26:2J-31

LEGISLATIVE HISTORY CHECKLIST

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(Medicare supplementary health insurance--conformity with Federal)

NJSA: 26:2J-31

LAWS OF: 1992 CHAPTER: 164

BILL NO: A1741

SPONSOR(S) Mikulak and others

DATE INTRODUCED: August 3, 1992

COMMITTEE: ASSEMBLY: Insurance

SENATE: ---

AMENDED DURING PASSAGE: No

DATE OF PASSAGE: ASSEMBLY: October 8, 1992

SENATE: October 29, 1992

DATE OF APPROVAL: December 2, 1992

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT: Yes

COMMITTEE STATEMENT: ASSEMBLY: Yes

SENATE: No

FISCAL NOTE: Yes

VETO MESSAGE: No

MESSAGE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

See newspaper clippings -- attached.

KBG:pp

P.L.1992, CHAPTER 184, *approved December 2, 1992*
1992 Assembly No. 1741

AN ACT concerning the provision of medicare supplement health care services by health maintenance organizations.

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

1. As used in this act:

"Applicant" means any individual who seeks enrollment with a health maintenance organization for the purpose of obtaining medicare supplement health care services.

"Commissioner" means the Commissioner of Insurance.

"Department" means the Department of Insurance.

"Enrollee" means an individual who is enrolled with a health maintenance organization.

"Evidence of coverage" means any booklet, certificate, agreement or contract issued to an enrollee setting out the services and other benefits to which he is entitled.

"Health care services" means those services, including, but not limited to, inpatient hospital and physician care, and outpatient medical services, as set forth in the evidence of coverage.

"Health maintenance organization" means any person which, directly or through contracts with providers, furnishes health care services on a prepaid basis to enrollees in a designated geographic area in this State pursuant to the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.).

"Medicare" means the program established by the "Health Insurance for the Aged Act," Title XVIII of the "Social Security Act," Pub.L. 89-97, as then constituted or later amended (42 U.S.C. §1395 et seq.).

"Medicare supplement contract" means a group or individual contract or plan which is advertised, marketed or designed primarily as providing, or is otherwise held out to provide, medicare supplement health care services and under which an individual is enrolled, other than a contract issued pursuant to a contract under 42 U.S.C. §1395l or 42 U.S.C. §1395mm or a contract issued under a demonstration project authorized pursuant to the "Health Insurance for the Aged Act," 42 U.S.C. §1395 et seq. The term does not include health care services provided pursuant to a contract or plan issued to one or more employers or labor organizations, or to the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees of the employers, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

"Medicare supplement evidence of coverage" means an evidence of coverage delivered to an enrollee who has medicare

supplement health care services coverage under a medicare supplement contract.

"Medicare supplement health care services" means health care services which supplement medicare, provided under a medicare supplement contract as set forth in a medicare supplement evidence of coverage.

"Provider" means any physician, hospital or other person which is licensed or otherwise authorized in this State to furnish health care services.

2. Except as otherwise specifically provided:

a. This act shall apply to all medicare supplement health care services provided pursuant to a medicare supplement contract or evidence of coverage delivered or issued for delivery in this State.

b. This act shall not apply to any health maintenance organization contract or evidence of coverage, including group conversion plans, provided to medicare eligible persons that are not advertised, marketed, designed primarily as or otherwise held out to provide medicare supplement health care services.

3. a. No medicare supplement contract or evidence of coverage shall provide for health care services which duplicate any benefits provided by medicare.

b. The commissioner shall promulgate regulations to establish specific standards for the provisions to be contained in any medicare supplement contract or evidence of coverage, which shall be in addition to and in accordance with the applicable laws of this State. The regulations may provide, but shall not be limited to:

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Non-duplication of coverage;

(4) Probationary periods;

(5) Benefit limitations, exceptions and reductions;

(6) Elimination periods;

(7) Requirements for replacement;

(8) Recurrent conditions; and

(9) Definition of terms.

c. The commissioner may promulgate regulations that specify prohibited medicare supplement contract or evidence of coverage provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any applicant for, or enrollee with, medicare supplement health care services coverage.

4. Notwithstanding any other provision of law to the contrary, a medicare supplement contract or evidence of coverage shall not deny medicare supplement health care services for losses incurred more than six months from the effective date of enrollment for a preexisting condition. The contract or evidence of coverage shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months of the effective date of enrollment.

5. The commissioner shall promulgate regulations to effectuate and enforce the provisions of this act and any regulations which are necessary to conform medicare supplement

health care services provided undor a medicare supplement contract or evidence of coverage with federal law. These regulations shall include, but not be limited to:

a. Establishment of minimum standards for benefits, claim payments, marketing and reporting practices and compensation arrangements;

b. Establishment of a uniform methodology for calculating and reporting loss ratios, and requiring refunds or credits if the medicare supplement contracts do not meet loss ratio requirements;

c. Establishment of a process for filing of all requests for premium increases and rate changes which may include public hearings as determined appropriate by the commissioner prior to approval of any premium increases;

d. Assurance of access by the public to policy, premium and loss ratio information; and

e. Establishment of standards for Medicare Select contracts at such time as this State is authorized under federal law to authorize Medicare Select contracts.

6. No health maintenance organization shall offer or provide medicare supplement health care services in this State without authorization by the commissioner. The commissioner shall grant authorization if he determines that the health maintenance organization has the financial and operational capability to provide such services. In making a determination, the commissioner may consider, but shall not be limited to, the following:

a. The number of enrollees;

b. The geographic area to be serviced;

c. The current and prospective financial condition of the health maintenance organization;

d. The anticipated impact on the health maintenance organization of providing medicare supplement health care services in addition to other services which it provides.

7. a. No health maintenance organization authorized pursuant to section 6 of this act shall deliver or issue for delivery in this State any medicare supplement contract or evidence of coverage or any application or notification used in connection with the issuance or continuance of a medicare supplement contract or evidence of coverage unless the form of which, including a copy of the underlying plan, has been submitted to and filed by the commissioner pursuant to the provisions of this subsection.

(1) At the expiration of 60 days after submission a form shall be deemed filed unless prior thereto it has been affirmatively filed or disapproved for filing by the commissioner.

(2) No form which is disapproved for filing by the commissioner during the 60-day period, may be delivered or issued for delivery in this State unless and until the disapproval for filing is withdrawn. Any disapproval shall be subject to review in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). Any form which is filed by the commissioner or deemed filed may be delivered or issued for delivery in this State until such time as any subsequent withdrawal of the filing by the commissioner, following an

opportunity for a hearing held in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

(3) The commissioner may extend the 60-day period provided in paragraph (1) of this subsection for not more than 60 additional days by giving written notice of extension before the expiration of the initial 60-day period. In the event of an extension, all of the provisions of this subsection, except this provision for an extension, relating to the initial 60-day period shall apply to the extended period instead of the initial 60-day period.

(4) The disapproval for filing or the withdrawal of the filing of any form by the commissioner shall state in writing the grounds therefor in such detail as is reasonable to inform the health maintenance organization of the reasons for withdrawal or disapproval.

(5) The provisions of this subsection shall not apply to documents which relate only to the manner of distribution of services or to the reservation of rights and services under the medicare supplement contract or evidence of coverage and which are used at the request of the enrollee.

(6) The disapproval by the commissioner of any form submitted for filing pursuant to the provisions of this subsection may be on the ground that the form contains provisions which are unjust, unfair, inequitable, misleading or contrary to law or to the public policy of this State.

b. Every health maintenance organization providing medicare supplement health care services to a resident of this State shall file annually with the commissioner its rates, rating schedule and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this State. All filings of rates and rating schedules shall be certified by a qualified actuary and shall demonstrate that the actual and expected costs in relation to services provided comply with the requirements of this act and any rule or regulation promulgated hereunder.

As used in this subsection, "qualified actuary" means a person, in good standing, who is a member of the American Academy of Actuaries, a fellow of the Casualty Actuarial Society, or a person who has otherwise demonstrated actuarial competence to the satisfaction of the commissioner.

c. Services provided under a medicare supplement contract or evidence of coverage shall be expected to return to enrollees services or other benefits which are reasonable in relation to the premium or other fee charged. The commissioner shall promulgate regulations to establish minimum standards for loss ratios under medicare supplement contracts or evidences of coverage on the basis of paid medicare supplement health care expenses and written earned premiums and fees in accordance with accepted actuarial principles and practices.

8. a. In order to provide for full and fair disclosure in the sale of medicare supplement contracts or evidences of coverage, no medicare supplement contract or evidence of coverage shall be delivered or issued for delivery in this State unless an outline of coverage is delivered to the applicant at the time application is made.

b. The commissioner shall prescribe the format and content of the outline of coverage required by subsection a. of this section. For the purposes of this section, "format" means style, arrangement and overall appearance, including the size, color and prominence of the font used, paper size and weight and the arrangement of text and captions. The outline of coverage shall include:

(1) A description of the principal medicare supplement health care services provided;

(2) A statement of any applicable exceptions, reductions and limitations in the available medicare supplement health care services;

(3) A statement of the renewal provisions, including any reservation by the health maintenance organization of the right to change premiums or other fees; and

(4) A statement that the outline of coverage is a summary of the medicare supplement contract or evidence of coverage issued or applied for and that the contract or evidence of coverage should be consulted to determine the governing contractual provisions.

c. The commissioner may require by regulation the publication of forms and an informational brochure with a standardized format and content, to serve as an aid in the selection of appropriate coverage, if any, by those eligible for medicare, and to aid the consumer in improving his understanding of medicare benefits. Except in the case of direct response solicitation for medicare supplement health care services, the commissioner may require by regulation that the informational brochure be provided, concurrently with delivery of the outline of coverage, to all prospective enrollees eligible for medicare. With respect to direct response solicitation for medicare supplement health care services, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective enrollee eligible for medicare, but in no event later than the time the medicare supplement contract or evidence of coverage is delivered.

d. The commissioner may promulgate regulations for captions or notice requirements for all contracts and evidences of coverage delivered or issued for delivery to persons eligible for medicare to inform prospective enrollees that the particular contract or evidence of coverage does not provide medicare supplement health care services. These notice requirements shall not apply to medicare supplement contracts or evidences of coverage or to contracts issued pursuant to a contract under 42 U.S.C. §1395l or 42 U.S.C. §1395mm.

e. The commissioner may further promulgate regulations to govern the full and fair disclosure of information in connection with the replacement of contracts or evidences of coverage by persons eligible for medicare.

9. Notice shall be prominently printed on the first page of each medicare supplement contract and evidence of coverage stating in substance that the applicant shall have the right to return the contract or evidence of coverage within 30 days of its delivery and to have any premium or other fee refunded if, after

examination of the contract or evidence of coverage, the applicant is not satisfied for any reason. Refunds made pursuant to this section shall be made in a timely manner and shall be paid directly to the applicant.

10. a. Every health maintenance organization shall file with the department a copy of all advertising materials to be used in promoting medicare supplement health care services to which residents of this State will have access, and through which the health maintenance organization intends, or by implication purports to the reasonable, targeted consumer its intent, to make such services available for enrollment in this State. The requirements of this section shall apply to all advertisements in any medium whether in print or by means of television or radio broadcast. Filings shall be made at least 30 days prior to the date on which the advertisement is to be used in this State, or made accessible to residents of this State.

b. The commissioner may, in the public interest, promulgate regulations governing medicare supplement health care services advertising including, but not limited to, specific filing procedures, standards upon which review may be based, celebrity endorsements, unfair practices and review and disapproval procedures.

c. Notwithstanding the provisions of subsection b. of this section, the commissioner may disapprove any advertisement for use in this State at any time if he determines that the advertisement misrepresents the product, misleads the targeted consumer, uses a strategy which involves scare tactics, unnecessarily confusing data or representations, false or fraudulent statements or otherwise violates any applicable law of this State or regulation promulgated thereunder.

11. In addition to any other applicable penalties for violation of the relevant provisions of law, the commissioner may require a health maintenance organization violating the provisions of this act to cease marketing any medicare supplement contract or evidence of coverage in this State which is related directly or indirectly to the violation, require the health maintenance organization to take such action as is necessary to comply with the provisions of this act, or both.

12. This act shall take effect immediately.

STATEMENT

This bill sets standards for medicare supplement health care services provided to New Jersey residents by health maintenance organizations (HMO's) in accordance with the federal mandate under which health maintenance organizations providing medicare supplement health care services must meet certain minimum standards, including nonduplication of benefits already provided by medicare.

Provides standards for medicare supplement contracts and evidences of coverage issued by health maintenance organizations.

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Provides standards for medicare supplement contracts and evidences of coverage issued by health maintenance organizations.

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1741

STATE OF NEW JERSEY

DATED: SEPTEMBER 21, 1992

The Assembly Insurance Committee reports favorably, Assembly Bill No. 1741.

This bill sets standards for medicare supplement health care services provided to New Jersey residents by health maintenance organizations (HMO's) in accordance with the federal mandate under which health maintenance organizations providing medicare supplement health care services must meet certain minimum standards, including nonduplication of benefits already provided by medicare.

This bill provides for the regulation of Medicare supplement contracts and evidences of coverage delivered or issued for delivery in this State by health maintenance organizations.

Under the bill, health maintenance organizations would be precluded from offering health care services under a Medicare supplement contract or evidence of coverage which duplicate any benefits provided by Medicare. The bill requires the Commissioner of Insurance to establish standards for Medicare Select contracts at such time as this State is authorized under federal law to authorize Medicare Select contracts. The commissioner is also required to promulgate regulations to: establish specific standards for provisions to be contained in any Medicare supplement contract or evidence of coverage, one of which shall prohibit excluding coverage for preexisting conditions for more than six months; establish minimum standards for benefits, claim payments, marketing and reporting practices and compensation arrangements; establish a uniform methodology for calculating and reporting loss ratios, and requiring refunds or credits if Medicare supplement contracts do not meet loss ratio requirements; establish a process for filing of all requests for premium increases and rate changes which may include public hearings as determined appropriate by the commissioner prior to approval of any premium increases; and assure access by the public to contract, premium and loss ratio information.

No health maintenance organization may offer or provide Medicare supplement health care services in this State without authorization by the commissioner upon a finding that the health maintenance organization has the financial and operational capability to provide such service. No health maintenance may deliver or issue for delivery in this State a Medicare supplement contract or evidence of coverage or any application or notification to be used in connection with the issuance or continuance of a Medicare supplement contract or evidence of coverage unless the form has been submitted to and filed by the commissioner.

The bill provides a filing procedure under which a form is deemed filed 60 days after it is submitted for filing unless it has

been affirmatively filed or disapproved for filing by the commissioner during the review period. This 60-day period may be extended an additional 60 days by the commissioner. A form may be disapproved by the commissioner on the ground that it contains provisions which are unjust, unfair, misleading, inequitable, or contrary to law or to the public policy of this State. Any disapproval of a filing is subject to review pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). Similarly, no filing may be subsequently withdrawn by the commissioner until there is an opportunity for a hearing pursuant to the "Administrative Procedure Act."

In addition, the bill requires any health maintenance organization providing Medicare supplement health care services in this State to make an annual filing with the commissioner of its rates, rating schedule and supporting documentation to demonstrate that it is in compliance with applicable loss ratio standards established by regulation of the commissioner. The minimum standards for loss ratios of Medicare supplement contracts or evidences of coverage are required to be established by the commissioner on the basis of paid Medicare supplement health care expenses and written earned premiums and fees in accordance with accepted actuarial principles and practices.

The bill contains several provisions intended to provide adequate disclosure to consumers so that they may improve their understanding of Medicare benefits and select appropriate supplemental coverage. These provisions authorize the commissioner to require the publication of coverage selection forms and an informational brochure and to prescribe the format and content of outlines of coverage which must be issued to all applicants for Medicare supplement coverage. The bill provides applicants for Medicare supplement contracts a "free-look" period of 30 days, with a right of timely refund paid directly to any applicant who is not satisfied during that period.

In addition to the filing of forms and rating plans, the bill requires the filing of all advertising materials to be used in promoting Medicare supplement contracts, to which residents of this State will have access, at least 30 days prior to the date on which the advertisement is to be used in, or made accessible to residents of, this State. The bill empowers the commissioner to promulgate regulations in the public interest which will govern Medicare supplement advertising, including, but not limited to, the promulgation of filing procedures, standards of review, celebrity endorsements, unfair practices and review and disapproval procedures. The commissioner may disapprove any advertisement at any time if he determines that the advertisement misrepresents the product, misleads the targeted consumer, uses a strategy which involves scare tactics, unnecessarily confusing data or representation, false or fraudulent statements or otherwise violates any applicable law or regulation.

FISCAL NOTE TO

ASSEMBLY, No. 1741

STATE OF NEW JERSEY

DATED: October 23, 1992

Assembly Bill No 1741 of 1992 provides for the regulation of Medicare supplement contracts and evidences of coverage delivered or issued for delivery in this State by health maintenance organizations to comply with federal minimum standards for those contracts or evidences. Under the bill, health maintenance organizations would be precluded from offering health care services under a Medicare supplement contract or evidence of coverage which duplicate any benefits provided by Medicare.

The bill requires the Commissioner of Insurance to establish standards for Medicare Select contracts at such time as this State is authorized under federal law to authorize Medicare Select contracts. The commissioner is also required to: promulgate regulations to establish specific standards for provisions to be contained in any Medicare supplement contract or evidence of coverage; establish minimum standards for benefits, claim payments, marketing and reporting practices and compensation arrangements; establish a uniform methodology for calculating and reporting loss ratios, and requiring refunds or credits if Medicare supplement contracts do not meet loss ratio requirements; establish a process for filing of all requests for premium increases and rate changes; and assure access by the public to contract, premium and loss ratio information.

Although the Office of Management and Budget and the Department of Insurance have not provided a fiscal note worksheet for this bill, the Department of Insurance has communicated in a memorandum that implementation of the revisions contained in the bill is expected to be accomplished by utilizing current staff.

The Office of Legislative Services (OLS) agrees that implementation of revisions contained in the bill could be accomplished by the department's current staff at no additional administrative cost. Therefore, this bill would have no impact on the State budget.

The OLS notes that under federal law, states may develop their own regulatory program for Medicare supplement policies marketed within their borders. A state's program must be approved by the Health Care Financing Administration, and in order to be approved, a state must adopt standards for Medicare supplement policies which are equal to or more stringent than the standards adopted by the National Association of Insurance Commissioners (NAIC) in its model acts and regulations. This bill forms the statutory framework for the Department of Insurance to adopt the NAIC model regulations for Medicare supplement policies and complies with federal minimum standards for Medicare supplement policies.

The OLS also notes that if New Jersey does not meet the federal requirements, Medicare supplement policies will be subject to approval by the United States Secretary of Health and Human Services under the Federal Certification Program and the State Department of Insurance before a Medicare supplement policy could

be issued in New Jersey. Therefore, failure to comply would create a two-tier system which could financially burden insurers who wish to introduce new Medicare supplement policies into the market and could increase the consumer cost of such policies.

This fiscal note has been prepared pursuant to P.L.1980,

OFFICE OF THE GOVERNOR
NEWS RELEASE

CN-001
Contact:

Jon Shure
Jo Astrid Glading
609-777-2600

TRENTON, N.J. 08625
Release:

Monday,
Nov. 30, 1992

Gov. Jim Florio tonight signed legislation to create a new system for funding uncompensated hospital care in New Jersey, reform the practices concerning insurance coverage for individuals and small groups, and establish NJ SHIELD to help provide coverage for those locked out of the system. He issued the following statement:

We have averted a crisis that could have shut down New Jersey's health care system at midnight December 1, when the Uncompensated Care Trust Fund expired. At the same time, we have enacted far-reaching insurance reforms that will help make sure no one in our state has to lie awake at night wondering how they would pay the bills if someone in the family gets sick.

The new method of paying for the care of those who can't afford it is far from perfect. But it was the only option that the legislative process made available. These measures also include new protections for consumers and new obligations for insurers, to make sure that fewer people walk into a hospital without coverage. This action will help bring down costs and make for both a healthier public and a healthier economy.

While we await the national solution that Washington must provide for all of our citizens, we in New Jersey are shifting toward preventive health care and away from costly, ineficient emergency room treatment. That is a positive step that will pay dividends far into the future. In the meantime, I am aware that the new law, as written, places burdens on urban hospitals. These burdens must be addressed so that quality healthcare is available in every part of New Jersey, and I look forward to working with the Legislature to make sure that happens rapidly.

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OFFICE OF THE GOVERNOR
NEWS RELEASE

CN-001
Contact: Jon Shure
Jo Astrid Glading
609-777-2600

TRENTON, N.J. 08625
Release:
Tuesday
Dec. 1, 1992

GOVERNOR FLORIO SIGNS SWEEPING HEALTH INSURANCE REFORMS

New Jersey today ushered in a new era of health care when Governor Jim Florio signed sweeping reforms that will help make insurance coverage and medical treatment available and affordable for virtually everyone.

"Health insurance is not a privilege, it is a fundamental right," Gov. Florio said. "These are the kinds of changes President-elect Bill Clinton is proposing on a national scale, and I am pleased New Jersey has moved ahead."

"This is a national problem, and it requires a national solution. But New Jersey isn't waiting," Gov. Florio said.

"There are nearly 1 million New Jersey residents who do not have health insurance coverage because they cannot afford it or because insurance companies won't enroll them," Gov. Florio said. "That is intolerable. These reforms will help make sure no one in our state has to lie awake at night wondering how to pay the bills if someone in the family gets sick."

"For many of our hardworking people, the health insurance bill costs more than the mortgage, forcing more and more families to drop their coverage and take their chances. And when someone in that family gets sick, they go to a hospital emergency room, the single most expensive setting to get medical treatment," Gov. Florio said.

"The changes we are making here in New Jersey will make sure more people are covered, and will shift the care they receive away from emergency rooms and toward preventive care where it belongs," Gov. Florio said.

"The reforms put an end to a system where people were routinely turned down for coverage and wound up in emergency rooms, waiting five hours to see a doctor for five minutes," Gov. Florio said. "At a time when modern medicine has given us cures for once-fatal

illnesses, too many people have seen the fear of illness replaced by the fear of financial ruin from paying the bills. Too often, you seek treatment to get well, and the bill makes you sick."

The reforms will require health insurers to provide mandatory open enrollment and community rating requiring insurers to cover all individuals seeking coverage, as well as small groups of fewer than 50 people. They also will require companies to streamline and cut wasteful administrative costs by offering five standardized policies.

Finally, companies will be required to spend at least 75 cents of every premium dollar collected on actual medical benefits, and no more than the remaining 25 cents on administrative costs, overhead and profits.

Under the current system, insurers have been free to pick and choose among applicants, and only Blue Cross has had to cover all those who seek coverage. As a result, commercial insurers only carry good risks, few companies write individual policies, Blue Cross' risk pool continues to worsen, and more and more families are forced to drop their coverage.

Community rating will require insurance companies to set one rate for everyone regardless of age, occupation or other factors, spreading the risk across a broad base of policyholders. This replaces the system where companies use age, health status, occupation, sex and geographic location in setting rates. Older people have had to pay five or more times what young people pay, people in certain occupations can pay up to twice what those in other occupations pay, and people in some geographic areas can pay up to twice what people in other areas pay.

"Right now, health insurance companies spend up to 40 cents of every dollar in small group business on administrative costs and deciding who not to insure. It has become a business of risk avoidance, rather than risk spreading," Gov. Florio said. "We're taking insurance back to what it was supposed to be. For too long insurance companies have concentrated on figuring out who not to insure. That's not fair, and it's not going to continue."

The third reform measure creates New Jersey SHIELD, which will provide coverage for those unable to afford health insurance. New Jersey SHIELD will be targeted toward the working uninsured, people who are temporarily unemployed, and part-time or seasonal workers. It will use a sliding income scale with modest co-payments so that people can receive coordinated care from practitioners in their local communities, and will direct health care dollars now spent on emergency room treatment for these families to preventive and primary care instead.

The managed care program under New Jersey SHIELD is similar to Hawaii's successful health insurance system which insures 98 percent of its residents with either employer-based insurance or its state health insurance plan.

New Jersey SHIELD, which would take effect Jan. 1, 1994, is not a replacement for Medicare, Medicaid or existing private insurance companies, but will be there for people who are not eligible, or cannot afford, existing coverage programs. New Jersey SHIELD also is not a state-run insurance system, but instead would contract with the best existing providers.

Under New Jersey SHIELD, families would receive a standard benefits package that includes:

Preventive Care
Primary Care
Emergency Room Visits
Prescription drugs
Hospitalization

The health insurance reforms were enacted at the same time that New Jersey replaced its system for funding hospital care for those who can't afford to pay for it. The prior funding system, which relied on a 19 percent tax on all hospital bills, had been ruled illegal for self-insured health plans by a federal judge. The primary users of the uncompensated care trust fund are uninsured working families, those not old enough for Medicare who do not have coverage from their employer and earn too much to qualify for Medicaid.

Under the new funding system, that tax on hospital bills will be replaced by funding from the state unemployment insurance fund. A trigger that would raise the unemployment tax on employers will take effect if the fund, now at $2.4 billion, drops below $1.5 billion after July, 1994.