill authorizes the board to establish additional policy forms by which a health maintenance organization may provide indemnity benefits. This would permit health maintenance organizations to offer point of service options in conjuction with their standard health benefits plans.

1 In order to provide the Legislature with information on which
2 to evaluate whether the small employer health benefits plans
3 shall be required to use community rating beginning in 1997, the
4 bill requires the Small Employer Health Benefits Program Board
5 to study the effect of the transition to community rating on a
6 representative number of small employer health benefits plans in
7 the State and to report to the Governor and the Legislature on its
8 findings by March 1, 1996.
9 Also the bill requires the board, in conjunction with the
10 Individual Health Insurance Program Board and the Department
11 of Insurance, to conduct a study to determine the impact on the
12 individual and small employer insurance markets of permitting
13 individuals to purchase a small employer health benefits plan.
14 The study shall include, but not be limited to, a consideration of
15 the benefit structure of the standard plans in the individual
16 insurance market, the effect of the rating differentials between
17 the individual and small employer markets on purchasers of
18 health benefits plans and the impact on rates of the assessments
19 on carriers for losses in the individual market. The board shall
20 report its findings to the Governor and the Legislature six months
21 from the date of enactment of this bill.
22 To provide small employers with adequate notice if they are no
23 longer eligible for a small employer health benefits plan, the bill
24 requires that carriers provide the small employer with 60-days
25 notice of such ineligibility. The notice requirement will not apply
26 in cases of nonpayment of premium or fraud or misrepresentation.
27 Finally, the bill amends the definition section of P.L.1992,
28 c.162 to provide that prescription only plans are excluded from
29 the definition of health benefits plan and to clarify that State,
30 county and municipal agencies, boards and departments shall not
31 be considered small employers. The bill also provides that in the
32 case of a health benefits plan issued in combination with a
33 hospital service corporation contract, the deductibles and
34 coinsurance limits for the contract combined may be allocated
35 between the separate contracts at the discretion of the carrier
36 and the hospital service corporation.
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41 Makes various changes to small employer health benefits program
42 law.

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

[FIRST REPRINT]

SENATE, No. 2380

STATE OF NEW JERSEY

DATED: DECEMBER 14, 1995

The Assembly Insurance Committee reports favorably Senate, No. 2380 (1R).

This bill makes various changes to the small employer health insurance law, P.L.1992, c.162 (C.17B:27A-17 et seq.).

The bill permanently "grandfathers" small employer health benefits plans that were in existence prior to January 1, 1994 and permits these nonstandard plans to be continued or renewed subject to the following conditions. (The law currently provides that these nonstandard plans must convert to one of the five standard plans by 1997.)

The plans must comply with regulations adopted by the Commissioner of Insurance in consultation with the Small Employer Health Benefits Program Board governing the rating methodology and manner in which loss ratios shall be calculated, and until such time as the regulations are adopted, the plans will be rated and subject to the loss ratio calculation in accordance with applicable law in effect on the effective date of this bill. The bill permits carriers with a closed book of business (a health benefits plan that has not been issued to a new small employer group since January 1, 1994), however, to continue to rate that plan based on the loss experience of that plan so that these plans will not be subject to the rating methodology for nonstandard plans that will be developed by the commissioner.

A health benefits plan issued through an out-of-State trust may be continued or renewed only upon the approval of the commissioner and if the benefits are at least equal to the actuarial value and benefits of the lowest rated standard health benefits plan adopted by the board, known as Plan A. The out-of-State trust must file the plan with the commissioner within 180 days of the effective date of the bill in order to be able to continue or renew the plan.

The bill requires associations, multiple employer arrangements and out-of-State trusts that offer health benefits coverage through a nonstandard plan to also make available to its small employer members at least one of the standard plans. In addition, the bill provides that the benefit structure of a nonstandard plan may be amended but the amendments cannot reduce the actuarial value of the health benefits plan below that of the lowest rated standard health benefits plan adopted by the board.

The bill provides that in the case of an association that made available a health benefits plan on or before March 1, 1994 and subsequently changed the issuing carrier between March 1, 1994 and the effective date of the bill, the new issuing carrier would be deemed to have been eligible to continue and renew the plan pursuant to paragraph (1) of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19).

The bill also permits an association, multiple employer arrangement, out-of-State trust or small employer who purchased a health benefits plan directly from a carrier, that made available a nonstandard health benefits plan on or before March 1, 1994, to prospectively change the issuing carrier for that plan after the effective date of the bill if the new issuing carrier files the health benefits plan with the commissioner for approval. In the case of a small employer who purchased the plan directly, however, the benefits of the plan cannot be changed for at least six months from the date the carrier was changed.

The bill permits carriers, associations, multiple employer arrangements and out-of-State trusts to withdraw a nonstandard health benefits plan with the approval of the commissioner if retention of the plan would cause an unreasonable financial burden to the issuing carrier.

The bill postpones the transition to community rating for one year from 1997 to 1998. In order to provide the Legislature with information on which to evaluate whether the small employer health benefits plans shall be required to use community rating beginning in 1998, the bill requires the Small Employer Health Benefits Program Board to study the effect of the transition to community rating on a representative number of small employer health benefits plans in the State and to report to the Governor and the Legislature on its findings by June 30, 1997.

Also, the bill requires the Small Employer Health Benefits Program Board, in conjunction with the Individual Health Coverage Program Board and the Department of Insurance, to conduct a study to determine the impact on the individual and small employer insurance markets of permitting individuals to purchase a small employer health benefits plan. The study shall include, but not be limited to, a consideration of the benefit structure of the standard plans in the individual insurance market, the effect of the rating differentials between the individual and small employer markets on purchasers of health benefits plans and the impact on rates of the assessments on carriers for losses in the individual market. The board shall report its findings to the Governor and the Legislature six months from the date of enactment of this bill.

To provide small employers with adequate notice if they are no longer eligible for a small employer health benefits plan, the bill requires that carriers provide the small employer with 60-days notice of such ineligibility. The notice requirement will not apply in cases of nonpayment of premium or fraud or misrepresentation.

The bill authorizes the board to establish additional policy forms by which a small employer carrier may provide indemnity benefits to an enrollee of a health maintenance organization by direct contract with the enrollees' small employer through a dual arrangement with the health maintenance organization. This would enable health maintenance organizations to offer dual contract point of service options in conjuction with their standard health benefits plans. This option is in addition to other options currently provided under law for health maintenance organization plans.

Finally, the bill amends the definition section of P.L.1992, c.162: to provide that prescription only plans are excluded from the definition of health benefits plan; to clarify that State, county and municipal agencies, boards and departments shall not be considered small employers; and to add a definition of "stop loss" or "excess risk insurance" that is similar to the one provided in Assembly Bill No. 2662(2R) (which is currently pending approval of the Governor's conditional veto), except that the specific attachment point or retention shall not be less than $20,000, in accordance with the recent recommendations of the National Association of Insurance Commissioners. The bill also provides that in the case of a health benefits plan issued in combination with a hospital service corporation contract, the deductibles and coinsurance limits for the contract combined may be allocated between the separate contracts at the discretion of the carrier and the hospital service corporation.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 2380

with committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 7, 1995

The Senate Health Committee favorably reports Senate Bill No. 2380 with committee amendments.

As amended by committee, this bill makes various changes to the small employer health insurance law, P.L.1992, c.162 (C.17B:27A-17 et seq.).

The bill permanently "grandfathers" small employer health benefits plans that were in existence prior to January 1, 1994 and permits these nonstandard plans to be continued or renewed subject to the following conditions. (The law currently provides that these nonstandard plans must convert to one of the five standard plans by 1997.)

The plans must comply with regulations adopted by the Commissioner of Insurance in consultation with the Small Employer Health Benefits Program Board governing the rating methodology and manner in which loss ratios shall be calculated, and until such time as the regulations are adopted, the plans will be rated and subject to the loss ratio calculation in accordance with applicable law in effect on the effective date of this bill. The bill permits carriers with a closed book of business (a health benefits plan that has not been issued to a new small employer group since January 1, 1994), however, to continue to rate that plan based on the loss experience of that plan so that these plans will not be subject to the rating methodology for nonstandard plans that will be developed by the commissioner.

A health benefits plan issued through an out-of-State trust may be continued or renewed only upon the approval of the commissioner and if the benefits are at least equal to the actuarial value and benefits of the lowest rated standard health benefits plan adopted by the board, known as Plan A. The out-of-State trust must file the plan with the commissioner within 180 days of the effective date of the bill in order to be able to continue or renew the plan.

The bill requires associations, multiple employer arrangements and out-of-State trusts that offer health benefits coverage through a nonstandard plan to also make available to its small employer members at least one of the standard plans. In addition, the bill provides that the benefit structure of a nonstandard plan may be amended but the amendments cannot reduce the actuarial value of the health benefits plan below that of the lowest rated standard health benefits plan adopted by the board.

The bill provides that in the case of an association that made available a health benefits plan on or before March 1, 1994 and subsequently changed the issuing carrier between March 1, 1994 and the effective date of the bill, the new issuing carrier would be

deemed to have been eligible to continue and renew the plan pursuant to paragraph (1) of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19).

The bill also permits an association, multiple employer arrangement, out-of-State trust or small employer who purchased a health benefits plan directly from a carrier, that made available a nonstandard health benefits plan on or before March 1, 1994, to prospectively change the issuing carrier for that plan after the effective date of the bill if the new issuing carrier files the health benefits plan with the commissioner for approval. In the case of a small employer who purchased the plan directly, however, the benefits of the plan cannot be changed for at least six months from the date the carrier was changed.

The bill permits carriers, associations, multiple employer arrangements and out-of-State trusts to withdraw a nonstandard health benefits plan with the approval of the commissioner if retention of the plan would cause an unreasonable financial burden to the issuing carrier.

The bill postpones the transition to community rating one year (from 1997 to 1998). In order to provide the Legislature with information on which to evaluate whether the small employer health benefits plans shall be required to use community rating beginning in 1998, the bill requires the Small Employer Health Benefits Program Board to study the effect of the transition to community rating on a representative number of small employer health benefits plans in the State and to report to the Governor and the Legislature on its findings by June 30, 1997.

Also, the bill requires the Small Employer Health Benefits Program Board, in conjunction with the Individual Health Insurance Program Board and the Department of Insurance, to conduct a study to determine the impact on the individual and small employer insurance markets of permitting individuals to purchase a small employer health benefits plan. The study shall include, but not be limited to, a consideration of the benefit structure of the standard plans in the individual insurance market, the effect of the rating differentials between the individual and small employer markets on purchasers of health benefits plans and the impact on rates of the assessments on carriers for losses in the individual market. The board shall report its findings to the Governor and the Legislature six months from the date of enactment of this bill.

To provide small employers with adequate notice if they are no longer eligible for a small employer health benefits plan, the bill requires that carriers provide the small employer with 60-days notice of such ineligibility. The notice requirement will not apply in cases of nonpayment of premium or fraud or misrepresentation.

The bill authorizes the board to establish additional policy forms by which a small employer carrier may provide indemnity benefits to an enrollee of a health maintenance organization by direct contract with the enrollees' small employer through a dual arrangement with the health maintenance organization. This would enable health maintenance organizations to offer dual contract point of service options in conjuction with their standard health benefits plans.

Finally, the bill amends the definition section of P.L.1992, c.162: to provide that prescription only plans are excluded from the definition of health benefits plan; to clarify that State, county and municipal agencies, boards and departments shall not be considered small employers; and to add a definition of "stop loss" or "excess risk insurance" that is similar to the one provided in Assembly Bill No. 2662(2R) (which is currently pending approval of the Governor's conditional veto), except that the specific attachment point or retention shall not be less than $20,000, in accordance with the recent recommendations of the National Association of Insurance Commissioners. The bill also provides that in the case of a health benefits plan issued in combination with a hospital service corporation contract, the deductibles and coinsurance limits for the contract combined may be allocated between the separate contracts at the discretion of the carrier and the hospital service corporation.

The committee's amendments add the definition of "stop loss;" clarify the authorization for dual contract (health maintenance organization/small employer indemnity carrier) point of service options; provide for the prospective changing of carriers for nonstandard plans; permit the withdrawal of nonstandard health benefits plans under certain circumstances; provide that the benefits structure of nonstandard plans may be amended if the amendment does not reduce the benefits coverage, as well as the actuarial value, of the plan below that of the lowest standard health benefits plan; and clarify that the methodology the commissioner shall develop which creates a linkage between the standard health benefits plans and the nonstandard plans, is for the purpose of rating and loss ratio calculation.

The committee amendments also postpone the transition to community rating one year and extend the time, from three months to 18 months, in which the board shall conduct its study of the transition to community rating and report to the Governor and Legislature. Finally, the amendments restore paragraph (2) of subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19), concerning the requirement that a carrier or out-of-State trust which writes the five standard health benefits plans, is required to offer those plans to any small employer, association or multiple employer arrangement. This paragraph was inadvertently deleted in the bill.