

17B:27A-4.4

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 368

NJSA: 17B:27A-4.4 (Affordable health benefits plans)

BILL NO: S13 (Substituted for A3447/2791)

SPONSOR(S): Matheussen and Sinagra

DATE INTRODUCED: September 21, 2000

COMMITTEE: **ASSEMBLY:** Health; Banking and Insurance
SENATE: Health

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** December 10, 2001
SENATE: January 7, 2002

DATE OF APPROVAL: January 8 2002

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (4th reprint enacted)
(Amendments during passage denoted by superscript numbers)

S13

SPONSORS STATEMENT: (Begins on page 6 of original bill)	Yes
COMMITTEE STATEMENT:	ASSEMBLY: Yes 5-3-2001(Health) 6-4-2001(Banking& Ins)
	SENATE: Yes
FLOOR AMENDMENT STATEMENTS:	Yes 12-4-2000 6-14-2001
LEGISLATIVE FISCAL ESTIMATE:	No

A3447/2791

SPONSORS STATEMENT (A3447): (Begins on page 6 of original bill)	Yes
SPONSORS STATEMENT (A2791): (Begins on page 6 of original bill)	Yes
COMMITTEE STATEMENT:	ASSEMBLY: Yes 5-3-2001(Health) 6-4-2001(Banking&Ins)
	Identical to Assembly Health statement for S13
	Identical to Assembly Banking statement to S13
	SENATE: No
FLOOR AMENDMENT STATEMENTS:	No
LEGISLATIVE FISCAL ESTIMATE:	No
FINAL VERSION (ACS, 1ST Reprint):	Yes
VETO MESSAGE:	No
GOVERNOR'S PRESS RELEASE ON SIGNING:	No

FOLLOWING WERE PRINTED:

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REPORTS:	No
HEARINGS:	Yes
974.90 New Jersey. Legislature. Senate. Health Committee.	
I59 Public meeting on the affordability and accessibility of health insurance, held	
2000 February 23, 2000. Trenton, 2000	
NEWSPAPER ARTICLES:	No

SENATE, No. 13

STATE OF NEW JERSEY 209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:

Senator JOHN J. MATHEUSSEN
District 4 (Camden and Gloucester)
Senator JACK SINAGRA
District 18 (Middlesex)

Co-Sponsored by:

**Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero,
Bennett, Bark, Palaia, Kavanaugh, Bassano and McNamara**

SYNOPSIS

Requires individual and small employer group carriers to offer a new health benefits plan.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 10/24/2000)

1 AN ACT concerning health insurance and supplementing
2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
3 (C.17:27A-17 et seq.).

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

7
8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
10 reform in 1992 for the individual and small group markets that
11 provided guaranteed-issue, guaranteed-renewal coverage, with a
12 prohibition against rating on the basis of health status and removing
13 most preexisting condition exclusions from policies, the plans that
14 were established by the respective boards did not offer sufficient
15 variety or options to insureds in terms of the range of coverages that
16 are provided under the standard plans;

17 b. The original intent of the Legislature was to give policyholders
18 a wider range of coverage options, including policies that provide
19 reimbursement for basic and essential health care services but do not
20 contain either the traditional mandated benefits to which the standard
21 plans are subject or reimbursement for services which the consumer
22 can more economically pay for himself, rather than having those
23 services paid for through a third-party system, which adds significantly
24 to the cost;

25 c. The boards of the New Jersey Individual Health Coverage
26 Program and the New Jersey Small Employer Health Benefits Program
27 elected to provide little variance in the coverage provided under the
28 standard plans; rather, reductions in premium cost can be obtained
29 primarily through increasing the deductibles to substantial sums, which
30 defeats the objective of making the policies affordable, in that large
31 deductibles represent large out-of-pocket expenses;

32 d. In the absence of any affirmative action by either board to
33 remedy this situation, it is the purpose of this bill to create a policy
34 that is more affordable than the options that presently exist; even
35 though the benefit package is not as rich as the existing plans, the
36 benefit plans provided by this act will make health insurance more
37 accessible to many individuals and small groups that do not have the
38 economic resources to afford the existing plans while still providing
39 essential coverage.

40 e. It is to the interest of the State and of all health care providers
41 that as many people have access to reasonably affordable health
42 insurance as possible, for this reduces the amount of charity care that
43 providers provide as well as the amount of bad debt that must be
44 absorbed by providers each year.

45
46 2. a. Notwithstanding the provisions of P.L. 1992, c. 161

1 (C.17B:27A-2 et seq.), every carrier shall offer a health benefits plan
2 in the individual health insurance market that includes only the
3 coverages enumerated in this section, as follows:
4 90 days hospital room and board - \$500 deductible per hospital stay;
5 Outpatient and ambulatory surgery;
6 Physicians' fees connected with hospital care, including general acute
7 care and surgery;
8 Anesthesia and the administration of anesthesia;
9 Coverage for newborns;
10 Treatment for complications of pregnancy;
11 IV Solutions, blood and blood plasma;
12 Oxygen and the administration of oxygen;
13 Radiation and x-ray therapy;
14 Physical therapy and hydrotherapy - \$20 deductible for outpatient
15 treatment;
16 Dialysis - inpatient or outpatient;
17 Inpatient diagnostic tests and \$500 annual aggregate for out-of-
18 hospital diagnostic tests;
19 Laboratory fees for treatment in hospital;
20 Delivery room fees;
21 Operating room fees;
22 Intensive care unit;
23 Treatment room fees;
24 Emergency room services for medically necessary treatment;
25 Pharmaceuticals dispensed in hospital;
26 Dressings;
27 Splints;
28 Treatment for Nervous and Mental Conditions - 30 Days inpatient or
29 outpatient - 30% copayment;
30 Alcohol and Substance Abuse Treatment - 30 days inpatient or
31 outpatient - 30% copayment;
32 Wellness benefit - \$600 per year, \$50 deductible, 20% coinsurance per
33 service; and
34 Physicians visits per year for diagnosed illness or injury - to an
35 aggregate of \$700 per year.
36 b. A carrier shall offer the benefits on an indemnity basis, with the
37 option that: (1) coverage is restricted to health care providers in the
38 carrier's network or preferred provider organization; and (2) coverage
39 is provided through health care providers in the carrier's network or
40 preferred provider organization with an out-of-network option with a
41 30% copayment in addition to whatever other copayment may be
42 applicable under the policy.
43 c. With respect to all policies or contracts issued pursuant to this
44 section, the premium rate charged by a carrier to the highest rated
45 individual or class of individuals shall not be greater than 350% of the
46 premium rate charged for the lowest rated individual or class of

1 individuals purchasing this health benefits plan, provided, however,
2 that the only factors upon which the rate differential may be based are
3 age, gender, and geography. Policies or contracts issued pursuant to
4 this section shall be rated separately from the five standard plans, in
5 accordance with their own loss experience.

6 d. Carriers may offer enhanced or additional benefits for an
7 additional premium amount in the form of a rider or riders, each of
8 which shall be comprised of a combination of enhanced or additional
9 benefits, in a manner which will avoid adverse selection to the extent
10 possible.

11 e. The provisions of P. L. 1992, c. 162 (C.17B:27A-2 et seq.) shall
12 apply to this section to the extent that they are not contrary to the
13 provisions of this section, including but not limited to, provisions
14 relating to guaranteed issue, calculation of loss ratio, and the liability
15 for assessment.

16 f. No later than 120 days following enactment of this act, every
17 carrier shall make an informational filing with the commissioner, which
18 shall include the policy form, the premiums to be charged for the
19 coverage, and the anticipated loss ratio. If the commissioner has not
20 disapproved the form within 30 days, the form shall be approved.

21 g. Every carrier and every insurance producer shall make a good
22 faith effort to market the contract or policy established pursuant to this
23 section. If the board determines that such a good faith effort has not
24 been made, they shall recommend to the commissioner that the carrier
25 be subject to a fine of not more than \$5,000, which shall be levied by
26 the commissioner pursuant to the provisions of the "Penalty
27 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

28

29 3. a. Notwithstanding the provisions of P.L. 1992, c. 162
30 (C.17B:27A-17 et seq.), every small employer carrier shall offer a
31 small employer health benefits plan that includes only the coverages
32 enumerated in this section, as follows:

33 90 days hospital room and board - \$500 deductible per stay;

34 Outpatient and ambulatory surgery;

35 Physicians' fees connected with hospital care, including general acute
36 care and surgery;

37 Anesthesia and the administration of anesthesia;

38 Coverage for newborns;

39 Treatment for complications of pregnancy;

40 IV Solutions, blood and blood plasma;

41 Oxygen and the administration of oxygen;

42 Radiation and x-ray therapy;

43 Physical therapy and hydrotherapy - \$20 deductible for outpatient
44 treatment;

45 Dialysis - inpatient or outpatient;

- 1 Inpatient diagnostic tests and \$500 annual aggregate for out-of-
- 2 hospital diagnostic tests;
- 3 Laboratory fees for treatment in hospital;
- 4 Delivery room fees;
- 5 Operating room fees;
- 6 Intensive care unit;
- 7 Treatment room fees;
- 8 Emergency room services for medically necessary treatment;
- 9 Pharmaceuticals dispensed in hospital;
- 10 Dressings;
- 11 Splints;
- 12 Treatment for Nervous and Mental Conditions - 30 Days inpatient or
- 13 outpatient - 30% copayment;
- 14 Alcohol and Substance Abuse Treatment - 30 days inpatient or
- 15 outpatient - 30% copayment;
- 16 Wellness benefit - \$600 per year, \$50 deductible, 20% coinsurance per
- 17 service; and
- 18 Physicians visits per year for diagnosed illness or injury - to an
- 19 aggregate of \$700 per year.
- 20 b. A carrier shall offer the benefits on an indemnity basis, with an
- 21 option that: (1) coverage is restricted to health care providers in the
- 22 carrier's network or preferred provider organization; or (2) coverage
- 23 is provided through health care providers in the carrier's network or
- 24 preferred provider organization with an out-of-network option with a
- 25 30% copayment in addition to whatever other copayment may be
- 26 applicable under the policy.
- 27 c. With respect to all policies or contracts issued pursuant to this
- 28 section, the premium rate charged by a carrier to the highest rated
- 29 small employer group shall not be greater than 350% of the premium
- 30 rate charged for the lowest rated small employer group purchasing this
- 31 health benefits plan, provided, however, that the only factors upon
- 32 which the rate differential may be based are age, gender, and
- 33 geography. Policies or contracts issued pursuant to this section shall
- 34 be rated separately from the five standard plans, in accordance with
- 35 their own loss experience.
- 36 d. Carriers may offer enhanced or additional benefits for an
- 37 additional premium in the form of a rider or riders, which shall be
- 38 comprised of a combination of enhanced or additional benefits, in a
- 39 manner which will avoid adverse selection to the extent possible.
- 40 e. The provisions of P. L. 1992, c. 162 (C.17B:27A-17 et seq.)
- 41 shall apply to this section to the extent that they are not contrary to
- 42 the provisions of this section, including but not limited to, provisions
- 43 relating to guaranteed issue, calculation of loss ratio, and the liability
- 44 for assessment.
- 45 f. No later than 120 days following enactment of this act, every
- 46 carrier shall make an informational filing with the commissioner, which

1 shall include the policy form, the premiums to be charged for the
2 coverage, and the anticipated loss ratio. If the commissioner has not
3 disapproved the form within 30 days, the form shall be deemed
4 approved.

5 g. Every carrier and every insurance producer shall make a good
6 faith effort to market the contract or policy established pursuant to this
7 section. If the board determines that such a good faith effort has not
8 been made, they shall recommend to the commissioner that the carrier
9 be subject to a fine of not more than \$5,000, which shall be levied by
10 the commissioner pursuant to the provisions of the "Penalty
11 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

12

13 4. This act shall take effect immediately.

14

15

16

STATEMENT

17

18 This bill adds an additional, more affordable health insurance policy
19 to the standard health benefit plans offered in the individual and small
20 employer group markets. When the respective boards of the New
21 Jersey Individual Health Coverage Program and the New Jersey Small
22 Employer Health Benefits Program formulated the standard plans, they
23 disregarded the language in the law and the legislative intent that there
24 would be a variation in benefits among the plans, creating lower-cost
25 policies. As a result, the standard plans are uniformly rich in benefits
26 and for many people, increasingly unaffordable.

27 The plans set forth in this bill are modeled on the indemnity plans
28 that dominated the market in the 1970's. At that time, there was
29 greater cost sharing between insurer and insured in the form of direct
30 payments to providers for health care services such as visits to
31 physicians' offices. This bill embodies that principle, providing for the
32 direct payment by insureds for health care services that are reasonably
33 affordable, which provides a more efficient use of the policyholders'
34 funds, eliminating the additional expenses that accrue if those services
35 are paid through premiums. These additional expenses are
36 administrative costs of processing claims, premium taxes,
37 commissions, insurer profits, and provider expenses connected with
38 the third party payer system.

39 This plan provides for essential services, including hospitalization
40 and hospital-based treatment, diagnostic tests, wellness benefits,
41 mental health and substance abuse benefits, and physician services. It
42 must be sold on a guaranteed-issue, guaranteed-renewal basis, and
43 rating cannot be based on the health status of the individual member
44 or a member of a small employer group. It contains the same
45 preexisting condition provisions as the standard plans.

46 The bill is aimed at making health insurance available for younger

1 families who do not have the resources to pay for coverage in the
2 individual market, as well as small employers who cannot afford the
3 small group policies currently offered. To this end, this policy is not
4 to be community rated, permitting a differential of 350% from the
5 highest-to-lowest premium, which is advantageous to the younger
6 people without insurance coverage; the other plans in the individual
7 market continue to be community rated and the standard plans in the
8 small employer group market continue to be rated at a 2-1 ratio of
9 highest-to-lowest premiums.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE, No. 13

with committee amendments

STATE OF NEW JERSEY

DATED: NOVEMBER 9, 2000

The Senate Health Committee reports favorably and with committee amendments Senate Bill No. 13.

As amended by committee, this bill adds an additional, more affordable health insurance policy to the standard health benefits plans offered in the individual and small employer markets.

The health benefits plans established in this bill are modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This bill embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policyholders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses include administrative costs of processing claims and provider expenses connected with the third party payer system.

The health benefits plans in this bill provide for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plans must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member or a member of a small employer group. The plans contain the same preexisting condition provisions as the standard plans.

The bill is aimed at making health insurance available for younger families who do not have the resources to pay for coverage in the individual market, as well as small employers who cannot afford the small group policies currently offered. To this end, this policy will not be community rated, permitting a differential of 350% from the highest-to-lowest premium, which is advantageous to younger persons without insurance coverage; the other plans in the individual market continue to be community rated and the standard plans in the small employer group market continue to be rated at a 2 to 1 ratio of highest-to-lowest premiums.

The committee adopted technical amendments to the bill to clarify the intent of the bill.

[First Reprint]
SENATE, No. 13

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:

Senator JOHN J. MATHEUSSEN

District 4 (Camden and Gloucester)

Senator JACK SINAGRA

District 18 (Middlesex)

Co-Sponsored by:

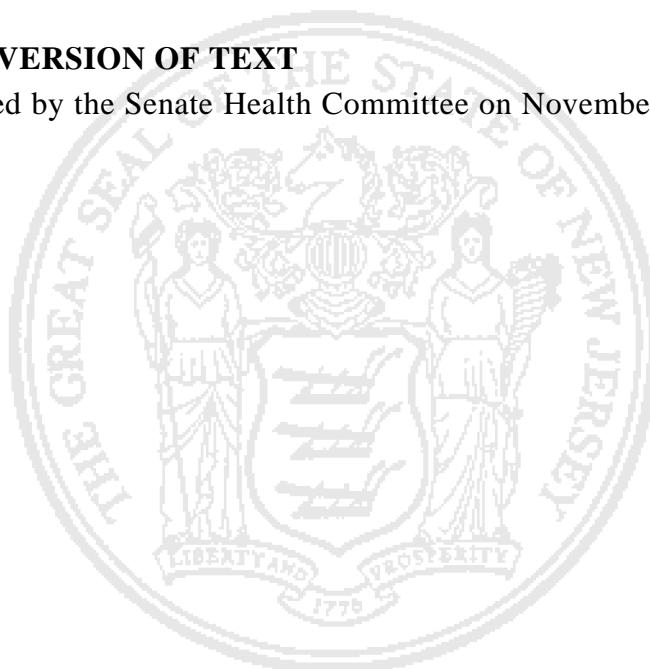
**Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero,
Bennett, Bark, Palaia, Kavanaugh, Bassano and McNamara**

SYNOPSIS

Requires individual and small employer group carriers to offer a new health benefits plan.

CURRENT VERSION OF TEXT

As reported by the Senate Health Committee on November 9, 2000, with amendments.



(Sponsorship Updated As Of: 10/24/2000)

1 AN ACT concerning health insurance and supplementing
2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
3 (C.17:27A-17 et seq.).

4

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

7

8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
10 reform in 1992 for the individual and small group markets that
11 provided guaranteed-issue, guaranteed-renewal coverage, with a
12 prohibition against rating on the basis of health status and removing
13 most preexisting condition exclusions from policies, the plans that
14 were established by the respective boards did not offer sufficient
15 variety or options to insureds in terms of the range of coverages that
16 are provided under the standard plans;

17 b. The original intent of the Legislature was to give policyholders
18 a wider range of coverage options, including policies that provide
19 reimbursement for basic and essential health care services but do not
20 contain either the traditional mandated benefits to which the standard
21 plans are subject or reimbursement for services which the consumer
22 can more economically pay for himself, rather than having those
23 services paid for through a third-party system, which adds significantly
24 to the cost;

25 c. The boards of the New Jersey Individual Health Coverage
26 Program and the New Jersey Small Employer Health Benefits Program
27 elected to provide little variance in the coverage provided under the
28 standard plans; rather, reductions in premium cost can be obtained
29 primarily through increasing the deductibles to substantial sums, which
30 defeats the objective of making the policies affordable, in that large
31 deductibles represent large out-of-pocket expenses;

32 d. In the absence of any affirmative action by either board to
33 remedy this situation, it is the purpose of this bill to create a policy
34 that is more affordable than the options that presently exist; even
35 though the benefit package is not as rich as the existing plans, the
36 benefit plans provided by this act will make health insurance more
37 accessible to many individuals and small groups that do not have the
38 economic resources to afford the existing plans while still providing
39 essential coverage.

40 e. It is to the interest of the State and of all health care providers
41 that as many people have access to reasonably affordable health
42 insurance as possible, for this reduces the amount of charity care that

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SHH committee amendments adopted November 9, 2000.

1 providers provide as well as the amount of bad debt that must be
2 absorbed by providers each year.

3

4 2. a. Notwithstanding the provisions of P.L.1992, c.161
5 (C.17B:27A-2 et seq.), every carrier ¹that writes individual health
6 benefits plans pursuant to P.L.1992, c.161¹ shall offer a health benefits
7 plan in the individual health insurance market that includes only the
8 coverages enumerated in this section, as follows:

9 90 days hospital room and board - \$500 deductible per hospital stay;

10 Outpatient and ambulatory surgery;

11 Physicians' fees connected with hospital care, including general acute
12 care and surgery;

13 Anesthesia and the administration of anesthesia;

14 Coverage for newborns;

15 Treatment for complications of pregnancy;

16 ¹[IV Solutions] Intravenous solutions¹, blood and blood plasma;

17 Oxygen and the administration of oxygen;

18 Radiation and x-ray therapy;

19 Physical therapy and hydrotherapy - \$20 deductible for outpatient
20 treatment;

21 Dialysis - inpatient or outpatient;

22 Inpatient diagnostic tests and \$500 annual aggregate for out-of-
23 hospital diagnostic tests;

24 Laboratory fees for treatment in hospital;

25 Delivery room fees;

26 Operating room fees;

27 Intensive care unit;

28 Treatment room fees;

29 Emergency room services for medically necessary treatment;

30 Pharmaceuticals dispensed in hospital;

31 Dressings;

32 Splints;

33 Treatment for Nervous and Mental Conditions- 30 Days inpatient or
34 outpatient - 30% copayment;

35 Alcohol and Substance Abuse Treatment - 30 days inpatient or
36 outpatient - 30% copayment;

37 Wellness benefit - \$600 per year, \$50 deductible, 20% coinsurance per
38 service; and

39 Physicians visits ¹[per year]¹ for diagnosed illness or injury - to an
40 aggregate of \$700 per year.

41 b. A carrier shall offer the benefits on an indemnity basis, with the
42 option that: (1) coverage is restricted to health care providers in the
43 carrier's network ¹[or preferred provider organization]¹; ¹[and] or¹
44 (2) coverage is provided through health care providers in the carrier's
45 network ¹[or preferred provider organization] ¹with an out-of-
46 network option with a 30% copayment in addition to whatever other

1 copayment may be applicable under the policy.

2 c. With respect to all policies or contracts issued pursuant to this
3 section, the premium rate charged by a carrier to the highest rated
4 individual or class of individuals shall not be greater than 350% of the
5 premium rate charged for the lowest rated individual or class of
6 individuals purchasing this health benefits plan, provided, however,
7 that the only factors upon which the rate differential may be based are
8 age, gender, and geography. Policies or contracts issued pursuant to
9 this section shall be rated separately from the five standard plans, in
10 accordance with their own loss experience.

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

16 e. The provisions of P.L.1992, c.¹[162] 161¹ (C.17B:27A-2 et
17 seq.) shall apply to this section to the extent that they are not contrary
18 to the provisions of this section, including but not limited to,
19 provisions relating to ¹preexisting conditions,¹ guaranteed issue,
20 calculation of loss ratio, and the liability for assessment.

21 f. No later than 120 days following enactment of this act, every
22 carrier shall make an informational filing with the commissioner, which
23 shall include the policy form, the premiums to be charged for the
24 coverage, and the anticipated loss ratio. If the commissioner has not
25 disapproved the form within 30 days, the form shall be ¹deemed¹
26 approved.

27 g. Every carrier and every insurance producer shall make a good
28 faith effort to market the contract or policy established pursuant to this
29 section. If the board determines that such a good faith effort has not
30 been made, they shall recommend to the commissioner that the carrier
31 be subject to a fine of not more than \$5,000, which shall be levied by
32 the commissioner pursuant to the provisions of the "Penalty
33 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).
34

35 3. a. Notwithstanding the provisions of P.L.1992, c.162
36 (C.17B:27A-17 et seq.), every ¹[small employer]¹ carrier ¹that writes
37 small employer health benefits plans pursuant to P.L.1992, c.162¹
38 shall offer a small employer health benefits plan that includes only the
39 coverages enumerated in this section, as follows:

40 90 days hospital room and board - \$500 deductible per stay;

41 Outpatient and ambulatory surgery;

42 Physicians' fees connected with hospital care, including general acute
43 care and surgery;

44 Anesthesia and the administration of anesthesia;

45 Coverage for newborns;

46 Treatment for complications of pregnancy;

- 1 ¹[IV Solutions] Intravenous solutions¹, blood and blood plasma;
- 2 Oxygen and the administration of oxygen;
- 3 Radiation and x-ray therapy;
- 4 Physical therapy and hydrotherapy - \$20 deductible for outpatient
- 5 treatment;
- 6 Dialysis - inpatient or outpatient;
- 7 Inpatient diagnostic tests and \$500 annual aggregate for out-of-
- 8 hospital diagnostic tests;
- 9 Laboratory fees for treatment in hospital;
- 10 Delivery room fees;
- 11 Operating room fees;
- 12 Intensive care unit;
- 13 Treatment room fees;
- 14 Emergency room services for medically necessary treatment;
- 15 Pharmaceuticals dispensed in hospital;
- 16 Dressings;
- 17 Splints;
- 18 Treatment for Nervous and Mental Conditions - 30 Days inpatient or
- 19 outpatient - 30% copayment;
- 20 Alcohol and Substance Abuse Treatment - 30 days inpatient or
- 21 outpatient - 30% copayment;
- 22 Wellness benefit - \$600 per year, \$50 deductible, 20% coinsurance per
- 23 service; and
- 24 Physicians visits ¹[per year]¹ for diagnosed illness or injury - to an
- 25 aggregate of \$700 per year.
- 26 b. A carrier shall offer the benefits on an indemnity basis, with an
- 27 option that: (1) coverage is restricted to health care providers in the
- 28 carrier's network ¹[or preferred provider organization]¹; or (2)
- 29 coverage is provided through health care providers in the carrier's
- 30 network ¹[or preferred provider organization]¹ with an out-of-
- 31 network option with a 30% copayment in addition to whatever other
- 32 copayment may be applicable under the policy.
- 33 c. With respect to all policies or contracts issued pursuant to this
- 34 section, the premium rate charged by a carrier to the highest rated
- 35 small employer group shall not be greater than 350% of the premium
- 36 rate charged for the lowest rated small employer group purchasing this
- 37 health benefits plan, provided, however, that the only factors upon
- 38 which the rate differential may be based are age, gender, and
- 39 geography. Policies or contracts issued pursuant to this section shall
- 40 be rated separately from the five standard plans, in accordance with
- 41 their own loss experience.
- 42 d. Carriers may offer enhanced or additional benefits for an
- 43 additional premium in the form of a rider or riders, which shall be
- 44 comprised of a combination of enhanced or additional benefits, in a
- 45 manner which will avoid adverse selection to the extent possible.
- 46 e. The provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) shall

1 apply to this section to the extent that they are not contrary to the
2 provisions of this section, including but not limited to, provisions
3 relating to preexisting conditions,¹ guaranteed issue, calculation of
4 loss ratio, and the liability for assessment.

5 f. No later than 120 days following enactment of this act, every
6 carrier shall make an informational filing with the commissioner, which
7 shall include the policy form, the premiums to be charged for the
8 coverage, and the anticipated loss ratio. If the commissioner has not
9 disapproved the form within 30 days, the form shall be deemed
10 approved.

11 g. Every carrier and every insurance producer shall make a good
12 faith effort to market the contract or policy established pursuant to this
13 section. If the board determines that such a good faith effort has not
14 been made, they shall recommend to the commissioner that the carrier
15 be subject to a fine of not more than \$5,000, which shall be levied by
16 the commissioner pursuant to the provisions of the "Penalty
17 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

18

19 4. This act shall take effect immediately.

STATEMENT TO

[First Reprint]

SENATE, No. 13

with Senate Floor Amendments
(Proposed By Senator MATHEUSSEN)

ADOPTED: DECEMBER 4, 2000

These amendments:

- (1) provide that the limited, new health benefits plan would apply only to individual policies and delete the provisions establishing such a plan for small employers;
- (2) clarify the benefits that shall be provided under the plan by:
 - establishing copayments for outpatient and ambulatory surgery (\$250 per surgery) and emergency room treatment (\$100 per visit);
 - providing coverage for physicians' fees connected with outpatient and ambulatory surgery, outpatient physical therapy (30 visits annually with a \$20 per treatment copayment, treatment for biologically-based mental illness (90 days inpatient with no coinsurance, but \$500 copayment per inpatient stay, and 30 days outpatient with 30% coinsurance), rather than treatment for nervous and mental conditions, and childhood and adult immunizations; and
 - replacing the terms deductible and copayment with copayment and coinsurance, respectively, to better reflect the nature of the insured's payment responsibility;
- (3) restore language permitting carriers to offer the benefits with the option that coverage is restricted to health care providers in the carrier's preferred provider organization, and add language specifying that a carrier may offer coverage through an exclusive provider organization (EPO);
- (4) delete language specifying that the policies issued under this bill shall be rated separately from the five standard plans in accordance with their own loss experience and specify, instead, that rates shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered;
- (5) delete language that provided that carrier liability for assessment under N.J.S.A.17B:27A-11 would also apply for policies issued under this bill, and provide, instead, that the board shall establish a separate formula for calculating the amount of the aggregate liability of a carrier that is attributable and allocated to policies issued under this bill. The formula shall provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in

their premium, taking into account the differential in benefit levels under the health benefits plans provided for in this bill and the five standard health benefits plans;

(6) extend the effective date of the bill from immediately to nine months after enactment and require carriers to make an informational filing with the board, including the policy form, within one year of the date of enactment;

(7) delete language that requires an insurance producer to make a good faith effort to market the plan and provide, instead, that a carrier shall make available and make a good faith effort to market the plan. Also, amendments delete the fine for failure to make a good faith effort, and provide, instead, that a carrier that fails to comply with the marketing requirement would be subject to the provisions of the insurance trade practices act, N.J.S.A.17B:30-1 et seq.;

(8) direct the individual and small employer boards to evaluate the effectiveness of the bill and determine if the limited health benefits plan should be extended to the small employer market; and

(9) permit carriers in the small employer market to offer one or more, but not all five, of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care.

[Second Reprint]
SENATE, No. 13

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:

Senator JOHN J. MATHEUSSEN

District 4 (Camden and Gloucester)

Senator JACK SINAGRA

District 18 (Middlesex)

Co-Sponsored by:

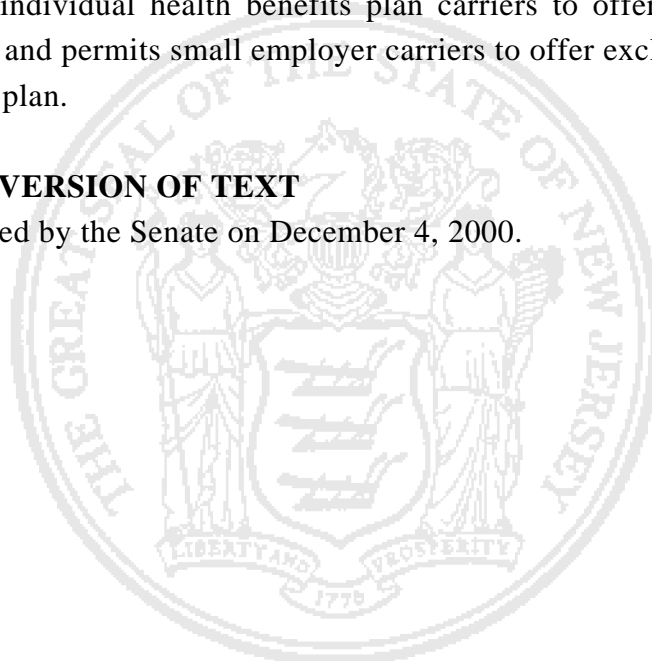
**Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero,
Bennett, Bark, Palaia, Kavanaugh, Bassano and McNamara**

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As amended by the Senate on December 4, 2000.



(Sponsorship Updated As Of: 10/24/2000)

1 AN ACT concerning health insurance and supplementing
 2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
 3 (C.17:27A-17 et seq.).

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

7
 8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
 10 reform in 1992 for the individual ²[and small group markets] market²
 11 that provided guaranteed-issue, guaranteed-renewal coverage, with a
 12 prohibition against rating on the basis of health status and ²[removing
 13 most] limiting² preexisting condition exclusions ²[from] in² policies,
 14 the plans that were established by the ²[respective boards] New Jersey
 15 Individual Health Coverage Program Board² did not offer sufficient
 16 variety or options to insureds in terms of the range of coverages that
 17 are provided under the standard plans;

18 b. The original intent of the Legislature was to give policyholders
 19 a wider range of coverage options, including policies that provide
 20 reimbursement for basic and essential health care services but do not
 21 contain either the traditional mandated benefits to which the standard
 22 plans are subject or reimbursement for services which the consumer
 23 can more economically pay for himself, rather than having those
 24 services paid for through a third-party system, which adds significantly
 25 to the cost;

26 c. The ²[boards of the]² New Jersey Individual Health Coverage
 27 Program ²[and the New Jersey Small Employer Health Benefits
 28 Program] Board² elected to provide little variance in the coverage
 29 provided under the standard plans; rather, reductions in premium cost
 30 can be obtained primarily through increasing the deductibles to
 31 substantial sums, which defeats the objective of making the policies
 32 affordable, in that large deductibles represent large out-of-pocket
 33 expenses;

34 d. In the absence of any affirmative action by ²[either] the² board
 35 to remedy this situation, it is the purpose of this bill to create a policy
 36 that is more affordable than the options that presently exist; even
 37 though the benefit package is not as rich as the existing plans, the
 38 benefit ²[plans] plan² provided by this act will make health insurance
 39 more accessible to many individuals ²[and small groups]² that do not
 40 have the economic resources to afford the existing plans while still

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SHH committee amendments adopted November 9, 2000.

² Senate floor amendments adopted December 4, 2000.

1 providing essential coverage.

2 e. It is to the interest of the State and of all health care providers
3 that as many people have access to reasonably affordable health
4 insurance as possible, for this reduces the amount of charity care that
5 providers provide as well as the amount of bad debt that must be
6 absorbed by providers each year.

7

8 2. a. Notwithstanding the provisions of P.L.1992, c.161
9 (C.17B:27A-2 et seq.), every carrier ¹that writes individual health
10 benefits plans pursuant to P.L.1992, c.161¹ shall offer a health benefits
11 plan in the individual health insurance market that includes only the
12 coverages enumerated in this section, as follows:

13 90 days hospital room and board - \$500 ²~~[deductible]~~copayment² per
14 hospital stay;

15 Outpatient and ambulatory surgery ²- \$250 copayment per surgery²;

16 Physicians' fees connected with hospital care, including general acute
17 care and surgery;

18 ²Physicians' fees connected with outpatient and ambulatory surgery²

19 Anesthesia and the administration of anesthesia;

20 Coverage for newborns;

21 Treatment for complications of pregnancy;

22 ¹~~[IV Solutions]~~ Intravenous solutions¹, blood and blood plasma;

23 Oxygen and the administration of oxygen;

24 Radiation and x-ray therapy;

25 ²~~[Physical]~~ Inpatient physical² therapy and hydrotherapy

26 ²Outpatient physical therapy² - ²30 visits annually per covered
27 person-² \$20 ²~~[deductible for outpatient treatment]~~ copayment per
28 treatment²;

29 Dialysis - inpatient or outpatient;

30 Inpatient diagnostic tests and \$500 annual aggregate ²per covered
31 person² for out-of-hospital diagnostic tests;

32 Laboratory fees for treatment in hospital;

33 Delivery room fees;

34 Operating room fees;

35 ²~~[Intensive]~~ Special² care unit;

36 Treatment room fees;

37 Emergency room services for medically necessary treatment ²- \$100
38 copayment per visit²;

39 Pharmaceuticals dispensed in hospital;

40 Dressings;

41 Splints;

42 ²~~[Treatment for Nervous and Mental Conditions- 30 Days inpatient~~
43 or outpatient- 30% copayment] Treatment for biologically-based
44 mental illness, as defined in P.L.1999, c.106 (C.17B:27A-7.5) - 90
45 days inpatient with no coinsurance - \$500 copayment per
46 inpatient stay, 30 days outpatient with 30% coinsurance²;

- 1 Alcohol and Substance Abuse Treatment - 30 days inpatient or
2 outpatient - 30% ²[copayment] coinsurance²;
- 3 ²Childhood immunizations in accordance with the provisions of
4 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
5 adult immunizations;²
- 6 Wellness benefit - \$600 ²[per year] annual aggregate per covered
7 person², \$50 ²annual² deductible, 20% coinsurance per service;
8 and
- 9 Physicians visits¹[per year]¹ for diagnosed illness or injury- to
10 an ²\$700 annual² aggregate ²[of \$700 per year] per covered
11 person².
- 12 b. A carrier shall offer the benefits on an indemnity basis, with the
13 option that: (1) coverage is restricted to health care providers in the
14 carrier's network ¹[or preferred provider organization]¹ ², including
15 an exclusive provider organization, or the carrier's preferred provider
16 organization²; ¹[and] or¹ (2) coverage is provided through health care
17 providers in the carrier's network ¹[or preferred provider
18 organization]¹ ²or preferred provider organization² with an out-of-
19 network option with ²[a]² 30% ²[copayment] coinsurance² in addition
20 to whatever other ²[copayment] coinsurance² may be applicable under
21 the policy.
- 22 c. With respect to all policies or contracts issued pursuant to this
23 section, the premium rate charged by a carrier to the highest rated
24 individual or class of individuals shall not be greater than 350% of the
25 premium rate charged for the lowest rated individual or class of
26 individuals purchasing this health benefits plan, provided, however,
27 that the only factors upon which the rate differential may be based are
28 age, gender, and geography. ²[Policies or contracts issued pursuant
29 to this section shall be rated separately from the five standard plans,
30 in accordance with their own loss experience.] Rates applicable to
31 policies or contracts issued pursuant to this section shall reflect past
32 and prospective loss experience for benefits included in such policies
33 or contracts, and shall be formulated in a manner that does not result
34 in an unfair subsidization of rates applicable to policies issued pursuant
35 to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the
36 result of differences in levels of benefits offered.²
- 37 d. Carriers may offer enhanced or additional benefits for an
38 additional premium amount in the form of a rider or riders, each of
39 which shall be comprised of a combination of enhanced or additional
40 benefits, in a manner which will avoid adverse selection to the extent
41 possible.
- 42 e. The provisions of P.L.1992, c. ¹[162] 161¹ (C.17B:27A-2 et
43 seq.) shall apply to this section to the extent that they are not contrary
44 to the provisions of this section, including but not limited to,
45 provisions relating to ¹preexisting conditions.¹ guaranteed issue,

1 calculation of loss ratio² [and the liability for assessment]². ² With
2 respect to liability for assessment, the board shall establish a separate
3 formula for calculating the amount of the aggregate liability of a
4 carrier that is attributable and allocated to health benefits plans issued
5 pursuant to this act. The formula shall provide for an equitable
6 allocation of a carrier's assessment pursuant to section 11 of P.L.
7 1992, c. 161 (C.17B:27A-11), so that persons covered by the health
8 benefits plan provided for in this act do not bear a disproportionate
9 burden of a carrier's assessment in their premium, taking into account
10 the differential in benefit levels under the health benefits plans
11 provided for in this act and those health benefits plans issued pursuant
12 to P.L. 1992, c.161 (C:17B:27A-2 et seq.). The formula may take
13 into account the relative loss experience, relative actuarial value based
14 on benefits offered, relative loss ratio, relative administrative expenses,
15 and such other items as the board deems appropriate.²

16 f. No later than ²[120 days] one year² following enactment of this
17 act, every carrier shall make an informational filing with the
18 ²[commissioner] board², which shall include the policy form, the
19 premiums to be charged for the coverage, and the anticipated loss
20 ratio. If the ²[commissioner] board² has not disapproved the form
21 within 30 days, the form shall be ¹deemed¹ approved.

22 g. Every carrier ²[and every insurance producer]that writes
23 individual health benefits plans pursuant to P.L.1992, c.161
24 (C.17B:27A-2 et seq.) shall make available and² shall make a good
25 faith effort to market the contract or policy established pursuant to this
26 section. ²[If the board determines that such a good faith effort has not
27 been made, they shall recommend to the commissioner that the carrier
28 be subject to a fine of not more than \$5,000, which shall be levied by
29 the commissioner pursuant to the provisions of the "Penalty
30 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).]
31 A carrier who is in violation of this section shall be subject to the
32 provisions of N.J.S.17B:30-1.²

33
34 ²[3. a. Notwithstanding the provisions of P.L.1992, c.162
35 (C.17B:27A-17 et seq.), every ¹[small employer]¹ carrier ¹that writes
36 small employer health benefits plans pursuant to P.L.1992, c.162¹
37 shall offer a small employer health benefits plan that includes only the
38 coverages enumerated in this section, as follows:

39 90 days hospital room and board - \$500 deductible per stay;

40 Outpatient and ambulatory surgery;

41 Physicians' fees connected with hospital care, including general acute
42 care and surgery;

43 Anesthesia and the administration of anesthesia;

44 Coverage for newborns;

45 Treatment for complications of pregnancy;

- 1 ¹[IV Solutions] Intravenous solutions¹, blood and blood plasma;
- 2 Oxygen and the administration of oxygen;
- 3 Radiation and x-ray therapy;
- 4 Physical therapy and hydrotherapy - \$20 deductible for outpatient
- 5 treatment;
- 6 Dialysis - inpatient or outpatient;
- 7 Inpatient diagnostic tests and \$500 annual aggregate for out-of-
- 8 hospital diagnostic tests;
- 9 Laboratory fees for treatment in hospital;
- 10 Delivery room fees;
- 11 Operating room fees;
- 12 Intensive care unit;
- 13 Treatment room fees;
- 14 Emergency room services for medically necessary treatment;
- 15 Pharmaceuticals dispensed in hospital;
- 16 Dressings;
- 17 Splints;
- 18 Treatment for Nervous and Mental Conditions - 30 Days inpatient or
- 19 outpatient - 30% copayment;
- 20 Alcohol and Substance Abuse Treatment - 30 days inpatient or
- 21 outpatient - 30% copayment;
- 22 Wellness benefit - \$600 per year, \$50 deductible, 20% coinsurance per
- 23 service; and
- 24 Physicians visits ¹[per year]¹ for diagnosed illness or injury - to an
- 25 aggregate of \$700 per year.
- 26 b. A carrier shall offer the benefits on an indemnity basis, with an
- 27 option that: (1) coverage is restricted to health care providers in the
- 28 carrier's network ¹[or preferred provider organization]¹; or (2)
- 29 coverage is provided through health care providers in the carrier's
- 30 network ¹[or preferred provider organization]¹ with an out-of-
- 31 network option with a 30% copayment in addition to whatever other
- 32 copayment may be applicable under the policy.
- 33 c. With respect to all policies or contracts issued pursuant to this
- 34 section, the premium rate charged by a carrier to the highest rated
- 35 small employer group shall not be greater than 350% of the premium
- 36 rate charged for the lowest rated small employer group purchasing this
- 37 health benefits plan, provided, however, that the only factors upon
- 38 which the rate differential may be based are age, gender, and
- 39 geography. Policies or contracts issued pursuant to this section shall
- 40 be rated separately from the five standard plans, in accordance with
- 41 their own loss experience.
- 42 d. Carriers may offer enhanced or additional benefits for an
- 43 additional premium in the form of a rider or riders, which shall be
- 44 comprised of a combination of enhanced or additional benefits, in a
- 45 manner which will avoid adverse selection to the extent possible.
- 46 e. The provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) shall

1 apply to this section to the extent that they are not contrary to the
2 provisions of this section, including but not limited to, provisions
3 relating to ¹preexisting conditions,¹ guaranteed issue, calculation of
4 loss ratio, and the liability for assessment.

5 f. No later than 120 days following enactment of this act, every
6 carrier shall make an informational filing with the commissioner, which
7 shall include the policy form, the premiums to be charged for the
8 coverage, and the anticipated loss ratio. If the commissioner has not
9 disapproved the form within 30 days, the form shall be deemed
10 approved.

11 g. Every carrier and every insurance producer shall make a good
12 faith effort to market the contract or policy established pursuant to this
13 section. If the board determines that such a good faith effort has not
14 been made, they shall recommend to the commissioner that the carrier
15 be subject to a fine of not more than \$5,000, which shall be levied by
16 the commissioner pursuant to the provisions of the "Penalty
17 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).]²
18

19 ²3. The New Jersey Individual Health Coverage Program Board,
20 in consultation with the New Jersey Small Employer Health Benefits
21 Program Board, shall evaluate the effectiveness of this act in providing
22 affordable health care coverage and whether the health benefits plan
23 established in this act or a similar plan should be made available to
24 small employers.

25 The boards shall report to the Legislature and Governor two years
26 after the effective date of this act on their evaluation of the health
27 benefits plan established in this act and shall include in their report the
28 number of policies or contracts sold, the premiums charged and the
29 effect, if any, that the health benefits plan has had on the five standard
30 health benefits plans offered to individuals in the State. The report
31 shall also include the boards' recommendations with respect to
32 expanding the number of, or making modifications to, the standard
33 health benefits plans currently offered to small employers to include
34 the health benefits plan established pursuant to this act or a similar
35 plan.²
36

37 ²4. A carrier that writes small employer health benefits plans
38 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may offer one or
39 more of the five health benefits plans, but shall not offer all five, as
40 policies or contracts that require the policy holder or contract holder
41 to receive plan benefits solely through the carrier's network of
42 providers, with no reimbursement for any out-of-network benefits
43 other than emergency care, urgent care, and continuity of care.
44 Policies or contracts written on this basis shall be rated in a separate
45 rating pool for the purposes of establishing a premium, but for the
46 purpose of determining a carrier's losses, these policies or contracts

1 shall be aggregated with the losses on the carrier's other business
2 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17
3 et seq.).²

4

5 ²[4.] 5.² This act shall take effect ²[immediately] on the 270th
6 day following enactment, but the New Jersey Individual Health
7 Coverage Program Board may take such anticipatory administrative
8 action in advance as shall be necessary for the implementation of the
9 act.²

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

[Second Reprint]

SENATE, No. 13

STATE OF NEW JERSEY

DATED: MAY 3, 2001

The Assembly Health Committee reports favorably Senate Bill No. 13 (2R).

This bill adds an additional, more affordable health insurance policy to the standard health benefits plans offered in the individual market.

The health benefits plan established in this bill is modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This bill embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policyholders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses include administrative costs of processing claims and provider expenses connected with the third party payer system.

The health benefits plan in this bill provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The bill specifies that the rates applicable to policies issued under the bill shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The bill directs the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-12 that is attributable and allocated to policies issued under this bill. The formula shall provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the

differential in benefit levels under the health benefits plan provided for in this bill and the five standard health benefits plans.

In addition, the bill requires that a carrier make available, and make a good faith effort to market, the policy. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The bill directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the bill in providing affordable health care coverage and whether the health benefits plan established in this bill or a similar plan should be made available to small employers.

The bill would permit carriers in the small employer market to offer one or more, but not all five, of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care.

The bill takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The bill is aimed at making health insurance available for younger families who do not have the resources to pay for coverage in the individual market. To this end, this policy will not be community rated, permitting a differential of 350% from the highest-to-lowest premium, which is advantageous to younger persons without insurance coverage; while the other plans in the individual market will continue to be community rated.

This bill is identical to the Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791 (Vandervalk/Gregg/Guear/Greenstein), which the committee also reported on this date.

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

[Second Reprint] **SENATE, No. 13**

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Banking and Insurance Committee reports favorably and with committee amendments, Senate Bill No. 13 (2R).

This bill, as amended by the committee, adds an additional health benefits plan to the five standard health benefits plans currently offered in the individual health insurance market.

With the committee amendments, the health benefits plan established under this bill provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The bill specifies that the rates applicable to policies issued under the bill shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The bill also provides that the health benefits plan established under the bill will not be community rated, permitting a differential of 350% from the highest-to-lowest premium; while the other plans in the individual market will continue to be community rated.

In addition, the bill requires that a carrier make available, and make a good faith effort to market, this health benefits plan. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the life and health insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The bill directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the bill in providing affordable health care coverage and whether the health benefits plan established in this bill or a similar plan should be made available to small employers.

The bill also permits that, in addition to the five health benefits plans, health insurance carriers that write in the small employer health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. A carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

The bill takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The committee amendments delete language from the bill which directed the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-12 that is attributable and allocated to the health benefits plan established by this bill and issued by the carriers in the individual market. The formula was to provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this bill and the five standard health benefits plans.

In addition, the amendments clarify that in addition to the five health benefits plans, health insurance carriers that write in the small employer health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. A carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

As released by the committee, this bill is identical to the Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791(1R).

[Third Reprint]

SENATE, No. 13

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:

Senator JOHN J. MATHEUSSEN

District 4 (Camden and Gloucester)

Senator JACK SINAGRA

District 18 (Middlesex)

Co-Sponsored by:

Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano, McNamara, Assemblywoman Vandervalk, Assemblymen Gregg, Guear, Assemblywomen Greenstein, Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As reported by the Assembly Banking and Insurance Committee on June 4, 2001, with amendments.

(Sponsorship Updated As Of: 6/15/2001)

1 AN ACT concerning health insurance and supplementing
 2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
 3 ³[(C.17:27A-17 et seq.)] (C.17B:27A-17 et seq.)³.

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

7
 8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
 10 reform in 1992 for the individual ²[and small group markets]market²
 11 that provided guaranteed-issue, guaranteed-renewal coverage, with a
 12 prohibition against rating on the basis of health status and ²[removing
 13 most] limiting² preexisting condition exclusions ²[from] in² policies,
 14 the plans that were established by the ²[respective boards]New Jersey
 15 Individual Health Coverage Program Board² did not offer sufficient
 16 variety or options to insureds in terms of the range of coverages that
 17 are provided under the standard plans;

18 b. The original intent of the Legislature was to give policyholders
 19 a wider range of coverage options, including policies that provide
 20 reimbursement for basic and essential health care services but do not
 21 contain either the traditional mandated benefits to which the standard
 22 plans are subject or reimbursement for services which the consumer
 23 can more economically pay for himself, rather than having those
 24 services paid for through a third-party system, which adds significantly
 25 to the cost;

26 c. The ²[boards of the]² New Jersey Individual Health Coverage
 27 Program ²[and the New Jersey Small Employer Health Benefits
 28 Program]Board² elected to provide little variance in the coverage
 29 provided under the standard plans; rather, reductions in premium cost
 30 can be obtained primarily through increasing the deductibles to
 31 substantial sums, which defeats the objective of making the policies
 32 affordable, in that large deductibles represent large out-of-pocket
 33 expenses;

34 d. In the absence of any affirmative action by ²[either]the² board
 35 to remedy this situation, it is the purpose of this bill to create a policy
 36 that is more affordable than the options that presently exist; even
 37 though the benefit package is not as rich as the existing plans, the
 38 benefit ²[plans] plan² provided by this act will make health insurance
 39 more accessible to many individuals ²[and small groups]² that do not
 40 have the economic resources to afford the existing plans while still

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SHH committee amendments adopted November 9, 2000.

² Senate floor amendments adopted December 4, 2000.

³ Assembly ABI committee amendments adopted June 4, 2001.

1 providing essential coverage.

2 e. It is to the interest of the State and of all health care providers
3 that as many people have access to reasonably affordable health
4 insurance as possible, for this reduces the amount of charity care that
5 providers provide as well as the amount of bad debt that must be
6 absorbed by providers each year.

7

8 2. a. Notwithstanding the provisions of P.L.1992, c.161
9 (C.17B:27A-2 et seq.), every carrier ¹that writes individual health
10 benefits plans pursuant to P.L.1992, c.161¹ shall offer a health benefits
11 plan in the individual health insurance market that includes only the
12 coverages enumerated in this section, as follows:

13 90 days hospital room and board - \$500 ²[deductible] copayment² per
14 hospital stay;

15 Outpatient and ambulatory surgery ²- \$250 copayment per surgery²;

16 Physicians' fees connected with hospital care, including general acute
17 care and surgery;

18 ²Physicians' fees connected with outpatient and ambulatory surgery²
19 ^{3,3}_u

20 Anesthesia and the administration of anesthesia;

21 Coverage for newborns;

22 Treatment for complications of pregnancy;

23 ¹[IV Solutions] Intravenous solutions¹, blood and blood plasma;

24 Oxygen and the administration of oxygen;

25 Radiation and x-ray therapy;

26 ²[Physical] Inpatient physical² therapy and hydrotherapy ^{3,3};

27 ²Outpatient physical therapy² - ²30 visits annually per covered
28 person-² \$20 ²[deductible for outpatient treatment] copayment per
29 treatment²;

30 Dialysis - inpatient or outpatient;

31 Inpatient diagnostic tests and \$500 annual aggregate ²per covered
32 person² for out-of-hospital diagnostic tests;

33 Laboratory fees for treatment in hospital;

34 Delivery room fees;

35 Operating room fees;

36 ²[Intensive] Special² care unit;

37 Treatment room fees;

38 Emergency room services for medically necessary treatment ²- \$100
39 copayment per visit²;

40 Pharmaceuticals dispensed in hospital;

41 Dressings;

42 Splints;

43 ²[Treatment for Nervous and Mental Conditions- 30 Days inpatient or
44 outpatient- 30% copayment] Treatment for biologically-based
45 mental illness, as defined in ³subsection a. of section 6 of³
46 P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no

- 1 coinsurance - \$500 copayment per inpatient stay, 30 days
2 outpatient with 30% coinsurance²;
- 3 Alcohol and Substance Abuse Treatment - 30 days inpatient or
4 outpatient - 30% ²[copayment] coinsurance²;
- 5 ²Childhood immunizations in accordance with the provisions of
6 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
7 adult immunizations²;
- 8 Wellness benefit - \$600 ²[per year] annual aggregate per covered
9 person², \$50 ²annual² deductible, 20% coinsurance per service;
10 and
- 11 Physicians visits¹[per year]¹ for diagnosed illness or injury - to ³[an]
12 a³ ²\$700 annual² aggregate ²[of \$700 per year] per covered
13 person².
- 14 b. A carrier shall offer the benefits on an indemnity basis, with the
15 option that: (1) coverage is restricted to health care providers in the
16 carrier's network ¹[or preferred provider organization]¹ ², including
17 an exclusive provider organization, or the carrier's preferred provider
18 organization²; ¹[and] or¹ (2) coverage is provided through health care
19 providers in the carrier's network ¹[or preferred provider
20 organization]¹ ²or preferred provider organization² with an out-of-
21 network option with ²[a]² 30% ²[copayment] coinsurance² in
22 addition to whatever other ²[copayment] coinsurance² may be
23 applicable under the policy.
- 24 c. With respect to all policies or contracts issued pursuant to this
25 section, the premium rate charged by a carrier to the highest rated
26 individual or class of individuals shall not be greater than 350% of the
27 premium rate charged for the lowest rated individual or class of
28 individuals purchasing this health benefits plan, provided, however,
29 that the only factors upon which the rate differential may be based are
30 age, gender, and geography. ²[Policies or contracts issued pursuant
31 to this section shall be rated separately from the five standard plans,
32 in accordance with their own loss experience.] Rates applicable to
33 policies or contracts issued pursuant to this section shall reflect past
34 and prospective loss experience for benefits included in such policies
35 or contracts, and shall be formulated in a manner that does not result
36 in an unfair subsidization of rates applicable to policies issued pursuant
37 to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the
38 result of differences in levels of benefits offered.²
- 39 d. Carriers may offer enhanced or additional benefits for an
40 additional premium amount in the form of a rider or riders, each of
41 which shall be comprised of a combination of enhanced or additional
42 benefits, in a manner which will avoid adverse selection to the extent
43 possible.
- 44 e. The provisions of P.L.1992, c.¹[162] 161¹ (C.17B:27A-2 et
45 seq.) shall apply to this section to the extent that they are not contrary

1 to the provisions of this section, including but not limited to,
2 provisions relating to ¹preexisting conditions,¹ guaranteed issue, ³and³
3 calculation of loss ratio² [, and the liability for assessment]². ³²With
4 respect to liability for assessment, the board shall establish a separate
5 formula for calculating the amount of the aggregate liability of a
6 carrier that is attributable and allocated to health benefits plans issued
7 pursuant to this act. The formula shall provide for an equitable
8 allocation of a carrier's assessment pursuant to section 11 of P.L.1992,
9 c.161 (C.17B:27A-11), so that persons covered by the health benefits
10 plan provided for in this act do not bear a disproportionate burden of
11 a carrier's assessment in their premium, taking into account the
12 differential in benefit levels under the health benefits plans provided
13 for in this act and those health benefits plans issued pursuant to
14 P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into
15 account the relative loss experience, relative actuarial value based on
16 benefits offered, relative loss ratio, relative administrative expenses,
17 and such other items as the board deems appropriate.²³

18 f. No later than ²[120 days] one year² following enactment of this
19 act, every carrier shall make an informational filing with the
20 ²[commissioner] board², which shall include the policy form, the
21 premiums to be charged for the coverage, and the anticipated loss
22 ratio. If the ²[commissioner] board² has not disapproved the form
23 within 30 days, the form shall be ¹deemed¹ approved.

24 g. Every carrier ²[and every insurance producer] that writes
25 individual health benefits plans pursuant to P.L.1992, c.161
26 (C.17B:27A-2 et seq.) shall make available and² shall make a good
27 faith effort to market the contract or policy established pursuant to this
28 section. ²[If the board determines that such a good faith effort has not
29 been made, they shall recommend to the commissioner that the carrier
30 be subject to a fine of not more than \$5,000, which shall be levied by
31 the commissioner pursuant to the provisions of the "Penalty
32 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).]
33 A carrier who is in violation of this section shall be subject to the
34 provisions of N.J.S.17B:30-1.²

35
36 ²3. The New Jersey Individual Health Coverage Program Board,
37 in consultation with the New Jersey Small Employer Health Benefits
38 Program Board, shall evaluate the effectiveness of this act in providing
39 affordable health care coverage and whether the health benefits plan
40 established in this act or a similar plan should be made available to
41 small employers.

42 The boards shall report to the Legislature and Governor two years
43 after the effective date of this act on their evaluation of the health
44 benefits plan established in this act and shall include in their report the
45 number of policies or contracts sold, the premiums charged and the
46 effect, if any, that the health benefits plan has had on the five standard

1 health benefits plans offered to individuals in the State. The report
2 shall also include the boards' recommendations with respect to
3 expanding the number of, or making modifications to, the standard
4 health benefits plans currently offered to small employers to include
5 the health benefits plan established pursuant to this act or a similar
6 plan.²

7
8 ²4. ³[A] In addition to the five health benefits plans offered by a
9 carrier on the effective date of this act, a³ carrier that writes small
10 employer health benefits plans pursuant to P.L.1992, c.162
11 (C.17B:27A-17 et seq.) may ³also³ offer one or more of the ³[five
12 health benefits]³ plans ³[, but shall not offer all five, as policies or
13 contracts that require the policy holder or contract holder to receive
14 plan benefits solely]³ through the carrier's network of providers, with
15 no reimbursement for any out-of-network benefits other than
16 emergency care, urgent care, and continuity of care. ³A carrier's
17 network of providers shall be subject to review and approval or
18 disapproval by the Commissioner of Banking and Insurance, in
19 consultation with the Commissioner of Health and Senior Services,
20 pursuant to regulations promulgated by the Department of Banking
21 and Insurance, including review and approval or disapproval before
22 plans with benefits provided through a carrier's network of providers
23 pursuant to this section may be offered by the carrier.³ Policies or
24 contracts written on this basis shall be rated in a separate rating pool
25 for the purposes of establishing a premium, but for the purpose of
26 determining a carrier's losses, these policies or contracts shall be
27 aggregated with the losses on the carrier's other business written
28 pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et
29 seq.).²

30
31 ²[4.] ^{5.}² This act shall take effect ²[immediately] on the 270th
32 day following enactment, but the New Jersey Individual Health
33 Coverage Program Board may take such anticipatory administrative
34 action in advance as shall be necessary for the implementation of the
35 act.²

STATEMENT TO

[Third Reprint]

SENATE, No. 13

with Assembly Floor Amendments
(Proposed By Assemblywoman VANDERVALK)

ADOPTED: JUNE 14, 2001

This amendment permits that, in addition to the five health benefits plans, health insurance carriers that write in the individual health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. The amendments provide that a carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

[Fourth Reprint]

SENATE, No. 13

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED SEPTEMBER 21, 2000

Sponsored by:

Senator JOHN J. MATHEUSSEN

District 4 (Camden and Gloucester)

Senator JACK SINAGRA

District 18 (Middlesex)

Co-Sponsored by:

Senators Bucco, Kosco, Allen, Inverso, Singer, Robertson, Cafiero, Bennett, Bark, Palaia, Kavanaugh, Bassano, McNamara, Assemblywoman Vandervalk, Assemblymen Gregg, Guear, Assemblywomen Greenstein, Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As amended by the General Assembly on June 14, 2001.

(Sponsorship Updated As Of: 6/15/2001)

1 AN ACT concerning health insurance and supplementing
 2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
 3 ³[(C.17:27A-17 et seq.)] (C.17B:27A-17 et seq.)³.

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

7
 8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
 10 reform in 1992 for the individual ²[and small group markets] market²
 11 that provided guaranteed-issue, guaranteed-renewal coverage, with a
 12 prohibition against rating on the basis of health status and ²[removing
 13 most] limiting² preexisting condition exclusions ²[from] in² policies,
 14 the plans that were established by the ²[respective boards] New Jersey
 15 Individual Health Coverage Program Board² did not offer sufficient
 16 variety or options to insureds in terms of the range of coverages that
 17 are provided under the standard plans;

18 b. The original intent of the Legislature was to give policyholders
 19 a wider range of coverage options, including policies that provide
 20 reimbursement for basic and essential health care services but do not
 21 contain either the traditional mandated benefits to which the standard
 22 plans are subject or reimbursement for services which the consumer
 23 can more economically pay for himself, rather than having those
 24 services paid for through a third-party system, which adds significantly
 25 to the cost;

26 c. The ²[boards of the]² New Jersey Individual Health Coverage
 27 Program ²[and the New Jersey Small Employer Health Benefits
 28 Program] Board² elected to provide little variance in the coverage
 29 provided under the standard plans; rather, reductions in premium cost
 30 can be obtained primarily through increasing the deductibles to
 31 substantial sums, which defeats the objective of making the policies
 32 affordable, in that large deductibles represent large out-of-pocket
 33 expenses;

34 d. In the absence of any affirmative action by ²[either] the² board
 35 to remedy this situation, it is the purpose of this bill to create a policy
 36 that is more affordable than the options that presently exist; even
 37 though the benefit package is not as rich as the existing plans, the
 38 benefit ²[plans] plan² provided by this act will make health insurance
 39 more accessible to many individuals ²[and small groups]² that do not

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SHH committee amendments adopted November 9, 2000.

² Senate floor amendments adopted December 4, 2000.

³ Assembly ABI committee amendments adopted June 4, 2001.

⁴ Assembly floor amendments adopted June 14, 2001.

1 have the economic resources to afford the existing plans while still
 2 providing essential coverage.

3 e. It is to the interest of the State and of all health care providers
 4 that as many people have access to reasonably affordable health
 5 insurance as possible, for this reduces the amount of charity care that
 6 providers provide as well as the amount of bad debt that must be
 7 absorbed by providers each year.

8

9 2. a. Notwithstanding the provisions of P.L.1992, c.161
 10 (C.17B:27A-2 et seq.), every carrier ¹that writes individual health
 11 benefits plans pursuant to P.L.1992, c.161¹ shall offer a health benefits
 12 plan in the individual health insurance market that includes only the
 13 coverages enumerated in this section, as follows:

14 90 days hospital room and board - \$500 ²[deductible] copayment² per
 15 hospital stay;

16 Outpatient and ambulatory surgery ²- \$250 copayment per surgery²;

17 Physicians' fees connected with hospital care, including general acute
 18 care and surgery;

19 ²Physicians' fees connected with outpatient and ambulatory surgery²
 20 ^{3,3}

21 Anesthesia and the administration of anesthesia;

22 Coverage for newborns;

23 Treatment for complications of pregnancy;

24 ¹[IV Solutions] Intravenous solutions¹, blood and blood plasma;

25 Oxygen and the administration of oxygen;

26 Radiation and x-ray therapy;

27 ²[Physical] Inpatient physical² therapy and hydrotherapy ^{3,3}

28 ²Outpatient physical therapy² - ²30 visits annually per covered
 29 person-² \$20 ²[deductible for outpatient treatment] copayment per
 30 treatment²;

31 Dialysis - inpatient or outpatient;

32 Inpatient diagnostic tests and \$500 annual aggregate ²per covered
 33 person² for out-of-hospital diagnostic tests;

34 Laboratory fees for treatment in hospital;

35 Delivery room fees;

36 Operating room fees;

37 ²[Intensive] Special² care unit;

38 Treatment room fees;

39 Emergency room services for medically necessary treatment ²- \$100
 40 copayment per visit²;

41 Pharmaceuticals dispensed in hospital;

42 Dressings;

43 Splints;

44 ²[Treatment for Nervous and Mental Conditions- 30 Days inpatient or
 45 outpatient- 30% copayment] Treatment for biologically-based
 46 mental illness, as defined in ³subsection a. of section 6 of³

- 1 P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no
2 coinsurance - \$500 copayment per inpatient stay, 30 days
3 outpatient with 30% coinsurance²;
4 Alcohol and Substance Abuse Treatment - 30 days inpatient or
5 outpatient - 30% ²[copayment] coinsurance²;
6 ²Childhood immunizations in accordance with the provisions of
7 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
8 adult immunizations;²
9 Wellness benefit - \$600 ²[per year] annual aggregate per covered
10 person², \$50 ²annual² deductible, 20% coinsurance per service;
11 and
12 Physicians visits¹[per year]¹ for diagnosed illness or injury - to ³[an]
13 a³ ²\$700 annual² aggregate ²[of \$700 per year] per covered
14 person².
15 b. A carrier shall offer the benefits on an indemnity basis, with the
16 option that: (1) coverage is restricted to health care providers in the
17 carrier's network ¹[or preferred provider organization]^{1 2}, including
18 an exclusive provider organization, or the carrier's preferred provider
19 organization²; ¹[and] or¹ (2) coverage is provided through health care
20 providers in the carrier's network ¹[or preferred provider
21 organization]^{1 2} or preferred provider organization² with an out-of-
22 network option with ²[a]² 30% ²[copayment] coinsurance² in
23 addition to whatever other ²[copayment] coinsurance² may be
24 applicable under the policy.
25 c. With respect to all policies or contracts issued pursuant to this
26 section, the premium rate charged by a carrier to the highest rated
27 individual or class of individuals shall not be greater than 350% of the
28 premium rate charged for the lowest rated individual or class of
29 individuals purchasing this health benefits plan, provided, however,
30 that the only factors upon which the rate differential may be based are
31 age, gender, and geography. ²[Policies or contracts issued pursuant
32 to this section shall be rated separately from the five standard plans,
33 in accordance with their own loss experience.] Rates applicable to
34 policies or contracts issued pursuant to this section shall reflect past
35 and prospective loss experience for benefits included in such policies
36 or contracts, and shall be formulated in a manner that does not result
37 in an unfair subsidization of rates applicable to policies issued pursuant
38 to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the
39 result of differences in levels of benefits offered.²
40 d. Carriers may offer enhanced or additional benefits for an
41 additional premium amount in the form of a rider or riders, each of
42 which shall be comprised of a combination of enhanced or additional
43 benefits, in a manner which will avoid adverse selection to the extent
44 possible.
45 e. The provisions of P.L.1992, c.¹[162] 161¹ (C.17B:27A-2 et

1 seq.) shall apply to this section to the extent that they are not contrary
2 to the provisions of this section, including but not limited to,
3 provisions relating to ¹preexisting conditions,¹ guaranteed issue, ³and³
4 calculation of loss ratio² [, and the liability for assessment]². ³[²With
5 respect to liability for assessment, the board shall establish a separate
6 formula for calculating the amount of the aggregate liability of a
7 carrier that is attributable and allocated to health benefits plans issued
8 pursuant to this act. The formula shall provide for an equitable
9 allocation of a carrier's assessment pursuant to section 11 of P.L.1992,
10 c.161 (C.17B:27A-11), so that persons covered by the health benefits
11 plan provided for in this act do not bear a disproportionate burden of
12 a carrier's assessment in their premium, taking into account the
13 differential in benefit levels under the health benefits plans provided
14 for in this act and those health benefits plans issued pursuant to
15 P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into
16 account the relative loss experience, relative actuarial value based on
17 benefits offered, relative loss ratio, relative administrative expenses,
18 and such other items as the board deems appropriate.²]³

19 f. No later than ²[120 days] one year² following enactment of this
20 act, every carrier shall make an informational filing with the
21 ²[commissioner] board², which shall include the policy form, the
22 premiums to be charged for the coverage, and the anticipated loss
23 ratio. If the ²[commissioner] board² has not disapproved the form
24 within 30 days, the form shall be ¹deemed¹ approved.

25 g. Every carrier ²[and every insurance producer] that writes
26 individual health benefits plans pursuant to P.L.1992, c.161
27 (C.17B:27A-2 et seq.) shall make available and² shall make a good
28 faith effort to market the contract or policy established pursuant to this
29 section. ²[If the board determines that such a good faith effort has not
30 been made, they shall recommend to the commissioner that the carrier
31 be subject to a fine of not more than \$5,000, which shall be levied by
32 the commissioner pursuant to the provisions of the "Penalty
33 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).]
34 A carrier who is in violation of this section shall be subject to the
35 provisions of N.J.S.17B:30-1.²

36

37 ²3. The New Jersey Individual Health Coverage Program Board,
38 in consultation with the New Jersey Small Employer Health Benefits
39 Program Board, shall evaluate the effectiveness of this act in providing
40 affordable health care coverage and whether the health benefits plan
41 established in this act or a similar plan should be made available to
42 small employers.

43 The boards shall report to the Legislature and Governor two years
44 after the effective date of this act on their evaluation of the health
45 benefits plan established in this act and shall include in their report the
46 number of policies or contracts sold, the premiums charged and the

1 effect, if any, that the health benefits plan has had on the five standard
2 health benefits plans offered to individuals in the State. The report
3 shall also include the boards' recommendations with respect to
4 expanding the number of, or making modifications to, the standard
5 health benefits plans currently offered to small employers to include
6 the health benefits plan established pursuant to this act or a similar
7 plan.²

8
9 ⁴4. In addition to the five health benefits plans offered by a carrier
10 on the effective date of this act, a carrier that writes individual health
11 benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may
12 also offer one or more of the plans through the carrier's network of
13 providers, with no reimbursement for any out-of-network benefits
14 other than emergency care, urgent care, and continuity of care. A
15 carrier's network of providers shall be subject to review and approval
16 or disapproval by the Commissioner of Banking and Insurance, in
17 consultation with the Commissioner of Health and Senior Services,
18 pursuant to regulations promulgated by the Department of Banking
19 and Insurance, including review and approval or disapproval before
20 plans with benefits provided through a carrier's network of providers
21 pursuant to this section may be offered by the carrier. Policies or
22 contracts written on this basis shall be rated in a separate rating pool
23 for the purposes of establishing a premium, but for the purpose of
24 determining a carrier's losses, these policies or contracts shall be
25 aggregated with the losses on the carrier's other business written
26 pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).⁴

27
28 ⁴^[24. 3] ^{5.} ⁴ ^[A] In addition to the five health benefits plans
29 offered by a carrier on the effective date of this act, a³ carrier that
30 writes small employer health benefits plans pursuant to P.L.1992,
31 c.162 (C.17B:27A-17 et seq.) may ³also³ offer one or more of the
32 ³[five health benefits]³ plans ³[, but shall not offer all five, as policies
33 or contracts that require the policy holder or contract holder to receive
34 plan benefits solely]³ through the carrier's network of providers, with
35 no reimbursement for any out-of-network benefits other than
36 emergency care, urgent care, and continuity of care. ³A carrier's
37 network of providers shall be subject to review and approval or
38 disapproval by the Commissioner of Banking and Insurance, in
39 consultation with the Commissioner of Health and Senior Services,
40 pursuant to regulations promulgated by the Department of Banking
41 and Insurance, including review and approval or disapproval before
42 plans with benefits provided through a carrier's network of providers
43 pursuant to this section may be offered by the carrier.³ Policies or
44 contracts written on this basis shall be rated in a separate rating pool
45 for the purposes of establishing a premium, but for the purpose of
46 determining a carrier's losses, these policies or contracts shall be

1 aggregated with the losses on the carrier's other business written
2 pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et
3 seq.).²

4

5 ²[4.] ⁴[5.²] 6.⁴ This act shall take effect ²[immediately] on the
6 270th day following enactment, but the New Jersey Individual Health
7 Coverage Program Board may take such anticipatory administrative
8 action in advance as shall be necessary for the implementation of the
9 act.²

ASSEMBLY, No. 3447

STATE OF NEW JERSEY
209th LEGISLATURE

INTRODUCED APRIL 19, 2001

Sponsored by:

Assemblywoman CHARLOTTE VANDERVALK

District 39 (Bergen)

Assemblyman GUY R. GREGG

District 24 (Sussex, Hunterdon and Morris)

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning health insurance and supplementing
2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
3 (C.17:27A-17 et seq.).

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

7
8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
10 reform in 1992 for the individual market that provided guaranteed-
11 issue, guaranteed-renewal coverage, with a prohibition against rating
12 on the basis of health status and limiting preexisting condition
13 exclusions in policies, the plans that were established by the New
14 Jersey Individual Health Coverage Program Board did not offer
15 sufficient variety or options to insureds in terms of the range of
16 coverages that are provided under the standard plans;

17 b. The original intent of the Legislature was to give policyholders
18 a wider range of coverage options, including policies that provide
19 reimbursement for basic and essential health care services but do not
20 contain either the traditional mandated benefits to which the standard
21 plans are subject or reimbursement for services which the consumer
22 can more economically pay for himself, rather than having those
23 services paid for through a third-party system, which adds significantly
24 to the cost;

25 c. The New Jersey Individual Health Coverage Program Board
26 elected to provide little variance in the coverage provided under the
27 standard plans; rather, reductions in premium cost can be obtained
28 primarily through increasing the deductibles to substantial sums, which
29 defeats the objective of making the policies affordable, in that large
30 deductibles represent large out-of-pocket expenses;

31 d. In the absence of any affirmative action by the board to remedy
32 this situation, it is the purpose of this bill to create a policy that is
33 more affordable than the options that presently exist; even though the
34 benefit package is not as rich as the existing plans, the benefit plan
35 provided by this act will make health insurance more accessible to
36 many individuals that do not have the economic resources to afford the
37 existing plans while still providing essential coverage.

38 e. It is to the interest of the State and of all health care providers
39 that as many people have access to reasonably affordable health
40 insurance as possible, for this reduces the amount of charity care that
41 providers provide as well as the amount of bad debt that must be
42 absorbed by providers each year.

43
44 2. a. Notwithstanding the provisions of P.L.1992, c.161
45 (C.17B:27A-2 et seq.), every carrier that writes individual health

1 benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits
2 plan in the individual health insurance market that includes only the
3 coverages enumerated in this section, as follows:
4 90 days hospital room and board - \$500 copayment per hospital stay;
5 Outpatient and ambulatory surgery - \$250 copayment per surgery;
6 Physicians' fees connected with hospital care, including general acute
7 care and surgery;
8 Physicians' fees connected with outpatient and ambulatory surgery
9 Anesthesia and the administration of anesthesia;
10 Coverage for newborns;
11 Treatment for complications of pregnancy;
12 Intravenous solutions, blood and blood plasma;
13 Oxygen and the administration of oxygen;
14 Radiation and x-ray therapy;
15 Inpatient physical therapy and hydrotherapy
16 Outpatient physical therapy - 30 visits annually per covered person -
17 \$20 copayment per treatment;
18 Dialysis - inpatient or outpatient;
19 Inpatient diagnostic tests and \$500 annual aggregate per covered
20 person for out-of-hospital diagnostic tests;
21 Laboratory fees for treatment in hospital;
22 Delivery room fees;
23 Operating room fees;
24 Special care unit;
25 Treatment room fees;
26 Emergency room services for medically necessary treatment - \$100
27 copayment per visit;
28 Pharmaceuticals dispensed in hospital;
29 Dressings;
30 Splints;
31 Treatment for biologically-based mental illness, as defined in P.L.1999,
32 c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance -
33 \$500 copayment per inpatient stay, 30 days outpatient with 30%
34 coinsurance;
35 Alcohol and Substance Abuse Treatment - 30 days inpatient or
36 outpatient - 30% coinsurance;
37 Childhood immunizations in accordance with the provisions of
38 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
39 adult immunizations;
40 Wellness benefit - \$600 annual aggregate per covered person, \$50
41 annual deductible, 20% coinsurance per service; and
42 Physicians visits for diagnosed illness or injury - to a \$700 annual
43 aggregate per covered person.
44 b. A carrier shall offer the benefits on an indemnity basis, with the
45 option that: (1) coverage is restricted to health care providers in the
46 carrier's network, including an exclusive provider organization, or the

1 carrier's preferred provider organization; or (2) coverage is provided
2 through health care providers in the carrier's network or preferred
3 provider organization with an out-of-network option with 30%
4 coinsurance in addition to whatever other coinsurance may be
5 applicable under the policy.

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

19 d. Carriers may offer enhanced or additional benefits for an
20 additional premium amount in the form of a rider or riders, each of
21 which shall be comprised of a combination of enhanced or additional
22 benefits, in a manner which will avoid adverse selection to the extent
23 possible.

24 e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall
25 apply to this section to the extent that they are not contrary to the
26 provisions of this section, including but not limited to, provisions
27 relating to preexisting conditions, guaranteed issue, calculation of loss
28 ratio. With respect to liability for assessment, the board shall establish
29 a separate formula for calculating the amount of the aggregate liability
30 of a carrier that is attributable and allocated to health benefits plans
31 issued pursuant to this act. The formula shall provide for an equitable
32 allocation of a carrier's assessment pursuant to section 11 of P.L.
33 1992, c. 161 (C.17B:27A-11), so that persons covered by the health
34 benefits plan provided for in this act do not bear a disproportionate
35 burden of a carrier's assessment in their premium, taking into account
36 the differential in benefit levels under the health benefits plans
37 provided for in this act and those health benefits plans issued pursuant
38 to P.L. 1992, c.161 (C:17B:27A-2 et seq.). The formula may take
39 into account the relative loss experience, relative actuarial value based
40 on benefits offered, relative loss ratio, relative administrative expenses,
41 and such other items as the board deems appropriate.

42 f. No later than one year following enactment of this act, every
43 carrier shall make an informational filing with the board, which shall
44 include the policy form, the premiums to be charged for the coverage,
45 and the anticipated loss ratio. If the board has not disapproved the
46 form within 30 days, the form shall be deemed approved.

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

7
8 3. The New Jersey Individual Health Coverage Program Board, in
9 consultation with the New Jersey Small Employer Health Benefits
10 Program Board, shall evaluate the effectiveness of this act in providing
11 affordable health care coverage and whether the health benefits plan
12 established in this act or a similar plan should be made available to
13 small employers.

14 The boards shall report to the Legislature and Governor two years
15 after the effective date of this act on their evaluation of the health
16 benefits plan established in this act and shall include in their report the
17 number of policies or contracts sold, the premiums charged and the
18 effect, if any, that the health benefits plan has had on the five standard
19 health benefits plans offered to individuals in the State. The report
20 shall also include the boards' recommendations with respect to
21 expanding the number of, or making modifications to, the standard
22 health benefits plans currently offered to small employers to include
23 the health benefits plan established pursuant to this act or a similar
24 plan.

25
26 4. A carrier that writes small employer health benefits plans
27 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may offer one or
28 more of the five health benefits plans, but shall not offer all five, as
29 policies or contracts that require the policy holder or contract holder
30 to receive plan benefits solely through the carrier's network of
31 providers, with no reimbursement for any out-of-network benefits
32 other than emergency care, urgent care, and continuity of care.
33 Policies or contracts written on this basis shall be rated in a separate
34 rating pool for the purposes of establishing a premium, but for the
35 purpose of determining a carrier's losses, these policies or contracts
36 shall be aggregated with the losses on the carrier's other business
37 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17
38 et seq.).

39
40 5. This act shall take effect on the 270th day following enactment,
41 but the New Jersey Individual Health Coverage Program Board may
42 take such anticipatory administrative action in advance as shall be
43 necessary for the implementation of the act.

STATEMENT

1
2

3 This bill adds an additional, more affordable health insurance policy
4 to the standard health benefits plans offered in the individual market.

5 The health benefits plan established in this bill is modeled on the
6 indemnity plans that dominated the market in the 1970's. At that time,
7 there was greater cost sharing between insurer and insured in the form
8 of direct payments to providers for health care services such as visits
9 to physicians' offices. This bill embodies that principle, providing for
10 the direct payment by insureds for health care services that are
11 reasonably affordable, which provides a more efficient use of the
12 policyholders' funds, eliminating the additional expenses that accrue if
13 those services are paid through premiums. These additional expenses
14 include administrative costs of processing claims and provider
15 expenses connected with the third party payer system.

16 The health benefits plan in this bill provides for essential services,
17 including hospitalization and hospital-based treatment, diagnostic
18 tests, wellness benefits, mental health and substance abuse benefits,
19 and physician services. The plan must be sold on a guaranteed-issue,
20 guaranteed-renewal basis, and rating cannot be based on the health
21 status of the individual member. The plan contains the same
22 preexisting condition provisions as the standard plans.

23 The bill specifies that the rates applicable to policies issued under
24 the bill shall reflect past and prospective loss experience for benefits
25 included in these policies, and shall be formulated in a manner that
26 does not result in an unfair subsidization of rates applicable to the five
27 standard plans as the result of differences in levels of benefits offered.

28 The bill directs the New Jersey Individual Health Coverage
29 Program Board to establish a separate formula for calculating the
30 amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-
31 11 that is attributable and allocated to policies issued under this bill.
32 The formula shall provide for an equitable allocation of a carrier's
33 assessment, so that persons covered by the health benefits plan
34 provided for in this bill do not bear a disproportionate burden of a
35 carrier's overall assessment in their premium, taking into account the
36 differential in benefit levels under the health benefits plan provided for
37 in this bill and the five standard health benefits plans.

38 In addition, the bill requires that a carrier make available, and make
39 a good faith effort to market, the policy. A carrier that fails to comply
40 with the marketing requirement would be subject to the provisions of
41 the insurance trade practices act, N.J.S.A.17B:30-1 et seq.

42 The bill directs the New Jersey Individual Health Coverage
43 Program Board, in consultation with the New Jersey Small Employer
44 Health Benefits Program Board, to evaluate the effectiveness of the
45 bill in providing affordable health care coverage and whether the
46 health benefits plan established in this bill or a similar plan should be

1 made available to small employers.

2 The bill would permit carriers in the small employer market to offer
3 one or more, but not all five, of the standard plans as exclusive
4 provider organization (EPO) plans, with no reimbursement for any
5 out-of-network benefits except emergency or urgent care and
6 continuity of care.

7 The bill takes effect nine months after enactment and requires
8 carriers to make an informational filing with the New Jersey Individual
9 Health Coverage Program Board, including the policy form, within one
10 year of the date of enactment.

11 The bill is aimed at making health insurance available for younger
12 families who do not have the resources to pay for coverage in the
13 individual market. To this end, this policy will not be community
14 rated, permitting a differential of 350% from the highest-to-lowest
15 premium, which is advantageous to younger persons without insurance
16 coverage; while the other plans in the individual market will continue
17 to be community rated.

ASSEMBLY, No. 2791

STATE OF NEW JERSEY 209th LEGISLATURE

INTRODUCED OCTOBER 5, 2000

Sponsored by:

Assemblyman GARY L. GUEAR, SR.

District 14 (Mercer and Middlesex)

Assemblywoman LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

Co-Sponsored by:

Assemblywomen Watson Coleman and Weinberg

SYNOPSIS

Requires individual and small employer group carriers to offer a new health benefits plan.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 5/4/2001)

1 AN ACT concerning health insurance and supplementing P.L.1992,
2 c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17:27A-17 et
3 seq.).
4

5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:
7

8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
10 reform in 1992 for the individual and small group markets that
11 provided guaranteed-issue, guaranteed-renewal coverage, with a
12 prohibition against rating on the basis of health status and removing
13 most preexisting condition exclusions from policies, the plans that
14 were established by the respective boards did not offer sufficient
15 variety or options to insureds in terms of the range of coverages that
16 are provided under the standard plans;

17 b. The original intent of the Legislature was to give policyholders
18 a wider range of coverage options, including policies that provide
19 reimbursement for basic and essential health care services but do not
20 contain either the traditional mandated benefits to which the standard
21 plans are subject or reimbursement for services which the consumer
22 can more economically pay for himself, rather than having those
23 services paid for through a third-party system, which adds significantly
24 to the cost;

25 c. The boards of the New Jersey Individual Health Coverage
26 Program and the New Jersey Small Employer Health Benefits Program
27 elected to provide little variance in the coverage provided under the
28 standard plans; rather, reductions in premium cost can be obtained
29 primarily through increasing the deductibles to substantial sums, which
30 defeats the objective of making the policies affordable, in that large
31 deductibles represent large out-of-pocket expenses;

32 d. In the absence of any affirmative action by either board to
33 remedy this situation, it is the purpose of this bill to create a policy
34 that is more affordable than the options that presently exist; even
35 though the benefit package is not as rich as the existing plans, the
36 benefit plans provided by this act will make health insurance more
37 accessible to many individuals and small groups that do not have the
38 economic resources to afford the existing plans while still providing
39 essential coverage.

40 e. It is to the interest of the State and of all health care providers
41 that as many people have access to reasonably affordable health
42 insurance as possible, for this reduces the amount of charity care that
43 providers provide as well as the amount of bad debt that must be
44 absorbed by providers each year.
45

46 2. a. Notwithstanding the provisions of P.L.1992, c.161
47 (C.17B:27A-2 et seq.), every carrier shall offer a health benefits plan

1 in the individual health insurance market that includes only the
2 coverages enumerated in this section, as follows:
3 90 days hospital room and board - \$500 deductible per hospital stay;
4 Outpatient and ambulatory surgery;
5 Physicians' fees connected with hospital care, including general acute
6 care and surgery;
7 Anesthesia and the administration of anesthesia;
8 Coverage for newborns;
9 Treatment for complications of pregnancy;
10 IV Solutions, blood and blood plasma;
11 Oxygen and the administration of oxygen;
12 Radiation and x-ray therapy;
13 Physical therapy and hydrotherapy - \$20 deductible for outpatient
14 treatment;
15 Dialysis - inpatient or outpatient;
16 Inpatient diagnostic tests and \$500 annual aggregate for out-of-
17 hospital diagnostic tests;
18 Laboratory fees for treatment in hospital;
19 Delivery room fees;
20 Operating room fees;
21 Intensive care unit;
22 Treatment room fees;
23 Emergency room services for medically necessary treatment;
24 Pharmaceuticals dispensed in hospital;
25 Dressings;
26 Splints;
27 Treatment for Nervous and Mental Conditions - 30 Days inpatient or
28 outpatient - 30% copayment;
29 Alcohol and Substance Abuse Treatment - 30 days inpatient or
30 outpatient - 30% copayment;
31 Wellness benefit - \$600 per year, \$50 deductible, 20% coinsurance per
32 service; and
33 Physicians visits per year for diagnosed illness or injury - to an
34 aggregate of \$700 per year.

35 b. A carrier shall offer the benefits on an indemnity basis, with the
36 option that: (1) coverage is restricted to health care providers in the
37 carrier's network or preferred provider organization; and (2) coverage
38 is provided through health care providers in the carrier's network or
39 preferred provider organization with an out-of-network option with a
40 30% copayment in addition to whatever other copayment may be
41 applicable under the policy.

42 c. With respect to all policies or contracts issued pursuant to this
43 section, the premium rate charged by a carrier to the highest rated
44 individual or class of individuals shall not be greater than 350% of the
45 premium rate charged for the lowest rated individual or class of
46 individuals purchasing this health benefits plan, provided, however,

1 that the only factors upon which the rate differential may be based are
2 age, gender, and geography. Policies or contracts issued pursuant to
3 this section shall be rated separately from the five standard plans, in
4 accordance with their own loss experience.

5 d. Carriers may offer enhanced or additional benefits for an
6 additional premium amount in the form of a rider or riders, each of
7 which shall be comprised of a combination of enhanced or additional
8 benefits, in a manner which will avoid adverse selection to the extent
9 possible.

10 e. The provisions of P.L.1992, c.162 (C.17B:27A-2 et seq.) shall
11 apply to this section to the extent that they are not contrary to the
12 provisions of this section, including but not limited to, provisions
13 relating to guaranteed issue, calculation of loss ratio, and the liability
14 for assessment.

15 f. No later than 120 days following enactment of this act, every
16 carrier shall make an informational filing with the commissioner, which
17 shall include the policy form, the premiums to be charged for the
18 coverage, and the anticipated loss ratio. If the commissioner has not
19 disapproved the form within 30 days, the form shall be approved.

20 g. Every carrier and every insurance producer shall make a good
21 faith effort to market the contract or policy established pursuant to this
22 section. If the board determines that such a good faith effort has not
23 been made, they shall recommend to the commissioner that the carrier
24 be subject to a fine of not more than \$5,000, which shall be levied by
25 the commissioner pursuant to the provisions of the "Penalty
26 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).
27

28 3. a. Notwithstanding the provisions of P.L.1992, c.162
29 (C.17B:27A-17 et seq.), every small employer carrier shall offer a
30 small employer health benefits plan that includes only the coverages
31 enumerated in this section, as follows:

32 90 days hospital room and board - \$500 deductible per stay;

33 Outpatient and ambulatory surgery;

34 Physicians' fees connected with hospital care, including general acute
35 care and surgery;

36 Anesthesia and the administration of anesthesia;

37 Coverage for newborns;

38 Treatment for complications of pregnancy;

39 IV Solutions, blood and blood plasma;

40 Oxygen and the administration of oxygen;

41 Radiation and x-ray therapy;

42 Physical therapy and hydrotherapy - \$20 deductible for outpatient
43 treatment;

44 Dialysis - inpatient or outpatient;

45 Inpatient diagnostic tests and \$500 annual aggregate for out-of-
46 hospital diagnostic tests;

- 1 Laboratory fees for treatment in hospital;
 - 2 Delivery room fees;
 - 3 Operating room fees;
 - 4 Intensive care unit;
 - 5 Treatment room fees;
 - 6 Emergency room services for medically necessary treatment;
 - 7 Pharmaceuticals dispensed in hospital;
 - 8 Dressings;
 - 9 Splints;
 - 10 Treatment for Nervous and Mental Conditions - 30 Days inpatient or
 - 11 outpatient - 30% copayment;
 - 12 Alcohol and Substance Abuse Treatment - 30 days inpatient or
 - 13 outpatient - 30% copayment;
 - 14 Wellness benefit - \$600 per year, \$50 deductible, 20% coinsurance per
 - 15 service; and
 - 16 Physicians visits per year for diagnosed illness or injury - to an
 - 17 aggregate of \$700 per year.
- 18 b. A carrier shall offer the benefits on an indemnity basis, with an
- 19 option that: (1) coverage is restricted to health care providers in the
- 20 carrier's network or preferred provider organization; or (2) coverage
- 21 is provided through health care providers in the carrier's network or
- 22 preferred provider organization with an out-of-network option with a
- 23 30% copayment in addition to whatever other copayment may be
- 24 applicable under the policy.
- 25 c. With respect to all policies or contracts issued pursuant to this
- 26 section, the premium rate charged by a carrier to the highest rated
- 27 small employer group shall not be greater than 350% of the premium
- 28 rate charged for the lowest rated small employer group purchasing this
- 29 health benefits plan, provided, however, that the only factors upon
- 30 which the rate differential may be based are age, gender, and
- 31 geography. Policies or contracts issued pursuant to this section shall
- 32 be rated separately from the five standard plans, in accordance with
- 33 their own loss experience.
- 34 d. Carriers may offer enhanced or additional benefits for an
- 35 additional premium in the form of a rider or riders, which shall be
- 36 comprised of a combination of enhanced or additional benefits, in a
- 37 manner which will avoid adverse selection to the extent possible.
- 38 e. The provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) shall
- 39 apply to this section to the extent that they are not contrary to the
- 40 provisions of this section, including but not limited to, provisions
- 41 relating to guaranteed issue, calculation of loss ratio, and the liability
- 42 for assessment.
- 43 f. No later than 120 days following enactment of this act, every
- 44 carrier shall make an informational filing with the commissioner, which
- 45 shall include the policy form, the premiums to be charged for the
- 46 coverage, and the anticipated loss ratio. If the commissioner has not

1 disapproved the form within 30 days, the form shall be deemed
2 approved.

3 g. Every carrier and every insurance producer shall make a good
4 faith effort to market the contract or policy established pursuant to this
5 section. If the board determines that such a good faith effort has not
6 been made, they shall recommend to the commissioner that the carrier
7 be subject to a fine of not more than \$5,000, which shall be levied by
8 the commissioner pursuant to the provisions of the "Penalty
9 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).
10

11 4. This act shall take effect immediately.
12
13

14 STATEMENT 15

16 This bill adds an additional, more affordable health insurance policy
17 to the standard health benefits plans offered in the individual and small
18 employer group markets. When the respective boards of the New
19 Jersey Individual Health Coverage Program and the New Jersey Small
20 Employer Health Benefits Program formulated the standard plans, they
21 disregarded the language in the law and the legislative intent that there
22 would be a variation in benefits among the plans, creating lower-cost
23 policies. As a result, the standard plans are uniformly rich in benefits
24 and for many people, increasingly unaffordable.

25 The plans set forth in this bill are modeled on the indemnity plans
26 that dominated the market in the 1970's. At that time, there was
27 greater cost sharing between insurer and insured in the form of direct
28 payments to providers for health care services such as visits to
29 physicians' offices. This bill embodies that principle, providing for the
30 direct payment by insureds for health care services that are reasonably
31 affordable, which provides a more efficient use of the policyholders'
32 funds, eliminating the additional expenses that accrue if those services
33 are paid through premiums. These additional expenses are
34 administrative costs of processing claims, premium taxes,
35 commissions, insurer profits, and provider expenses connected with
36 the third party payer system.

37 This plan provides for essential services, including hospitalization
38 and hospital-based treatment, diagnostic tests, wellness benefits,
39 mental health and substance abuse benefits, and physician services. It
40 must be sold on a guaranteed-issue, guaranteed-renewal basis, and
41 rating cannot be based on the health status of the individual member
42 or a member of a small employer group. It contains the same
43 preexisting condition provisions as the standard plans.

44 The bill is aimed at making health insurance available for younger
45 families who do not have the resources to pay for coverage in the
46 individual market, as well as small employers who cannot afford the

A2791 GUEAR, GREENSTEIN

7

1 small group policies currently offered. To this end, this policy is not
2 to be community rated, permitting a differential of 350% from the
3 highest-to-lowest premium, which is advantageous to the younger
4 people without insurance coverage; the other plans in the individual
5 market continue to be community rated and the standard plans in the
6 small employer group market continue to be rated at a 2-1 ratio of
7 highest-to-lowest premiums.

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 3447 and 2791

STATE OF NEW JERSEY
209th LEGISLATURE

ADOPTED MAY 3, 2001

Sponsored by:

Assemblywoman CHARLOTTE VANDERVALK

District 39 (Bergen)

Assemblyman GUY R. GREGG

District 24 (Sussex, Hunterdon and Morris)

Assemblyman GARY L. GUEAR, SR.

District 14 (Mercer and Middlesex)

Assemblywoman LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

Co-Sponsored by:

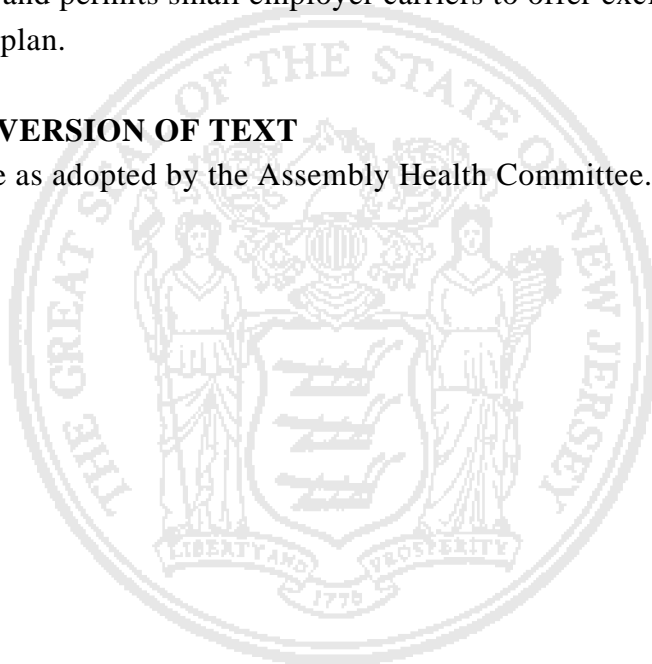
Assemblywomen Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

Substitute as adopted by the Assembly Health Committee.



1 AN ACT concerning health insurance and supplementing
2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
3 (C.17B:27A-17 et seq.).

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

7
8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
10 reform in 1992 for the individual market that provided guaranteed-
11 issue, guaranteed-renewal coverage, with a prohibition against rating
12 on the basis of health status and limiting preexisting condition
13 exclusions in policies, the plans that were established by the New
14 Jersey Individual Health Coverage Program Board did not offer
15 sufficient variety or options to insureds in terms of the range of
16 coverages that are provided under the standard plans;

17 b. The original intent of the Legislature was to give policy holders
18 a wider range of coverage options, including policies that provide
19 reimbursement for basic and essential health care services but do not
20 contain either the traditional mandated benefits to which the standard
21 plans are subject or reimbursement for services which the consumer
22 can more economically pay for himself, rather than having those
23 services paid for through a third-party system, which adds significantly
24 to the cost;

25 c. The New Jersey Individual Health Coverage Program Board
26 elected to provide little variance in the coverage provided under the
27 standard plans; rather, reductions in premium cost can be obtained
28 primarily through increasing the deductibles to substantial sums, which
29 defeats the objective of making the policies affordable, in that large
30 deductibles represent large out-of-pocket expenses;

31 d. In the absence of any affirmative action by the board to remedy
32 this situation, it is the purpose of this bill to create a policy that is
33 more affordable than the options that presently exist; even though the
34 benefit package is not as rich as the existing plans, the benefit plan
35 provided by this act will make health insurance more accessible to
36 many individuals that do not have the economic resources to afford the
37 existing plans while still providing essential coverage.

38 e. It is to the interest of the State and of all health care providers
39 that as many people have access to reasonably affordable health
40 insurance as possible, for this reduces the amount of charity care that
41 providers provide as well as the amount of bad debt that must be
42 absorbed by providers each year.

43
44 2. a. Notwithstanding the provisions of P.L.1992, c.161
45 (C.17B:27A-2 et seq.), every carrier that writes individual health
46 benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits

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

1 through health care providers in the carrier's network or preferred
2 provider organization with an out-of-network option with 30%
3 coinsurance in addition to whatever other coinsurance may be
4 applicable under the policy.

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

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

23 e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall
24 apply to this section to the extent that they are not contrary to the
25 provisions of this section, including but not limited to, provisions
26 relating to preexisting conditions, guaranteed issue, calculation of loss
27 ratio. With respect to liability for assessment, the board shall establish
28 a separate formula for calculating the amount of the aggregate liability
29 of a carrier that is attributable and allocated to health benefits plans
30 issued pursuant to this act. The formula shall provide for an equitable
31 allocation of a carrier's assessment pursuant to section 11 of P.L.1992,
32 c.161 (C.17B:27A-12), so that persons covered by the health benefits
33 plan provided for in this act do not bear a disproportionate burden of
34 a carrier's assessment in their premium, taking into account the
35 differential in benefit levels under the health benefits plan provided for
36 in this act and those health benefits plans issued pursuant to P.L.1992,
37 c.161 (C.17B:27A-2 et seq.). The formula may take into account the
38 relative loss experience, relative actuarial value based on benefits
39 offered, relative loss ratio, relative administrative expenses, and such
40 other items as the board deems appropriate.

41 f. No later than one year following enactment of this act, every
42 carrier shall make an informational filing with the board, which shall
43 include the policy form, the premiums to be charged for the coverage,
44 and the anticipated loss ratio. If the board has not disapproved the
45 form within 30 days, the form shall be deemed approved.

46 g. Every carrier that writes individual health benefits plans

1 pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) shall make
2 available and shall make a good faith effort to market the contract or
3 policy established pursuant to this section. A carrier who is in
4 violation of this section shall be subject to the provisions of
5 N.J.S.17B:30-1.

6

7 3. The New Jersey Individual Health Coverage Program Board, in
8 consultation with the New Jersey Small Employer Health Benefits
9 Program Board, shall evaluate the effectiveness of this act in providing
10 affordable health care coverage and whether the health benefits plan
11 established in this act or a similar plan should be made available to
12 small employers.

13 The boards shall report to the Legislature and Governor two years
14 after the effective date of this act on their evaluation of the health
15 benefits plan established in this act and shall include in their report the
16 number of policies or contracts sold, the premiums charged and the
17 effect, if any, that the health benefits plan has had on the five standard
18 health benefits plans offered to individuals in the State. The report
19 shall also include the boards' recommendations with respect to
20 expanding the number of, or making modifications to, the standard
21 health benefits plans currently offered to small employers to include
22 the health benefits plan established pursuant to this act or a similar
23 plan.

24

25 4. A carrier that writes small employer health benefits plans
26 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may offer one or
27 more of the five health benefits plans, but shall not offer all five, as
28 policies or contracts that require the policy holder or contract holder
29 to receive plan benefits solely through the carrier's network of
30 providers, with no reimbursement for any out-of-network benefits
31 other than emergency care, urgent care, and continuity of care.
32 Policies or contracts written on this basis shall be rated in a separate
33 rating pool for the purposes of establishing a premium, but for the
34 purpose of determining a carrier's losses, these policies or contracts
35 shall be aggregated with the losses on the carrier's other business
36 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17
37 et seq.).

38

39 5. This act shall take effect on the 270th day following enactment,
40 but the New Jersey Individual Health Coverage Program Board may
41 take such anticipatory administrative action in advance as shall be
42 necessary for the implementation of the act.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR **ASSEMBLY, Nos. 3447 and 2791**

STATE OF NEW JERSEY

DATED: MAY 3, 2001

The Assembly Health Committee reports favorably an Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791.

This committee substitute adds an additional, more affordable health insurance policy to the standard health benefits plans offered in the individual market.

The health benefits plan established in this substitute is modeled on the indemnity plans that dominated the market in the 1970's. At that time, there was greater cost sharing between insurer and insured in the form of direct payments to providers for health care services such as visits to physicians' offices. This substitute embodies that principle, providing for the direct payment by insureds for health care services that are reasonably affordable, which provides a more efficient use of the policy holders' funds, eliminating the additional expenses that accrue if those services are paid through premiums. These additional expenses include administrative costs of processing claims and provider expenses connected with the third-party payer system.

The health benefits plan in this substitute provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The substitute specifies that the rates applicable to policies issued under the substitute shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The substitute directs the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-12 that is attributable and allocated to policies issued under this substitute. The formula shall provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits

plan provided for in this substitute do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this substitute and the five standard health benefits plans.

In addition, the substitute requires that a carrier make available, and make a good faith effort to market, the policy. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The substitute directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the substitute in providing affordable health care coverage and whether the health benefits plan established in this substitute or a similar plan should be made available to small employers.

The substitute would permit carriers in the small employer market to offer one or more, but not all five, of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care.

The substitute takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The substitute is aimed at making health insurance available for younger families who do not have the resources to pay for coverage in the individual market. To this end, this policy will not be community rated, permitting a differential of 350% from the highest to lowest premium, which is advantageous to younger persons without insurance coverage; while the other plans in the individual market will continue to be community rated.

This substitute is identical to Senate Bill No. 13 (2R) (Matheussen/Sinagra), which the committee also reported on this date.

[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 3447 and 2791

STATE OF NEW JERSEY
209th LEGISLATURE

ADOPTED MAY 3, 2001

Sponsored by:

Assemblywoman CHARLOTTE VANDERVALK

District 39 (Bergen)

Assemblyman GUY R. GREGG

District 24 (Sussex, Hunterdon and Morris)

Assemblyman GARY L. GUEAR, SR.

District 14 (Mercer and Middlesex)

Assemblywoman LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

Co-Sponsored by:

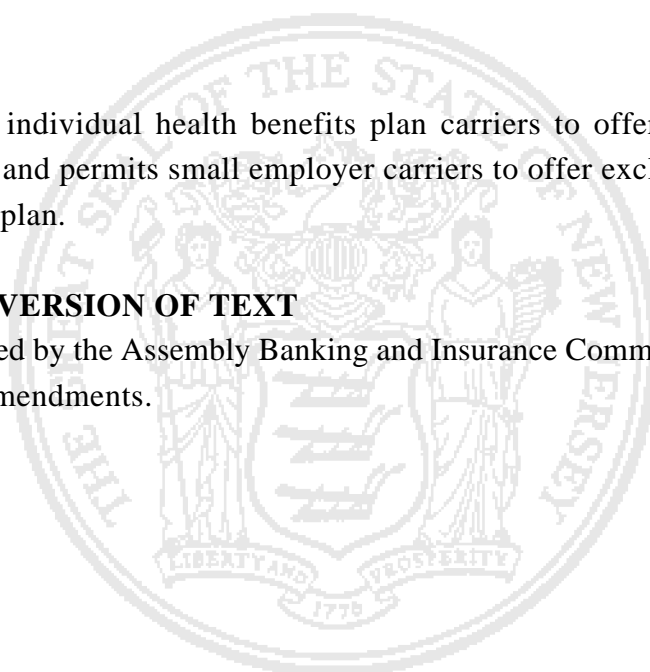
Assemblywomen Watson Coleman and Weinberg

SYNOPSIS

Requires individual health benefits plan carriers to offer a new health benefits plan and permits small employer carriers to offer exclusive provider organization plan.

CURRENT VERSION OF TEXT

As reported by the Assembly Banking and Insurance Committee on June 4, 2001, with amendments.



1 AN ACT concerning health insurance and supplementing
2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
3 (C.17B:27A-17 et seq.).

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

7
8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
10 reform in 1992 for the individual market that provided guaranteed-
11 issue, guaranteed-renewal coverage, with a prohibition against rating
12 on the basis of health status and limiting preexisting condition
13 exclusions in policies, the plans that were established by the New
14 Jersey Individual Health Coverage Program Board did not offer
15 sufficient variety or options to insureds in terms of the range of
16 coverages that are provided under the standard plans;

17 b. The original intent of the Legislature was to give policy holders
18 a wider range of coverage options, including policies that provide
19 reimbursement for basic and essential health care services but do not
20 contain either the traditional mandated benefits to which the standard
21 plans are subject or reimbursement for services which the consumer
22 can more economically pay for himself, rather than having those
23 services paid for through a third-party system, which adds significantly
24 to the cost;

25 c. The New Jersey Individual Health Coverage Program Board
26 elected to provide little variance in the coverage provided under the
27 standard plans; rather, reductions in premium cost can be obtained
28 primarily through increasing the deductibles to substantial sums, which
29 defeats the objective of making the policies affordable, in that large
30 deductibles represent large out-of-pocket expenses;

31 d. In the absence of any affirmative action by the board to remedy
32 this situation, it is the purpose of this bill to create a policy that is
33 more affordable than the options that presently exist; even though the
34 benefit package is not as rich as the existing plans, the benefit plan
35 provided by this act will make health insurance more accessible to
36 many individuals that do not have the economic resources to afford the
37 existing plans while still providing essential coverage.

38 e. It is to the interest of the State and of all health care providers
39 that as many people have access to reasonably affordable health
40 insurance as possible, for this reduces the amount of charity care that
41 providers provide as well as the amount of bad debt that must be
42 absorbed by providers each year.

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Assembly ABI committee amendments adopted June 4, 2001.

1 2. a. Notwithstanding the provisions of P.L.1992, c.161
2 (C.17B:27A-2 et seq.), every carrier that writes individual health
3 benefits plans pursuant to P.L.1992, c.161 shall offer a health benefits
4 plan in the individual health insurance market that includes only the
5 coverages enumerated in this section, as follows:
6 90 days hospital room and board - \$500 copayment per hospital stay;
7 Outpatient and ambulatory surgery - \$250 copayment per surgery;
8 Physicians' fees connected with hospital care, including general acute
9 care and surgery;
10 Physicians' fees connected with outpatient and ambulatory surgery;
11 Anesthesia and the administration of anesthesia;
12 Coverage for newborns;
13 Treatment for complications of pregnancy;
14 Intravenous solutions, blood and blood plasma;
15 Oxygen and the administration of oxygen;
16 Radiation and x-ray therapy;
17 Inpatient physical therapy and hydrotherapy;
18 Outpatient physical therapy - 30 visits annually per covered person -
19 \$20 copayment per treatment;
20 Dialysis - inpatient or outpatient;
21 Inpatient diagnostic tests and \$500 annual aggregate per covered
22 person for out-of-hospital diagnostic tests;
23 Laboratory fees for treatment in hospital;
24 Delivery room fees;
25 Operating room fees;
26 Special care unit;
27 Treatment room fees;
28 Emergency room services for medically necessary treatment - \$100
29 copayment per visit;
30 Pharmaceuticals dispensed in hospital;
31 Dressings;
32 Splints;
33 Treatment for biologically-based mental illness, as defined in
34 subsection a. of section 6 of¹ P.L.1999, c.106 (C.17B:27A-7.5) -
35 90 days inpatient with no coinsurance - \$500 copayment per
36 inpatient stay, 30 days outpatient with 30% coinsurance;
37 Alcohol and Substance Abuse Treatment - 30 days inpatient or
38 outpatient - 30% coinsurance;
39 Childhood immunizations in accordance with the provisions of
40 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
41 adult immunizations;
42 Wellness benefit - \$600 annual aggregate per covered person, \$50
43 annual deductible, 20% coinsurance per service; and
44 Physicians visits for diagnosed illness or injury - to a \$700 annual
45 aggregate per covered person.
46 b. A carrier shall offer the benefits on an indemnity basis, with the

1 option that: (1) coverage is restricted to health care providers in the
2 carrier's network, including an exclusive provider organization, or the
3 carrier's preferred provider organization; or (2) coverage is provided
4 through health care providers in the carrier's network or preferred
5 provider organization with an out-of-network option with 30%
6 coinsurance in addition to whatever other coinsurance may be
7 applicable under the policy.

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

21 d. Carriers may offer enhanced or additional benefits for an
22 additional premium amount in the form of a rider or riders, each of
23 which shall be comprised of a combination of enhanced or additional
24 benefits, in a manner which will avoid adverse selection to the extent
25 possible.

26 e. The provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall
27 apply to this section to the extent that they are not contrary to the
28 provisions of this section, including but not limited to, provisions
29 relating to preexisting conditions, guaranteed issue, ¹and¹ calculation
30 of loss ratio. ¹[With respect to liability for assessment, the board shall
31 establish a separate formula for calculating the amount of the
32 aggregate liability of a carrier that is attributable and allocated to
33 health benefits plans issued pursuant to this act. The formula shall
34 provide for an equitable allocation of a carrier's assessment pursuant
35 to section 11 of P.L.1992, c.161 (C.17B:27A-12), so that persons
36 covered by the health benefits plan provided for in this act do not bear
37 a disproportionate burden of a carrier's assessment in their premium,
38 taking into account the differential in benefit levels under the health
39 benefits plan provided for in this act and those health benefits plans
40 issued pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.). The
41 formula may take into account the relative loss experience, relative
42 actuarial value based on benefits offered, relative loss ratio, relative
43 administrative expenses, and such other items as the board deems
44 appropriate.]¹

45 f. No later than one year following enactment of this act, every
46 carrier shall make an informational filing with the board, which shall

1 include the policy form, the premiums to be charged for the coverage,
2 and the anticipated loss ratio. If the board has not disapproved the
3 form within 30 days, the form shall be deemed approved.

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

10
11 3. The New Jersey Individual Health Coverage Program Board, in
12 consultation with the New Jersey Small Employer Health Benefits
13 Program Board, shall evaluate the effectiveness of this act in providing
14 affordable health care coverage and whether the health benefits plan
15 established in this act or a similar plan should be made available to
16 small employers.

17 The boards shall report to the Legislature and Governor two years
18 after the effective date of this act on their evaluation of the health
19 benefits plan established in this act and shall include in their report the
20 number of policies or contracts sold, the premiums charged and the
21 effect, if any, that the health benefits plan has had on the five standard
22 health benefits plans offered to individuals in the State. The report
23 shall also include the boards' recommendations with respect to
24 expanding the number of, or making modifications to, the standard
25 health benefits plans currently offered to small employers to include
26 the health benefits plan established pursuant to this act or a similar
27 plan.

28
29 4. ¹[A] In addition to the five health benefits plans offered by a
30 carrier on the effective date of this act, a¹ carrier that writes small
31 employer health benefits plans pursuant to P.L.1992, c.162
32 (C.17B:27A-17 et seq.) may ¹also¹ offer one or more of the ¹[five
33 health benefits]¹ plans ¹[, but shall not offer all five, as policies or
34 contracts that require the policy holder or contract holder to receive
35 plan benefits solely]¹ through the carrier's network of providers, with
36 no reimbursement for any out-of-network benefits other than
37 emergency care, urgent care, and continuity of care. ¹A carrier's
38 network of providers shall be subject to review and approval or
39 disapproval by the Commissioner of Banking and Insurance, in
40 consultation with the Commissioner of Health and Senior Services,
41 pursuant to regulations promulgated by the Department of Banking
42 and Insurance, including review and approval or disapproval before
43 plans with benefits provided through a carrier's network of providers
44 pursuant to this section may be offered by the carrier.¹ Policies or
45 contracts written on this basis shall be rated in a separate rating pool
46 for the purposes of establishing a premium, but for the purpose of

1 determining a carrier's losses, these policies or contracts shall be
2 aggregated with the losses on the carrier's other business written
3 pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).
4

5 5. This act shall take effect on the 270th day following enactment,
6 but the New Jersey Individual Health Coverage Program Board may
7 take such anticipatory administrative action in advance as shall be
8 necessary for the implementation of the act.

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR **ASSEMBLY, Nos. 3447 and 2791**

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 4, 2001

The Assembly Banking and Insurance Committee reports favorably and with committee amendments, the Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791.

This bill, an Assembly Committee Substitute for Assembly Bill Nos. 3447 and 2791, as amended by the committee, adds an additional health benefits plan to the five standard health benefits plans currently offered in the individual health insurance market.

With the committee amendments, the health benefits plan established under this bill provides for essential services, including hospitalization and hospital-based treatment, diagnostic tests, wellness benefits, mental health and substance abuse benefits, and physician services. The plan must be sold on a guaranteed-issue, guaranteed-renewal basis, and rating cannot be based on the health status of the individual member. The plan contains the same preexisting condition provisions as the standard plans.

The bill specifies that the rates applicable to policies issued under the bill shall reflect past and prospective loss experience for benefits included in these policies, and shall be formulated in a manner that does not result in an unfair subsidization of rates applicable to the five standard plans as the result of differences in levels of benefits offered.

The bill also provides that the health benefits plan established under the bill will not be community rated, permitting a differential of 350% from the highest-to-lowest premium; while the other plans in the individual market will continue to be community rated.

In addition, the bill requires that a carrier make available, and make a good faith effort to market, this health benefits plan. A carrier that fails to comply with the marketing requirement would be subject to the provisions of the life and health insurance trade practices act, N.J.S.A.17B:30-1 et seq.

The bill directs the New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, to evaluate the effectiveness of the bill in providing affordable health care coverage and whether the

health benefits plan established in this bill or a similar plan should be made available to small employers.

The bill also permits that, in addition to the five health benefits plans, health insurance carriers that write in the small employer health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. A carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

The bill takes effect nine months after enactment and requires carriers to make an informational filing with the New Jersey Individual Health Coverage Program Board, including the policy form, within one year of the date of enactment.

The committee amendments delete language from the bill which directed the New Jersey Individual Health Coverage Program Board to establish a separate formula for calculating the amount of the aggregate liability of a carrier under N.J.S.A.17B:27A-12 that is attributable and allocated to the health benefits plan established by this bill and issued by the carriers in the individual market. The formula was to provide for an equitable allocation of a carrier's assessment, so that persons covered by the health benefits plan provided for in this bill do not bear a disproportionate burden of a carrier's overall assessment in their premium, taking into account the differential in benefit levels under the health benefits plan provided for in this bill and the five standard health benefits plans.

In addition, the amendments clarify that in addition to the five health benefits plans, health insurance carriers that write in the small employer health benefits market may also offer one or more of the standard plans as exclusive provider organization (EPO) plans, with no reimbursement for any out-of-network benefits except emergency or urgent care and continuity of care. A carrier's network of providers is subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through an EPO may be offered by the carrier.

As released by the committee, this bill is identical to Senate Bill No.13 (3R).

§§1-4 -
C.17B:27A-4.4
to 17B:27A-4.7
§5 -
C.17B:27A-19.11
§6 - Note to §§1-5

P.L. 2001, CHAPTER 368, *approved January 8, 2002*
Senate, No. 13 (*Fourth Reprint*)

1 AN ACT concerning health insurance and supplementing
2 P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162
3 ³[(C.17:27A-17 et seq.)] (C.17B:27A-17 et seq.)³.

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

7
8 1. The Legislature hereby finds and declares that:

9 a. While the Legislature enacted ground-breaking health insurance
10 reform in 1992 for the individual ²[and small group markets] market²
11 that provided guaranteed-issue, guaranteed-renewal coverage, with a
12 prohibition against rating on the basis of health status and ²[removing
13 most] limiting² preexisting condition exclusions ²[from] in² policies,
14 the plans that were established by the ²[respective boards] New Jersey
15 Individual Health Coverage Program Board² did not offer sufficient
16 variety or options to insureds in terms of the range of coverages that
17 are provided under the standard plans;

18 b. The original intent of the Legislature was to give policyholders
19 a wider range of coverage options, including policies that provide
20 reimbursement for basic and essential health care services but do not
21 contain either the traditional mandated benefits to which the standard
22 plans are subject or reimbursement for services which the consumer
23 can more economically pay for himself, rather than having those
24 services paid for through a third-party system, which adds significantly
25 to the cost;

26 c. The ²[boards of the]² New Jersey Individual Health Coverage
27 Program ²[and the New Jersey Small Employer Health Benefits
28 Program] Board² elected to provide little variance in the coverage
29 provided under the standard plans; rather, reductions in premium cost
30 can be obtained primarily through increasing the deductibles to
31 substantial sums, which defeats the objective of making the policies
32 affordable, in that large deductibles represent large out-of-pocket
33 expenses;

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Senate SHH committee amendments adopted November 9, 2000.

² Senate floor amendments adopted December 4, 2000.

³ Assembly ABI committee amendments adopted June 4, 2001.

⁴ Assembly floor amendments adopted June 14, 2001.

1 d. In the absence of any affirmative action by ²[either] the² board
 2 to remedy this situation, it is the purpose of this bill to create a policy
 3 that is more affordable than the options that presently exist; even
 4 though the benefit package is not as rich as the existing plans, the
 5 benefit ²[plans] plan² provided by this act will make health insurance
 6 more accessible to many individuals ²[and small groups]² that do not
 7 have the economic resources to afford the existing plans while still
 8 providing essential coverage.

9 e. It is to the interest of the State and of all health care providers
 10 that as many people have access to reasonably affordable health
 11 insurance as possible, for this reduces the amount of charity care that
 12 providers provide as well as the amount of bad debt that must be
 13 absorbed by providers each year.

14

15 2. a. Notwithstanding the provisions of P.L.1992, c.161
 16 (C.17B:27A-2 et seq.), every carrier ¹that writes individual health
 17 benefits plans pursuant to P.L.1992, c.161¹ shall offer a health benefits
 18 plan in the individual health insurance market that includes only the
 19 coverages enumerated in this section, as follows:

20 90 days hospital room and board - \$500 ²[deductible] copayment² per
 21 hospital stay;

22 Outpatient and ambulatory surgery ²- \$250 copayment per surgery²;

23 Physicians' fees connected with hospital care, including general acute
 24 care and surgery;

25 ²Physicians' fees connected with outpatient and ambulatory surgery²
 26 ^{3,3}₁

27 Anesthesia and the administration of anesthesia;

28 Coverage for newborns;

29 Treatment for complications of pregnancy;

30 ¹[IV Solutions] Intravenous solutions¹, blood and blood plasma;

31 Oxygen and the administration of oxygen;

32 Radiation and x-ray therapy;

33 ²[Physical] Inpatient physical² therapy and hydrotherapy ^{3,3}₁

34 ²Outpatient physical therapy² - ²30 visits annually per covered
 35 person² - ²\$20 ²[deductible for outpatient treatment] copayment per
 36 treatment²;

37 Dialysis - inpatient or outpatient;

38 Inpatient diagnostic tests and \$500 annual aggregate ²per covered
 39 person² for out-of-hospital diagnostic tests;

40 Laboratory fees for treatment in hospital;

41 Delivery room fees;

42 Operating room fees;

43 ²[Intensive] Special² care unit;

44 Treatment room fees;

45 Emergency room services for medically necessary treatment ²- \$100
 46 copayment per visit²;

1 Pharmaceuticals dispensed in hospital;
2 Dressings;
3 Splints;
4 ²[Treatment for Nervous and Mental Conditions- 30 Days inpatient or
5 outpatient- 30% copayment] Treatment for biologically-based
6 mental illness, as defined in ³subsection a. of section 6 of³
7 P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no
8 coinsurance - \$500 copayment per inpatient stay, 30 days
9 outpatient with 30% coinsurance²;
10 Alcohol and Substance Abuse Treatment - 30 days inpatient or
11 outpatient - 30% ²[copayment] coinsurance²;
12 ²Childhood immunizations in accordance with the provisions of
13 subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
14 adult immunizations;²
15 Wellness benefit - \$600 ²[per year] annual aggregate per covered
16 person², \$50 ²annual² deductible, 20% coinsurance per service;
17 and
18 Physicians visits¹[per year]¹ for diagnosed illness or injury - to ³[an]
19 a³ ²\$700 annual² aggregate ²[of \$700 per year] per covered
20 person².
21 b. A carrier shall offer the benefits on an indemnity basis, with the
22 option that: (1) coverage is restricted to health care providers in the
23 carrier's network ¹[or preferred provider organization]¹ ², including
24 an exclusive provider organization, or the carrier's preferred provider
25 organization²; ¹[and] or¹ (2) coverage is provided through health care
26 providers in the carrier's network ¹[or preferred provider
27 organization]¹ ²or preferred provider organization² with an out-of-
28 network option with ²[a]² 30% ²[copayment] coinsurance² in
29 addition to whatever other ²[copayment] coinsurance² may be
30 applicable under the policy.
31 c. With respect to all policies or contracts issued pursuant to this
32 section, the premium rate charged by a carrier to the highest rated
33 individual or class of individuals shall not be greater than 350% of the
34 premium rate charged for the lowest rated individual or class of
35 individuals purchasing this health benefits plan, provided, however,
36 that the only factors upon which the rate differential may be based are
37 age, gender, and geography. ²[Policies or contracts issued pursuant
38 to this section shall be rated separately from the five standard plans,
39 in accordance with their own loss experience.] Rates applicable to
40 policies or contracts issued pursuant to this section shall reflect past
41 and prospective loss experience for benefits included in such policies
42 or contracts, and shall be formulated in a manner that does not result
43 in an unfair subsidization of rates applicable to policies issued pursuant
44 to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) as the
45 result of differences in levels of benefits offered.²

1 d. Carriers may offer enhanced or additional benefits for an
2 additional premium amount in the form of a rider or riders, each of
3 which shall be comprised of a combination of enhanced or additional
4 benefits, in a manner which will avoid adverse selection to the extent
5 possible.

6 e. The provisions of P.L.1992, c.¹[162] 161¹ (C.17B:27A-2 et
7 seq.) shall apply to this section to the extent that they are not contrary
8 to the provisions of this section, including but not limited to,
9 provisions relating to ¹preexisting conditions,¹ guaranteed issue,³and³
10 calculation of loss ratio²[, and the liability for assessment]². ³²With
11 respect to liability for assessment, the board shall establish a separate
12 formula for calculating the amount of the aggregate liability of a
13 carrier that is attributable and allocated to health benefits plans issued
14 pursuant to this act. The formula shall provide for an equitable
15 allocation of a carrier's assessment pursuant to section 11 of P.L.1992,
16 c.161 (C.17B:27A-11), so that persons covered by the health benefits
17 plan provided for in this act do not bear a disproportionate burden of
18 a carrier's assessment in their premium, taking into account the
19 differential in benefit levels under the health benefits plans provided
20 for in this act and those health benefits plans issued pursuant to
21 P.L.1992, c.161 (C:17B:27A-2 et seq.). The formula may take into
22 account the relative loss experience, relative actuarial value based on
23 benefits offered, relative loss ratio, relative administrative expenses,
24 and such other items as the board deems appropriate.²³

25 f. No later than ²[120 days] one year² following enactment of this
26 act, every carrier shall make an informational filing with the
27 ²[commissioner] board², which shall include the policy form, the
28 premiums to be charged for the coverage, and the anticipated loss
29 ratio. If the ²[commissioner] board² has not disapproved the form
30 within 30 days, the form shall be ¹deemed¹ approved.

31 g. Every carrier ²[and every insurance producer] that writes
32 individual health benefits plans pursuant to P.L.1992, c.161
33 (C.17B:27A-2 et seq.) shall make available and² shall make a good
34 faith effort to market the contract or policy established pursuant to this
35 section. ²[If the board determines that such a good faith effort has not
36 been made, they shall recommend to the commissioner that the carrier
37 be subject to a fine of not more than \$5,000, which shall be levied by
38 the commissioner pursuant to the provisions of the "Penalty
39 Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).]
40 A carrier who is in violation of this section shall be subject to the
41 provisions of N.J.S.17B:30-1.²

42
43 ²3. The New Jersey Individual Health Coverage Program Board,
44 in consultation with the New Jersey Small Employer Health Benefits
45 Program Board, shall evaluate the effectiveness of this act in providing

1 affordable health care coverage and whether the health benefits plan
2 established in this act or a similar plan should be made available to
3 small employers.

4 The boards shall report to the Legislature and Governor two years
5 after the effective date of this act on their evaluation of the health
6 benefits plan established in this act and shall include in their report the
7 number of policies or contracts sold, the premiums charged and the
8 effect, if any, that the health benefits plan has had on the five standard
9 health benefits plans offered to individuals in the State. The report
10 shall also include the boards' recommendations with respect to
11 expanding the number of, or making modifications to, the standard
12 health benefits plans currently offered to small employers to include
13 the health benefits plan established pursuant to this act or a similar
14 plan.²

15
16 ⁴In addition to the five health benefits plans offered by a carrier
17 on the effective date of this act, a carrier that writes individual health
18 benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may
19 also offer one or more of the plans through the carrier's network of
20 providers, with no reimbursement for any out-of-network benefits
21 other than emergency care, urgent care, and continuity of care. A
22 carrier's network of providers shall be subject to review and approval
23 or disapproval by the Commissioner of Banking and Insurance, in
24 consultation with the Commissioner of Health and Senior Services,
25 pursuant to regulations promulgated by the Department of Banking
26 and Insurance, including review and approval or disapproval before
27 plans with benefits provided through a carrier's network of providers
28 pursuant to this section may be offered by the carrier. Policies or
29 contracts written on this basis shall be rated in a separate rating pool
30 for the purposes of establishing a premium, but for the purpose of
31 determining a carrier's losses, these policies or contracts shall be
32 aggregated with the losses on the carrier's other business written
33 pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).⁴

34
35 ⁴^[²4. ³] ^{5.} ⁴ ^[A] In addition to the five health benefits plans
36 offered by a carrier on the effective date of this act, a³ carrier that
37 writes small employer health benefits plans pursuant to P.L.1992,
38 c.162 (C.17B:27A-17 et seq.) may ³also³ offer one or more of the
39 ³[five health benefits]³ plans ³[, but shall not offer all five, as policies
40 or contracts that require the policy holder or contract holder to receive
41 plan benefits solely]³ through the carrier's network of providers, with
42 no reimbursement for any out-of-network benefits other than
43 emergency care, urgent care, and continuity of care. ³A carrier's
44 network of providers shall be subject to review and approval or
45 disapproval by the Commissioner of Banking and Insurance, in
46 consultation with the Commissioner of Health and Senior Services,

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

11

12 ²[4.] ⁴[5.²] ^{6.}⁴ This act shall take effect ²[immediately] on the
13 270th day following enactment, but the New Jersey Individual Health
14 Coverage Program Board may take such anticipatory administrative
15 action in advance as shall be necessary for the implementation of the
16 act.²

17

18

19

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21 _____
22 Requires individual health benefits plan carriers to offer a new health
23 benefits plan and permits small employer carriers to offer exclusive
provider organization plan.

CHAPTER 368

AN ACT concerning health insurance and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.) and P.L.1992, c.162 (C.17B:27A-17 et seq.).

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

C.17B:27A-4.4 Findings, declarations relative to exclusive provider organization health benefit plans.

1. The Legislature hereby finds and declares that:

a. While the Legislature enacted ground-breaking health insurance reform in 1992 for the individual market that provided guaranteed-issue, guaranteed-renewal coverage, with a prohibition against rating on the basis of health status and limiting preexisting condition exclusions in policies, the plans that were established by the New Jersey Individual Health Coverage Program Board did not offer sufficient variety or options to insureds in terms of the range of coverages that are provided under the standard plans;

b. The original intent of the Legislature was to give policyholders a wider range of coverage options, including policies that provide reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost;

c. The New Jersey Individual Health Coverage Program Board elected to provide little variance in the coverage provided under the standard plans; rather, reductions in premium cost can be obtained primarily through increasing the deductibles to substantial sums, which defeats the objective of making the policies affordable, in that large deductibles represent large out-of-pocket expenses;

d. In the absence of any affirmative action by the board to remedy this situation, it is the purpose of this bill to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plan provided by this act will make health insurance more accessible to many individuals that do not have the economic resources to afford the existing plans while still providing essential coverage;

e. It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year.

C.17B:27A-4.5 Carrier offering plans pursuant to C.17B:27A-2 et seq. to offer EPO; coverages.

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

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

Outpatient and ambulatory surgery- \$250 copayment per surgery;

Physicians' fees connected with hospital care, including general acute care and surgery;

Physicians' fees connected with outpatient and ambulatory surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

Intravenous solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Inpatient physical therapy and hydrotherapy;

Outpatient physical therapy - 30 visits annually per covered person- \$20 copayment per treatment;

Dialysis - inpatient or outpatient;

Inpatient diagnostic tests and \$500 annual aggregate per covered person for out-of-hospital diagnostic tests;

Laboratory fees for treatment in hospital;

Delivery room fees;
Operating room fees;
Special care unit;
Treatment room fees;
Emergency room services for medically necessary treatment - \$100 copayment per visit;
Pharmaceuticals dispensed in hospital;
Dressings;
Splints;
Treatment for biologically-based mental illness, as defined in subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90 days inpatient with no coinsurance - \$500 copayment per inpatient stay, 30 days outpatient with 30% coinsurance;
Alcohol and Substance Abuse Treatment - 30 days inpatient or outpatient - 30% coinsurance;
Childhood immunizations in accordance with the provisions of subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and adult immunizations;
Wellness benefit - \$600 annual aggregate per covered person, \$50 annual deductible, 20% coinsurance per service; and
Physicians visits for diagnosed illness or injury - to a \$700 annual aggregate per covered person.

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

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

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

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

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

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

C.17B:27A-4.6 Evaluation as to effectiveness of act.

3. The New Jersey Individual Health Coverage Program Board, in consultation with the New Jersey Small Employer Health Benefits Program Board, shall evaluate the effectiveness of this act in providing affordable health care coverage and whether the health benefits plan established in this act or a similar plan should be made available to small employers.

The boards shall report to the Legislature and Governor two years after the effective date of this act on their evaluation of the health benefits plan established in this act and shall include in

their report the number of policies or contracts sold, the premiums charged and the effect, if any, that the health benefits plan has had on the five standard health benefits plans offered to individuals in the State. The report shall also include the boards' recommendations with respect to expanding the number of, or making modifications to, the standard health benefits plans currently offered to small employers to include the health benefits plan established pursuant to this act or a similar plan.

C.17B:27A-4.7 Carrier offering plans pursuant to C.17B:27A-2 et seq. may offer additional plan with certain limited benefits.

4. In addition to the five health benefits plans offered by a carrier on the effective date of this act, a carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.).

C.17B:27A-19.11 Carrier offering plans pursuant to C.17B:27A-17 et seq. may offer additional plan with certain limited benefits.

5. In addition to the five health benefits plans offered by a carrier on the effective date of this act, a carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

6. This act shall take effect on the 270th day following enactment, but the New Jersey Individual Health Coverage Program Board may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act

Approved January 8, 2002.