17B:27A-3

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(Health coverage, individual)

NJSA: 17B:27A-3

LAWS OF: 1993 **CHAPTER:** 164

BILL NO: A2495

SPONSOR(S) Corodemus and Zecker

DATE INTRODUCED: May 6, 1993

COMMITTEE: **ASSEMBLY:** Insurance

SENATE: ---

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First reprint enacted

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COMMITTEE STATEMENT: **ASSEMBLY:** Yes

SENATE: No

FISCAL NOTE: No

VETO MESSAGE: No

MESSAGE ON SIGNING: No

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

974.90 New Jersey. Governor's Commission on Health Care Costs.
I59 Cost accessibility, responsibility...October 1, 1990.
1990 Trenton, 1990.
[see especially pp.36-37, 39]

(over)

974.90 New Jersey. Legislative. Assembly. Health Care Policy Study
I59 Commission.
1990a Public hearing held 4-16-90, 5-24-90, 7-18-90,
Woodbridge, Edison, Kenilworth, NJ, 1990.

974.90 New Jersey. Legislature. Assembly. Health Care Polcy Study
I59 Commission.
1990b Interim report...November 28, 1990. Trenton, 1990.
[see espeically p.12]

974.90 New Jersey. Legislature. Senate. Health and Welfare Committee.
I59 Public hearing on Governor's Commission on Health Care Costs,
1990c Health Care Costs, held 11-14-90. Trenton, 1990.

KBG:pp

[FIRST REPRINT]

ASSEMBLY, No. 2495

STATE OF NEW JERSEY

INTRODUCED MAY 6, 1993

By Assemblymen CORODEMUS and ZECKER

AN ACT concerning [1][the New Jersey Individual Health Coverage Program and amending P.L.1992, c.161] individual health benefits coverage, amending and supplementing P.L.1992, c.161 and repealing section 16 of P.L.1992, c.161[1].

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

[1]1. 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, 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

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 asterisks or stars has been adopted as follows:

Assembly floor amendments adopted May 20, 1993.

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.

"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.[1]

(cf: P.L.1992, c.161, s.1)

[1][1.] 2.[1] Section 2 of P.L.1992, c.161 (C.17B:27A-3) is amended to read as follows:

2. a. An individual health benefits plan issued on or after the effective date of this act shall be subject to the provisions of this act.

b. (1) An individual health benefits plan issued on an open enrollment, modified community rated basis or community rated basis prior to the effective date of this act shall not be subject to sections 3 through 8, inclusive, of this act, unless otherwise specified therein.

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

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

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

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

e. Every individual health benefits plan issued prior to the effective date of this act shall be rated as follows:

(1) No later than 180 days after the effective date of this act,

the premium rate charged by a carrier to the highest rated individual who purchased an individual health benefits plan prior to the effective date of this act shall not be greater than 150% of the premium rate charged to the lowest rated individual purchasing that same or a similar health benefits plan.

(2) During the period July 1, 1994 to June 30, 1995, the premium rate charged by a carrier to the highest rated individual who purchased an individual health benefits plan prior to the effective date of this act shall not be greater than 125% of the premium rate charged to the lowest rated individual purchasing that same or a similar health benefits plan.

(3) On and after July 1, 1995, every individual health benefits plan which was issued before the effective date of this act shall be community rated upon the date of its renewal.

(4) A carrier that issues an individual health benefits plan with modified community rating subject to the provisions of this subsection shall make an informational filing with the board whenever it adjusts or modifies its rates.

(cf: P.L.1992, c.161, s.2)

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

3. a. No later than 180 days after the effective date of this act, a carrier shall, as a condition of issuing health benefits plans in this State, offer individual health benefits plans. The plans shall be offered on an open enrollment, community rated basis, pursuant to the provisions of this act; except that a carrier shall be deemed to have satisfied its obligation to provide the individual health benefits plans by paying an assessment or receiving an exemption pursuant to section 11 of this act.

b. A carrier shall offer to an eligible person a choice of five individual health benefits plans, any of which may contain provisions for managed care. One plan shall be a basic health benefits plan, one plan shall be a managed care plan and three plans shall include enhanced benefits of proportionally increasing actuarial value. A carrier may elect to convert any individual health benefits plans in force on the effective date of this act to any of the five benefit plans, except that the replacement plan shall be of no less actuarial value than the policy or contract being replaced.

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

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

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

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

(3) A contract or policy for a basic health benefits plan provided for in this section may contain or provide for coinsurance or deductibles, or both, except that no deductible shall be payable in excess of a total of $250 by an individual or $500 by a family unit during any benefit year; and no coinsurance shall be payable in excess of a total of $500 by an individual or by a family unit during any benefit year[; and neither coinsurance nor deductibles shall apply to maternity benefits or preventative care examinations].

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

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

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

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

e. If all five of the individual health benefits plans are not established by the board by the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), a carrier may phase-in the offering of the five health benefits plans by offering each health benefits plan as it is established by the board; however, once the board establishes all five plans, the carrier shall be required to offer the five plans in accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

(cf: P.L.1992, c.161, s.3)

[1][2.] 4.[1] 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. 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 shall contain a limitation of no more than 12 months on coverage for pre-existing conditions, except that the limitation shall not apply to an individual who has, under a prior group or individual health benefits plan, with no intervening lapse in coverage, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation [under a prior group or individual health benefits plan with no intervening lapse in coverage].

c. In addition to the five standard individual health benefits plans provided for in section 3 of this act, 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.

d. After the board's establishment of the individual health benefits plans required pursuant to section 3 of this act, 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.1992, c.161, s.6)

[1]5. Section 9 of P.L.1992, c.161 (C.17B:27A-10) is amended to read as follows:

9. a. There is created the New Jersey Individual Health Coverage Program. All carriers subject to the provisions of this act shall be members of the program.

b. Within 30 days of the effective date of this act, the commissioner shall give notice to all members of the time and place for the initial organizational meeting, which shall take place within 60 days of the effective date. The board shall consist of nine representatives. The commissioner or his designee shall serve as an ex officio member on the board. Four members of the board shall be appointed by the Governor, with the advice and consent of the Senate: one of whom shall be a representative of an employer, appointed upon the recommendation of a business trade association, who is a person with experience in the management or administration of an employee health benefit plan; one of whom shall be a representative of organized labor, appointed upon the recommendation of the A.F.L.-C.I.O., who is a person with experience in the management or administration of an employee health benefit plan; and two of whom shall be consumers of a health benefits plan who are reflective of the population in the State. Four board members who represent carriers shall be elected by the members, subject to the approval

of the commissioner, as follows: to the extent there is one licensed in this State that is willing to have a representative serve on the board, a representative from each of the following entities shall be elected:

(1) a health service corporation;

(2) a health maintenance organization;

(3) a mutual health insurer of this State subject to Subtitle 3 of Title 17B of the New Jersey Statutes; and

(4) a foreign health insurance company authorized to do business in this State.

In approving the selection of the carrier representatives of the board, the commissioner shall assure that all members of the program are fairly represented.

Initially, two of the Governor's appointees and two of the carrier representatives shall serve for a term of three years; one of the Governor's appointees and one of the carrier representatives shall serve for a term of two years; and one of the Governor's appointees and one of the carrier representatives shall serve for a term of one year. Thereafter, all board members shall serve for a term of three years. Vacancies shall be filled in the same manner as the original appointments.

c. If the initial carrier representatives to the board are not elected at the organizational meeting, the commissioner shall appoint those members to the initial board within 15 days of the organizational meeting.

d. Within 90 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter, any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The commissioner may disapprove the plan of operation, if the commissioner determines that it is not suitable to assure the fair, reasonable, and equitable administration of the program, and that it does not provide for the sharing of program losses on an equitable and proportionate basis in accordance with the provisions of section 11 of this act. The plan of operation or amendments thereto shall become effective unless disapproved in writing by the commissioner within 45 days of receipt by the commissioner.

e. If the board fails to submit a suitable plan of operation within 90 days after its appointment, the commissioner shall [, after notice and hearing,] adopt [and promulgate] a temporary plan of operation pursuant to section 7 of P.L. , c. (C.) (pending before the Legislature as this bill). The commissioner shall amend or rescind a temporary plan adopted under this subsection, at the time a plan of operation is submitted by the board.

f. The plan of operation shall establish procedures for:

(1) the handling and accounting of assets and monies of the program, and an annual fiscal reporting to the commissioner;

(2) collecting assessments from members to provide for sharing program losses in accordance with the provisions of section 11 of this act and administrative expenses incurred or estimated to be incurred during the period for which the assessment is made:

(3) approving the coverage, benefit levels, and contract forms for individual health benefits plans in accordance with the provisions of section 3 of this act;

(4) the imposition of an interest penalty for late payment of an assessment pursuant to section 11 of this act; and

(5) any additional matters at the discretion of the board.

g. The board shall appoint an insurance producer licensed to sell health insurance pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.) to advise the board on issues related to sales of individual health benefits plans issued pursuant to this act.[1]

(cf: P.L.1992, c.161, s.9)

[1]6. Section 10 of P.L.1992, c.161 (C.17B:27A-11) is amended to read as follows:

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

The board shall have the specific authority to:

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

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

c. review rate applications and form filings submitted by carriers in accordance with this act;

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

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

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

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

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

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

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

k. appoint from among its members appropriate legal, actuarial, and other committees as necessary to provide technical

and other assistance in the operation of the program, in policy and other contract design, and any other function within the authority of the program; [and]

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

m. contract for an independent actuary and any other professional services the board deems necessary to carry out its duties under P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

(cf: P.L.1992, c.161, s.10)

[1]7. (New section) Upon the effective date of this act and through December 31, 1993, all actions adopted by the board shall be subject to the provisions of this section, notwithstanding the provisions of P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary.

a. For the purposes of this section, "action" includes, but is not limited to:

(1) the establishment and modification of health benefits plans;

(2) procedures and standards for the: (a) assessment of members and the apportionment thereof; (b) filing of policy forms; (c) making of rate filings; (d) evaluation of material submitted by carriers with respect to loss ratios; and (e) establishment of refunds to policy or contract holders; and

(3) the promulgation or modification of policy forms.

"Action" shall not include the hearing and resolution of contested cases, personnel matters and applications for withdrawal or exemptions.

b. Prior to the adoption of an action of the board, the board shall publish notice of its intended action in three newspapers of general circulation in this State, and may publish the notice of intended action in any trade or professional publication which it deems necessary. The notice of intended action shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views. The board shall provide the notice of intended action and a detailed description of the intended action by mail, or otherwise, to affected trade and professional associations, carriers subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) and such other interested persons or organizations which may request notification. The board shall forward the notice of intended action and the detailed description of the intended action concurrently to the Office of Administrative Law for publication in the New Jersey Register.

The board shall not charge any fee for placement upon the mailing list of associations, carriers or other persons to be notified, but the board may charge a fee to an association, carrier or other person requesting a copy of the text of the intended action, which fee shall not be in excess of the actual cost of reproducing and mailing the copy.

A copy of the text of the intended action shall be available in the Department of Insurance in accordance with the provisions of P.L.1963, c.73 (C.47:1A-1 et seq.).

c. The board shall hold a public hearing on the establishment and modification of health benefits plans, and the board may hold

a public hearing on any other intended action. Notice of a hearing shall be given in the notice of intended action provided for in subsection b. of this section.

d. Whether or not a public hearing is held, the board shall afford all interested persons an opportunity to comment in writing on the intended action. Written comments shall be submitted to the board within the time established by the board in the notice of intended action, which time shall not be less than 15 calendar days from the date of notice.

The board shall give due consideration to all comments received. Within a reasonable period of time following submission of the comments pursuant to this subsection, the board shall prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the board's response to the data, views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

e. The board may adopt the intended action immediately following the expiration of the public comment period provided in subsection d. of this section, or the hearing provided for in subsection c. of this section, whichever date is later. The final action adopted by the board shall be submitted for publication in the New Jersey Register to the Office of Administrative Law, and shall be effective on the date of the submission or such later date as the board may establish.

f. Actions filed with the Office of Administrative Law pursuant to this section shall be filed subject to the provisions of subsections (a), (c), (d) and (e) of section 5 of P.L.1968, c.410 (C.52:14B-5).

g. Nothing in this section shall be construed to prohibit the board from adopting any action pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

h. Nothing in this section shall be construed to prohibit the commissioner from adopting any rule or regulation pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), or from taking any other action required or authorized by P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

[1]8. (New section) a. Effective January 1, 1994, all actions adopted by the board shall be subject to the provisions of this section, notwithstanding the provisions of P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary.

a. For the purposes of this section, "action" includes, but is not limited to:

(1) the establishment and modification of health benefits plans;

(2) procedures and standards for the: (a) assessment of members and the apportionment thereof; (b) filing of policy forms; (c) making of rate filings; (d) evaluation of material submitted by carriers with respect to loss ratios; and (e) establishment of refunds to policy or contract holders; and

(3) the promulgation or modification of policy forms.

"Action" shall not include the hearing and resolution of

contested cases, personnel matters and applications for withdrawal or exemptions.

b. Prior to the adoption of an action of the board, the board shall publish notice of its intended action in three newspapers of general circulation in this State, and may publish the notice of intended action in any trade or professional publication which it deems necessary. The notice of intended action shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views. The board shall provide the notice of intended action and a detailed description of the intended action by mail, or otherwise, to affected trade and professional associations, carriers subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) and such other interested persons or organizations which may request notification. The board shall forward the notice of intended action and the detailed description of the intended action concurrently to the Office of Administrative Law for publication in the New Jersey Register.

The board shall not charge any fee for placement upon the mailing list of associations, carriers or other persons to be notified, but the board may charge a fee to an association, carrier or other person requesting a copy of the text of the intended action, which fee shall not be in excess of the actual cost of reproducing and mailing the copy.

A copy of the text of the intended action shall be available in the Department of Insurance in accordance with the provisions of P.L.1963, c.73 (C.47:1A-1 et seq.).

c. The board shall hold a public hearing on the establishment and modification of health benefits plans, and the board may hold a public hearing on any other intended action. Notice of a hearing shall be given in the notice of intended action provided for in subsection b. of this section.

d. Whether or not a public hearing is held, the board shall afford all interested persons an opportunity to comment in writing on the intended action. Written comments shall be submitted to the board within the time established by the board in the notice of intended action, which time shall not be less than 20 calendar days from the date of notice.

The board shall give due consideration to all comments received. Within a reasonable period of time following submission of the comments pursuant to this subsection, the board shall prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the board's response to the data, views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

e. The board may adopt the intended action immediately following the expiration of the public comment period provided in subsection d. of this section, or the hearing provided for in subsection c. of this section, whichever date is later. The final action adopted by the board shall be submitted for publication in the New Jersey Register to the Office of Administrative Law,

and shall be effective on the date of the submission or such later date as the board may establish.

f. Actions filed with the Office of Administrative Law pursuant to this section shall be filed subject to the provisions of subsections (a), (c), (d) and (e) of section 5 of P.L.1968, c.410 (C.52:14B-5).

g. Nothing in this section shall be construed to prohibit the board from adopting any action pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

h. Nothing in this section shall be construed to prohibit the commissioner from adopting any rule or regulation pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), or from taking any other action required or authorized by P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

[1]9. (New section) a. The commissioner shall, under the procedures provided pursuant to section 7 of P.L. , c. (C.) (pending before the Legislature as this bill), adopt a temporary plan of operation prepared pursuant to section 9 of P.L.1992, c.161 (C.17B:27A-10), pending submission or approval of a plan of operation prepared by the board pursuant to that section 9.

b. Subsequent amendments to the plan of operation shall be reviewed and approved by the commissioner pursuant to the procedures provided in sections 7 and 8 of P.L. , c. (C.) (pending before the Legislature as this bill), as applicable.

[1]10. (New section) A carrier shall not require an eligible person to purchase any other insurance coverage, including, but not limited to, life insurance, accident insurance or disability insurance, as a condition of or in conjunction with the purchase of a health benefits plan pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

[1]11. (New section) The board, in conjunction with the board of the New Jersey Small Employer Health Benefits Program established pursuant to section 12 of P.L.1992, c.162 (C.17B:27A-28), shall adopt one standard claim form.

In order to provide a standard system of payment for medical services, all claim forms for a claimant's use under an individual health benefits plan issued or delivered in this State shall conform to the form adopted by the board.[1]

[1]12. Section 16 of P.L.1992, c.161 is repealed.[1]

[1][3.] 13.[1] This act shall take effect immediately.

Concerns health benefits coverage for certain individuals currently covered under individual health benefits plans.

up to five rider packages. Premium rates for the rider packages shall be determined in accordance with section 8 of this act.

d. After the board's establishment of the individual health benefits plans required pursuant to section 3 of this act, 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.

3. This act shall take effect immediately.

STATEMENT

This bill permits an individual who is eligible for coverage under a group health benefits plan, but is currently covered by an individual health benefits plan, to retain his current coverage until the first anniversary date of the group plan occuring on or after January 1, 1994, which is the date that guaranteed issue and modified community rating are required under small group health benefits plans pursuant to P.L.1992, c.162, (C.17B:27A-17 et seq.). Under the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), an individual covered under an individual health benefits plan who is eligible to be covered under a group plan would not be permitted to continue this coverage after November 30, 1992. Currently, some individuals with a preexisting medical condition may not be included in a group's health benefits plan because their inclusion in the group plan would skew the rates of the group. These individuals may, instead, be provided coverage under individual plans. This bill would ensure that such individuals would be able to retain their individual health benefits coverage until they would be guaranteed coverage under a small employer policy.

Additionally, this bill clarifies that a preexisting condition exclusion limitation under an individual health benefits plan would not apply to an individual who has, under a prior group or individual health benefits plan, with no intervening lapse in coverage, been treated or diagnosed by a physician for a condition or satisfied a 12 month preexisting condition limitation under a prior group or individual health benefits plan.

Concerns health benefits coverage for certain individuals currently covered under individual health benefits plans.

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2495

STATE OF NEW JERSEY

DATED: MAY 6, 1993

The Assembly Insurance Committee reports favorably Assembly Bill No. 2495.

This bill permits an individual who is eligible for coverage under a group health benefits plan, but is currently covered by an individual health benefits plan, to retain his current coverage until the first anniversary date of the group plan occuring on or after January 1, 1994, which is the date that guaranteed issue and modified community rating are required under small group health benefits plans pursuant to P.L.1992, c.162, (C.17B:27A-17 et seq.). Under the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), an individual covered under an individual health benefits plan who is eligible to be covered under a group plan would not be permitted to continue this coverage after November 30, 1992. Currently, some individuals with a preexisting medical condition may not be included in a group's health benefits plan because their inclusion in the group plan would skew the rates of the group. These individuals may, instead, be provided coverage under individual plans. This bill would ensure that such individuals would be able to retain their individual health benefits coverage until they would be guaranteed coverage under a small employer policy.

Additionally, this bill clarifies that a preexisting condition exclusion limitation under an individual health benefits plan would not apply to an individual who has, under a prior group or individual health benefits plan, with no intervening lapse in coverage, been treated or diagnosed by a physician for a condition or satisfied a 12 month preexisting condition limitation under a prior group or individual health benefits plan.

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HS 0068
SR XXXX
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ASSEMBLY Amendments
(Proposed by Assemblyman Corodemus)

to

ASSEMBLY, No. 2495

(Sponsored by Assemblyman Corodemus)

Speaker
Clerk (3) ✓
Majority Leader
Minority Leader
Sponsor of Aa
Sponsor of Bill

Suggested
Location -
§ 7 - 11:
17B:27A-16.1
et seq.
§ 12 - repealer -
note

REPLACE TITLE TO READ:

AN ACT concerning [1][the New Jersey Individual Health Coverage Program and amending P.L.1992, c.161] individual health benefits coverage, amending and supplementing P.L.1992, c.161 and repealing section 16 of P.L.1992, c.161[1].

INSERT NEW SECTION 1 TO READ:

[1]1. 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, 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.

"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.1992.c.161.s.1)

RENUMBER SECTION 1 AS 2

INSERT NEW SECTION 3 TO READ:

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

3. a. No later than 180 days after the effective date of this act, a carrier shall, as a condition of issuing health benefits plans in this State, offer individual health benefits plans. The plans shall be offered on an open enrollment, community rated basis, pursuant to the provisions of this act; except that a carrier shall be deemed to have satisfied its obligation to provide the individual health benefits plans by paying an assessment or receiving an exemption pursuant to section 11 of this act.

b. A carrier shall offer to an eligible person a choice of five individual health benefits plans, any of which may contain provisions for managed care. One plan shall be a basic health benefits plan, one plan shall be a managed care plan and three plans shall include enhanced benefits of proportionally increasing actuarial value. A carrier may elect to convert any individual health benefits plans in force on the effective date of this act to any of the five benefit plans, except that the replacement plan shall be of no less actuarial value than the policy or contract being replaced.

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

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

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

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

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

individual or by a family unit during any benefit year[; and neither coinsurance nor deductibles shall apply to maternity benefits or preventative care examinations].

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

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

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

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

e. If all five of the individual health benefits plans are not established by the board by the effective date of P.L. . c. (C.)(pending before the Legislature as this bill), a carrier may phase-in the offering of the five health benefits plans by offering each health benefits plan as it is established by the board; however, once the board establishes all five plans, the carrier ~~is~~ shall be required to offer the five plans in accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

(cf: P.L.1992,c.161,s.3)

RENUMBER SECTION 2 AS 4

INSERT NEW SECTIONS 5 THROUGH 12 TO READ:

[1]5. Section 9 of P.L.1992, c.161 (C. 17B:27A-10) is amended to read as follows:

9. a. There is created the New Jersey Individual Health Coverage Program. All carriers subject to the provisions of this act shall be members of the program.

b. Within 30 days of the effective date of this act, the commissioner shall give notice to all members of the time and place for the initial organizational meeting, which shall take place within 60 days of the effective date. The board shall consist of nine representatives. The commissioner or his designee shall serve as an ex officio member on the board. Four members of the board shall be appointed by the Governor, with the advice and consent of the Senate: one of whom shall be a representative of an employer, appointed upon the recommendation of a business trade association, who is a person with experience in the management or administration of an employee health benefit plan; one of whom shall be a representative of organized labor, appointed upon the recommendation of the A.F.L.-C.I.O., who is a person with experience in the management or administration of an employee health benefit plan; and two of whom shall be

consumers of a health benefits plan who are reflective of the population in the State. Four board members who represent carriers shall be elected by the members, subject to the approval of the commissioner, as follows: to the extent there is one licensed in this State that is willing to have a representative serve on the board, a representative from each of the following entities shall be elected:

(1) a health service corporation;

(2) a health maintenance organization;

(3) a mutual health insurer of this State subject to Subtitle 3 of Title 17B of the New Jersey Statutes; and

(4) a foreign health insurance company authorized to do business in this State.

In approving the selection of the carrier representatives of the board, the commissioner shall assure that all members of the program are fairly represented.

Initially, two of the Governor's appointees and two of the carrier representatives shall serve for a term of three years; one of the Governor's appointees and one of the carrier representatives shall serve for a term of two years; and one of the Governor's appointees and one of the carrier representatives shall serve for a term of one year. Thereafter, all board members shall serve for a term of three years. Vacancies shall be filled in the same manner as the original appointments.

c. If the initial carrier representatives to the board are not elected at the organizational meeting, the commissioner shall appoint those members to the initial board within 15 days of the organizational meeting.

d. Within 90 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter, any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The commissioner may disapprove the plan of operation, if the commissioner determines that it is not suitable to assure the fair, reasonable, and equitable administration of the program, and that it does not provide for the sharing of program losses on an equitable and proportionate basis in accordance with the provisions of section 11 of this act. The plan of operation or amendments thereto shall become effective unless disapproved in writing by the commissioner within 45 days of receipt by the commissioner.

e. If the board fails to submit a suitable plan of operation within 90 days after its appointment, the commissioner shall[, after notice and hearing,] adopt [and promulgate] a temporary plan of operation pursuant to section 7 of P.L. , c. (C.)(pending before the Legislature as this bill). The commissioner shall amend or rescind a temporary plan adopted under this subsection, at the time a plan of operation is submitted by the board.

f. The plan of operation shall establish procedures for:

(1) the handling and accounting of assets and monies of the program, and an annual fiscal reporting to the commissioner:

(2) collecting assessments from members to provide for sharing program losses in accordance with the provisions of section 11 of this act and administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(3) approving the coverage, benefit levels, and contract forms for individual health benefits plans in accordance with the provisions of section 3 of this act;

(4) the imposition of an interest penalty for late payment of an assessment pursuant to section 11 of this act; and

(5) any additional matters at the discretion of the board.

g. The board shall appoint an insurance producer licensed to sell health insurance pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.) to advise the board on issues related to sales of individual health benefits plans issued pursuant to this act.[1]

(cf: P.L.1992, c.161, s.9)

[1]6. Section 10 of P.L.1992, c.161 (C.17B:27A-11) is amended to read as follows:

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

The board shall have the specific authority to:

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

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

c. review rate applications and form filings submitted by carriers in accordance with this act;

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

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

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

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

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

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

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

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

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

m. contract for an independent actuary and any other professional services the board deems necessary to carry out its duties under P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

(cf: P.L.1992,c.161,s.10)

[1]7. (New section) Upon the effective date of this act and through December 31, 1993, all actions adopted by the board shall be subject to the provisions of this section, notwithstanding the provisions of P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary.

a. For the purposes of this section, "action" includes, but is not limited to:

(1) the establishment and modification of health benefits plans;

(2) procedures and standards for the: (a) ~~the~~ assessment of members and the apportionment thereof; (b) filing of policy forms; (c) making of rate filings; (d) evaluation of material submitted by carriers with respect to loss ratios; (e) and establishment of refunds to policy or contract holders; and

(3) the promulgation or modification of policy forms.

"Action" shall not include the hearing and resolution of contested cases, personnel matters and applications for withdrawal or exemptions.

b. Prior to the adoption of an action of the board, the board shall publish notice of its intended action in three newspapers of general circulation in this State, and may publish the notice of intended action in any trade or professional publication which it deems necessary. The notice of intended action shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views. The board shall provide the notice of intended action and a detailed description of the intended action by mail, or otherwise, to affected trade and professional associations, carriers subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) and such other interested persons or organizations which may request notification. The board shall forward the notice of intended action and the detailed description of the intended action concurrently to the Office of Administrative Law for publication in the New Jersey Register.

The board shall not charge any fee for placement upon the mailing list of associations, carriers or other persons to be notified, but the board may charge a fee to an association, carrier or other person requesting a copy of the text of the intended action, which fee shall not be in excess of the actual cost of reproducing and mailing the copy.

A copy of the text of the intended action shall be available in the Department of Insurance in accordance with the provisions of P.L.1963, c.73 (C.47:1A-1 et seq.).

c. The board shall hold a public hearing on the establishment and modification of health benefits plans, and the board may hold a public hearing on any other intended action. Notice of a hearing shall be given in the notice of intended action provided for in subsection b. of this section.

d. Whether or not a public hearing is held, the board shall afford all interested persons an opportunity to comment in writing on the intended action. Written comments shall be submitted to the board within the time established by the board in the notice of intended action, which time shall not be less than 15 calendar days from the date of notice.

The board shall give due consideration to all comments received. Within a reasonable period of time following submission of the comments pursuant to this subsection, the board shall prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the board's response to the data, views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

e. The board may adopt the intended action immediately following the expiration of the public comment period provided in subsection d. of this section, or the hearing provided for in subsection c. of this section, whichever date is later. The final action adopted by the board shall be submitted for publication in the New Jersey Register to the Office of Administrative Law, and shall be effective on the date of the submission or such later date as the board may establish.

f. Actions filed with the Office of Administrative Law pursuant to this section shall be filed subject to the provisions of subsections (a), (c), (d) and (e) of section 5 of P.L.1968, c.410 (C.52:14B-5).

g. Nothing in this section shall be construed to prohibit the board from adopting any action pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

h. Nothing in this section shall be construed to prohibit the commissioner from adopting any rule or regulation pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), or from taking any other action required or authorized by P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

[1]8. (New section) a. Effective January 1, 1994, all actions adopted by the board shall be subject to the provisions of this section, notwithstanding the provisions of P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary.

a. For the purposes of this section, "action" includes, but is not limited to:

(1) the establishment and modification of health benefits plans;

(2) procedures and standards for the: (a) the assessment of members and the apportionment thereof; (b) filing of policy forms; (c) making of rate filings; (d) evaluation of material submitted by carriers with respect to loss ratios; ((e)) and establishment of refunds to policy or contract holders; and

(3) the promulgation or modification of policy forms.

"Action" shall not include the hearing and resolution of contested cases, personnel matters and applications for withdrawal or exemptions.

b. Prior to the adoption of an action of the board, the board shall publish notice of its intended action in three newspapers of general circulation in this State, and may publish the notice of intended action in any trade or professional publication which it deems necessary. The notice of intended action shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views. The board shall provide the notice of intended action and a detailed description of the intended action by mail, or otherwise, to affected trade and professional associations, carriers subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) and such other interested persons or organizations which may request notification. The board shall forward the notice of intended action and the detailed description of the intended action concurrently to the Office of Administrative Law for publication in the New Jersey Register.

The board shall not charge any fee for placement upon the mailing list of associations, carriers or other persons to be notified, but the board may charge a fee to an association, carrier or other person requesting a copy of the text of the intended action, which fee shall not be in excess of the actual cost of reproducing and mailing the copy.

A copy of the text of the intended action shall be available in the Department of Insurance in accordance with the provisions of P.L.1963, c.73 (C.47:1A-1 et seq.).

c. The board shall hold a public hearing on the establishment and modification of health benefits plans, and the board may hold a public hearing on any other intended action. Notice of a hearing shall be given in the notice of intended action provided for in subsection b. of this section.

d. Whether or not a public hearing is held, the board shall afford all interested persons an opportunity to comment in writing on the intended action. Written comments shall be submitted to the board within the time established by the board in the notice of intended action, which time shall not be less than 20 calendar days from the date of notice.

The board shall give due consideration to all comments received. Within a reasonable period of time following submission of the comments pursuant to this subsection, the board shall prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the board's response to the data, views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

e. The board may adopt the intended action immediately following the expiration of the public comment period provided in subsection d. of this section, or the hearing provided for in subsection c. of this section, whichever date is later. The final action adopted by the board shall be submitted for publication in the New Jersey Register to the Office of Administrative Law, and shall be effective on the date of the submission or such later date as the board may establish.

f. Actions filed with the Office of Administrative Law pursuant to this section shall be filed subject to the provisions of subsections (a), (c), (d) and (e) of section 5 of P.L.1968, c.410 (C.52:14B-5).

g. Nothing in this section shall be construed to prohibit the board from adopting any action pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

h. Nothing in this section shall be construed to prohibit the commissioner from adopting any rule or regulation pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), or from taking any other action required or authorized by P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

[1]9. (New section) a. The commissioner shall, under the procedures provided pursuant to section 7 of P.L. , c. (C.)(pending before the Legislature as this bill), adopt a temporary plan of operation prepared pursuant to section 9 of P.L.1992, c.161 (C.17B:27A-10), pending submission or approval of a plan of operation prepared by the board pursuant to ~~that law~~ section 9.

b. Subsequent amendments to the plan of operation shall be reviewed and approved by the commissioner pursuant to the procedures provided in sections 7 and 8 of P.L. , c. (C.)(pending before the Legislature as this bill), as applicable.

[1]10. (New section) A carrier shall not require an eligible person to purchase any other insurance coverage, including, but not limited to, life insurance, accident insurance or disability insurance, as a condition of or in conjunction with the purchase of a health benefits plan pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.).[1]

[1]11. (New section) The board, in conjunction with the board of the New Jersey Small Employer Health Benefits Program established pursuant to section 12 of P.L.1992, c.162 (C.17B:27A-28), shall adopt one standard claim form.

OIC

In order to provide a standard system of payment for medical services, all claim forms for a claimant's use under an individual health benefits plan issued or delivered in this State shall conform to the form adopted by the board.[1]

[1]12. Section 16 of P.L.1992, c.161 is repealed.[1]

RENUMBER SECTION 3 AS 13

STATEMENT

These amendments:

- exempt CHAMPUS supplement coverage from the definition of health benefits plan;
- clarify the definition of individual health benefits plan by providing that policies or contracts issued to certain trusts or associations are included in the term;
- delete the provision that maternity benefits or preventative care examinations shall not be subject to coinsurance or deductibles;
- permit carriers to phase-in the offering of health benefits plans, as they are established, if the board has not established all five of the plans on the effective date of this bill;
- authorize the board to contract for an independent actuary and any other professional services the board deems necessary;
- establish procedures for providing public notice of certain actions taken by the board;
- permit the Commissioner of Insurance to adopt a temporary plan of operation for the board pursuant to the public notice procedures established in the bill;
- prohibit a carrier from requiring an eligible person to purchase any other form of insurance, including life insurance, as a condition of or in conjunction with the purchase of a health benefits plan;
- direct the board, in conjunction with the New Jersey Small Employer Health Benefits Program board, to adopt a standard claim form; and
- repeal section 16 of P.L.1992, c.161, which required the board to adopt regulations pursuant to the "Administrative Procedure Act," as that section is no longer necessary with the public notice provisions in this bill.