

# **Chapter 38, P.L. 2008**

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**[Third Reprint]**

**SENATE, No. 1557**

**STATE OF NEW JERSEY**

**213th LEGISLATURE**

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INTRODUCED APRIL 7, 2008

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**SYNOPSIS**

Expands NJ FamilyCare, establishes mandate for health care coverage of children, makes various reforms to individual and small employer insurance markets and certain dependent coverage; appropriates \$1 million.

**CURRENT VERSION OF TEXT**

As reported by the Senate Budget and Appropriations Committee on June 19, 2008, with amendments.

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3

1 AN ACT concerning health care coverage <sup>1</sup>**[and]**,<sup>1</sup> revising parts of  
2 statutory law <sup>1</sup>, and making an appropriation<sup>1</sup>.

3

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

6

7 1. (New section) The Legislature finds and declares:

8 a. There are an estimated 1.25 million residents of the State  
9 who have no health insurance coverage, of which over 240,000 are  
10 children, and the number of uninsured residents is increasing each  
11 year;

12 b. While employer-sponsored health care coverage in the State  
13 is well above the national average and has been a major factor in  
14 keeping the number of uninsured lower than in many states, because  
15 of the rising cost of the coverage, increasing numbers of employers  
16 are considering dropping coverage for their employees and  
17 dependents, or are requiring employees to share in a greater  
18 percentage of premium costs and to bear larger copayments and  
19 coinsurance, which is making health care coverage increasingly  
20 unaffordable to low and moderate income working families;

21 c. Persons without health insurance coverage receive less  
22 preventive care, poorer treatment for both minor and serious  
23 chronic and acute illnesses, and in many cases live shorter lives  
24 than comparable insured populations;

25 d. Many uninsured are forced to seek health care in  
26 inappropriate settings such as hospital emergency rooms because  
27 they cannot obtain needed health care services in a convenient and  
28 more cost-effective setting such as a primary care provider's office  
29 or clinic, which contributes to higher health care costs;

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

<sup>1</sup>Senate SHH committee amendments adopted May 15, 2008.

<sup>2</sup>Senate SBA committee amendments adopted May 19, 2008.

<sup>3</sup>Senate SBA committee amendments adopted June 19, 2008.

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1 e. The uninsured are commonly billed at higher rates than  
2 those who have health care coverage. Health care costs have  
3 become a leading cause of bankruptcy in this country, and those  
4 without insurance are most at risk;

5 f. The State has recognized the importance of increasing access  
6 to health care coverage and, over the last several years, has enacted  
7 several reforms to make health care coverage more affordable and  
8 accessible to residents of the State. Among these reforms are the  
9 expansions of coverage under the State Medicaid and NJ  
10 FamilyCare programs. Despite these efforts, too many low income  
11 parents and children lack access to health care coverage;

12 g. In order to ensure that more low income parents in the State  
13 have access to health care coverage and all children in the State are  
14 covered under a health plan, thus moving closer to providing  
15 universal coverage for all residents of this State, it is necessary to  
16 further expand coverage for parents under the NJ FamilyCare  
17 Program, and mandate that all children in the State have health care  
18 coverage, either through public programs or private coverage; and

19 h. In order to make insurance coverage more affordable to  
20 residents and small businesses in this State, and to stabilize  
21 enrollment in, and the costs of, individual and small employer  
22 health benefits plans, it is also necessary to adopt comprehensive  
23 reform measures to the insurance marketplace.

24  
25 2. (New section) a. Beginning one year after the date of  
26 enactment of this act, all residents of this State 18 years of age and  
27 younger shall obtain and maintain health care coverage that  
28 provides hospital and medical benefits. The coverage may be  
29 provided through an employer-sponsored or individual health  
30 benefits plan, the Medicaid program, NJ FamilyCare Program, or  
31 the NJ FamilyCare Advantage buy-in program.

32 b. As used in this section:

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1       “Medicaid” means the New Jersey Medical Assistance and  
2 Health Services Program established pursuant to P.L.1968, c.413  
3 (C.30:4D-1 et seq.).

4       “NJ FamilyCare” means the NJ FamilyCare Program established  
5 pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

6       “NJ FamilyCare Advantage” means the buy-in program  
7 established pursuant to subsection j. of section 5 of P.L.2005, c.156  
8 (C.30:4J-12).

9  
10       3. Section 4 of P.L.2005, 156 (C.30:4J-11) is amended to read  
11 as follows:

12       4. As used in this act:

13       "Commissioner" means the Commissioner of Human Services.

14       "Department" means the Department of Human Services.

15       "Medicaid" means the New Jersey Medical Assistance and  
16 Health Services Program established pursuant to P.L.1968, c.413  
17 (C.30:4D-1 et seq.).

18       "NJ FamilyCare" or "program" means the NJ FamilyCare  
19 Program established pursuant to sections 3 through 5 of P.L.2005,  
20 156 (C.30:4J-10 through C.30:4J-12).

21       "Poverty level" means the official federal poverty level based on  
22 family size, established and adjusted under Section 673(2) of  
23 Subtitle B, the "Community Services Block Grant Act," Pub.L.97-  
24 35 (42 U.S.C. s.9902(2)).

25       "Qualified applicant" means:

26       a. a child under 19 years of age: (1) whose family gross income  
27 does not exceed 350% of the poverty level; (2) who has no health  
28 insurance, as determined by the commissioner, and is ineligible for  
29 Medicaid; (3) who is a resident of this State; and (4) who is a  
30 citizen of the United States, or has been lawfully admitted for  
31 permanent residence into and remains lawfully present in the United  
32 States;

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1       b. a parent or caretaker: (1) whose gross family income does  
2 not exceed 200% of the poverty level; (2) **【**who is enrolled in NJ  
3 FamilyCare on the effective date of P.L.2005, c.156 (C.30:4J-8 et  
4 al.); (3)**】** who has no health insurance, as determined by the  
5 commissioner, and is ineligible for Medicaid; **【(4)】** (3) who is a  
6 resident of this State; and **【(5)】** (4) who is a citizen of the United  
7 States, or has been lawfully admitted for permanent residence into  
8 and remains lawfully present in the United States; and

9       c. a single adult or couple without dependent children: (1)  
10 whose family gross income does not exceed 100% of the poverty  
11 level; (2) who is enrolled in NJ FamilyCare on the effective date of  
12 P.L.2005, c.156 (C.30:4J-8 et al.) and is ineligible for Medicaid; (3)  
13 who is a resident of this State; and (4) who is a citizen of the United  
14 States, or has been lawfully admitted for permanent residence into  
15 and remains lawfully present in the United States.

16 (cf: P.L.2005, c.156, s.4)

17

18       4. Section 5 of P.L.2005, c.156 (C.30:4J-12) is amended to  
19 read as follows:

20       5. a. The purpose of the program shall be to provide subsidized  
21 health insurance coverage, and other health care benefits as  
22 determined by the commissioner, to children under 19 years of age  
23 and their parents or caretakers and to adults without dependent  
24 children, within the limits of funds appropriated or otherwise made  
25 available for the program.

26       The program shall require families to pay copayments and make  
27 premium contributions, based upon a sliding income scale. The  
28 program shall include the provision of well-child and other  
29 preventive services, hospitalization, physician care, laboratory and  
30 x-ray services, prescription drugs, mental health services, and other  
31 services as determined by the commissioner.

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- 1       b. The commissioner shall take such actions as are necessary to  
2 implement and operate the program in accordance with the State  
3 Children's Health Insurance Program established pursuant to 42  
4 U.S.C.s.1397aa et seq.
- 5       c. The commissioner:
- 6       (1) shall, by regulation, establish standards for determining  
7 eligibility and other program requirements, including, but not  
8 limited to, restrictions on voluntary disenrollments from existing  
9 health insurance coverage;
- 10       (2) shall require that a parent or caretaker who is a qualified  
11 applicant purchase coverage, if available, through an employer-  
12 sponsored health insurance plan which is determined to be cost-  
13 effective and is approved by the commissioner, and shall provide  
14 assistance to the qualified applicant to purchase that coverage,  
15 except that the provisions of this paragraph shall not be construed to  
16 require an employer to provide health insurance coverage for any  
17 employee or employee's spouse or dependent child;
- 18       (3) may, by regulation, establish plans of coverage and benefits  
19 to be covered under the program, except that the provisions of this  
20 section shall not apply to coverage for medications used exclusively  
21 to treat AIDS or HIV infection; and
- 22       (4) shall establish, by regulation, other requirements for the  
23 program, including, but not limited to, premium payments and  
24 copayments, and may contract with one or more appropriate  
25 entities, including managed care organizations, to assist in  
26 administering the program. The period for which eligibility for the  
27 program is determined shall be the maximum period permitted  
28 under federal law.
- 29       d. The commissioner shall establish procedures for determining  
30 eligibility, which shall include, at a minimum, the following  
31 enrollment simplification practices:

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- 1       (1) A streamlined application form as established pursuant to  
2 subsection k. of this section;
- 3       (2) Require new applicants to submit no more than one recent  
4 pay stub from the applicant's employer, or, if the applicant has more  
5 than one employer, no more than one from each of the applicant's  
6 employers, to verify income. In the event the applicant cannot  
7 provide a recent pay stub, the applicant may submit another form of  
8 income verification as deemed appropriate by the commissioner. If  
9 an applicant does not submit income verification in a timely  
10 manner, before determining the applicant ineligible for the program,  
11 the commissioner shall seek to verify the applicant's income by  
12 reviewing available Department of the Treasury or Department of  
13 Labor and Workforce Development records concerning the  
14 applicant, or such other records as the commissioner determines  
15 appropriate.
- 16       The commissioner may establish such retrospective auditing or  
17 income verification procedures as he deems appropriate, such as  
18 sample auditing and matching reported income with records of the  
19 Department of the Treasury or the Department of Labor and  
20 Workforce Development or such other records as the commissioner  
21 determines appropriate.
- 22       If the commissioner elects to match reported income with  
23 confidential records of the Department of the Treasury, the  
24 commissioner shall require an applicant to provide written  
25 authorization for the Division of Taxation in the Department of the  
26 Treasury to release applicable tax information to the commissioner  
27 for the purposes of establishing income eligibility for the program.  
28 The authorization, which shall be included on the program  
29 application form, shall be developed by the commissioner, in  
30 consultation with the State Treasurer;
- 31       (3) Online enrollment and renewal, in addition to enrollment  
32 and renewal by mail. The online enrollment and renewal forms

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- 1 shall include electronic links to other State and federal health and  
2 social services programs;
- 3 (4) Continuous enrollment;
- 4 (5) Simplified renewal by sending an enrollee a preprinted  
5 renewal form and requiring the enrollee to sign and return the form,  
6 with any applicable changes in the information provided in the  
7 form, no later than 30 days after the date the enrollee's annual  
8 eligibility expires. The commissioner may establish such auditing or  
9 income verification procedures as he deems appropriate, as  
10 provided in paragraph (1) of this subsection; and
- 11 (6) Provision of program eligibility-identification cards that are  
12 issued no more frequently than once a year.
- 13 e. The commissioner shall take, or cause to be taken, any  
14 action necessary to secure for the State the maximum amount of  
15 federal financial participation available with respect to the program,  
16 subject to the constraints of fiscal responsibility and within the  
17 limits of available funding in any fiscal year. In this regard,  
18 notwithstanding the definition of "qualified applicant," the  
19 commissioner may enroll in the program such children or their  
20 parents or caretakers who may otherwise be eligible for the  
21 Medicaid program in order to maximize use of federal funds that  
22 may be available pursuant to 42 U.S.C. s.1397aa et seq.
- 23 f. Subject to federal approval, a child shall be determined  
24 ineligible for the program if the child was voluntarily disenrolled  
25 from employer-sponsored group insurance coverage within six  
26 months prior to application to the program.
- 27 g. The commissioner shall provide, by regulation, for  
28 presumptive eligibility for the program in accordance with the  
29 following provisions:
- 30 (1) A child who presents himself for treatment at a general  
31 hospital, federally qualified or community health center, local  
32 health department that provides primary care, or other State

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- 1 licensed community-based primary care provider shall be deemed  
2 presumptively eligible for the program if a preliminary  
3 determination by hospital, health center, local health department or  
4 licensed health care provider staff indicates that the child meets  
5 program eligibility standards and is a member of a household with  
6 an income that does not exceed 350% of the poverty level;
- 7 (2) The provisions of paragraph (1) of this subsection shall also  
8 apply to a child who is deemed presumptively eligible for Medicaid  
9 coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);
- 10 (3) The parent or caretaker of a child deemed presumptively  
11 eligible pursuant to this subsection shall be required to submit a  
12 completed application for the program no later than the end of the  
13 month following the month in which presumptive eligibility is  
14 determined;
- 15 (4) A child shall be eligible to receive all services covered by  
16 the program during the period in which the child is presumptively  
17 eligible; and
- 18 (5) The commissioner may, by regulation, establish a limit on  
19 the number of times a child may be deemed presumptively eligible  
20 for NJ FamilyCare.
- 21 h. The commissioner, in consultation with the Commissioner of  
22 Education, shall administer an ongoing enrollment initiative to  
23 provide outreach to children throughout the State who may be  
24 eligible for the program.
- 25 (1) With respect to school-age children, the commissioner, in  
26 consultation with the Commissioner of Education and the Secretary  
27 of Agriculture, shall develop a form that provides information about  
28 the NJ FamilyCare and Medicaid programs and provides an  
29 opportunity for the parent or guardian who signs the school lunch  
30 application form to give consent for information to be shared with  
31 the Department of Human Services for the purpose of determining

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1 eligibility for the programs. The form shall be attached to, included  
2 with, or incorporated into, the school lunch application form.

3 The commissioner, in consultation with the Commissioner of  
4 Education, shall establish procedures for schools to transmit  
5 information attached to, included with, or provided on the school  
6 lunch application form regarding the NJ FamilyCare and Medicaid  
7 programs to the Department of Human Services, in order to enable  
8 the department to determine eligibility for the programs.

9 (2) The commissioner or the Commissioner of Education, as  
10 applicable, shall:

11 (a) make available to each elementary and secondary school,  
12 licensed child care center, registered family day care home, unified  
13 child care agency, local health department that provides primary  
14 care, and community-based primary care provider, informational  
15 materials about the program, including instructions for applying  
16 online or by mail, as well as copies of the program application  
17 form.

18 The entity shall make the informational and application materials  
19 available, upon request, to persons interested in the program; and

20 (b) request each entity to distribute a notice at least annually, as  
21 developed by the commissioner, to households of children attending  
22 or receiving its services or care, informing them about the program  
23 and the availability of informational and application materials. In  
24 the case of elementary and secondary schools, the information  
25 attached to, included with, or incorporated into, the school lunch  
26 application form for school-age children pursuant to this  
27 subparagraph shall be deemed to meet the requirements of this  
28 paragraph.

29 i. Subject to federal approval, the commissioner shall, by  
30 regulation, establish that in determining income eligibility for a  
31 child, any gross family income above 200% of the poverty level, up  
32 to a maximum of 350% of the poverty level, shall be disregarded.

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1 j. The commissioner shall establish a NJ FamilyCare coverage  
2 buy-in program through which a parent or caretaker whose family  
3 income exceeds 350% of the poverty level may purchase coverage  
4 under NJ FamilyCare for a child under the age of 19, who is  
5 uninsured and was not voluntarily disenrolled from employer-  
6 sponsored group insurance coverage within six months prior to  
7 application to the program. The program shall be known as NJ  
8 FamilyCare Advantage.

9 The commissioner shall establish the premium and cost sharing  
10 amounts required to purchase coverage, except that the premium  
11 shall not exceed the amount the program pays per month to a  
12 managed care organization under NJ FamilyCare for a child of  
13 comparable age whose family income is between 200% and 350%  
14 of the poverty level, plus a reasonable processing fee.

15 k. The commissioner, in consultation with the Rutgers Center  
16 for State Health Policy, shall develop a streamlined application  
17 form for the NJ FamilyCare and Medicaid programs.

18 <sup>3</sup>l. Subject to federal approval, the Commissioner of Human  
19 Services shall establish a hardship waiver for part or all of the  
20 premium for an eligible child under the NJ FamilyCare program. A  
21 parent or caretaker may apply to the commissioner for a hardship  
22 waiver in a manner and form established by the commissioner. If  
23 the parent or caretaker can demonstrate to the satisfaction of the  
24 commissioner, pursuant to regulations adopted by the  
25 commissioner, that payment of all or part of the premium for the  
26 parent or caretaker's child presents a hardship, the commissioner  
27 shall grant the waiver for a prescribed period of time.<sup>3</sup>

28 (cf: P.L.2005, c.156, s.5)

29

30 5. (New section) The Commissioner of Human Services shall  
31 apply for such waivers as may be necessary to implement the  
32 provisions of section 4 of P.L.2005, c.156 (C.30:4J-11) and to

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1 secure federal financial participation for NJ FamilyCare  
2 expenditures under the State Children's Health Insurance Program  
3 pursuant to 42 U.S.C.s.1397aa et seq.  
4

5 6. (New section) Notwithstanding the provisions of section 3 of  
6 P.L.2004, c.113 (C.26:2H-18.59i) to the contrary, a hospital shall  
7 not submit charity care claims to the Department of Health and  
8 Senior Services for health care services provided to a child under 19  
9 years of age who presents at a hospital for emergency care and who  
10 may be deemed presumptively eligible for NJ FamilyCare coverage  
11 pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) or Medicaid coverage  
12 pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

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1       7. (New section) a. Beginning with the 2008 tax year and for  
2 each tax year thereafter, the Department of the Treasury shall  
3 require that each individual <sup>2</sup>**[taxpayer]** who files a resident New  
4 Jersey Gross Income Tax return<sup>2</sup> indicate on the taxpayer's income  
5 tax return whether the taxpayer and dependents, if applicable, has  
6 health insurance coverage on the date of filing of the return.

7       b. The department shall<sup>3</sup>**[**, in consultation with the  
8 Commissioner] transmit to the Department<sup>3</sup> of Human Services<sup>3</sup>**[**,  
9 administer an ongoing enrollment initiative to identify and provide  
10 outreach to] information permitting the Department of Human  
11 Services to identify<sup>3</sup> taxpayers who are uninsured and may be  
12 eligible to enroll in the Medicaid or NJ FamilyCare program. <sup>3</sup>**[**As  
13 part of the initiative, the department shall send an application for  
14 the Medicaid or NJ FamilyCare program, as applicable, to any  
15 taxpayer who reports on the tax return form that he or his  
16 dependents do not have health insurance coverage and who, based  
17 on the income reported on the tax return form and the tax payer's  
18 family size, may be eligible for either of the State's health care  
19 coverage programs.] The Department of Human Services shall use  
20 this information in furtherance of its Medicaid and NJ FamilyCare  
21 outreach and enrollment initiative established pursuant to section 26  
22 of P.L., c. (C. )(pending before the Legislature as this bill).<sup>3</sup>

23       c. As used in this section:

24       "Medicaid" means the New Jersey Medical Assistance and  
25 Health Services Program established pursuant to P.L.1968, c.413  
26 (C.30:4D-1 et seq.).

27       "NJ FamilyCare" or "program" means the NJ FamilyCare  
28 Program established pursuant to P.L.2005, <sup>2</sup>**[156]** c.156<sup>2</sup> (C.30:4J-  
29 8 et al.).

30

31       8. R.S.54:50-9 is amended to read as follows:

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- 1       54:50-9. Nothing herein contained shall be construed to prevent:
- 2       a. The delivery to a taxpayer or the taxpayer's duly authorized
- 3       representative of a copy of any report or any other paper filed by
- 4       the taxpayer pursuant to the provisions of this subtitle or of any
- 5       such State tax law;
- 6       b. The publication of statistics so classified as to prevent the
- 7       identification of a particular report and the items thereof;
- 8       c. The director, in the director's discretion and subject to
- 9       reasonable conditions imposed by the director, from disclosing the
- 10      name and address of any licensee under any State tax law, unless
- 11      expressly prohibited by such State tax law;
- 12      d. The inspection by the Attorney General or other legal
- 13      representative of this State of the reports or files relating to the
- 14      claim of any taxpayer who shall bring an action to review or set
- 15      aside any tax imposed under any State tax law or against whom an
- 16      action or proceeding has been instituted in accordance with the
- 17      provisions thereof;
- 18      e. The examination of said records and files by the
- 19      Comptroller, State Auditor or State Commissioner of Finance, or by
- 20      their respective duly authorized agents;
- 21      f. The furnishing, at the discretion of the director, of any
- 22      information contained in tax reports or returns or any audit thereof
- 23      or the report of any investigation made with respect thereto, filed
- 24      pursuant to the tax laws, to the taxing officials of any other state,
- 25      the District of Columbia, the United States and the territories
- 26      thereof, providing said jurisdictions grant like privileges to this
- 27      State and providing such information is to be used for tax purposes
- 28      only;
- 29      g. The furnishing, at the discretion of the director, of any
- 30      material information disclosed by the records or files to any law
- 31      enforcing authority of this State who shall be charged with the

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- 1 investigation or prosecution of any violation of the criminal  
2 provisions of this subtitle or of any State tax law;
- 3 h. The furnishing by the director to the State agency  
4 responsible for administering the Child Support Enforcement  
5 program pursuant to Title IV-D of the federal Social Security Act,  
6 Pub.L.93-647 (42 U.S.C. s.651 et seq.), with the names, home  
7 addresses, social security numbers and sources of income and assets  
8 of all absent parents who are certified by that agency as being  
9 required to pay child support, upon request by the State agency and  
10 pursuant to procedures and in a form prescribed by the director;
- 11 i. The furnishing by the director to the Board of Public  
12 Utilities any information contained in tax information statements,  
13 reports or returns or any audit thereof or a report of any  
14 investigation made with respect thereto, as may be necessary for the  
15 administration of P.L.1991, c.184 (C.54:30A-18.6 et al.) and  
16 P.L.1997, c.162 (C.54:10A-5.25 et al.);
- 17 j. The furnishing by the director to the Director of the Division  
18 of Alcoholic Beverage Control in the Department of Law and  
19 Public Safety any information contained in tax information  
20 statements, reports or returns or any audit thereof or a report of any  
21 investigation made with respect thereto, as may be relevant, in the  
22 discretion of the director, in any proceeding conducted for the  
23 issuance, suspension or revocation of any license authorized  
24 pursuant to Title 33 of the Revised Statutes;
- 25 k. The inspection by the Attorney General or other legal  
26 representative of this State of the reports or files of any tobacco  
27 product manufacturer, as defined in section 2 of P.L.1999, c.148  
28 (C.52:4D-2), for any period in which that tobacco product  
29 manufacturer was not or is not in compliance with subsection a. of  
30 section 3 of P.L.1999, c.148 (C.52:4D-3), or of any licensed  
31 distributor as defined in section 102 of P.L.1948, c.65 (C.54:40A-

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- 1 2), for the purpose of facilitating the administration of the  
2 provisions of P.L.1999, c.148 (C.52:4D-1 et seq.);
- 3 l. The furnishing, at the discretion of the director, of  
4 information as to whether a contractor or subcontractor holds a  
5 valid business registration as defined in section 1 of P.L.2001, c.134  
6 (C.52:32-44);
- 7 m. The furnishing by the director to a State agency as defined in  
8 section 1 of P.L.1995, c.158 (C.54:50-24) the names of licensees  
9 subject to suspension for non-payment of State tax indebtedness  
10 pursuant to P.L.2004, c.58 (C.54:50-26.1 et al.);
- 11 n. The release to the United States Department of the Treasury,  
12 Bureau of Financial Management Service, or its successor of  
13 relevant taxpayer information for purposes of implementing a  
14 reciprocal collection and offset of indebtedness agreement entered  
15 into between the State of New Jersey and the federal government  
16 pursuant to section 1 of P.L.2006, c.32 (C.54:49-12.7);
- 17 o. The examination of said records and files by the  
18 Commissioner of Health and Senior Services, the Commissioner of  
19 Human Services, the Medicaid Inspector General, or their  
20 respective duly authorized agents, pursuant to section 5 of  
21 P.L.2007, c.217 (C.26:2H-18.60e)<sup>2</sup>, section 3 of P.L.1968, c.413  
22 (C.30:4D-3), or section 5 of P.L.2005, c.156 (C.30:4J-12)<sup>2</sup>;
- 23 p. The furnishing at the discretion of the director of employer  
24 provided wage and tax withholding information contained in tax  
25 reports or returns filed pursuant to N.J.S.54A:7-2, 54A:7-4 and  
26 54A:7-7, to the designated municipal officer of a municipality  
27 authorized to impose an employer payroll tax pursuant to the  
28 provisions of Article 5 (Employer Payroll Tax) of the "Local Tax  
29 Authorization Act," P.L.1970, c.326 (C.40:48C-14 et seq.), for the  
30 limited purpose of verifying the payroll information reported by  
31 employers subject to the employer payroll tax.  
32 (cf: P.L.2007, c.294, s.2)

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1

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

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

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

6       "Carrier" means any entity subject to the insurance laws and  
7 regulations of this State, or subject to the jurisdiction of the  
8 commissioner, that contracts or offers to contract to provide,  
9 deliver, arrange for, pay for, or reimburse any of the costs of health  
10 care services, including a sickness and accident insurance company,  
11 a health maintenance organization, a nonprofit hospital or health  
12 service corporation, or any other entity providing a plan of health  
13 insurance, health benefits or health services. For purposes of this  
14 act, carriers that are affiliated companies shall be treated as one  
15 carrier.

16       "Church plan" has the same meaning given that term under Title  
17 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
18 Security Act of 1974" (29 U.S.C.s.1002(33)).

19       "Commissioner" means the Commissioner of Banking and  
20 Insurance.

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

26       "Creditable coverage" means, with respect to an individual,  
27 coverage of the individual under any of the following: a group  
28 health plan; a group or individual health benefits plan; Part A or  
29 Part B of Title XVIII of the federal Social Security Act (42 U.S.C.  
30 s.1395 et seq.); Title XIX of the federal Social Security Act (42  
31 U.S.C. s.1396 et seq.), other than coverage consisting solely of  
32 benefits under section 1928 of Title XIX of the federal Social

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1 Security Act (42 U.S.C.s.1396s); Chapter 55 of Title 10, United  
2 States Code (10 U.S.C. s.1071 et seq.); a medical care program of  
3 the Indian Health Service or of a tribal organization; a State health  
4 plan offered under chapter 89 of Title 5, United States Code (5  
5 U.S.C. 8901 et seq.); a public health plan as defined by federal  
6 regulation; and a health benefits plan under section 5(e) of the  
7 "Peace Corps Act" (22 U.S.C. s.2504(e)); or coverage under any  
8 other type of plan as set forth by the commissioner by regulation.

9 Creditable coverage shall not include coverage consisting solely  
10 of the following: coverage only for accident or disability income  
11 insurance, or any combination thereof; coverage issued as a  
12 supplement to liability insurance; liability insurance, including  
13 general liability insurance and automobile liability insurance;  
14 workers' compensation or similar insurance; automobile medical  
15 payment insurance; credit only insurance; coverage for on-site  
16 medical clinics; coverage, as specified in federal regulation, under  
17 which benefits for medical care are secondary or incidental to the  
18 insurance benefits; and other coverage expressly excluded from the  
19 definition of health benefits plan.

20 "Department" means the Department of Banking and Insurance.

21 "Dependent" means the spouse, domestic partner as defined in  
22 section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as  
23 defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an  
24 eligible person, subject to applicable terms of the individual health  
25 benefits plan.

26 "Eligible person" means a person who is a resident who is not  
27 eligible to be covered under a group health benefits plan, group  
28 health plan, governmental plan, church plan, or Part A or Part B of  
29 Title XVIII of the Social Security Act (42 U.S.C.s.1395 et seq.).

30 "Federally defined eligible individual" means an eligible person:  
31 (1) for whom, as of the date on which the individual seeks coverage  
32 under P.L.1992, c.161 (C.17B:27A-2 et seq.), the aggregate of the

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1 periods of creditable coverage is 18 or more months; (2) whose  
2 most recent prior creditable coverage was under a group health  
3 plan, governmental plan, church plan, or health insurance coverage  
4 offered in connection with any such plan; (3) who is not eligible for  
5 coverage under a group health plan, Part A or Part B of Title XVIII  
6 of the Social Security Act (42 U.S.C.s.1395 et seq.), or a State plan  
7 under Title XIX of the Social Security Act (42 U.S.C.s.1396 et seq.)  
8 or any successor program, and who does not have another health  
9 benefits plan, or hospital or medical service plan; (4) with respect to  
10 whom the most recent coverage within the period of aggregate  
11 creditable coverage was not terminated based on a factor relating to  
12 nonpayment of premiums or fraud; (5) who, if offered the option of  
13 continuation coverage under the COBRA continuation provision or  
14 a similar State program, elected that coverage; and (6) who has  
15 elected continuation coverage described in (5) above and has  
16 exhausted that continuation coverage.

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

22 "Governmental plan" has the meaning given that term under Title  
23 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
24 Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental  
25 plan established or maintained for its employees by the Government  
26 of the United States or by any agency or instrumentality of that  
27 government.

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

30 "Group health plan" means an employee welfare benefit plan, as  
31 defined in Title I, section 3 of Pub.L.93-406, the "Employee  
32 Retirement Income Security Act of 1974" (29 U.S.C. s.1002(1)), to

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1 the extent that the plan provides medical care, and including items  
2 and services paid for as medical care to employees or their  
3 dependents directly or through insurance, reimbursement, or  
4 otherwise.

5 "Health benefits plan" means a hospital and medical expense  
6 insurance policy; health service corporation contract; hospital  
7 service corporation contract; medical service corporation contract;  
8 health maintenance organization subscriber contract; or other plan  
9 for medical care delivered or issued for delivery in this State. For  
10 purposes of this act, health benefits plan shall not include one or  
11 more, or any combination of, the following: coverage only for  
12 accident, or disability income insurance, or any combination  
13 thereof; coverage issued as a supplement to liability insurance;  
14 liability insurance, including general liability insurance and  
15 automobile liability insurance; stop loss or excess risk insurance;  
16 workers' compensation or similar insurance; automobile medical  
17 payment insurance; credit-only insurance; coverage for on-site  
18 medical clinics; and other similar insurance coverage, as specified  
19 in federal regulations, under which benefits for medical care are  
20 secondary or incidental to other insurance benefits. Health benefits  
21 plans shall not include the following benefits if they are provided  
22 under a separate policy, certificate or contract of insurance or are  
23 otherwise not an integral part of the plan: limited scope dental or  
24 vision benefits; benefits for long-term care, nursing home care,  
25 home health care, community-based care, or any combination  
26 thereof; and such other similar, limited benefits as are specified in  
27 federal regulations. Health benefits plan shall not include hospital  
28 confinement indemnity coverage if the benefits are provided under  
29 a separate policy, certificate or contract of insurance, there is no  
30 coordination between the provision of the benefits and any  
31 exclusion of benefits under any group health benefits plan  
32 maintained by the same plan sponsor, and those benefits are paid

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1 with respect to an event without regard to whether benefits are  
2 provided with respect to such an event under any group health plan  
3 maintained by the same plan sponsor. Health benefits plan shall not  
4 include the following if it is offered as a separate policy, certificate  
5 or contract of insurance: Medicare supplemental health insurance  
6 as defined under section 1882(g)(1) of the federal Social Security  
7 Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the  
8 coverage provided under chapter 55 of Title 10, United States Code  
9 (10 U.S.C. s.1071 et seq.); and similar supplemental coverage  
10 provided to coverage under a group health plan.

11 "Health status-related factor" means any of the following factors:  
12 health status; medical condition, including both physical and mental  
13 illness; claims experience; receipt of health care; medical history;  
14 genetic information; evidence of insurability, including conditions  
15 arising out of acts of domestic violence; and disability.

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

24 Individual health benefits plan shall not include a certificate  
25 issued under a policy or contract issued to a trust, or to the trustees  
26 of a fund, which trust or fund is an employee welfare benefit plan,  
27 to the extent the "Employee Retirement Income Security Act of  
28 1974" (29 U.S.C. s.1001 et seq.) preempts the application of  
29 P.L.1992, c.161 (C.17B:27A-2 et seq.) to that plan.

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

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1 "Medical care" means amounts paid: (1) for the diagnosis, care,  
2 mitigation, treatment, or prevention of disease, or for the purpose of  
3 affecting any structure or function of the body; and (2)  
4 transportation primarily for and essential to medical care referred to  
5 in (1) above.

6 "Member" means a carrier that issues or has in force health  
7 benefits plans in New Jersey. Member shall not include a carrier  
8 whose combined average Medicare, Medicaid, and NJ FamilyCare  
9 **【and NJ KidCare】** enrollment represents more than 75% of its  
10 average total enrollment for all health benefits plans or whose  
11 combined Medicare, Medicaid, and NJ FamilyCare **【and NJ**  
12 **KidCare】** net earned premium for the two-year calculation period  
13 represents more than 75% of its total net earned premium for the  
14 two-year calculation period.

15 "Modified community rating" means a rating system in which the  
16 premium for all persons covered **【**by a contract is formulated based  
17 on the experience of all persons covered by that contract, without  
18 regard to age, sex, occupation and geographical location, but which  
19 may differ by health status. The term modified community rating  
20 shall apply to contracts and policies issued prior to the effective  
21 date of this act which are subject to the provisions of subsection e.  
22 of section 2 of this act.**】** under a policy or contract for a specific  
23 health benefits plan and a specific date of issue of that plan is the  
24 same without regard to sex, health status, occupation, geographical  
25 location or any other factor or characteristic of covered persons,  
26 other than age.

27 The rating system shall provide that the premium rate charged by  
28 the carrier for the highest rated individual or class of individuals  
29 shall not be greater than 350% of the premium rate charged for the  
30 lowest rated individual or class of individuals purchasing the same  
31 individual health benefits plan. The rate differential among the  
32 premium rates charged to individuals covered under the same

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1 individual health benefits plans shall be based on the actual or  
2 expected experience of persons covered under that plan; provided,  
3 however, that the rate differential may also be based upon age. The  
4 factors upon which the rate differential is applied shall be consistent  
5 with regulations promulgated by the commissioner, which shall  
6 include age classifications established, at a minimum, in five year  
7 increments. There may be a reasonable differential among the  
8 premium rates charged for different family structure rating tiers  
9 within an individual health benefits plan or for different health  
10 benefits plans offered by the carrier.

11 "Net earned premium" means the premiums earned in this State  
12 on health benefits plans, less return premiums thereon and  
13 dividends paid or credited to policy or contract holders on the  
14 health benefits plan business. Net earned premium shall include the  
15 aggregate premiums earned on the carrier's insured group and  
16 individual business and health maintenance organization business,  
17 including premiums from any Medicare, Medicaid, or NJ  
18 FamilyCare or **【NJ KidCare】** contracts with the State or federal  
19 government, but shall not include premiums earned from contracts  
20 funded pursuant to the "Federal Employee Health Benefits Act of  
21 1959," 5 U.S.C. ss.8901-8914, any excess risk or stop loss  
22 insurance coverage issued by a carrier in connection with any self  
23 insured health benefits plan, or Medicare supplement policies or  
24 contracts.

25 "NJ FamilyCare" means the NJ FamilyCare **【Health Coverage】**  
26 Program established pursuant to **【P.L.2000, c.71 (C.30:4J-1 et**  
27 seq.) **】** **【P.L.2005, c.156 (C.30:4J-8 et al.)**

28 **【"NJ KidCare" means the Children's Health Care Coverage**  
29 **Program established pursuant to P.L.1997, c.272 (C.30:4I-1 et**  
30 **seq.)**】****

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25

1 "Non-group person life year" means coverage of a person for 12  
2 months by an individual health benefits plan or conversion policy or  
3 contract subject to P.L.1992, c.161 (C.17B:27A-2 et seq.), Medicare  
4 cost or risk contract or Medicaid contract.

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

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

10 "Plan sponsor" shall have the meaning given that term under  
11 Title I, section 3 of Pub.L.93-406, the "Employee Retirement  
12 Income Security Act of 1974" (29 U.S.C. s.1002(16)(B)).

13 "Preexisting condition" means a condition that, during a  
14 specified period of not more than six months immediately preceding  
15 the effective date of coverage, had manifested itself in such a  
16 manner as would cause an ordinarily prudent person to seek medical  
17 advice, diagnosis, care or treatment, or for which medical advice,  
18 diagnosis, care or treatment was recommended or received as to that  
19 condition or as to a pregnancy existing on the effective date of  
20 coverage.

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

23 "Resident" means a person whose primary residence is in New  
24 Jersey and who is present in New Jersey for at least six months of  
25 the calendar year, or, in the case of a person who has moved to New  
26 Jersey less than six months before applying for individual health  
27 coverage, who intends to be present in New Jersey for at least six  
28 months of the calendar year.

29 "Two-year calculation period" means a two calendar year period,  
30 the first of which shall begin January 1, 1997 and end December 31,  
31 1998.

32 (cf: P.L.2001, c.349, s.1)

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

3        2. a. An individual health benefits plan issued on or after  
4 **【August 1, 1993 shall be subject to the provisions of this act】** the  
5 effective date of <sup>1</sup>this section of<sup>1</sup> P.L. , c. (pending before the  
6 Legislature as this bill) shall be subject to the rating provisions  
7 established in P.L. , c. (pending before the Legislature as this bill)<sup>3</sup>;  
8 except that for the four years next following the effective date of  
9 this section, in the case of a person who is 55 years of age or older  
10 who purchases a health benefits plan on or after that effective date,  
11 the annual rate increase for that person shall be limited to the lower  
12 of 15% or the medical trend assumption used by the carrier to  
13 project claims<sup>3</sup>.

14        In the case of an individual health benefits plan issued to a  
15 covered person prior to the effective date <sup>1</sup>this section of<sup>1</sup> of P.L.  
16 , c. (pending before the Legislature as this bill) and renewed  
17 thereafter, for the <sup>3</sup>**【five】** four<sup>3</sup> years next following <sup>1</sup>**【enactment of**  
18 P.L. , c. (pending before the Legislature as this bill)】 that  
19 effective date<sup>1</sup>, the annual rate increase filed for the plan shall be  
20 limited to the lower of 15% or the medical trend assumption used  
21 by the carrier to project claims.

22        b. **【(1) An individual health benefits plan issued on an open**  
23 **enrollment, modified community rated basis or community rated**  
24 **basis prior to August 1, 1993 shall not be subject to sections 3**  
25 **through 8, inclusive, of this act, unless otherwise specified therein.**

26        (2) An individual health benefits plan issued other than on an  
27 open enrollment basis prior to August 1, 1993 shall not be subject  
28 to the provisions of this act, except that the plan shall be liable for  
29 assessments made pursuant to section 11 of this act.

30        (3) A group conversion contract or policy issued prior to August  
31 1, 1993 that is not issued on a modified community rated basis or

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1 community rated basis, shall not be subject to the provisions of this  
2 act, except that the contract or policy shall be liable for assessments  
3 made pursuant to section 11 of this act.

4 (4) Notwithstanding any other provision of law to the contrary,  
5 an individual health benefits plan issued by a hospital service  
6 corporation or medical service corporation prior to the effective  
7 date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to  
8 the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that  
9 the plan shall guarantee renewal pursuant to subsection b. of section  
10 5 of P.L.1992, c.161 (C.17B:27A-6).

11 (5) Notwithstanding any other provision of law to the contrary,  
12 an individual health benefits plan issued by a hospital service  
13 corporation or medical service corporation to an eligible person or  
14 federally defined eligible individual after the effective date of  
15 P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the  
16 provisions of subsections c. and d. of section 2, subsection b. of  
17 section 3, section 5, subsection b. of section 6, and subsections c.,  
18 d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3,  
19 C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall  
20 not be subject to the remaining provisions of P.L.1992, c. 161.】  
21 <sup>3</sup>【(Deleted by amendment, P.L. \_\_\_\_\_, c. \_\_\_\_\_) (pending before the  
22 Legislature as this bill).】

23 (1) An individual health benefits plan issued on an open  
24 enrollment, modified community rated basis or community rated  
25 basis prior to August 1, 1993 shall not be subject to sections 3  
26 through 8, inclusive, of P.L.1992, c.161 (C.17B:27A-4 through  
27 17B:27A-9), unless otherwise specified therein.

28 (2) An individual health benefits plan issued other than on an  
29 open enrollment basis prior to August 1, 1993 shall not be subject  
30 to the provisions of this act, except that the plan shall be liable for  
31 assessments made pursuant to section 11 of P.L.1992, c.161  
32 (C.17B:27A-12).

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1       (3) A group conversion contract or policy issued prior to August  
2 1, 1993 that is not issued on a modified community rated basis or  
3 community rated basis, shall not be subject to the provisions of this  
4 act, except that the contract or policy shall be liable for assessments  
5 made pursuant to section 11 of P.L.1992, c.161 (C.17B:27A-12).

6       (4) Notwithstanding any other provision of law to the contrary,  
7 an individual health benefits plan issued by a hospital service  
8 corporation or medical service corporation prior to the effective  
9 date of P.L.1997, c.146 (C.17B:27-54 et al.) shall not be subject to  
10 the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.), except that  
11 the plan shall guarantee renewal pursuant to subsection b. of section  
12 5 of P.L.1992, c.161 (C.17B:27A-6).

13       (5) Notwithstanding any other provision of law to the contrary,  
14 an individual health benefits plan issued by a hospital service  
15 corporation or medical service corporation to an eligible person or  
16 federally defined eligible individual after the effective date of  
17 P.L.1997, c.146 (C.17B:27-54 et al.) shall comply with the  
18 provisions of subsections c. and d. of section 2, subsection b. of  
19 section 3, section 5, subsection b. of section 6, and subsections c.,  
20 d., and e. of section 8 of P.L.1992, c.161 (C.17B:27A-3,  
21 C.17B:27A-4, 17B:27A-6, 17B:27A-7, and 17B:27A-9), but shall  
22 not be subject to the remaining provisions of P.L.1992, c. 161.<sup>3</sup>

23       c. **【**After August 1, 1993, an individual who is eligible to  
24 participate in a group health benefits plan that provides coverage for  
25 hospital or medical expenses shall not be covered by an individual  
26 health benefits plan which provides benefits for hospital and  
27 medical expenses that are the same or similar to coverage provided  
28 in the group health benefits plan, except that an individual who is  
29 eligible to participate in a group health benefits plan but is currently  
30 covered by an individual health benefits plan may continue to be  
31 covered by that plan until the first anniversary date of the group  
32 health benefits plan occurring on or after January 1, 1994. **】**

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1 <sup>1</sup>[(Deleted by amendment, P.L. , c. ) (pending before the  
2 Legislature as this bill).]

3 After August 1, 1993, an individual who is eligible to participate  
4 in a group health benefits plan that provides coverage for hospital  
5 or medical expenses shall not be covered by an individual health  
6 benefits plan which provides benefits for hospital and medical  
7 expenses that are the same or similar to coverage provided in the  
8 group health benefits plan, except that an individual who is eligible  
9 to participate in a group health benefits plan but is currently  
10 covered by an individual health benefits plan may continue to be  
11 covered by that plan until the first anniversary date of the group  
12 health benefits plan occurring on or after January 1, 1994.<sup>1</sup>

13 d. **[**Except as otherwise provided in subsection c. of this  
14 section, after August 1, 1993, a person who is covered by an  
15 individual health benefits plan who is a participant in, or is eligible  
16 to participate in, a group health benefits plan that provides the same  
17 or similar coverages as the individual health benefits plan, and a  
18 person, including an employer or insurance producer, who causes  
19 another person to be covered by an individual health benefits plan  
20 which person is a participant in, or who is eligible to participate in a  
21 group health benefits plan that provides the same or similar  
22 coverages as the individual health benefits plan, shall be subject to  
23 a fine by the commissioner in an amount not less than twice the  
24 annual premium paid for the individual health benefits plan,  
25 together with any other penalties permitted by law.**]** <sup>1</sup>[(Deleted by  
26 amendment, P.L. , c. )(pending before the Legislature as this  
27 bill).]

28 Except as otherwise provided in subsection c. of this section,  
29 after August 1, 1993, a person who is covered by an individual  
30 health benefits plan who is a participant in, or is eligible to  
31 participate in, a group health benefits plan that provides the same or

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1 similar coverage as the individual health benefits plan, and a  
2 person, including an employer or insurance producer, who causes  
3 another person to be covered by an individual health benefits plan  
4 which person is a participant in, or who is eligible to participate in a  
5 group health benefits plan that provides the same or similar  
6 coverage as the individual health benefits plan, shall be subject to a  
7 fine by the commissioner in an amount not less than twice the  
8 annual premium paid for the individual health benefits plan,  
9 together with any other penalties permitted by law.<sup>1</sup>

10 e. (Deleted by amendment, P.L.1997, c.146).

11 (cf: P.L.1997, c.146, s.2)

12

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

15 3. a. No later than 180 days after the effective date of **[this**  
16 **act]** <sup>1</sup>this section of P.L. , c. (pending before the Legislature as  
17 this bill), a carrier shall, as a condition of issuing small employer  
18 health benefits plans in this State, also offer individual health  
19 benefits plans. The plans shall be offered on an open enrollment,  
20 modified community rated basis, pursuant to the provisions of this  
21 act**;** except that a carrier shall be deemed to have satisfied its  
22 obligation to provide the individual health benefits plans by paying  
23 an assessment or receiving an exemption pursuant to section 11 of  
24 this act **]** and P.L. , c. (pending before the Legislature as this  
25 bill). Every carrier that issues small employer health benefits plans  
26 pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall make a  
27 good faith effort to market individual health benefits plans.

28 b. A carrier shall offer to an eligible person a choice of **[five]**  
29 at least three individual health benefits plans **[any of which may**  
30 **contain provisions for managed care]** established by the board  
31 pursuant to section 6 of P.L.1992, c.161 (C.17B:27A-7). One plan

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1 shall be a basic health benefits plan**【**, one plan shall be a managed  
2 care plan and three plans shall include enhanced benefits of  
3 proportionally increasing actuarial value**】**. A carrier may elect to  
4 convert any individual contract or policy forms in force on the  
5 effective date of **【this act】** P.L. , c. (pending before the Legislature  
6 as this bill) to any of the **【five】** benefit plans, except that the carrier  
7 may not convert more than 25% of existing contracts or policies  
8 each year, and the replacement plan shall be of no less actuarial  
9 value than the policy or contract being replaced.

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

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

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

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

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1 if the board changes the benefits included in the basic health  
2 benefits plan.

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

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

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

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

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

29 e. **【**If all five of the individual health benefits plans are not  
30 established by the board by the effective date of P.L.1993, c.164  
31 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the  
32 five health benefits plans by offering each health benefits plan as it

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1 is established by the board; however, once the board establishes all  
2 five plans, the carrier shall be required to offer the five plans in  
3 accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et  
4 al.).~~】 (Deleted by amendment, P.L. , c. )(pending before the~~  
5 Legislature as this bill).

6 f. In addition to the rider packages provided for in subsection  
7 c. of section 6 of P.L.1992, c.161 (C.17B:27A-7), every carrier may  
8 offer, in connection with the health benefits plans required to be  
9 offered by this section, any number of riders which may <sup>1</sup>【revise  
10 the coverage offered by the plans in any way, provided, however,  
11 that any form of such rider or amendment thereof which decreases  
12 benefits or decreases the actuarial value of one of the plans shall be  
13 filed for informational purposes with the board and for approval by  
14 the commissioner before such rider may be sold】 <sup>1</sup>add benefits or  
15 increase the actuarial value of any of the plans<sup>1</sup>. <sup>1</sup>Any <sup>1</sup>such <sup>1</sup>rider  
16 or amendment thereof <sup>1</sup>【which adds benefits or increases the  
17 actuarial value of one of the plans】<sup>1</sup> shall be filed with the board for  
18 informational purposes before <sup>1</sup>【such】 <sup>1</sup>the <sup>1</sup>rider may be sold. The  
19 added premium <sup>1</sup>【or reduction in premium】<sup>1</sup> for each rider <sup>1</sup>【, as  
20 applicable,】<sup>1</sup> shall be listed separately from the premium for the  
21 standard plan.

22 The commissioner shall disapprove any rider filed pursuant to  
23 this subsection that is unjust, unfair, inequitable, unreasonably  
24 discriminatory, misleading, contrary to law or the public policy of  
25 this State. <sup>1</sup>【The commissioner shall not approve any rider which  
26 reduces benefits below those required by sections 55, 57 and 59 of  
27 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and  
28 required to be sold pursuant to this section.】<sup>1</sup> The commissioner's  
29 determination shall be in writing and shall be appealable.

30 (cf: P.L.1994, c.102, s.1)

31

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1       12. Section 2 of P.L.2001, c.368 (C.17B:27A-4.5) is amended to  
2 read as follows:

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

8 90 days hospital room and board - \$500 copayment per hospital  
9 stay;

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

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

13 Physicians' fees connected with outpatient and ambulatory surgery;

14 Anesthesia and the administration of anesthesia;

15 Coverage for newborns;

16 Treatment for complications of pregnancy;

17 Intravenous solutions, blood and blood plasma;

18 Oxygen and the administration of oxygen;

19 Radiation and x-ray therapy;

20 Inpatient physical therapy and hydrotherapy;

21 Outpatient physical therapy - 30 visits annually per covered person-  
22 \$20 copayment per treatment;

23 Dialysis - inpatient or outpatient;

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

26 Laboratory fees for treatment in hospital;

27 Delivery room fees;

28 Operating room fees;

29 Special care unit;

30 Treatment room fees;

31 Emergency room services for medically necessary treatment - \$100  
32 copayment per visit;

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- 1   Pharmaceuticals dispensed in hospital;
- 2   Dressings;
- 3   Splints;
- 4   Treatment for biologically-based mental illness, as defined in
- 5   subsection a. of section 6 of P.L.1999, c.106 (C.17B:27A-7.5) - 90
- 6   days inpatient with no coinsurance - \$500 copayment per inpatient
- 7   stay, 30 days outpatient with 30% coinsurance;
- 8   Alcohol and Substance Abuse Treatment - 30 days inpatient or
- 9   outpatient - 30% coinsurance;
- 10   Childhood immunizations in accordance with the provisions of
- 11   subsection b. of section 7 of P.L.1995, c.316 (C.26:2-137.1) and
- 12   adult immunizations;
- 13   Wellness benefit - \$600 annual aggregate per covered person, \$50
- 14   annual deductible, 20% coinsurance per service; and
- 15   Physicians visits for diagnosed illness or injury - to a \$700 annual
- 16   aggregate per covered person.
- 17    b.   A carrier shall offer the benefits on an indemnity basis, with
- 18   the option that: (1) coverage is restricted to health care providers in
- 19   the carrier's network, including an exclusive provider organization,
- 20   or the carrier's preferred provider organization; or (2) coverage is
- 21   provided through health care providers in the carrier's network or
- 22   preferred provider organization with an out-of-network option with
- 23   30% coinsurance in addition to whatever other coinsurance may be
- 24   applicable under the policy.
- 25    c.   With respect to all policies or contracts issued pursuant to
- 26   this section, the premium rate charged by a carrier to the highest
- 27   rated individual or class of individuals shall not be greater than
- 28   350% of the premium rate charged for the lowest rated individual or
- 29   class of individuals purchasing this health benefits plan, provided,
- 30   however, that the only factors upon which the rate differential may
- 31   be based are age, gender, and geography. Rates applicable to
- 32   policies or contracts issued pursuant to this section shall reflect past

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1 and prospective loss experience for benefits included in such  
2 policies or contracts, and shall be formulated in a manner that does  
3 not result in an unfair subsidization of rates applicable to policies  
4 issued pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2  
5 et seq.) as the result of differences in levels of benefits offered.

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  
9 additional benefits, in a manner which will avoid adverse selection  
10 to the extent possible.

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

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

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

28 (cf: P.L.2001, c.368, s.2)

29

30 13. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to  
31 read as follows:

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

21 (cf: P.L.2001, c.368, s.4)

22

23       14. Section 5 of P.L.1992, c.161 (C.17B:27A-6) is amended to  
24 read as follows:

25       5. An individual health benefits plan issued pursuant to section  
26 3 of this act is subject to the following provisions:

27       a. The health benefits plan shall guarantee coverage for an  
28 eligible person and his dependents on a modified community rated  
29 basis.

30       b. A health benefits plan shall be renewable with respect to an  
31 eligible person and his dependents at the option of the policy or

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1 contract holder. A carrier may terminate a health benefits plan  
2 under the following circumstances:

3 (1) the policy or contract holder has failed to pay premiums in  
4 accordance with the terms of the policy or contract or the carrier has  
5 not received timely premium payments;

6 (2) the policy or contract holder has performed an act or practice  
7 that constitutes fraud or made an intentional misrepresentation of  
8 material fact under the terms of the coverage;

9 c. A carrier may not renew a health benefits plan only under  
10 the following circumstances:

11 (1) termination of eligibility of the policy or contract holder if  
12 the person is no longer a resident or becomes eligible for a group  
13 health benefits plan, group health plan, governmental plan or church  
14 plan;

15 (2) cancellation or amendment by the board of the specific  
16 individual health benefits plan;

17 (3) **【board】** approval by the commissioner of a request by  
18 the individual carrier to not renew a particular type of health  
19 benefits plan, in accordance with rules adopted by the **【board】**  
20 commissioner. After receiving **【board】** approval by the  
21 commissioner, a carrier may not renew a type of health benefits  
22 plan only if the carrier: (a) provides notice to each covered  
23 individual provided coverage of this type of the nonrenewal at least  
24 90 days prior to the date of the nonrenewal of the coverage; (b)  
25 offers to each individual provided coverage of this type the option  
26 to purchase any other individual health benefits plan currently being  
27 offered by the carrier; and (c) in exercising the option to not renew  
28 coverage of this type and in offering coverage as required under (b)  
29 above, the carrier acts uniformly without regard to any health  
30 status-related factor of enrolled individuals or individuals who may  
31 become eligible for coverage;

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1 (4) **【board】** approval by the commissioner of a request by the  
2 individual carrier to cease doing business in the individual health  
3 benefits market. A carrier may not renew all individual health  
4 benefits plans only if the carrier: (a) first receives approval from  
5 the **【board】** commissioner; and (b) provides notice to each  
6 individual of the nonrenewal at least 180 days prior to the date of  
7 the expiration of such coverage. A carrier ceasing to do business in  
8 the individual health benefits market may not provide for the  
9 issuance of any health benefits plan in the individual **【market】** or  
10 small employer markets during the five-year period beginning on  
11 the date of the termination of the last health benefits plan not so  
12 renewed; and

13 (5) In the case of a health benefits plan made available by a  
14 health maintenance organization carrier, the carrier shall not be  
15 required to renew coverage to an eligible individual who no longer  
16 resides, lives, or works in the service area, or in an area for which  
17 the carrier is authorized to do business, but only if coverage is  
18 terminated under this paragraph uniformly without regard to any  
19 health status-related factor of covered individuals.

20 (cf. P.L.1997, c.146, s.3)

21

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

24 6. The **【board】** commissioner shall **【establish】** approve the  
25 policy and contract forms and benefit levels to be made available by  
26 all carriers for the health benefits plans required to be issued  
27 pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall  
28 adopt such modifications to one or more plans as the board  
29 determines are necessary to make available a "high deductible  
30 health plan" or plans consistent with section 301 of Title III of the  
31 "Health Insurance Portability and Accountability Act of 1996,"  
32 Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical

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1 savings accounts, within 60 days after the enactment of P.L.1997,  
2 c.414 (C.54A:3-4 et al.). The **board** commissioner shall provide  
3 the **commissioner** board with an informational filing of the policy  
4 and contract forms and benefit levels it **establishes** approves.

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

13 b. An individual health benefits plan offered pursuant to  
14 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a  
15 limitation of no more than 12 months on coverage for preexisting  
16 conditions. An individual health benefits plan offered pursuant to  
17 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a  
18 preexisting condition limitation of any period under the following  
19 circumstances:

20 (1) to an individual who has, under creditable coverage, with no  
21 intervening lapse in coverage of more than 31 days, been treated or  
22 diagnosed by a physician for a condition under that plan or satisfied  
23 a 12-month preexisting condition limitation; or

24 (2) to a federally defined eligible individual who applies for an  
25 individual health benefits plan within 63 days of termination of the  
26 prior coverage.

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

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

13       e. Effective immediately for an individual health benefits plan  
14 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
15 35.27 et al.) and effective on the first 12-month anniversary date of  
16 an individual health benefits plan in effect on the effective date of  
17 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health  
18 benefits plans required pursuant to section 3 of P.L.1992, c.161  
19 (C.17B:27A-4), including any plan offered by a federally qualified  
20 health maintenance organization, shall contain benefits for expenses  
21 incurred in the following:

22       (1) Screening by blood lead measurement for lead poisoning for  
23 children, including confirmatory blood lead testing as specified by  
24 the Department of Health and Senior Services pursuant to section 7  
25 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any  
26 necessary medical follow-up and treatment for lead poisoned  
27 children.

28       (2) All childhood immunizations as recommended by the  
29 Advisory Committee on Immunization Practices of the United  
30 States Public Health Service and the Department of Health and  
31 Senior Services pursuant to section 7 of P.L.1995, c.316 (C.26:2-  
32 137.1). A carrier shall notify its insureds, in writing, of any change

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1 in the health care services provided with respect to childhood  
2 immunizations and any related changes in premium. Such  
3 notification shall be in a form and manner to be determined by the  
4 Commissioner of Banking and Insurance.

5 (3) Screening for newborn hearing loss by appropriate  
6 electrophysiologic screening measures and periodic monitoring of  
7 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
8 (C.26:2-103.1 et al.). Payment for this screening service shall be  
9 separate and distinct from payment for routine new baby care in the  
10 form of a newborn hearing screening fee as negotiated with the  
11 provider and facility.

12 The benefits provided pursuant to this subsection shall be  
13 provided to the same extent as for any other medical condition  
14 under the health benefits plan, except that a deductible shall not be  
15 applied for benefits provided pursuant to this subsection; however,  
16 with respect to a health benefits plan that qualifies as a high  
17 deductible health plan for which qualified medical expenses are  
18 paid using a health savings account established pursuant to section  
19 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),  
20 a deductible shall not be applied for any benefits provided pursuant  
21 to this subsection that represent preventive care as permitted by that  
22 federal law, and shall not be applied as provided pursuant to section  
23 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall  
24 apply to all individual health benefits plans in which the carrier has  
25 reserved the right to change the premium.

26 f. Effective immediately for a health benefits plan issued on or  
27 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and  
28 effective on the first 12-month anniversary date of a health benefits  
29 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z  
30 et al.), the health benefits plans required pursuant to section 3 of  
31 P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses  
32 incurred in the purchase of prescription drugs shall provide benefits

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1 for expenses incurred in the purchase of specialized non-standard  
2 infant formulas, when the covered infant's physician has diagnosed  
3 the infant as having multiple food protein intolerance and has  
4 determined such formula to be medically necessary, and when the  
5 covered infant has not been responsive to trials of standard non-cow  
6 milk-based formulas, including soybean and goat milk. The  
7 coverage may be subject to utilization review, including periodic  
8 review, of the continued medical necessity of the specialized infant  
9 formula.

10 The benefits shall be provided to the same extent as for any other  
11 prescribed items under the health benefits plan.

12 This subsection shall apply to all individual health benefits plans  
13 in which the carrier has reserved the right to change the premium.

14 g. Effective immediately for an individual health benefits plan  
15 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-  
16 35.27 et al.) and effective on the first 12-month anniversary date of  
17 an individual health benefits plan in effect on the effective date of  
18 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans  
19 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)  
20 that qualify as high deductible health plans for which qualified  
21 medical expenses are paid using a health savings account  
22 established pursuant to section 223 of the federal Internal Revenue  
23 Code of 1986 (26 U.S.C. s.223), including any plan offered by a  
24 federally qualified health maintenance organization, shall contain  
25 benefits for expenses incurred in connection with any medically  
26 necessary benefits provided in-network which represent preventive  
27 care as permitted by that federal law.

28 The benefits provided pursuant to this subsection shall be  
29 provided to the same extent as for any other medical condition  
30 under the health benefits plan, except that a deductible shall not be  
31 applied for benefits provided pursuant to this subsection. This

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1 subsection shall apply to all individual health benefits plans in  
2 which the carrier has reserved the right to change the premium.  
3 (cf: P.L.2005, c.248, s.13)  
4

5 16. Section 8 of P.L.1992, c.161 (C.17B:27A-9) is amended to  
6 read as follows:

7 8. a. **【**The board shall make application to the Hospital Rate  
8 Setting Commission on behalf of all carriers for approval of  
9 discounted or reduced rates of payment to hospitals for health care  
10 services provided under an individual health benefits plan provided  
11 pursuant to this act.**】** (Deleted by amendment, P.L. , c. )(pending  
12 before the Legislature as this bill).

13 b. **【**In addition to discounted or reduced rates of hospital  
14 payment, the**】** The board shall make application on behalf of all  
15 carriers for any other subsidies, discounts, or funds that may be  
16 provided for under State or federal law or regulation. A carrier may  
17 include **【**discounted or reduced rates of hospital payment and other**】**  
18 subsidies or funds granted to the board to reduce its premium rates  
19 for individual health benefits plans subject to this act.

20 c. A carrier shall not issue individual health benefits plans on a  
21 new contract or policy form pursuant to this act until an  
22 informational filing of a full schedule of rates which applies to the  
23 contract or policy form has been filed with the **【**board**】**  
24 commissioner. The **【**board**】** commissioner shall **【**forward**】** provide  
25 a copy of the informational filing to the **【**commissioner and the**】**  
26 Attorney General and the board.

27 d. **【**A carrier shall make an informational filing with the board  
28 of any change in its rates for individual health benefits plans  
29 pursuant to section 3 of this act prior to the date the rates become  
30 effective. The board shall file the informational filing with the  
31 commissioner and the Attorney General. If the carrier has filed all

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1 information required by the board, the filing shall be deemed to be  
2 complete.】 A carrier desiring to increase or decrease premiums for  
3 any contract or policy form may implement that increase or  
4 decrease upon making an informational filing with the  
5 commissioner of that increase or decrease, along with the actuarial  
6 assumptions and methods used by the carrier in establishing that  
7 increase or decrease. The commissioner may disapprove any  
8 informational filing on a finding that it is incomplete and not in  
9 substantial compliance with P.L.1992, c.161 (C.17B:27A-2 et seq.),  
10 or that the rates are inadequate or unfairly discriminatory.

11 e. (1) Rates shall be formulated on contracts or policies  
12 required pursuant to section 3 of this act so that the anticipated  
13 minimum loss ratio for a contract or policy form shall not be less  
14 than **【75%】** 80% of the premium. The carrier shall submit with its  
15 rate filing supporting data, as determined by the **【board】**  
16 commissioner, and a certification by a member of the American  
17 Academy of Actuaries, or other individuals in a format acceptable  
18 to the **【board and to the】** commissioner, that the carrier is in  
19 compliance with the provisions of this subsection.

20 (2) **【Following the close of each calendar year, if the board**  
21 **determines that a carrier's loss ratio was less than 75% for that**  
22 **calendar year, the carrier shall be required to refund to policy or**  
23 **contract holders the difference between the amount of net earned**  
24 **premium it received that year and the amount that would have been**  
25 **necessary to achieve the 75% loss ratio.】**

26 Each calendar year, a carrier shall return, in the form of  
27 aggregate benefits for all of the policy or contract forms offered by  
28 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161  
29 (C.17:B:27A-4), at least 80% of the aggregate premiums collected  
30 for all of the policy or contract forms during that calendar year.  
31 Carriers shall annually report, no later than August 1 of each year,

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1 the loss ratio calculated pursuant to this section for all of the policy  
2 or contract forms for the previous calendar year. In each case in  
3 which the loss ratio fails to comply with the 80% loss ratio  
4 requirement, the carrier shall issue a dividend or credit against  
5 future premiums for all policy or contract holders, as applicable, in  
6 an amount sufficient to assure that the aggregate benefits paid in the  
7 previous calendar year plus the amount of the dividends and credits  
8 equal 80% of the aggregate premiums collected for the policy or  
9 contract forms in the previous calendar year. All dividends and  
10 credits shall be distributed by December 31 of the year following  
11 the calendar year in which the loss ratio requirements were not  
12 satisfied. The annual report required by this subsection shall include  
13 a carrier's calculation of the dividends and credits applicable to all  
14 policy or contract forms, as well as an explanation of the carrier's  
15 plan to issue dividends or credits. The instructions and format for  
16 calculating and reporting loss ratios and issuing dividends or credits  
17 shall be specified by the commissioner by regulation. Those  
18 regulations shall include provisions for the distribution of a  
19 dividend or credit in the event of cancellation or termination by a  
20 policyholder.

21 f. **【**Notwithstanding the provisions of P.L.1992, c.161  
22 (C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed  
23 pursuant to this section by a carrier which insured at least 50% of  
24 the community-rated individually insured persons on the effective  
25 date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required  
26 to produce a loss ratio which when combined with the carrier's  
27 administrative costs and investment income results in self-  
28 sustaining rates prior to January 1, 1996, for individual policies or  
29 contracts issued prior to August 1, 1993. The carrier shall, not later  
30 than 30 days after the effective date of P.L.1994, c.102  
31 (C.17B;27A-4 et al.), file with the board for approval, a plan to

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1 achieve this objective.】 (Deleted by amendment, P.L., c. )(pending  
2 before the Legislature as this bill).  
3 (cf: P.L.1994, c.102, s.2)  
4

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

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

13 The board shall have the specific authority to:

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

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

24 c. **【review rate applications and form filings submitted by**  
25 **carriers in accordance with this act;】** (Deleted by amendment,  
26 P.L. , c. )(pending before the Legislature as this bill).

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

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

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- 1 f. establish a procedure for the joint distribution of information  
2 on individual health benefits plans issued pursuant to section 3 of  
3 this act;
- 4 g. establish, at the board's discretion, standards for the  
5 application of a means test for individual health benefits plans  
6 issued pursuant to section 3 of this act;
- 7 h. establish, at the board's discretion, reasonable guidelines for  
8 the purchase of new individual health benefits plans by persons who  
9 already are enrolled in or insured by another individual health  
10 benefits plan;
- 11 i. establish minimum requirements for performance standards  
12 for carriers that are reimbursed for losses submitted to the program  
13 and provide for performance audits from time to time;
- 14 j. sue or be sued, including taking any legal actions necessary  
15 or proper for recovery of an assessment for, on behalf of, or against  
16 the program or a member;
- 17 k. appoint from among its members appropriate legal, actuarial,  
18 and other committees as necessary to provide technical and other  
19 assistance in the operation of the program, in policy and other  
20 contract design, and any other function within the authority of the  
21 program;
- 22 l. borrow money to effect the purposes of the program. Any  
23 notes or other evidence of indebtedness of the program not in  
24 default shall be legal investments for carriers and may be carried as  
25 admitted assets; and
- 26 m. contract for an independent actuary and any other  
27 professional services the board deems necessary to carry out its  
28 duties under P.L.1992, c.161 (C.17B:27A-2 et al.).  
29 (cf: P.L.1993, c.164, s.6)
- 30
- 31 18. Section 11 of P.L.1992, c.161 (C.17B:27A-12) is amended  
32 to read as follows:

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1        11. The board shall establish procedures for the equitable  
2 sharing of program losses among all members in accordance with  
3 their total market share as follows:

4        a. (1) By March 1, 1999, and following the close of each two-  
5 year calculation period thereafter, or on a different date established  
6 by the board:

7        (a) every carrier issuing health benefits plans in this State shall  
8 file with the board its net earned premium for the preceding two-  
9 year calculation period; and

10       (b) every carrier issuing individual health benefits plans in the  
11 State shall file with the board the net earned premium on health  
12 benefits plans issued pursuant to paragraph (1) of subsection b. of  
13 section 2 and section 3 of this act and the claims paid. If the claims  
14 paid for all health benefits plans during the two-year calculation  
15 period exceed 115% of the net earned premium and any investment  
16 income thereon for the two-year calculation period, the amount of  
17 the excess shall be the net paid loss for the carrier that shall be  
18 reimbursable under this act.

19       (2) Every member shall be liable for an assessment to reimburse  
20 carriers issuing individual health benefits plans in this State which  
21 sustain net paid losses during the two-year calculation period,  
22 unless the member has received an exemption from the board  
23 pursuant to subsection d. of this section and has written a minimum  
24 number of non-group person life years as provided for in that  
25 subsection. The assessment of each member shall be in the  
26 proportion that the net earned premium of the member for the two-  
27 year calculation period preceding the assessment bears to the net  
28 earned premium of all members for the two-year calculation period  
29 preceding the assessment. Notwithstanding the provisions of this  
30 subsection to the contrary, a medical service corporation or a  
31 hospital service corporation shall not be liable for an assessment to  
32 reimburse carriers which sustain net paid losses.

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1       (3) A member that is financially impaired may seek from the  
2 commissioner a deferment in whole or in part from any assessment  
3 issued by the board. The commissioner may defer, in whole or in  
4 part, the assessment of the member if, in the opinion of the  
5 commissioner, the payment of the assessment would endanger the  
6 ability of the member to fulfill its contractual obligations. If an  
7 assessment against a member is deferred in whole or in part, the  
8 amount by which the assessment is deferred may be assessed  
9 against the other members in a manner consistent with the basis for  
10 assessment set forth in this section. The member receiving the  
11 deferment shall remain liable to the program for the amount  
12 deferred.

13       b. The participation in the program as a member, the  
14 establishment of rates, forms or procedures, or any other joint or  
15 collective action required by this act shall not be the basis of any  
16 legal action, criminal or civil liability, or penalty against the  
17 program, a member of the board or a member of the program either  
18 jointly or separately except as otherwise provided in this act.

19       c. Payment of an assessment made under this section shall be a  
20 condition of issuing health benefits plans in the State for a carrier.  
21 Failure to pay the assessment shall be grounds for forfeiture of a  
22 carrier's authorization to issue health benefits plans of any kind in  
23 the State, as well as any other penalties permitted by law.

24       d. (1) Notwithstanding the provisions of this act to the  
25 contrary, a carrier may apply to the board, by a date established by  
26 the board, for an exemption from the assessment and reimbursement  
27 for losses provided for in this section. A carrier which applies for  
28 an exemption shall agree to cover a minimum number of non-group  
29 person life years on an open enrollment community rated basis,  
30 under a managed care or indemnity plan, as specified in this  
31 subsection, provided that any indemnity plan so issued conforms  
32 with sections 2 through 7, inclusive, of P.L.1992, c.161

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1 (C.17B:27A-3 through 17B:27A-8). For the purposes of this  
2 subsection, non-group persons include individually enrolled  
3 persons, conversion policies issued pursuant to this act, Medicare  
4 cost and risk lives and Medicaid recipients; except that in  
5 determining whether the carrier meets the minimum number of non-  
6 group person life years required to be covered pursuant to this  
7 subsection, the number of Medicaid recipients and Medicare cost  
8 and risk lives shall not exceed 50% of the total. Pursuant to  
9 regulations adopted by the board, the carrier shall determine the  
10 number of non-group person life years it has covered by adding the  
11 number of non-group persons covered on the last day of each  
12 calendar quarter of the two-year calculation period, taking into  
13 account the limitations on counting Medicaid recipients and  
14 Medicare cost and risk lives, and dividing the total by eight.

15 (2) Notwithstanding the provisions of paragraph (1) of this  
16 subsection to the contrary, a health maintenance organization  
17 qualified pursuant to the "Health Maintenance Organization Act of  
18 1973," Pub.L93-222 (42U.S.C. s.300e et seq.) and tax exempt  
19 pursuant to paragraph (3) of subsection (c) of section 501 of the  
20 federal Internal Revenue Code of 1986, 26U.S.C. s.501, may  
21 include up to one third Medicaid recipients and up to one third  
22 Medicare recipients in determining whether it meets its minimum  
23 number of non-group person life years.

24 (3) The minimum number of non-group person life years  
25 required to be covered, as determined by the board, shall equal the  
26 total number of non-group person life years of community rated,  
27 individually enrolled or insured persons, including Medicare cost  
28 and risk lives and enrolled Medicaid lives, of all carriers subject to  
29 this act for the two-year calculation period, multiplied by the  
30 proportion that that carrier's net earned premium bears to the net  
31 earned premium of all carriers for that two-year calculation period,  
32 including those carriers that are exempt from the assessment.

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1 (4) On or before March 1 of the first year of each two-year  
2 calculation period, every carrier seeking an exemption pursuant to  
3 this subsection shall file with the board a statement of its net earned  
4 premium for the two-year calculation period. The board shall  
5 determine each carrier's minimum number of non-group person life  
6 years in accordance with this subsection.

7 (5) On or before March 1 of each year immediately following  
8 the close of a two-year calculation period, every carrier that was  
9 granted an exemption for the preceding two-year calculation period  
10 shall file with the board the number of non-group person life years,  
11 by category, covered for the two-year calculation period.

12 To the extent that the carrier has failed to cover the minimum  
13 number of non-group person life years established by the board, the  
14 carrier shall be assessed by the board on a pro rata basis for any  
15 differential between the minimum number established by the board  
16 and the actual number covered by the carrier.

17 (6) A carrier that applies for the exemption shall be deemed to  
18 be in compliance with the requirements of this subsection if it has  
19 covered 100% of the minimum number of non-group person life  
20 years required.

21 (7) Any carrier that writes both managed care and indemnity  
22 business that is granted an exemption pursuant to this subsection  
23 may satisfy its obligation to cover a minimum number of non-group  
24 person life years by issuing either managed care or indemnity  
25 business, or both.

26 e. (Deleted by amendment, P.L.1997, c.146).

27 f. The loss assessment for the '2007-2008' two-year  
28 calculation period 'in which P.L. , c. (pending before the  
29 Legislature as this bill) takes effect]' shall be the last loss  
30 assessment authorized under this section, and no further loss  
31 assessments shall be calculated or collected; provided, however,  
32 that nothing in this subsection shall relieve a carrier of its

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1 obligations for loss assessments authorized under this section prior  
2 to the effective date of <sup>1</sup>this section of<sup>1</sup> P.L. , c. (pending before  
3 the Legislature as this bill).

4 (cf: P.L.1997, c.146, s.6)

5

6 19. Section 5 of P.L.1995, c.196 (C.17B:27A-16.5) is amended  
7 to read as follows:

8 5. A domestic mutual insurer which has converted from a  
9 health service corporation pursuant to the provisions of sections 2  
10 through 4 of P.L.1995, c.196 (C.17:48E-46 through C.17:48E-48)  
11 shall not renew individual hospital or medical insurance policies or  
12 health service contracts originally issued prior to November 30,  
13 1992, until it has made an informational filing with the **【New Jersey**  
14 **Individual Health Coverage Program Board**, of a full schedule of  
15 rates which are to apply to those contracts. The New Jersey  
16 **Individual Health Coverage Program Board** shall forward a copy of  
17 such filing to the **】** commissioner. The rates shall be formulated so  
18 that the anticipated minimum loss ratio for such policy or contract  
19 form shall not be less than **【75%】 80%** of the premium. Such  
20 domestic mutual insurer shall submit with its rate filing supporting  
21 data and a certification that the insurer is in compliance with the  
22 anticipated loss ratio requirement. The content and form of the  
23 supporting data and certification required pursuant to subsection e.  
24 of section 8 of P.L.1992, c.161 (C.17B:27A-9) shall satisfy the  
25 requirements of this section. Any other insurer may irrevocably  
26 elect to become subject to the provisions of this section by written  
27 notice to the commissioner **【**, except that such informational filing  
28 by any other insurer shall be **】** in a format specified by the  
29 commissioner **【and shall be made directly to the commissioner and**  
30 **not to the New Jersey Individual Health Coverage Program Board】**.

31 (cf: P.L.1995, c.196, s.5)

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2       20. Section 1 of P.L.1992, c.162 (C.17B:27A-17) is amended to  
3 read as follows:

4       1. As used in this act:

5       "Actuarial certification" means a written statement by a member  
6 of the American Academy of Actuaries or other individual  
7 acceptable to the commissioner that a small employer carrier is in  
8 compliance with the provisions of section 9 of P.L.1992, c.162  
9 (C.17B:27A-25), based upon examination, including a review of the  
10 appropriate records and actuarial assumptions and methods used by  
11 the small employer carrier in establishing premium rates for  
12 applicable health benefits plans.

13       "Anticipated loss ratio" means the ratio of the present value of  
14 the expected benefits, not including dividends, to the present value  
15 of the expected premiums, not reduced by dividends, over the entire  
16 period for which rates are computed to provide coverage. For  
17 purposes of this ratio, the present values must incorporate realistic  
18 rates of interest which are determined before federal taxes but after  
19 investment expenses.

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

21       "Carrier" means any entity subject to the insurance laws and  
22 regulations of this State, or subject to the jurisdiction of the  
23 commissioner, that contracts or offers to contract to provide,  
24 deliver, arrange for, pay for, or reimburse any of the costs of health  
25 care services, including an insurance company authorized to issue  
26 health insurance, a health maintenance organization, a hospital  
27 service corporation, medical service corporation and health service  
28 corporation, or any other entity providing a plan of health  
29 insurance, health benefits or health services. The term "carrier"  
30 shall not include a joint insurance fund established pursuant to State  
31 law. For purposes of this act, carriers that are affiliated companies  
32 shall be treated as one carrier, except that any insurance company,

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1 health service corporation, hospital service corporation, or medical  
2 service corporation that is an affiliate of a health maintenance  
3 organization located in New Jersey or any health maintenance  
4 organization located in New Jersey that is affiliated with an  
5 insurance company, health service corporation, hospital service  
6 corporation, or medical service corporation shall treat the health  
7 maintenance organization as a separate carrier.

8 "Church plan" has the same meaning given that term under Title  
9 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
10 Security Act of 1974" (29 U.S.C.s.1002(33)).

11 "Commissioner" means the Commissioner of Banking and  
12 Insurance.

13 "Community rating" or "community rated" means a rating  
14 methodology in which the premium charged by a carrier for all  
15 persons covered by a policy or contract form is the same based upon  
16 the experience of the entire pool of risks covered by that policy or  
17 contract form without regard to age, gender, health status, residence  
18 or occupation.

19 "Creditable coverage" means, with respect to an individual,  
20 coverage of the individual under any of the following: a group  
21 health plan; a group or individual health benefits plan; Part A or  
22 part B of Title XVIII of the federal Social Security Act (42 U.S.C.  
23 s.1395 et seq.); Title XIX of the federal Social Security Act (42  
24 U.S.C. 1396 et seq.), other than coverage consisting solely of  
25 benefits under section 1928 of Title XIX of the federal Social  
26 Security Act (42 U.S.C.s.1396s); chapter 55 of Title 10, United  
27 States Code (10 U.S.C. 1071 et seq.); a medical care program of the  
28 Indian Health Service or of a tribal organization; a state health plan  
29 offered under chapter 89 of Title 5, United States Code (5 U.S.C.  
30 s.8901 et seq.); a public health plan as defined by federal  
31 regulation; a health benefits plan under section 5(e) of the "Peace

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1 Corps Act" (22 U.S.C. s.2504(e)); or coverage under any other type  
2 of plan as set forth by the commissioner by regulation.

3 Creditable coverage shall not include coverage consisting solely  
4 of the following: coverage only for accident or disability income  
5 insurance, or any combination thereof; coverage issued as a  
6 supplement to liability insurance; liability insurance, including  
7 general liability insurance and automobile liability insurance;  
8 workers' compensation or similar insurance; automobile medical  
9 payment insurance; credit only insurance; coverage for on-site  
10 medical clinics; coverage, as specified in federal regulation, under  
11 which benefits for medical care are secondary or incidental to the  
12 insurance benefits; and other coverage expressly excluded from the  
13 definition of health benefits plan.

14 "Department" means the Department of Banking and Insurance.

15 "Dependent" means the spouse, domestic partner as defined in  
16 section 3 of P.L.2003, c.246 (C.26:8A-3), civil union partner as  
17 defined in section 2 of P.L.2006, c.103 (C.37:1-29), or child of an  
18 eligible employee, subject to applicable terms of the health benefits  
19 plan covering the employee.

20 "Eligible employee" means a full-time employee who works a  
21 normal work week of 25 or more hours. The term includes a sole  
22 proprietor, a partner of a partnership, or an independent contractor,  
23 if the sole proprietor, partner, or independent contractor is included  
24 as an employee under a health benefits plan of a small employer,  
25 but does not include employees who work less than 25 hours a  
26 week, work on a temporary or substitute basis or are participating in  
27 an employee welfare arrangement established pursuant to a  
28 collective bargaining agreement.

29 "Enrollment date" means, with respect to a person covered under  
30 a health benefits plan, the date of enrollment of the person in the  
31 health benefits plan or, if earlier, the first day of the waiting period  
32 for such enrollment.

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

6 "Governmental plan" has the meaning given that term under Title  
7 I, section 3 of Pub.L.93-406, the "Employee Retirement Income  
8 Security Act of 1974" (29 U.S.C.s.1002(32)) and any governmental  
9 plan established or maintained for its employees by the Government  
10 of the United States or by any agency or instrumentality of that  
11 government.

12 "Group health plan" means an employee welfare benefit plan, as  
13 defined in Title I of section 3 of Pub.L.93-406, the "Employee  
14 Retirement Income Security Act of 1974" (29 U.S.C.s.1002(1)), to  
15 the extent that the plan provides medical care and including items  
16 and services paid for as medical care to employees or their  
17 dependents directly or through insurance, reimbursement or  
18 otherwise.

19 "Health benefits plan" means any hospital and medical expense  
20 insurance policy or certificate; health, hospital, or medical service  
21 corporation contract or certificate; or health maintenance  
22 organization subscriber contract or certificate delivered or issued  
23 for delivery in this State by any carrier to a small employer group  
24 pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For  
25 purposes of this act, "health benefits plan" shall not include one or  
26 more, or any combination of, the following: coverage only for  
27 accident or disability income insurance, or any combination thereof;  
28 coverage issued as a supplement to liability insurance; liability  
29 insurance, including general liability insurance and automobile  
30 liability insurance; workers' compensation or similar insurance;  
31 automobile medical payment insurance; credit-only insurance;  
32 coverage for on-site medical clinics; and other similar insurance

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1 coverage, as specified in federal regulations, under which benefits  
2 for medical care are secondary or incidental to other insurance  
3 benefits. Health benefits plans shall not include the following  
4 benefits if they are provided under a separate policy, certificate or  
5 contract of insurance or are otherwise not an integral part of the  
6 plan: limited scope dental or vision benefits; benefits for long-term  
7 care, nursing home care, home health care, community-based care,  
8 or any combination thereof; and such other similar, limited benefits  
9 as are specified in federal regulations. Health benefits plan shall  
10 not include hospital confinement indemnity coverage if the benefits  
11 are provided under a separate policy, certificate or contract of  
12 insurance, there is no coordination between the provision of the  
13 benefits and any exclusion of benefits under any group health  
14 benefits plan maintained by the same plan sponsor, and those  
15 benefits are paid with respect to an event without regard to whether  
16 benefits are provided with respect to such an event under any group  
17 health plan maintained by the same plan sponsor. Health benefits  
18 plan shall not include the following if it is offered as a separate  
19 policy, certificate or contract of insurance: Medicare supplemental  
20 health insurance as defined under section 1882(g)(1) of the federal  
21 Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage  
22 supplemental to the coverage provided under chapter 55 of Title 10,  
23 United States Code (10 U.S.C. s.1071 et seq.); and similar  
24 supplemental coverage provided to coverage under a group health  
25 plan.

26 "Health status-related factor" means any of the following factors:  
27 health status; medical condition, including both physical and mental  
28 illness; claims experience; receipt of health care; medical history;  
29 genetic information; evidence of insurability, including conditions  
30 arising out of acts of domestic violence; and disability.

31 "Late enrollee" means an eligible employee or dependent who  
32 requests enrollment in a health benefits plan of a small employer

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1 following the initial minimum 30-day enrollment period provided  
2 under the terms of the health benefits plan. An eligible employee or  
3 dependent shall not be considered a late enrollee if the individual: a.  
4 was covered under another employer's health benefits plan at the  
5 time he was eligible to enroll and stated at the time of the initial  
6 enrollment that coverage under that other employer's health benefits  
7 plan was the reason for declining enrollment, but only if the plan  
8 sponsor or carrier required such a statement at that time and  
9 provided the employee with notice of that requirement and the  
10 consequences of that requirement at that time; b. has lost coverage  
11 under that other employer's health benefits plan as a result of  
12 termination of employment or eligibility, reduction in the number of  
13 hours of employment, involuntary termination, the termination of  
14 the other plan's coverage, death of a spouse, or divorce or legal  
15 separation; and c. requests enrollment within 90 days after  
16 termination of coverage provided under another employer's health  
17 benefits plan. An eligible employee or dependent also shall not be  
18 considered a late enrollee if the individual is employed by an  
19 employer which offers multiple health benefits plans and the  
20 individual elects a different plan during an open enrollment period;  
21 the individual had coverage under a COBRA continuation provision  
22 and the coverage under that provision was exhausted and the  
23 employee requests enrollment not later than 30 days after the date  
24 of exhaustion of COBRA coverage; or if a court of competent  
25 jurisdiction has ordered coverage to be provided for a spouse or  
26 minor child under a covered employee's health benefits plan and  
27 request for enrollment is made within 30 days after issuance of that  
28 court order.

29 "Medical care" means amounts paid: (1) for the diagnosis, care,  
30 mitigation, treatment, or prevention of disease, or for the purpose of  
31 affecting any structure or function of the body; and (2)

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1 transportation primarily for and essential to medical care referred to  
2 in (1) above.

3 "Member" means all carriers issuing health benefits plans in this  
4 State on or after the effective date of this act.

5 "Multiple employer arrangement" means an arrangement  
6 established or maintained to provide health benefits to employees  
7 and their dependents of two or more employers, under an insured  
8 plan purchased from a carrier in which the carrier assumes all or a  
9 substantial portion of the risk, as determined by the commissioner,  
10 and shall include, but is not limited to, a multiple employer welfare  
11 arrangement, or MEWA, multiple employer trust or other form of  
12 benefit trust.

13 "Plan of operation" means the plan of operation of the program  
14 including articles, bylaws and operating rules approved pursuant to  
15 section 14 of P.L.1992, c.162 (C.17B:27A-30).

16 "Plan sponsor" has the meaning given that term under Title I of  
17 section 3 of Pub.L.93-406, the "Employee Retirement Income  
18 Security Act of 1974" (29 U.S.C.s.1002(16)(B)).

19 "Preexisting condition exclusion" means, with respect to  
20 coverage, a limitation or exclusion of benefits relating to a  
21 condition based on the fact that the condition was present before the  
22 date of enrollment for that coverage, whether or not any medical  
23 advice, diagnosis, care, or treatment was recommended or received  
24 before that date. Genetic information shall not be treated as a  
25 preexisting condition in the absence of a diagnosis of the condition  
26 related to that information.

27 "Program" means the New Jersey Small Employer Health  
28 Benefits Program established pursuant to section 12 of P.L.1992,  
29 c.162 (C.17B:27A-28).

30 "Small employer" means, in connection with a group health plan  
31 with respect to a calendar year and a plan year, any person, firm,  
32 corporation, partnership, or political subdivision that is actively

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1 engaged in business that employed an average of at least two but  
2 not more than 50 eligible employees on business days during the  
3 preceding calendar year and who employs at least two employees  
4 on the first day of the plan year, and the majority of the employees  
5 are employed in New Jersey. All persons treated as a single  
6 employer under subsection (b), (c), (m) or (o) of section 414 of the  
7 Internal Revenue Code of 1986 (26 U.S.C.s.414) shall be treated as  
8 one employer. Subsequent to the issuance of a health benefits plan  
9 to a small employer and for the purpose of determining continued  
10 eligibility, the size of a small employer shall be determined  
11 annually. Except as otherwise specifically provided, provisions of  
12 P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small  
13 employer shall continue to apply at least until the plan anniversary  
14 following the date the small employer no longer meets the  
15 requirements of this definition. In the case of an employer that was  
16 not in existence during the preceding calendar year, the  
17 determination of whether the employer is a small or large employer  
18 shall be based on the average number of employees that it is  
19 reasonably expected that the employer will employ on business  
20 days in the current calendar year. Any reference in P.L.1992, c.162  
21 (C.17B:27A-17 et seq.) to an employer shall include a reference to  
22 any predecessor of such employer.

23 "Small employer carrier" means any carrier that offers health  
24 benefits plans covering eligible employees of one or more small  
25 employers.

26 "Small employer health benefits plan" means a health benefits  
27 plan for small employers approved by the commissioner pursuant to  
28 section 17 of P.L.1992, c.162 (C.17B:27A-33).

29 "Stop loss" or "excess risk insurance" means an insurance policy  
30 designed to reimburse a self-funded arrangement of one or more  
31 small employers for catastrophic, excess or unexpected expenses,  
32 wherein neither the employees nor other individuals are third party

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1 beneficiaries under the insurance policy. In order to be considered  
2 stop loss or excess risk insurance for the purposes of P.L.1992,  
3 c.162 (C.17B:27A-17 et seq.), the policy shall establish a per person  
4 attachment point or retention or aggregate attachment point or  
5 retention, or both, which meet the following requirements:

6 a. If the policy establishes a per person attachment point or  
7 retention, that specific attachment point or retention shall not be  
8 less than \$20,000 per covered person per plan year; and

9 b. If the policy establishes an aggregate attachment point or  
10 retention, that aggregate attachment point or retention shall not be  
11 less than 125% of expected claims per plan year.

12 "Supplemental limited benefit insurance" means insurance that is  
13 provided in addition to a health benefits plan on an indemnity non-  
14 expense incurred basis.

15 (cf: P.L.1997, c.146, s.7)

16

17 21. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to  
18 read as follows:

19 3. a. Except as provided in subsection f. of this section, every  
20 small employer carrier shall, as a condition of transacting business  
21 in this State, offer to every small employer at least three of the  
22 **【five】** health benefit plans established by the board, as provided in  
23 this section, and also offer and make a good faith effort to market  
24 individual health benefits plans as provided in section 3 of  
25 P.L.1992, c.161 (C.17B:27A-4). The board shall establish a  
26 standard policy form for each of the **【five】** plans, which except as  
27 otherwise provided in subsection j. of this section, shall be the only  
28 plans offered to small groups on or after January 1, 1994. One  
29 policy form shall contain the benefits provided for in sections 55,  
30 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and  
31 26:2J-4.3). In the case of indemnity carriers, one policy form shall  
32 be established which contains benefits and cost sharing levels which

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1 are equivalent to the health benefits plans of health maintenance  
2 organizations pursuant to the "Health Maintenance Organization  
3 Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.). The  
4 remaining policy forms shall contain basic hospital and medical-  
5 surgical benefits, including, but not limited to:

- 6 (1) Basic inpatient and outpatient hospital care;
- 7 (2) Basic and extended medical-surgical benefits;
- 8 (3) Diagnostic tests, including X-rays;
- 9 (4) Maternity benefits, including prenatal and postnatal care;
- 10 and
- 11 (5) Preventive medicine, including periodic physical  
12 examinations and inoculations.

13 At least three of the forms shall provide for major medical  
14 benefits in varying lifetime aggregates, one of which shall provide  
15 at least \$1,000,000 in lifetime aggregate benefits. The policy forms  
16 provided pursuant to this section shall contain benefits representing  
17 progressively greater actuarial values.

18 Notwithstanding the provisions of this subsection to the contrary,  
19 the board also may establish additional policy forms by which a  
20 small employer carrier, other than a health maintenance  
21 organization, may provide indemnity benefits for health  
22 maintenance organization enrollees by direct contract with the  
23 enrollees' small employer through a dual arrangement with the  
24 health maintenance organization. The dual arrangement shall be  
25 filed with the commissioner for approval. The additional policy  
26 forms shall be consistent with the general requirements of P.L.1992,  
27 c.162 (C.17B:27A-17 et seq.).

28 b. Initially, a carrier shall offer a plan within 90 days of the  
29 approval of such plan by the commissioner. Thereafter, the plans  
30 shall be available to all small employers on a continuing basis.  
31 Every small employer which elects to be covered under any health  
32 benefits plan who pays the premium therefor and who satisfies the

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1 participation requirements of the plan shall be issued a policy or  
2 contract by the carrier.

3 c. The carrier may establish a premium payment plan which  
4 provides installment payments and which may contain reasonable  
5 provisions to ensure payment security, provided that provisions to  
6 ensure payment security are uniformly applied.

7 d. In addition to the **【five】** standard policies described in  
8 subsection a. of this section, the board may develop up to five rider  
9 packages. Any such package which a carrier chooses to offer shall  
10 be issued to a small employer who pays the premium therefor, and  
11 shall be subject to the rating methodology set forth in section 9 of  
12 P.L.1992, c.162 (C.17B:27A-25).

13 e. **【Notwithstanding the provisions of subsection a. of this**  
14 **section to the contrary, the board may approve a health benefits**  
15 **plan containing only medical-surgical benefits or major medical**  
16 **expense benefits, or a combination thereof, which is issued as a**  
17 **separate policy in conjunction with a contract of insurance for**  
18 **hospital expense benefits issued by a hospital service corporation, if**  
19 **the health benefits plan and hospital service corporation contract**  
20 **combined otherwise comply with the provisions of P.L.1992, c.162**  
21 **(C.17B:27A-17 et seq.). Deductibles and coinsurance limits for the**  
22 **contract combined may be allocated between the separate contracts**  
23 **at the discretion of the carrier and the hospital service corporation.】**  
24 (Deleted by amendment, P.L. , c. ) (pending before the  
25 Legislature as this bill).

26 f. Notwithstanding the provisions of this section to the  
27 contrary, a health maintenance organization which is a qualified  
28 health maintenance organization pursuant to the "Health  
29 Maintenance Organization Act of 1973," Pub.L.93-222 (42  
30 U.S.C.s.300e et seq.) shall be permitted to offer health benefits  
31 plans formulated by the board and approved by the commissioner

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1 which are in accordance with the provisions of that law in lieu of  
2 the **【five】** plans required pursuant to this section.

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

12 g. A carrier shall not be required to own or control a health  
13 maintenance organization or otherwise affiliate with a health  
14 maintenance organization in order to comply with the provisions of  
15 this section, but the carrier shall be required to offer **【the five】** at  
16 least three of the health benefits plans which are formulated by the  
17 board and approved by the commissioner, including one plan which  
18 contains benefits and cost sharing levels that are equivalent to those  
19 required for health maintenance organizations.

20 h. Notwithstanding the provisions of subsection a. of this  
21 section to the contrary, the board may modify the benefits provided  
22 for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2,  
23 17B:26B-2 and 26:2J-4.3).

24 i. (1) In addition to the rider packages provided for in  
25 subsection d. of this section, every carrier may offer, in connection  
26 with the **【five】** health benefits plans required to be offered by this  
27 section, any number of riders which may revise the coverage  
28 offered by the **【five】** plans in any way, provided, however, that any  
29 form of such rider or amendment thereof which decreases benefits  
30 or decreases the actuarial value of **【one of the five plans】** a plan  
31 shall be filed for informational purposes with the board and for

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1 approval by the commissioner before such rider may be sold. Any  
2 rider or amendment thereof which adds benefits or increases the  
3 actuarial value of ~~【one of the five plans】~~ a plan shall be filed with  
4 the board for informational purposes before such rider may be sold.  
5 The added premium or reduction in premium for each rider, as  
6 applicable, shall be listed separately from the premium for the  
7 standard plan.

8 The commissioner shall disapprove any rider filed pursuant to  
9 this subsection that is unjust, unfair, inequitable, unreasonably  
10 discriminatory, misleading, contrary to law or the public policy of  
11 this State. The commissioner shall not approve any rider which  
12 reduces benefits below those required by sections 55, 57 and 59 of  
13 P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and  
14 required to be sold pursuant to this section. The commissioner's  
15 determination shall be in writing and shall be appealable.

16 (2) The benefit riders provided for in paragraph (1) of this  
17 subsection shall be subject to the provisions of section 2, subsection  
18 b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162  
19 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-  
20 24, 17B:27A-25, and 17B:27A-27).

21 j. (1) Notwithstanding the provisions of P.L.1992, c.162  
22 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued  
23 by or through a carrier, association, or multiple employer  
24 arrangement prior to January 1, 1994 or, if the requirements of  
25 subparagraph (c) of paragraph (6) of this subsection are met, issued  
26 by or through an out-of-State trust prior to January 1, 1994, at the  
27 option of a small employer policy or contract holder, may be  
28 renewed or continued after February 28, 1994, or in the case of such  
29 a health benefits plan whose anniversary date occurred between  
30 March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-  
31 19.1 et al.), may be reinstated within 60 days of that anniversary  
32 date and renewed or continued if, beginning on the first 12-month

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1 anniversary date occurring on or after the sixtieth day after the  
2 board adopts regulations concerning the implementation of the  
3 rating factors permitted by section 9 of P.L.1992, c.162  
4 (C.17B:27A-25) and, regardless of the situs of delivery of the health  
5 benefits plan, the health benefits plan renewed, continued or  
6 reinstated pursuant to this subsection complies with the provisions  
7 of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and  
8 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22,  
9 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and  
10 section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

11 Nothing in this subsection shall be construed to require an  
12 association, multiple employer arrangement or out-of-State trust to  
13 provide health benefits coverage to small employers that are not  
14 contemplated by the organizational documents, bylaws, or other  
15 regulations governing the purpose and operation of the association,  
16 multiple employer arrangement or out-of-State trust.  
17 Notwithstanding the foregoing provision to the contrary, an  
18 association, multiple employer arrangement or out-of-State trust  
19 that offers health benefits coverage to its members' employees and  
20 dependents:

21 (a) shall offer coverage to all eligible employees and their  
22 dependents within the membership of the association, multiple  
23 employer arrangement or out-of-State trust;

24 (b) shall not use actual or expected health status in determining  
25 its membership; and

26 (c) shall make available to its small employer members at least  
27 one of the standard benefits plans, as determined by the  
28 commissioner, in addition to any health benefits plan permitted to  
29 be renewed or continued pursuant to this subsection.

30 (2) Notwithstanding the provisions of this subsection to the  
31 contrary, a carrier or out-of-State trust which writes the health  
32 benefits plans required pursuant to subsection a. of this section shall

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1 be required to offer those plans to any small employer, association  
2 or multiple employer arrangement.

3 (3) (a) A carrier, association, multiple employer arrangement or  
4 out-of-State trust may withdraw a health benefits plan marketed to  
5 small employers that was in effect on December 31, 1993 with the  
6 approval of the commissioner. The commissioner shall approve a  
7 request to withdraw a plan, consistent with regulations adopted by  
8 the commissioner, only on the grounds that retention of the plan  
9 would cause an unreasonable financial burden to the issuing carrier,  
10 taking into account the rating provisions of section 9 of P.L.1992,  
11 c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340  
12 (C.17B:27A-19.3).

13 (b) A carrier which has renewed, continued or reinstated a  
14 health benefits plan pursuant to this subsection that has not been  
15 newly issued to a new small employer group since January 1, 1994,  
16 may, upon approval of the commissioner, continue to establish its  
17 rates for that plan based on the loss experience of that plan if the  
18 carrier does not issue that health benefits plan to any new small  
19 employer groups.

20 (4) (Deleted by amendment, P.L.1995, c.340).

21 (5) A health benefits plan that otherwise conforms to the  
22 requirements of this subsection shall be deemed to be in compliance  
23 with this subsection, notwithstanding any change in the plan's  
24 deductible or copayment.

25 (6) (a) Except as otherwise provided in subparagraphs (b) and  
26 (c) of this paragraph, a health benefits plan renewed, continued or  
27 reinstated pursuant to this subsection shall be filed with the  
28 commissioner for informational purposes within 30 days after its  
29 renewal date. No later than 60 days after the board adopts  
30 regulations concerning the implementation of the rating factors  
31 permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing  
32 shall be amended to show any modifications in the plan that are

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1 necessary to comply with the provisions of this subsection. The  
2 commissioner shall monitor compliance of any such plan with the  
3 requirements of this subsection, except that the board shall enforce  
4 the loss ratio requirements.

5 (b) A health benefits plan filed with the commissioner pursuant  
6 to subparagraph (a) of this paragraph may be amended as to its  
7 benefit structure if the amendment does not reduce the actuarial  
8 value and benefits coverage of the health benefits plan below that of  
9 the lowest standard health benefits plan established by the board  
10 pursuant to subsection a. of this section. The amendment shall be  
11 filed with the commissioner for approval pursuant to the terms of  
12 sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2,  
13 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as  
14 applicable, and shall comply with the provisions of sections 2 and 9  
15 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7  
16 of P.L.1995, c.340 (C.17B:27A-19.3).

17 (c) A health benefits plan issued by a carrier through an out-of-  
18 State trust shall be permitted to be renewed or continued pursuant to  
19 paragraph (1) of this subsection upon approval by the commissioner  
20 and only if the benefits offered under the plan are at least equal to  
21 the actuarial value and benefits coverage of the lowest standard  
22 health benefits plan established by the board pursuant to subsection  
23 a. of this section. For the purposes of meeting the requirements of  
24 this subparagraph, carriers shall be required to file with the  
25 commissioner the health benefits plans issued through an out-of-  
26 State trust no later than 180 days after the date of enactment of  
27 P.L.1995, c.340. A health benefits plan issued by a carrier through  
28 an out-of-State trust that is not filed with the commissioner pursuant  
29 to this subparagraph, shall not be permitted to be continued or  
30 renewed after the 180-day period.

31 (7) Notwithstanding the provisions of P.L.1992, c.162  
32 (C.17B:27A-17 et seq.) to the contrary, an association, multiple

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1 employer arrangement or out-of-State trust may offer a health  
2 benefits plan authorized to be renewed, continued or reinstated  
3 pursuant to this subsection to small employer groups that are  
4 otherwise eligible pursuant to paragraph (1) of subsection j. of this  
5 section during the period for which such health benefits plan is  
6 otherwise authorized to be renewed, continued or reinstated.

7 (8) Notwithstanding the provisions of P.L.1992, c.162  
8 (C.17B:27A-17 et seq.) to the contrary, a carrier, association,  
9 multiple employer arrangement or out-of-State trust may offer  
10 coverage under a health benefits plan authorized to be renewed,  
11 continued or reinstated pursuant to this subsection to new  
12 employees of small employer groups covered by the health benefits  
13 plan in accordance with the provisions of paragraph (1) of this  
14 subsection.

15 (9) Notwithstanding the provisions of P.L.1992, c.162  
16 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et seq.) to  
17 the contrary, any individual, who is eligible for small employer  
18 coverage under a policy issued, renewed, continued or reinstated  
19 pursuant to this subsection, but who would be subject to a  
20 preexisting condition exclusion under the small employer health  
21 benefits plan, or who is a member of a small employer group who  
22 has been denied coverage under the small employer group health  
23 benefits plan for health reasons, may elect to purchase or continue  
24 coverage under an individual health benefits plan until such time as  
25 the group health benefits plan covering the small employer group of  
26 which the individual is a member complies with the provisions of  
27 P.L.1992, c.162 (C.17B:27A-17 et seq.).

28 (10) In a case in which an association made available a health  
29 benefits plan on or before March 1, 1994 and subsequently changed  
30 the issuing carrier between March 1, 1994 and the effective date of  
31 P.L.1995, c.340, the new issuing carrier shall be deemed to have

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1 been eligible to continue and renew the plan pursuant to paragraph  
2 (1) of this subsection.

3 (11) In a case in which an association, multiple employer  
4 arrangement or out-of-State trust made available a health benefits  
5 plan on or before March 1, 1994 and subsequently changes the  
6 issuing carrier for that plan after the effective date of P.L.1995,  
7 c.340, the new issuing carrier shall file the health benefits plan with  
8 the commissioner for approval in order to be deemed eligible to  
9 continue and renew that plan pursuant to paragraph (1) of this  
10 subsection.

11 (12) In a case in which a small employer purchased a health  
12 benefits plan directly from a carrier on or before March 1, 1994 and  
13 subsequently changes the issuing carrier for that plan after the  
14 effective date of P.L.1995, c.340, the new issuing carrier shall file  
15 the health benefits plan with the commissioner for approval in order  
16 to be deemed eligible to continue and renew that plan pursuant to  
17 paragraph (1) of this subsection.

18 Notwithstanding the provisions of subparagraph (b) of paragraph  
19 (6) of this subsection to the contrary, a small employer who changes  
20 its health benefits plan's issuing carrier pursuant to the provisions of  
21 this paragraph, shall not, upon changing carriers, modify the benefit  
22 structure of that health benefits plan within six months of the date  
23 the issuing carrier was changed.

24 k. Effective immediately for a health benefits plan issued on or  
25 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)  
26 and effective on the first 12-month anniversary date of a health  
27 benefits plan in effect on the effective date of P.L.2005, c.248  
28 (C.17:48E-35.27 et al.), the health benefits plans required pursuant  
29 to this section, including any plans offered by a State approved or  
30 federally qualified health maintenance organization, shall contain  
31 benefits for expenses incurred in the following:

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1 (1) Screening by blood lead measurement for lead poisoning for  
2 children, including confirmatory blood lead testing as specified by  
3 the Department of Health and Senior Services pursuant to section 7  
4 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any  
5 necessary medical follow-up and treatment for lead poisoned  
6 children.

7 (2) All childhood immunization as recommended by the  
8 Advisory Committee on Immunization Practices of the United  
9 **[State]** States Public Health Service and the Department of Health  
10 and Senior Services pursuant to section 7 of P.L.1995, c.316  
11 (C.26:2-137.1). A carrier shall notify its insureds, in writing, of any  
12 change in the health care services provided with respect to  
13 childhood immunizations and any related changes in premium.  
14 Such notification shall be in a form and manner to be determined by  
15 the Commissioner of Banking and Insurance.

16 (3) Screening for newborn hearing loss by appropriate  
17 electrophysiologic screening measures and periodic monitoring of  
18 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373  
19 (C.26:2-103.1 et al.). Payment for this screening service shall be  
20 separate and distinct from payment for routine new baby care in the  
21 form of a newborn hearing screening fee as negotiated with the  
22 provider and facility.

23 The benefits provided pursuant to this subsection shall be  
24 provided to the same extent as for any other medical condition  
25 under the health benefits plan, except that a deductible shall not be  
26 applied for benefits provided pursuant to this subsection; however,  
27 with respect to a small employer health benefits plan that qualifies  
28 as a high deductible health plan for which qualified medical  
29 expenses are paid using a health savings account established  
30 pursuant to section 223 of the federal Internal Revenue Code of  
31 1986 (26 U.S.C. s.223), a deductible shall not be applied for any  
32 benefits that represent preventive care as permitted by that federal

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1 law, and shall not be applied as provided pursuant to section 16 of  
2 P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to  
3 all small employer health benefits plans in which the carrier has  
4 reserved the right to change the premium.

5 l. The board shall consider including benefits for speech-  
6 language pathology and audiology services, as rendered by speech-  
7 language pathologists and audiologists within the scope of their  
8 practices, in at least one of the **[five]** standard policies and in at  
9 least one of the five riders to be developed under this section.

10 m. Effective immediately for a health benefits plan issued on or  
11 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and  
12 effective on the first 12-month anniversary date of a health benefits  
13 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z  
14 et al.), the health benefits plans required pursuant to this section  
15 that provide benefits for expenses incurred in the purchase of  
16 prescription drugs shall provide benefits for expenses incurred in  
17 the purchase of specialized non-standard infant formulas, when the  
18 covered infant's physician has diagnosed the infant as having  
19 multiple food protein intolerance and has determined such formula  
20 to be medically necessary, and when the covered infant has not been  
21 responsive to trials of standard non-cow milk-based formulas,  
22 including soybean and goat milk. The coverage may be subject to  
23 utilization review, including periodic review, of the continued  
24 medical necessity of the specialized infant formula.

25 The benefits shall be provided to the same extent as for any other  
26 prescribed items under the health benefits plan.

27 This subsection shall apply to all small employer health benefits  
28 plans in which the carrier has reserved the right to change the  
29 premium.

30 n. Effective immediately for a health benefits plan issued on or  
31 after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.)  
32 and effective on the first 12-month anniversary date of a small

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1 employer health benefits plan in effect on the effective date of  
2 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans  
3 required pursuant to this section that qualify as high deductible  
4 health plans for which qualified medical expenses are paid using a  
5 health savings account established pursuant to section 223 of the  
6 federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including  
7 any plans offered by a State approved or federally qualified health  
8 maintenance organization, shall contain benefits for expenses  
9 incurred in connection with any medically necessary benefits  
10 provided in-network that represent preventive care as permitted by  
11 that federal law.

12 The benefits provided pursuant to this subsection shall be  
13 provided to the same extent as for any other medical condition  
14 under the health benefits plan, except that no deductible shall be  
15 applied for benefits provided pursuant to this subsection. This  
16 subsection shall apply to all small employer health benefits plans in  
17 which the carrier has reserved the right to change the premium.

18 (cf: P.L.2005, c.248, s.15)

19

20 22. Section 5 of P.L.2001, c.368 (C.17B:27A-19.11) is amended  
21 to read as follows:

22 5. In addition to the **[five]** standard health benefits plans  
23 offered by a carrier on the effective date of this act, a carrier that  
24 writes small employer health benefits plans pursuant to P.L.1992,  
25 c.162 (C.17B:27A-17 et seq.) may also offer one or more of the  
26 plans through the carrier's network of providers, with no  
27 reimbursement for any out-of-network benefits other than  
28 emergency care, urgent care, and continuity of care. A carrier's  
29 network of providers shall be subject to review and approval or  
30 disapproval by the Commissioner of Banking and Insurance, in  
31 consultation with the Commissioner of Health and Senior Services,  
32 pursuant to regulations promulgated by the Department of Banking

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1 and Insurance, including review and approval or disapproval before  
2 plans with benefits provided through a carrier's network of  
3 providers pursuant to this section may be offered by the carrier.  
4 Policies or contracts written on this basis shall be rated in a separate  
5 rating pool for the purposes of establishing a premium, but for the  
6 purpose of determining a carrier's losses, these policies or contracts  
7 shall be aggregated with the losses on the carrier's other business  
8 written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-  
9 17 et seq.).  
10 (cf: P.L.2001, c.368, s.5)

11  
12 23. Section 7 of P.L.1992, c.162 (C.17B:27A-23) is amended to  
13 read as follows:

14 7. Every policy or contract issued to small employers in this  
15 State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall be  
16 renewable with respect to all eligible employees or dependents at  
17 the option of the policy or contract holder, or small employer except  
18 that a carrier may discontinue or not renew a health benefits plan in  
19 accordance with the provisions of this section:

20 a. A carrier may discontinue such coverage only if:

21 (1) The policyholder, contract holder, or employer has failed to  
22 pay premiums or contributions in accordance with the terms of the  
23 health benefits plan or the carrier has not received timely premium  
24 payments; or

25 (2) The policyholder, contract holder, or employer has  
26 performed an act or practice that constitutes fraud or made an  
27 intentional misrepresentation of material fact under the terms of the  
28 coverage;

29 b. (Deleted by amendment, P.L.1997, c.146).

30 c. The number of employees covered under the health benefits  
31 plan is less than the number or percentage of employees required by

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1 participation requirements under the health benefits policy or  
2 contract;

3 d. Noncompliance with a carrier's employment contribution  
4 requirements;

5 e. Any carrier doing business pursuant to the provisions of this  
6 act ceases doing business in the small employer market, if the  
7 following conditions are satisfied:

8 (1) The carrier gives notice to cease doing business in the small  
9 employer market to the commissioner not later than eight months  
10 prior to the date of the planned withdrawal from the small **【group**  
11 **market】** employer market, during which time the carrier shall  
12 continue to be governed by this act with respect to business written  
13 pursuant to this act. For the purposes of this subsection, "date of  
14 withdrawal" means the date upon which the first notice to small  
15 employers is sent by the carrier pursuant to paragraph (2) of this  
16 subsection;

17 (2) No later than two months following the date of the  
18 notification to the commissioner that the carrier intends to cease  
19 doing business in the small employer market, the carrier shall mail a  
20 notice to every small business employer insured by the carrier, and  
21 all covered persons, that the policy or contract of insurance will not  
22 be renewed. This notice shall be sent by certified mail to the small  
23 business employer not less than six months in advance of the  
24 effective date of the nonrenewal date of the policy or contract;

25 (3) Any carrier that ceases to do business pursuant to this act  
26 shall be prohibited from writing new business in the small employer  
27 **【market】** and individual health benefits plan markets for a period of  
28 five years from the date of termination of the last health insurance  
29 coverage not so renewed;

30 f. In the case of policies or contracts issued in connection with  
31 membership in an association or trust of employers, an employer  
32 ceases to maintain its membership in the association or trust, but

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1 only if such coverage is terminated under this provision uniformly  
2 without regard to any health status-related factor relating to any  
3 covered individual.

4 g. (Deleted by amendment, P.L.1995, c.50).

5 h. A decision by the small employer carrier to cease offering  
6 and not renew a particular type of group health benefits plan in the  
7 small employer market, if the board discontinues a standard health  
8 benefits plan or as permitted or required pursuant to subsection j. of  
9 section 3 of P.L.1992, 162 (C.17B:27A-19), and pursuant to  
10 regulations adopted by the commissioner;

11 i. In the case of a health maintenance organization plan issued  
12 to a small employer:

13 (1) an eligible person who no longer resides, lives, or works in  
14 the carrier's approved service area, but only if coverage is  
15 terminated under this paragraph uniformly without regard to any  
16 health status-related factor of covered individuals; or

17 (2) a small employer that no longer has any enrollee in  
18 connection with such plan who lives, resides, or works in the  
19 service area of the carrier and the carrier would deny enrollment  
20 with respect to such plan pursuant to subsection a. of section 10 of  
21 P.L.1992, c.162 (C.17B:27A-26).

22 (cf: P.L.1997, c.146, s.10)

23

24 <sup>1</sup>~~25.~~ 24.<sup>1</sup> Section 9 of P.L.1992, c.162 (C.17B:27A-25) is  
25 amended to read as follows:

26 9. a. (1) (Deleted by amendment, P.L.1997, c.146).

27 (2) (Deleted by amendment, P.L.1997, c.146).

28 (3) <sup>1</sup>(a)<sup>1</sup> For all policies or contracts providing health benefits  
29 plans for small employers issued pursuant to section 3 of P.L.1992,  
30 c.162 (C.17B:27A-19), and including policies or contracts offered  
31 by a carrier to a small employer who is a member of a Small  
32 Employer Purchasing Alliance pursuant to the provisions of

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1 P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged  
2 by a carrier to the highest rated small group purchasing a small  
3 employer health benefits plan issued pursuant to section 3 of  
4 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than 200% of  
5 the premium rate charged for the lowest rated small group  
6 purchasing that same health benefits plan; provided, however, that  
7 the only factors upon which the rate differential may be based are  
8 age, gender and geography <sup>1</sup>], and provided further, that such] .  
9 <sup>3</sup>[In addition, rates may vary to reflect commissions and other  
10 compensation actually paid as provided in subparagraph (c) of this  
11 paragraph (3).]<sup>3</sup> Such<sup>1</sup> factors <sup>1</sup>[are] shall be<sup>1</sup> applied in a manner  
12 consistent with regulations adopted by the <sup>1</sup>[board] commissioner<sup>1</sup>.  
13 For the purposes of this paragraph (3), policies or contracts offered  
14 by a carrier to a small employer who is a member of a Small  
15 Employer Purchasing Alliance shall be rated separately from the  
16 carrier's other small employer health benefits policies or contracts.

17 <sup>1</sup>(b)<sup>1</sup> A health benefits plan issued pursuant to subsection j. of  
18 section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in  
19 accordance with the provisions of section 7 of P.L.1995, c.340  
20 (C.17B:27A-19.3), for the purposes of meeting the requirements of  
21 this paragraph.

22 <sup>3</sup><sup>1</sup>(c) The amount of the commission or other compensation paid  
23 to an insurance producer in connection with a policy or contract  
24 issued to a small employer shall be disclosed to the small employer,  
25 as provided in section 25 of P.L. , c. (pending before the  
26 Legislature as this bill). Rates charged to a small employer shall  
27 differ based on the actual compensation paid to an insurance  
28 producer, in a manner consistent with regulations adopted by the  
29 commissioner. Variations in rates attributable solely to differences  
30 in commissions or other compensation paid are not subject to the

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1 200% limitation provided in subparagraph (a) of this paragraph  
2 (3).<sup>1</sup><sup>3</sup>

3 (4) (Deleted by amendment, P.L.1994, c.11).

4 (5) Any policy or contract issued after January 1, 1994 to a  
5 small employer who was not previously covered by a health  
6 benefits plan issued by the issuing small employer carrier, shall be  
7 subject to the same premium rate restrictions as provided in  
8 paragraph (3) of this subsection, which rate restrictions shall be  
9 effective on the date the policy or contract is issued.

10 (6) The board shall establish, pursuant to section 17 of  
11 P.L.1993, c.162 (C.17B:27A-51):

12 (a) up to six geographic territories, none of which is smaller  
13 than a county; and

14 (b) age classifications which, at a minimum, shall be in five-  
15 year increments.

16 b. (Deleted by amendment, P.L.1993, c.162).

17 c. (Deleted by amendment, P.L.1995, c.298).

18 d. Notwithstanding any other provision of law to the contrary,  
19 this act shall apply to a carrier which provides a health benefits plan  
20 to one or more small employers through a policy issued to an  
21 association or trust of employers.

22 A carrier which provides a health benefits plan to one or more  
23 small employers through a policy issued to an association or trust of  
24 employers after the effective date of P.L.1992, c.162 (C.17B:27A-  
25 17 et seq.), shall be required to offer small employer health benefits  
26 plans to non-association or trust employers in the same manner as  
27 any other small employer carrier is required pursuant to P.L.1992,  
28 c.162 (C.17B:27A-17 et seq.).

29 e. Nothing contained herein shall prohibit the use of premium  
30 rate structures to establish different premium rates for individuals  
31 and family units.

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1 f. No insurance contract or policy subject to this act, including  
2 a contract or policy entered into with a small employer who is a  
3 member of a Small Employer Purchasing Alliance pursuant to the  
4 provisions of P.L.2001, c.225 (C.17B:27A-25.1 et al.), may be  
5 entered into unless and until the carrier has made an informational  
6 filing with the commissioner of a schedule of premiums, not to  
7 exceed 12 months in duration, to be paid pursuant to such contract  
8 or policy, of the carrier's rating plan and classification system in  
9 connection with such contract or policy, and of the actuarial  
10 assumptions and methods used by the carrier in establishing  
11 premium rates for such contract or policy.

12 g. (1) Beginning January 1, 1995, a carrier desiring to increase  
13 or decrease premiums for any policy form or benefit rider offered  
14 pursuant to subsection i. of section 3 of P.L.1992, c.162  
15 (C.17B:27A-19) subject to this act may implement such increase or  
16 decrease upon making an informational filing with the  
17 commissioner of such increase or decrease, along with the actuarial  
18 assumptions and methods used by the carrier in establishing such  
19 increase or decrease, provided that the anticipated minimum loss  
20 ratio for all policy forms shall not be less than **【75%】** 80% of the  
21 premium therefor as provided in paragraph (2) of this subsection.  
22 The commissioner may disapprove any informational filing on a  
23 finding that it is incomplete and not in substantial compliance with  
24 P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are  
25 inadequate or unfairly discriminatory. Until December 31, 1996,  
26 the informational filing shall also include the carrier's rating plan  
27 and classification system in connection with such increase or  
28 decrease.

29 (2) Each calendar year, a carrier shall return, in the form of  
30 aggregate benefits for all of the **【five】** standard policy forms  
31 offered by the carrier pursuant to subsection a. of section 3 of  
32 P.L.1992, c.162 (C.17B:27A-19), at least **【75%】** 80% of the

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1 aggregate premiums collected for all of the standard policy forms,  
2 other than alliance policy forms, and at least **【75%】** 80% of the  
3 aggregate premiums collected for all of the non-standard policy  
4 forms during that calendar year. A carrier shall return at least  
5 **【75%】** 80% of the premiums collected for all of the alliances  
6 during that calendar year, which loss ratio may be calculated in the  
7 aggregate for all of the alliances or separately for each alliance.  
8 Carriers shall annually report, no later than August 1st of each year,  
9 the loss ratio calculated pursuant to this section for all of the  
10 standard, other than alliance policy forms, non-standard policy  
11 forms and alliance policy forms for the previous calendar year,  
12 provided that a carrier may annually report the loss ratio calculated  
13 pursuant to this section for all of the alliances in the aggregate or  
14 separately for each alliance. In each case where the loss ratio fails  
15 to substantially comply with the **【75%】** 80% loss ratio requirement,  
16 the carrier shall issue a dividend or credit against future premiums  
17 for all policyholders with the standard, other than alliance policy  
18 forms, nonstandard policy forms or alliance policy forms, as  
19 applicable, in an amount sufficient to assure that the aggregate  
20 benefits paid in the previous calendar year plus the amount of the  
21 dividends and credits shall equal **【75%】** 80% of the aggregate  
22 premiums collected for the respective policy forms in the previous  
23 calendar year. All dividends and credits must be distributed by  
24 December 31 of the year following the calendar year in which the  
25 loss ratio requirements were not satisfied. The annual report  
26 required by this paragraph shall include a carrier's calculation of the  
27 dividends and credits applicable to standard, other than alliance  
28 policy forms, non-standard policy forms and alliance policy forms,  
29 as well as an explanation of the carrier's plan to issue dividends or  
30 credits. The instructions and format for calculating and reporting  
31 loss ratios and issuing dividends or credits shall be specified by the  
32 commissioner by regulation. Such regulations shall include

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1 provisions for the distribution of a dividend or credit in the event of  
2 cancellation or termination by a policyholder. For purposes of this  
3 paragraph, "alliance policy forms" means policies purchased by  
4 small employers who are members of Small Employer Purchasing  
5 Alliances.

6 (3) The loss ratio of a health benefits plan issued pursuant to  
7 subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall  
8 be calculated in accordance with the provisions of section 7 of  
9 P.L.1995, c.340 (C.17B:27A-19.3), for the purposes of meeting the  
10 requirements of this subsection.

11 h. (Deleted by amendment, P.L.1993, c.162).

12 i. The provisions of this act shall apply to health benefits plans  
13 which are delivered, issued for delivery, renewed or continued on or  
14 after January 1, 1994.

15 j. (Deleted by amendment, P.L.1995, c.340).

16 k. A carrier who negotiates a reduced premium rate with a  
17 Small Employer Purchasing Alliance for members of that alliance  
18 shall provide a reduction in the premium rate filed in accordance  
19 with paragraph (3) of subsection a. of this section, expressed as a  
20 percentage, which reduction shall be based on volume or other  
21 efficiencies or economies of scale and shall not be based on health  
22 status-related factors.

23 (cf: P.L.2003, c.163, s.1)

24

25 <sup>1</sup>**[26.]** 25.<sup>1</sup> (New section) a. An insurance producer licensed  
26 pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.) who sells,  
27 solicits, or negotiates health insurance policies or contracts to  
28 residents of this State shall notify the purchaser of the insurance, in  
29 writing, of the amount of any commission, service fee, brokerage,  
30 or other valuable consideration that the producer will receive as a  
31 result of the sale, solicitation or negotiation of the health insurance  
32 policy or contract. If the commission, fee, brokerage, or other

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1 valuable consideration is based on a percentage of premium, the  
2 insurance producer shall include that information in the notification  
3 to the purchaser.

4 b. <sup>1</sup>Upon seeking renewal of a license issued pursuant to  
5 P.L.2001, c.210 (C.17:22A-26 et seq.), an insurance producer shall  
6 report to the Commissioner of Banking and Insurance, in a form and  
7 manner specified by the commissioner, how the producer is  
8 compensated for the sale, solicitation, or negotiation of health  
9 insurance policies and contracts, including the basis for determining  
10 a commission, service fee, brokerage, or other valuable  
11 consideration for the sale, solicitation, or negotiation of a health  
12 insurance policy or contract. The insurance producer shall provide  
13 such other information regarding compensation as the commissioner  
14 deems appropriate.

15 c. Notwithstanding the provisions of any law to the contrary,  
16 the commissioner shall not renew the license of an insurance  
17 producer who is subject to the provisions of this section unless the  
18 insurance producer provides the information required pursuant to  
19 this section.

20 d. <sup>1</sup>b. The commissioner may specify, by regulation, the  
21 information that shall be provided by an insurance producer in the  
22 notification to a purchaser of health insurance and the procedure for  
23 providing the notification.

24

25 <sup>1</sup>26. (New section) The Commissioner of Human Services shall  
26 establish an enhanced NJ FamilyCare outreach and enrollment  
27 initiative to increase public awareness about the availability of, and  
28 benefits to enrolling in, Medicaid, NJ FamilyCare, and the NJ  
29 FamilyCare Advantage buy-in programs.

30 The initiative shall include culturally sensitive, Statewide and  
31 local media public awareness campaigns addressing the availability  
32 of health care coverage for parents and children under the Medicaid

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1 and NJ FamilyCare programs and health care coverage for children  
2 under the NJ FamilyCare Advantage buy-in program.

3 The initiative shall also include the provision of training and  
4 support services, upon request, to community groups, legislative  
5 district offices, and community-based health care providers to  
6 enable these parties to assist in enrolling parents and children in the  
7 applicable programs.<sup>1</sup>

8  
9 <sup>1</sup>27. (New section) The Commissioner of Human Services shall  
10 establish an Outreach, Enrollment, and Retention Working Group to  
11 develop a plan to carry out ongoing and sustainable measures to  
12 strengthen outreach to low and moderate income families who may  
13 be eligible for Medicaid, NJ FamilyCare, or NJ Family Care  
14 Advantage, to maximize enrollment in these programs, and to  
15 ensure retention of enrollees in these programs.

16 a. The members of the working group shall include:

17 (1) The Commissioners of Human Services, Health and Senior  
18 Services, Banking and Insurance, Labor and Workforce  
19 Development, Education, and Community Affairs, the Secretary of  
20 Agriculture, and the Child Advocate, or their designees, who shall  
21 serve ex officio; and

22 (2) Six public members appointed by the Commissioner of  
23 Human Services who shall include: one person who represents  
24 racial and ethnic minorities in this State; one person who represents  
25 managed care organizations that participate in the Medicaid and NJ  
26 FamilyCare programs; one person who represents the vendor under  
27 contract with the Division of Medical Assistance and Health  
28 Services to provide NJ FamilyCare eligibility, enrollment, and  
29 health benefit coordinator services to the division; one person who  
30 represents New Jersey Policy Perspective; one person who  
31 represents the Association for Children of New Jersey; and one  
32 person who represents Legal Services of New Jersey.

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1        b. As part of the plan, the working group shall:

2        (1) determine if there are obstacles to enrollment of minorities in  
3 the State in the Medicaid, NJ FamilyCare and NJ FamilyCare  
4 Advantage programs due to ethnic and cultural differences and, if  
5 so, develop strategies for the Department of Human Services to  
6 overcome these obstacles and increase enrollment among  
7 minorities;

8        (2) recommend outreach strategies to identify and enroll all  
9 eligible children in the Medicaid, NJ FamilyCare and NJ  
10 FamilyCare Advantage programs and to retain enrollment of  
11 children and their parents in the programs;

12        (3) establish monthly enrollment goals for the number of  
13 children who need to be enrolled in Medicaid, NJ FamilyCare, and  
14 NJ FamilyCare Advantage in order to ensure that as many children  
15 as possible who are eligible for these programs are enrolled within a  
16 reasonable period of time, in accordance with the mandate  
17 established pursuant to section 2 of P.L. , c. (C. ) (pending before  
18 the Legislature as this bill); and

19        (4) make such other recommendations to the Commissioner of  
20 Human Services as the working group determines necessary and  
21 appropriate to achieve the purposes of this section.

22        c. The working group shall organize as soon as practicable  
23 following the appointment of its members and shall select a  
24 chairperson and vice-chairperson from among the members. The  
25 chairperson shall appoint a secretary who need not be a member of  
26 the working group.

27        (1) The public members shall serve without compensation, but  
28 shall be reimbursed for necessary expenses incurred in the  
29 performance of their duties and within the limits of funds available  
30 to the working group.

31        (2) The working group shall be entitled to call to its assistance  
32 and avail itself of the services of the employees of any State, county

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1 or municipal department, board, bureau, commission or agency as it  
2 may require and as may be available to it for its purposes.

3 d. Upon completion of the plan, the working group shall report  
4 on its activities to the chairmen of the Senate and Assembly  
5 standing reference committees on health and human services, and  
6 include a copy of the plan and any recommendations for legislative  
7 action it deems appropriate.

8 e. The Commissioner of Human Services shall post the plan on  
9 the department's Internet website and include a table showing the  
10 monthly enrollment goals established in the plan and the actual new  
11 and continued enrollments for that month. The commissioner shall  
12 update the table monthly.

13 f. The Department of Human Services shall provide staff  
14 support to the working group.<sup>1</sup>

15  
16 <sup>1</sup>28. There is appropriated to the Department of Human Services  
17 from the General Fund \$1 million for the purpose of carrying out  
18 the enhanced NJ FamilyCare outreach, enrollment, and retention  
19 initiative established pursuant to section 26 of this act.<sup>1</sup>

20  
21 <sup>3</sup>29. Section 1 of P.L.2005 c.375 (C.17:48-6.19) is amended to  
22 read as follows:

23 1. a. As used in this section, "dependent" means a subscriber's  
24 child by blood or by law who:

25 (1) is **less than** 30 years of age or younger;

26 (2) is unmarried;

27 (3) has no dependent of his own;

28 (4) is a resident of this State or is enrolled as a full-time student  
29 at an accredited public or private institution of higher education;  
30 and

31 (5) (a) is not actually provided coverage as a named subscriber,  
32 insured, enrollee, or covered person under any other group or

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1 individual health benefits plan, group health plan, church plan or  
2 health benefits plan, or entitled to benefits under Title XVIII of the  
3 Social Security Act, **【Pub.L.89-97】** Pub.L.74-271 (42 U.S.C.  
4 s.1395 et seq.) at the time dependent coverage pursuant to this  
5 section begins or will begin; and

6 (b) there is evidence of prior creditable coverage or receipt of  
7 benefits under a benefits plan or by law as set forth in subparagraph  
8 (a) of this paragraph.

9 b. (1) A hospital service corporation contract that provides  
10 coverage for a subscriber's dependent under which coverage of the  
11 dependent terminates at a specific age on or before the dependent's  
12 30th birthday, and is delivered, issued, executed or renewed in this  
13 State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved  
14 for issuance or renewal in this State by the Commissioner of  
15 Banking and Insurance on or after the effective date of this section  
16 of P.L. , c. (pending before the Legislature as this bill), shall,  
17 upon application of the dependent as set forth in subsection c. of  
18 this section, provide coverage to the dependent after that specific  
19 age, until the dependent's **【30th】** 31st birthday.

20 (2) Nothing herein shall be construed to require:

21 (a) coverage for services provided to a dependent before the  
22 effective date of this section of P.L. , c. (pending before the  
23 Legislature as this bill); or

24 (b) that an employer or other group policyholder pay all or part  
25 of the cost of coverage for a dependent as provided pursuant to this  
26 section.

27 c. (1) A dependent covered by a subscriber's contract, which  
28 coverage under the contract terminates at a specific age on or before  
29 the dependent's 30th birthday, may make a written election for  
30 coverage as a dependent pursuant to this section, until the  
31 dependent's 30th birthday:

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- 1 (a) within 30 days prior to the termination of coverage at the  
2 specific age provided in the contract;
- 3 (b) within 30 days after meeting the requirements for dependent  
4 status as set forth in subsection a. of this section, when coverage for  
5 the dependent under the contract previously terminated; or
- 6 (c) during an open enrollment period, as provided pursuant to  
7 the contract, if the dependent meets the requirements for dependent  
8 status as set forth in subsection a. of this section during the open  
9 enrollment period.
- 10 (2) **For 12 months after the effective date of this section, a**  
11 **dependent who qualifies for dependent status as set forth in**  
12 **subsection a. of this section, but whose coverage as a dependent**  
13 **under a subscriber's contract terminated under the terms of the**  
14 **contract prior to the effective date of this section, may make a**  
15 **written election to reinstate coverage under that contract as a**  
16 **dependent pursuant to this section.** (Deleted by amendment,  
17 P.L. , c. (pending before the Legislature as this bill)
- 18 d. (1) Coverage for a dependent who makes a written election for  
19 coverage pursuant to subsection c. of this section shall consist of  
20 coverage which is identical to the coverage provided to that  
21 dependent prior to the termination of coverage at the specific age  
22 provided in the contract. If coverage is modified under the contract  
23 for any similarly situated dependents for coverage prior to the  
24 termination of coverage at the specific age provided in the contract,  
25 the coverage shall also be modified in the same manner for the  
26 dependent.
- 27 (2) Coverage for a dependent who makes a written election for  
28 coverage pursuant to subsection c. of this section shall not be  
29 conditioned upon, or discriminate on the basis of, lack of evidence  
30 of insurability.
- 31 e. (1) The subscriber's contract may require payment of a  
32 premium by the subscriber or dependent, as appropriate, subject to

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1 the approval of the Commissioner of Banking and Insurance, for  
2 any period of coverage relating to a dependent's written election for  
3 coverage pursuant to subsection c. of this section. The payment  
4 shall not exceed 102% of the applicable portion of the premium  
5 previously paid for that dependent's coverage under the contract  
6 prior to the termination of coverage at the specific age provided in  
7 the contract.

8 (2) The applicable portion of the premium previously paid for  
9 the dependent's coverage under the contract shall be determined  
10 pursuant to regulations promulgated by the Commissioner of  
11 Banking and Insurance, based upon the difference between the  
12 contract's rating tiers for adult and dependent coverage or family  
13 coverage, as appropriate, and single coverage, or based upon any  
14 other formula or dependent rating tier deemed appropriate by the  
15 commissioner which provides a substantially similar result.

16 (3) Payments of the premium may, at the election of the payor,  
17 be made in monthly installments.

18 f. Coverage for a dependent provided pursuant to this section  
19 shall be provided until the earlier of the following:

20 (1) the date upon which the dependent is disqualified for  
21 dependent status as set forth in subsection a. of this section;

22 (2) the date **[on]** upon which coverage ceases under the contract  
23 by reason of a failure to make a timely payment of any premium  
24 required under the contract by the subscriber or dependent for  
25 coverage provided pursuant to this section. The payment of any  
26 premium shall be considered to be timely if made within 30 days  
27 after the due date or within a longer period as may be provided for  
28 by the contract; or

29 (3) the date upon which the **[employer under whose]** contract ,  
30 under which coverage is provided to a dependent<sub>1</sub> ceases to provide  
31 coverage to the subscriber.

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1 Nothing herein shall be construed to permit a hospital service  
2 corporation to refuse a written election for coverage by a dependent  
3 pursuant to subsection c. of this section, based upon the dependent's  
4 prior disqualification pursuant to paragraph (1) of this subsection,  
5 other than a disqualification based on age or lack of evidence of  
6 prior, creditable coverage or receipt of benefits.

7 g. Notice regarding coverage for a dependent as provided  
8 pursuant to this section shall be provided to a subscriber by the  
9 hospital service corporation:

10 (1) in the certificate of coverage or other equivalent document  
11 prepared for subscribers **【by the hospital service corporation】** and  
12 delivered on or about the date of commencement of the subscribers'  
13 coverage; and

14 (2) **【by the subscriber's employer:**

15 (a) on or before the coverage of a subscriber's dependent  
16 terminates at the specific age as provided in the contract;

17 (b) at the time coverage of the dependent is no longer provided  
18 pursuant to this section because the dependent is disqualified for  
19 dependent status as set forth in subsection a. of this section, except  
20 this employer notice shall not be required when a dependent no  
21 longer qualifies based upon paragraph (1) or (3) of subsection a. of  
22 this section;

23 (c) before any open enrollment period permitting a dependent to  
24 make a written election for coverage pursuant to subsection c. of  
25 this section; and

26 (d) immediately following the effective date of this section, with  
27 respect to information concerning a dependent's opportunity, for 12  
28 months after the effective date of the section, to make a written  
29 election to reinstate coverage under a contract pursuant to paragraph  
30 (2) of subsection c. of this section **】** (Deleted by amendment,  
31 P.L. , c. (pending before the Legislature as this bill)

32 (3) in a notice delivered to subscribers on a quarterly basis.

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1 h. This section shall apply to those contracts in which the  
2 hospital service corporation has reserved the right to change the  
3 premium.<sup>3</sup>

4 (cf: P.L.2005, c.375, s.1)

5  
6 <sup>3</sup>30. Section 2 of P.L.2005, c.375 (C.17:48A-7.13) is amended  
7 to read as follows:

8 2. a. As used in this section, "dependent" means a subscriber's  
9 child by blood or by law who:

10 (1) is **less than** 30 years of age or younger;

11 (2) is unmarried;

12 (3) has no dependent of his own;

13 (4) is a resident of this State or is enrolled as a full-time student  
14 at an accredited public or private institution of higher education;  
15 and

16 (5) (a) is not actually provided coverage as a named subscriber,  
17 insured, enrollee, or covered person under any other group or  
18 individual health benefits plan, group health plan, church plan or  
19 health benefits plan, or entitled to benefits under Title XVIII of the  
20 Social Security Act, **Pub.L.89-97** Pub.L.74-271 (42 U.S.C.  
21 s.1395 et seq.) at the time dependent coverage pursuant to this  
22 section begins or will begin; and

23 (b) there is evidence of prior, creditable coverage or receipt of  
24 benefits under a benefits plan or by law as set forth in subparagraph  
25 (a) of this paragraph.

26 b. (1) A medical service corporation contract that provides  
27 coverage for a subscriber's dependent under which coverage of the  
28 dependent terminates at a specific age on or before the dependent's  
29 30th birthday, and is delivered, issued, executed or renewed in this  
30 State pursuant to P.L.1940, c.74 (C.17:48A 1 et seq.), or approved  
31 for issuance or renewal in this State by the Commissioner of  
32 Banking and Insurance on or after the effective date of this section

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1 of P.L. , c. (pending before the Legislature as this bill), shall,  
2 upon application of the dependent as set forth in subsection c. of  
3 this section, provide coverage to the dependent after that specific  
4 age, until the dependent's **【30th】** 31st birthday.

5 (2) Nothing herein shall be construed to require:

6 (a) coverage for services provided to a dependent before the  
7 effective date of this section of P.L. , c. (pending before the  
8 Legislature as this bill); or

9 (b) that an employer or other group policyholder pay all or part  
10 of the cost of coverage for a dependent as provided pursuant to this  
11 section.

12 c. (1) A dependent covered by a subscriber's contract, which  
13 coverage under the contract terminates at a specific age on or before  
14 the dependent's 30th birthday, may make a written election for  
15 coverage as a dependent pursuant to this section, until the  
16 dependent's 30th birthday:

17 (a) within 30 days prior to the termination of coverage at the  
18 specific age provided in the contract;

19 (b) within 30 days after meeting the requirements for dependent  
20 status as set forth in subsection a. of this section, when coverage for  
21 the dependent under the contract previously terminated; or

22 (c) during an open enrollment period, as provided pursuant to  
23 the contract, if the dependent meets the requirements for dependent  
24 status as set forth in subsection a. of this section during the open  
25 enrollment period.

26 (2) **【**For 12 months after the effective date of this section, a  
27 dependent who qualifies for dependent status as set forth in  
28 subsection a. of this section, but whose coverage as a dependent  
29 under a subscriber's contract terminated under the terms of the  
30 contract prior to the effective date of this section, may make a  
31 written election to reinstate coverage under that contract as a

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1 dependent pursuant to this section.】 (Deleted by amendment,  
2 P.L. , c. (pending before the Legislature as this bill)

3 d. (1) Coverage for a dependent who makes a written election for  
4 coverage pursuant to subsection c. of this section shall consist of  
5 coverage which is identical to the coverage provided to that  
6 dependent prior to the termination of coverage at the specific age  
7 provided in the contract. If coverage is modified under the contract  
8 for any similarly situated dependents for coverage prior to the  
9 termination of coverage at the specific age provided in the contract,  
10 the coverage shall also be modified in the same manner for the  
11 dependent.

12 (2) Coverage for a dependent who makes a written election for  
13 coverage pursuant to subsection c. of this section shall not be  
14 conditioned upon, or discriminate on the basis of, lack of evidence  
15 of insurability.

16 e. (1) The subscriber's contract may require payment of a  
17 premium by the subscriber or dependent, as appropriate, subject to  
18 the approval of the Commissioner of Banking and Insurance, for  
19 any period of coverage relating to a dependent's written election for  
20 coverage pursuant to subsection c. of this section. The premium  
21 shall not exceed 102% of the applicable portion of the premium  
22 previously paid for that dependent's coverage under the contract  
23 prior to the termination of coverage at the specific age provided in  
24 the contract.

25 (2) The applicable portion of the premium previously paid for  
26 the dependent's coverage under the contract shall be determined  
27 pursuant to regulations promulgated by the Commissioner of  
28 Banking and Insurance, based upon the difference between the  
29 contract's rating tiers for adult and dependent coverage or family  
30 coverage, as appropriate, and single coverage, or based upon any  
31 other formula or dependent rating tier deemed appropriate by the  
32 commissioner which provides a substantially similar result.

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1 (3) Payments of the premium may, at the election of the payor,  
2 be made in monthly installments.

3 f. Coverage for a dependent provided pursuant to this section  
4 shall be provided until the earlier of the following:

5 (1) the date upon which the dependent is disqualified for  
6 dependent status as set forth in subsection a. of this section;

7 (2) the date **[on]** upon which coverage ceases under the contract  
8 by reason of a failure to make a timely payment of any premium  
9 required under the contract by the subscriber or dependent for  
10 coverage provided pursuant to this section. The payment of any  
11 premium shall be considered to be timely if made within 30 days  
12 after the due date or within a longer period as may be provided for  
13 by the contract; or

14 (3) the date upon which the **[employer under whose]** contract,  
15 under which coverage is provided to a dependent, ceases to provide  
16 coverage to the subscriber.

17 Nothing herein shall be construed to permit a medical service  
18 corporation to refuse a written election for coverage by a dependent  
19 pursuant to subsection c. of this section, based upon the dependent's  
20 prior disqualification pursuant to paragraph (1) of this subsection,  
21 other than a disqualification based on age or lack of evidence of  
22 prior, creditable coverage or receipt of benefits.

23 g. Notice regarding coverage for a dependent as provided  
24 pursuant to this section shall be provided to a subscriber by the  
25 medical service corporation:

26 (1) in the certificate of coverage or other equivalent document  
27 prepared for subscribers **[by the medical service corporation]** and  
28 delivered on or about the date of commencement of the subscribers'  
29 coverage; and

30 (2) **[by the subscriber's employer:**

31 (a) on or before the coverage of a subscriber's dependent  
32 terminates at the specific age as provided in the contract;

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1 (b) at the time coverage of the dependent is no longer provided  
2 pursuant to this section because the dependent is disqualified for  
3 dependent status as set forth in subsection a. of this section, except  
4 this employer notice shall not be required when a dependent no  
5 longer qualifies based upon paragraph (1) or (3) of subsection a. of  
6 this section;

7 (c) before any open enrollment period permitting a dependent to  
8 make a written election for coverage pursuant to subsection c. of  
9 this section; and

10 (d) immediately following the effective date of this section, with  
11 respect to information concerning a dependent's opportunity, for 12  
12 months after the effective date of the section, to make a written  
13 election to reinstate coverage under a contract pursuant to paragraph  
14 (2) of subsection c. of this section.  ~~(Deleted by amendment,~~  
15  P.L. , c. (pending before the Legislature as this bill)

16  (3) in a notice delivered to subscribers on a quarterly basis.

17 h. This section shall apply to those contracts in which the  
18 medical service corporation has reserved the right to change the  
19 premium.<sup>3</sup>

20 (cf: P.L.2005, c.375, s.2)

21

22 <sup>3</sup>31. Section 3 of P.L.2005, c.375 (C.17:48E-30.1) is amended to  
23 read as follows:

24 3. a. As used in this section, "dependent" means a subscriber's  
25 child by blood or by law who:

26 (1) is ~~less than~~ 30 years of age or younger;

27 (2) is unmarried;

28 (3) has no dependent of his own;

29 (4) is a resident of this State or is enrolled as a full-time student  
30 at an accredited public or private institution of higher education;

31 and

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1 (5) (a) is not actually provided coverage as a named subscriber,  
2 insured, enrollee, or covered person under any other group or  
3 individual health benefits plan, group health plan, church plan or  
4 health benefits plan, or entitled to benefits under Title XVIII of the  
5 Social Security Act, **【Pub.L.89-97】** Pub.L.74-271 (42 U.S.C.  
6 s.1395 et seq.) at the time the dependent coverage pursuant to this  
7 section begins or will begin; and

8 (b) there is evidence of prior, creditable coverage or receipt of  
9 benefits under a benefits plan or by law as set forth in subparagraph  
10 (a) of this paragraph.

11 b. (1) A health service corporation contract that provides  
12 coverage for a subscriber's dependent under which coverage of the  
13 dependent terminates at a specific age on or before the dependent's  
14 30th birthday, and is delivered, issued, executed or renewed in this  
15 State pursuant to P.L.1985, c.236 (C.17:48E 1 et seq.), or approved  
16 for issuance or renewal in this State by the Commissioner of  
17 Banking and Insurance on or after the effective date of this section  
18 of P.L. , c. (pending before the Legislature as this bill), shall,  
19 upon application of the dependent as set forth in subsection c. of  
20 this section, provide coverage to the dependent after that specific  
21 age, until the dependent's **【30th】** 31st birthday.

22 (2) Nothing herein shall be construed to require:

23 (a) coverage for services provided to a dependent before the  
24 effective date of this section of P.L. , c. (pending before the  
25 Legislature as this bill); or

26 (b) that an employer or other group policyholder pay all or part  
27 of the cost of coverage for a dependent as provided pursuant to this  
28 section.

29 c. (1) A dependent covered by a subscriber's contract, which  
30 coverage under the contract terminates at a specific age on or before  
31 the dependent's 30th birthday, may make a written election for

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1 coverage as a dependent pursuant to this section, until the  
2 dependent's 30th birthday:

3 (a) within 30 days prior to the termination of coverage at the  
4 specific age provided in the contract;

5 (b) within 30 days after meeting the requirements for dependent  
6 status as set forth in subsection a. of this section, when coverage for  
7 the dependent under the contract previously terminated; or

8 (c) during an open enrollment period, as provided pursuant to  
9 the contract, if the dependent meets the requirements for dependent  
10 status as set forth in subsection a. of this section during the open  
11 enrollment period.

12 (2) **【**For 12 months after the effective date of this section, a  
13 dependent who qualifies for dependent status as set forth in  
14 subsection a. of this section, but whose coverage as a dependent  
15 under a subscriber's contract terminated under the terms of the  
16 contract prior to the effective date of this section, may make a  
17 written election to reinstate coverage under that contract as a  
18 dependent pursuant to this section.**】** (Deleted by amendment,  
19 P.L. , c. (pending before the Legislature as this bill)

20 d. (1) Coverage for a dependent who makes a written election for  
21 coverage pursuant to subsection c. of this section shall consist of  
22 coverage which is identical to the coverage provided to that  
23 dependent prior to the termination of coverage at the specific age  
24 provided in the contract. If coverage is modified under the contract  
25 for any similarly situated dependents for coverage prior to the  
26 termination of coverage at the specific age provided in the contract,  
27 the coverage shall also be modified in the same manner for the  
28 dependent.

29 (2) Coverage for a dependent who makes a written election for  
30 coverage pursuant to subsection c. of this section shall not be  
31 conditioned upon, or discriminate on the basis of, lack of evidence  
32 of insurability.

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- 1 e. (1) The subscriber's contract may require payment of a  
2 premium by the subscriber or dependent, as appropriate, subject to  
3 the approval of the Commissioner of Banking and Insurance, for  
4 any period of coverage relating to a dependent's written election for  
5 coverage pursuant to subsection c. of this section. The premium  
6 shall not exceed 102% of the applicable portion of the premium  
7 previously paid for that dependent's coverage under the contract  
8 prior to the termination of coverage at the specific age provided in  
9 the contract.
- 10 (2) The applicable portion of the premium previously paid for  
11 the dependent's coverage under the contract shall be determined  
12 pursuant to regulations promulgated by the Commissioner of  
13 Banking and Insurance, based upon the difference between the  
14 contract's rating tiers for adult and dependent coverage or family  
15 coverage, as appropriate, and single coverage, or based upon any  
16 other formula or dependent rating tier deemed appropriate by the  
17 commissioner which provides a substantially similar result.
- 18 (3) Payments of the premium may, at the election of the payor,  
19 be made in monthly installments.
- 20 f. Coverage for a dependent provided pursuant to this section  
21 shall be provided until the earlier of the following:
- 22 (1) the date upon which the dependent is disqualified for  
23 dependent status as set forth in subsection a. of this section;
- 24 (2) the date **[on]** upon which coverage ceases under the contract  
25 by reason of a failure to make a timely payment of any premium  
26 required under the contract by the subscriber or dependent for  
27 coverage provided pursuant to this section. The payment of any  
28 premium shall be considered to be timely if made within 30 days  
29 after the due date or within a longer period as may be provided for  
30 by the contract; or

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- 1 (3) the date upon which the **【employer under whose】** contract,  
2 under which coverage is provided to a dependent, ceases to provide  
3 coverage to the subscriber.
- 4 Nothing herein shall be construed to permit a health service  
5 corporation to refuse a written election for coverage by a dependent  
6 pursuant to subsection c. of this section, based upon the dependent's  
7 prior disqualification pursuant to paragraph (1) of this subsection,  
8 other than a disqualification based on age or lack of evidence of  
9 prior, creditable coverage or receipt of benefits.
- 10 g. Notice regarding coverage for a dependent as provided  
11 pursuant to this section shall be provided to a subscriber by the  
12 health service corporation:
- 13 (1) in the certificate of coverage or other equivalent document  
14 prepared for subscribers **【by the health service corporation】** and  
15 delivered on or about the date of commencement of the subscribers'  
16 coverage; and
- 17 (2) **【by the subscriber's employer:**
- 18 (a) on or before the coverage of a subscriber's dependent  
19 terminates at the specific age as provided in the contract;
- 20 (b) at the time coverage of the dependent is no longer provided  
21 pursuant to this section because the dependent is disqualified for  
22 dependent status as set forth in subsection a. of this section, except  
23 this employer notice shall not be required when a dependent no  
24 longer qualifies based upon paragraphs (1) or (3) of subsection a. of  
25 this section;
- 26 (c) before any open enrollment period permitting a dependent to  
27 make a written election for coverage pursuant to subsection c. of  
28 this section; and
- 29 (d) immediately following the effective date of this section, with  
30 respect to information concerning a dependent's opportunity, for 12  
31 months after the effective date of the section, to make a written  
32 election to reinstate coverage under a contract pursuant to paragraph

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1 (2) of subsection c. of this section] (Deleted by amendment,  
2 P.L. , c. (pending before the Legislature as this bill)

3 (3) in a notice delivered to subscribers on a quarterly basis.

4 h. This section shall apply to those contracts in which the  
5 health service corporation has reserved the right to change the  
6 premium.<sup>3</sup>

7 (cf: P.L.2005, c.375, s.3)

8  
9 <sup>3</sup>32. Section 4 of P.L.2005, c.375 (C.17B:27-30.5) is amended  
10 to read as follows:

11 4. a. As used in this section, "dependent" means an insured's  
12 child by blood or by law who:

13 (1) is **[less than]** 30 years of age or younger;

14 (2) is unmarried;

15 (3) has no dependent of his own;

16 (4) is a resident of this State or is enrolled as a full-time student  
17 at an accredited public or private institution of higher education;  
18 and

19 (5) (a) is not actually provided coverage as a named subscriber,  
20 insured, enrollee, or covered person under any other group or  
21 individual health benefits plan, group health plan, church plan or  
22 health benefits plan, or entitled to benefits under Title XVIII of the  
23 Social Security Act, **[Pub.L.89-97]** Pub.L.74-271 (42 U.S.C.  
24 s.1395 et seq.) at the time dependent coverage pursuant to this  
25 section begins or will begin; and

26 (b) there is evidence of prior, creditable coverage or receipt of  
27 benefits under a benefits plan or by law as set forth in subparagraph  
28 (a) of this paragraph.

29 b. (1) A group health insurance policy that provides coverage for  
30 an insured's dependent under which coverage of the dependent  
31 terminates at a specific age on or before the dependent's 30th  
32 birthday, and is delivered, issued, executed or renewed in this State

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1 pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or  
2 approved for issuance or renewal in this State by the Commissioner  
3 of Banking and Insurance on or after the effective date of this  
4 section of P.L. , c. (pending before the Legislature as this bill),  
5 shall, upon application of the dependent as set forth in subsection c.  
6 of this section, provide coverage to the dependent after that specific  
7 age, until the dependent's **[30th]** 31st birthday.

8 (2) Nothing herein shall be construed to require:

9 (a) coverage for services provided to a dependent before the  
10 effective date of this section of P.L. , c. (pending before the  
11 Legislature as this bill); or

12 (b) that an employer or other group policyholder pay all or part  
13 of the cost of coverage for a dependent as provided pursuant to this  
14 section .

15 c. (1) A dependent covered by an insured's policy, which  
16 coverage under the policy terminates at a specific age on or before  
17 the dependent's 30th birthday, may make a written election for  
18 coverage as a dependent pursuant to this section, until the  
19 dependent's 30th birthday:

20 (a) within 30 days prior to the termination of coverage at the  
21 specific age provided in the policy;

22 (b) within 30 days after meeting the requirements for dependent  
23 status as set forth in subsection a. of this section, when coverage for  
24 the dependent under the policy previously terminated; or

25 (c) during an open enrollment period, as provided pursuant to  
26 the policy, if the dependent meets the requirements for dependent  
27 status as set forth in subsection a. of this section during the open  
28 enrollment period.

29 (2) **[**For 12 months after the effective date of this section, a  
30 dependent who qualifies for dependent status as set forth in  
31 subsection a. of this section, but whose coverage as a dependent  
32 under an insured's policy terminated under the terms of the policy

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1 prior to the effective date of this section, may make a written  
2 election to reinstate coverage under that policy as a dependent  
3 pursuant to this section.】 (Deleted by amendment,  
4 P.L. , c. (pending before the Legislature as this bill)

5 d. (1) Coverage for a dependent who makes a written election for  
6 coverage pursuant to subsection c. of this section shall consist of  
7 coverage which is identical to the coverage provided to that  
8 dependent prior to the termination of coverage at the specific age  
9 provided in the policy. If coverage is modified under the policy for  
10 any similarly situated dependents for coverage prior to the  
11 termination of coverage at the specific age provided in the policy,  
12 the coverage shall also be modified in the same manner for the  
13 dependent.

14 (2) Coverage for a dependent who makes a written election for  
15 coverage pursuant to subsection c. of this section shall not be  
16 conditioned upon, or discriminate on the basis of, lack of evidence  
17 of insurability.

18 e. (1) The insured's policy may require payment of a premium by  
19 the insured or dependent, as appropriate, subject to the approval of  
20 the Commissioner of Banking and Insurance, for any period of  
21 coverage relating to a dependent's written election for coverage  
22 pursuant to subsection c. of this section. The premium shall not  
23 exceed 102% of the applicable portion of the premium previously  
24 paid for that dependent's coverage under the policy prior to the  
25 termination of coverage at the specific age provided in the policy.

26 (2) The applicable portion of the premium previously paid for  
27 the dependent's coverage under the policy shall be determined  
28 pursuant to regulations promulgated by the Commissioner of  
29 Banking and Insurance, based upon the difference between the  
30 policy's rating tiers for adult and dependent coverage or family  
31 coverage, as appropriate, and single coverage, or based upon any

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1 other formula or dependent rating tier deemed appropriate by the  
2 commissioner which provides a substantially similar result.

3 (3) Payments of the premium may, at the election of the payor,  
4 be made in monthly installments.

5 f. Coverage for a dependent provided pursuant to this section  
6 shall be provided until the earlier of the following:

7 (1) the date upon which the dependent is disqualified for  
8 dependent status as set forth in subsection a. of this section;

9 (2) the date **【on】** upon which coverage ceases under the policy  
10 by reason of a failure to make a timely payment of any premium  
11 required under the policy by the insured or dependent for coverage  
12 provided pursuant to this section. The payment of any premium  
13 shall be considered to be timely if made within 30 days after the  
14 due date or within a longer period as may be provided for by the  
15 policy; or

16 (3) the date upon which the **【employer under whose】** policy,  
17 under which coverage is provided to a dependent, ceases to provide  
18 coverage to the insured.

19 Nothing herein shall be construed to permit an insurer to refuse a  
20 written election for coverage by a dependent pursuant to subsection  
21 c. of this section, based upon the dependent's prior disqualification  
22 pursuant to paragraph (1) of this subsection, other than a  
23 disqualification based on age or lack of evidence of prior, creditable  
24 coverage or receipt of benefits.

25 g. Notice regarding coverage for a dependent as provided  
26 pursuant to this section shall be provided to an insured by the  
27 insurer:

28 (1) in the certificate of coverage or other equivalent document  
29 prepared for insureds **【by the insurer】** and delivered on or about the  
30 date of commencement of the insureds' coverage; and

31 (2) **【by the insured's employer:**

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1 (a) on or before the coverage of an insured's dependent  
2 terminates at the specific age as provided in the policy;

3 (b) at the time coverage of the dependent is no longer provided  
4 pursuant to this section because the dependent is disqualified for  
5 dependent status as set forth in subsection a. of this section, except  
6 this employer notice shall not be required when a dependent no  
7 longer qualifies based upon paragraph (1) or (3) of subsection a. of  
8 this section;

9 (c) before any open enrollment period permitting a dependent to  
10 make a written election for coverage pursuant to subsection c. of  
11 this section; and

12 (d) immediately following the effective date of this section, with  
13 respect to information concerning a dependent's opportunity, for 12  
14 months after the effective date of the section, to make a written  
15 election to reinstate coverage under a policy pursuant to paragraph  
16 (2) of subsection c. of this section. **】** (Deleted by amendment, P.L.  
17 , c. (pending before the Legislature as this bill)

18 h. This section shall apply to those policies in which the insurer  
19 has reserved the right to change the premium.<sup>3</sup>

20 (cf: P.L.2005, c.375, s.4)

21

22 <sup>3</sup>33. Section 5 of P.L.2005, c.375 (C.17B:27A-19.16) is  
23 amended to read as follows:

24 5. a. As used in this section, "dependent" means a covered  
25 person's child by blood or by law who:

26 (1) is **】**less than**】** 30 years of age or younger;

27 (2) is unmarried;

28 (3) has no dependent of his own;

29 (4) is a resident of this State or is enrolled as a full-time student  
30 at an accredited public or private institution of higher education;

31 and

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1 (5) (a) is not actually provided coverage as a named subscriber,  
2 insured, enrollee, or covered person under any other group or  
3 individual health benefits plan, group health plan, church plan or  
4 health benefits plan, or entitled to benefits under Title XVIII of the  
5 Social Security Act, **【Pub.L.89-97】** Pub.L.74-271 (42 U.S.C.  
6 s.1395 et seq.) at the time dependent coverage pursuant to this  
7 section begins or will begin; and

8 (b) there is evidence of prior, creditable coverage or receipt of  
9 benefits under a benefits plan or by law as set forth in subparagraph  
10 (a) of this paragraph.

11 b. (1) A small employer health benefits plan that provides  
12 coverage for a covered person's dependent under which coverage of  
13 the dependent terminates at a specific age on or before the  
14 dependent's 30th birthday, and is delivered, issued, executed or  
15 renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et  
16 seq.) or approved for issuance or renewal in this State by the  
17 Commissioner of Banking and Insurance on or after the effective  
18 date of this section of P.L. , c. (pending before the Legislature as  
19 this bill), shall, upon application of the dependent as set forth in  
20 subsection c. of this section, provide coverage to the dependent  
21 after that specific age, until the dependent's **【30th】** 31st birthday.

22 (2) Nothing herein shall be construed to require:

23 (a) coverage for services provided to a dependent before the  
24 effective date of this section of P.L. , c. (pending before the  
25 Legislature as this bill); or

26 (b) that an employer pay all or part of the cost of coverage for a  
27 dependent as provided pursuant to this section.

28 c. (1) A dependent covered by a covered person's plan, which  
29 coverage under the plan terminates at a specific age on or before the  
30 dependent's 30th birthday, may make a written election for  
31 coverage as a dependent pursuant to this section, until the  
32 dependent's 30th birthday:

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- 1 (a) within 30 days prior to the termination of coverage at the  
2 specific age provided in the plan;
- 3 (b) within 30 days after meeting the requirements for dependent  
4 status as set forth in subsection a. of this section, when coverage for  
5 the dependent under the plan previously terminated; or
- 6 (c) during a 30-day period in each year following the year  
7 coverage terminates at the specific age as provided in the plan,  
8 which period shall begin on the anniversary date on which the  
9 dependent's coverage terminates at the specific age as provided in  
10 the plan, if the dependent meets the requirements for dependent  
11 status as set forth in subsection a. of this section during the 30-day  
12 period.
- 13 (2) **【For 12 months after the effective date of this section, a**  
14 **dependent who qualifies for dependent status as set forth in**  
15 **subsection a. of this section, but whose coverage as a dependent**  
16 **under a covered person's plan terminated under the terms of the plan**  
17 **prior to the effective date of this section, may make a written**  
18 **election to reinstate coverage under that plan as a dependent**  
19 **pursuant to this section.】** (Deleted by amendment, P.L. \_\_\_\_\_, c.  
20 (pending before the Legislature as this bill)
- 21 d. (1) Coverage for a dependent who makes a written election for  
22 coverage pursuant to subsection c. of this section shall consist of  
23 coverage which is identical to the coverage provided to that  
24 dependent prior to the termination of coverage at the specific age  
25 provided in the plan. If coverage is modified under the plan for any  
26 similarly situated dependents for coverage prior to the termination  
27 of coverage at the specific age provided in the plan, the coverage  
28 shall also be modified in the same manner for the dependent.
- 29 (2) Coverage for a dependent who makes a written election for  
30 coverage pursuant to subsection c. of this section shall not be  
31 conditioned upon, or discriminate on the basis of, lack of evidence  
32 of insurability.

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- 1 e. (1) The covered person's plan may require payment of a  
2 premium by the covered person or dependent, as appropriate,  
3 subject to the approval of the Commissioner of Banking and  
4 Insurance, for any period of coverage relating to a dependent's  
5 written election for coverage pursuant to subsection c. of this  
6 section. The premium shall not exceed 102% of the applicable  
7 portion of the premium previously paid for that dependent's  
8 coverage under the plan prior to the termination of coverage at the  
9 specific age provided in the plan.
- 10 (2) The applicable portion of the premium previously paid for  
11 the dependent's coverage under the plan shall be determined  
12 pursuant to regulations promulgated by the Commissioner of  
13 Banking and Insurance, based upon the difference between the  
14 plan's rating tiers for adult and dependent coverage or family  
15 coverage, as appropriate, and single coverage, or based upon any  
16 other formula or dependent rating tier deemed appropriate by the  
17 commissioner which provides a substantially similar result.
- 18 (3) Payments of the premium may, at the election of the payor,  
19 be made in monthly installments.
- 20 f. Coverage for a dependent provided pursuant to this section  
21 shall be provided until the earlier of the following:
- 22 (1) the date upon which the dependent is disqualified for  
23 dependent status as set forth in subsection a. of this section;
- 24 (2) the date **[on]** upon which coverage ceases under the plan by  
25 reason of a failure to make a timely payment of any premium  
26 required under the plan by the covered person or dependent for  
27 coverage provided pursuant to this section. The payment of any  
28 premium shall be considered to be timely if made within 30 days  
29 after the due date or within a longer period as may be provided for  
30 by the plan; or

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1 (3) the date upon which the **【employer under whose】** plan,  
2 under which coverage is provided to a dependent, ceases to provide  
3 coverage to the covered person.

4 Nothing herein shall be construed to permit a carrier to refuse a  
5 written election for coverage by a dependent pursuant to subsection  
6 c. of this section, based upon the dependent's prior disqualification  
7 pursuant to paragraph (1) of this subsection, other than a  
8 disqualification based on age or lack of evidence of prior, creditable  
9 coverage or receipt of benefits.

10 g. Notice regarding coverage for a dependent as provided  
11 pursuant to this section shall be provided to a covered person by the  
12 carrier:

13 (1) in the certificate of coverage or other equivalent document  
14 prepared for covered persons **【by the carrier】** and delivered on or  
15 about the date of commencement of the covered persons' coverage;  
16 and

17 (2) **【by the covered person's employer:**

18 (a) on or before the coverage of a covered person's dependent  
19 terminates at the specific age as provided in the plan;

20 (b) at the time coverage of the dependent is no longer provided  
21 pursuant to this section because the dependent is disqualified for  
22 dependent status as set forth in subsection a. of this section, except  
23 this employer notice shall not be required when a dependent no  
24 longer qualifies based upon paragraph (1) or (3) of subsection a. of  
25 this section;

26 (c) before the 30 day period in each year following the year  
27 coverage terminates at the specific age as provided in the plan,  
28 permitting a dependent to make a written election for coverage  
29 pursuant to subsection c. of this section; and

30 (d) immediately following the effective date of this section, with  
31 respect to information concerning a dependent's opportunity, for 12  
32 months after the effective date of this section, to make a written

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1 election to reinstate coverage under a plan pursuant to paragraph (2)  
2 of subsection c. of this section.】 (Deleted by amendment, P.L. , c.  
3 (pending before the Legislature as this bill)

4 (3) in a notice delivered to covered persons on a quarterly basis.

5 h. This section shall apply to those plans in which the carrier  
6 has reserved the right to change the premium.<sup>3</sup>

7 (cf: P.L.2005, c.375, s.5)

8

9 <sup>3</sup>34. Section 6 of P.L.2005, c.375 (C.26:2J-10.3) is amended to  
10 read as follows:

11 6. a. As used in this section, "dependent" means an enrollee's  
12 child by blood or by law who:

13 (1) is **】less than】** 30 years of age or younger;

14 (2) is unmarried;

15 (3) has no dependent of his own;

16 (4) is a resident of this State or is enrolled as a full-time student  
17 at an accredited public or private institution of higher education;  
18 and

19 (5) (a) is not actually provided coverage as a named subscriber,  
20 insured, enrollee, or covered person under any other group or  
21 individual health benefits plan, group health plan, church plan or  
22 health benefits plan, or entitled to benefits under Title XVIII of the  
23 Social Security Act, **】Pub.L.89-97】 Pub.L.74-271** (42 U.S.C.  
24 s.1395 et seq.) at the time dependent coverage pursuant to this  
25 section begins or will begin; and

26 (b) there is evidence of prior, creditable coverage or receipt of  
27 benefits under a benefits plan or by law as set forth in subparagraph  
28 (a) of this paragraph.

29 b. (1) A health maintenance organization contract that provides  
30 coverage for an enrollee's dependent under which coverage of the  
31 dependent terminates at a specific age before the dependent's 30th  
32 birthday, and is delivered, issued, executed or renewed in this State

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1 pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) on or after the  
2 effective date of this section of P.L. \_\_\_\_\_, c. \_\_\_\_\_ (pending before the  
3 Legislature as this bill), shall, upon the application of the dependent  
4 as set forth in subsection c. of this section, provide coverage to the  
5 dependent after that specific age, until the dependent's **[30th]** 31st  
6 birthday.

7 (2) Nothing herein shall be construed to require:

8 (a) coverage for services provided to a dependent before the  
9 effective date of this section of P.L. \_\_\_\_\_, c. \_\_\_\_\_ (pending before the  
10 Legislature as this bill); or

11 (b) that an employer or other group contract holder pay all or  
12 part of the cost of coverage for a dependent as provided pursuant to  
13 this section.

14 c. (1) A dependent covered by an enrollee's contract, which  
15 coverage under the contract terminates at a specific age on or before  
16 the dependent's 30th birthday, may make a written election for  
17 coverage as a dependent pursuant to this section, until the  
18 dependent's 30th birthday:

19 (a) within 30 days prior to the termination of coverage at the  
20 specific age provided in the contract;

21 (b) within 30 days after meeting the requirements for dependent  
22 status as set forth in subsection a. of this section, when coverage for  
23 the dependent under the contract previously terminated; or

24 (c) during an open enrollment period, as provided pursuant to  
25 the contract, if the dependent meets the requirements for dependent  
26 status as set forth in subsection a. of this section during the open  
27 enrollment period.

28 (2) **[**For 12 months after the effective date of this section, a  
29 dependent who qualifies for dependent status as set forth in  
30 subsection a. of this section, but whose coverage as a dependent  
31 under an enrollee's contract terminated under the terms of the  
32 contract prior to the effective date of this section, may make a

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1 written election to reinstate coverage under that contract as a  
2 dependent pursuant to this section.】 (Deleted by amendment,  
3 P.L. , c. (pending before the Legislature as this bill)

4 d. (1) Coverage for a dependent who makes a written election for  
5 coverage pursuant to subsection c. of this section shall consist of  
6 coverage which is identical to the coverage provided to that  
7 dependent prior to the termination of coverage at the specific age  
8 provided in the contract. If coverage is modified under the contract  
9 for any similarly situated dependents for coverage prior to the  
10 termination of coverage at the specific age provided in the contract,  
11 the coverage shall also be modified in the same manner for the  
12 dependent.

13 (2) Coverage for a dependent who makes a written election for  
14 coverage pursuant to subsection c. of this section shall not be  
15 conditioned upon, or discriminate on the basis of, lack of evidence  
16 of insurability.

17 e. (1) The enrollee's contract may require payment under the  
18 schedule of charges by the enrollee or dependent, as appropriate,  
19 subject to the approval of the Commissioner of Banking and  
20 Insurance, for any period of coverage relating to a dependent's  
21 written election for coverage pursuant to subsection c. of this  
22 section. The payment shall not exceed 102% of the applicable  
23 portion of the schedule of charges previously paid for that  
24 dependent's coverage under the contract prior to the termination of  
25 coverage at the specific age provided in the contract.

26 (2) The applicable portion of the schedule of charges previously  
27 paid for the dependent's coverage under the contract shall be  
28 determined pursuant to regulations promulgated by the  
29 Commissioner of Banking and Insurance, based upon the difference  
30 between the contract's rating tiers for adult and dependent coverage  
31 or family coverage, as appropriate, and single coverage, or based

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1 upon any other formula or dependent rating tier deemed appropriate  
2 by the commissioner which provides a substantially similar result.

3 (3) Payments under the schedule of charges may, at the election  
4 of the payor, be made in monthly installments.

5 f. Coverage for a dependent provided pursuant to this section  
6 shall be provided until the earlier of the following:

7 (1) the date upon which the dependent is disqualified for  
8 dependent status as set forth in subsection a. of this section;

9 (2) the date **【on】** upon which coverage ceases under the contract  
10 by reason of a failure to make a timely payment under any schedule  
11 of charges required under the contract by the enrollee or dependent  
12 for coverage provided pursuant to this section. The payment under  
13 any schedule of charges shall be considered to be timely if made  
14 within 30 days after the due date or within a longer period as may  
15 be provided for by the contract; or

16 (3) the date upon which the **【employer under whose】** contract,  
17 under which coverage is provided to a dependent, ceases to provide  
18 coverage to the enrollee.

19 Nothing herein shall be construed to permit a health maintenance  
20 organization to refuse a written election for coverage by a  
21 dependent pursuant to subsection c. of this section, based upon the  
22 dependent's prior disqualification pursuant to paragraph (1) of this  
23 subsection, other than a disqualification based on age or lack of  
24 evidence of prior, creditable coverage or receipt of benefits.

25 g. Notice regarding coverage for a dependent as provided  
26 pursuant to this section shall be provided to an enrollee by the  
27 health maintenance organization:

28 (1) in the certificate of coverage or other equivalent document  
29 prepared for enrollees **【by the health maintenance organization】**  
30 and delivered on or about the date of commencement of the  
31 enrollees' coverage; and

32 (2) **【by the enrollee's employer:**

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1 (a) on or before the coverage of an enrollee's dependent  
2 terminates at the specific age as provided in the contract;

3 (b) at the time coverage of the dependent is no longer provided  
4 pursuant to this section because the dependent is disqualified for  
5 dependent status as set forth in subsection a. of this section, except  
6 this employer notice shall not be required when a dependent no  
7 longer qualifies based upon paragraph (1) or (3) of subsection a. of  
8 this section;

9 (c) before any open enrollment period permitting a dependent to  
10 make a written election for coverage pursuant to subsection c. of  
11 this section; and

12 (d) immediately following the effective date of this section, with  
13 respect to information concerning a dependent's opportunity, for 12  
14 months after the effective date of the section, to make a written  
15 election to reinstate coverage under a contract pursuant to paragraph  
16 (2) of subsection c. of this section. **】** (Deleted by amendment,  
17 P.L. , c. (pending before the Legislature as this bill)

18 (3) in a notice delivered to enrollees on a quarterly basis.

19 h. This section shall apply to those contracts in which the  
20 health maintenance organization has reserved the right to change  
21 the schedule of charges.<sup>3</sup>

22 (cf: P.L.2005, c.375, s.6)

23

24 <sup>3</sup>35. Section 7 of P.L.2005, c.375 (C.52:14-17.29k) is amended  
25 to read as follows:

26 7. a. As used in this section, "dependent" means a covered  
27 person's child by blood or by law who:

28 (1) is **】**less than**】** 30 years of age or younger;

29 (2) is unmarried;

30 (3) has no dependent of his own;

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1 (4) is a resident of this State or is enrolled as a full-time student  
2 at an accredited public or private institution of higher education;  
3 and

4 (5) (a) is not actually provided coverage as a named subscriber,  
5 insured, enrollee, or covered person under any other group or  
6 individual health benefits plan, group health plan, church plan or  
7 health benefits plan, or entitled to benefits under Title XVIII of the  
8 Social Security Act, **【Pub.L.89-97】** Pub.L.74-271 (42 U.S.C.  
9 s.1395 et seq.) at the time dependent coverage pursuant to this  
10 section begins or will begin; and

11 (b) there is evidence of prior, creditable coverage or receipt of  
12 benefits under a benefits plan or by law as set forth in subparagraph  
13 (a) of this paragraph.

14 b. The State Health Benefits Commission shall ensure that  
15 every contract purchased or renewed by the commission on or after  
16 the effective date of P.L.2005, c.375 (C.17:48-6.19 et al.), prohibits  
17 the termination of coverage of a dependent before the dependent's  
18 23rd birthday by reason of age, and complies with the provisions of  
19 **【P.L.2005, c.375 (C.17:48-6.19 et al.)】** this section of P.L. , c.  
20 (pending before the Legislature as this bill) concerning the coverage  
21 of a dependent by written election, as set forth in subsection d. of  
22 this section, until the dependent's **【30th】** 31st birthday. **【The cost of**  
23 **coverage pursuant to this section shall be reimbursed by the**  
24 **employee to the New Jersey State Health Benefits Program, in**  
25 **accordance with a rate to be determined by the commission.】**

26 c. Nothing within this section shall be construed to: (1) prevent  
27 any contract purchased or renewed by the commission from  
28 providing coverage for a dependent which terminates at a specific  
29 age after the dependent child's 23rd birthday; or (2) require  
30 coverage for services provided to a dependent before the effective  
31 date of **【P.L.2005, c.375 (C.17:48-6.19 et al.)】** this section of  
32 P.L. , c. (pending before the Legislature as this bill).

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- 1       d. A dependent covered by a covered person's contract, which  
2 coverage under the contract terminates at a specific age on or before  
3 the dependent's 30th birthday, may make a written election for  
4 coverage as a dependent pursuant to this section, until the  
5 dependent's 30th birthday:
- 6       (a) within 30 days prior to the termination of coverage at the  
7 specific age provided in the contract;
- 8       (b) within 30 days after meeting the requirements for dependent  
9 status as set forth in subsection a. of this section, when coverage for  
10 the dependent under the contract previously terminated; or
- 11       (c) during an open enrollment period, as provided pursuant to the  
12 contract, if the dependent meets the requirements for dependent  
13 status as set forth in subsection a. of this section.
- 14       e. (1) Coverage for a dependent who makes a written election for  
15 coverage pursuant to subsection d. of this section shall consist of  
16 coverage which is identical to the coverage provided to that  
17 dependent prior to the termination of coverage at the specific age  
18 provided in the contract. If coverage is modified under the contract  
19 for any similarly situated dependents for coverage prior to the  
20 termination of coverage at the specific age provided in the contract,  
21 the coverage shall also be modified in the same manner for the  
22 dependent.
- 23       (2) Coverage for a dependent who makes a written election for  
24 coverage pursuant to subsection d. of this section shall not be  
25 conditioned upon, or discriminate on the basis of, lack of evidence  
26 of insurability.
- 27       f. (1) The covered person's contract may require payment of a  
28 premium by the covered person or dependent, as appropriate, for  
29 any period of coverage relating to a dependent's written election for  
30 coverage pursuant to subsection d. of this section. The premium  
31 shall not exceed 102% of the applicable portion of the premium  
32 previously paid for that dependent's coverage under the contract

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1 prior to the termination of coverage at the specific age provided in  
2 the contract.

3 (2) The applicable portion of the premium previously paid for  
4 the dependent's coverage under the contract shall be determined by  
5 the commission, based upon the difference between the contract's  
6 rating tiers for adult and dependent coverage or family coverage, as  
7 appropriate, and single coverage, or based upon any other formula  
8 or dependent rating tier deemed appropriate by the commission  
9 which provides a substantially similar result.

10 (3) Payments of the premium may, at the election of the payor,  
11 be made in monthly installments.

12 g. Coverage for a dependent provided pursuant to this section  
13 shall be provided until the earlier of the following:

14 (1) the date upon which the dependent is disqualified for  
15 dependent status as set forth in subsection a. of this section;

16 (2) the date upon which coverage ceases under the contract by  
17 reason of a failure to make a timely payment of any premium  
18 required under the contract by the covered person or dependent for  
19 coverage provided pursuant to this section. The payment of any  
20 premium shall be considered to be timely if made within 30 days  
21 after the due date or within a longer period as may be provided for  
22 by the contract; or

23 (3) the date upon which the contract, under which coverage is  
24 provided to a dependent, ceases to provide coverage to the covered  
25 person.

26 Nothing herein shall be construed to permit the commission to  
27 refuse a written election for coverage by a dependent pursuant to  
28 subsection d. of this section, based upon the dependent's prior  
29 disqualification pursuant to paragraph (1) of this subsection, other  
30 than a disqualification based on age or lack of evidence or prior,  
31 creditable coverage or receipt of benefits.

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1 h. Notice regarding coverage for a dependent as provided  
2 pursuant to this section shall be provided to a covered person by the  
3 commission:

4 (1) in the certificate of coverage or other equivalent document  
5 prepared for covered persons and delivered on or about the date of  
6 commencement of the covered persons' coverage; and

7 (2) in a notice delivered to covered persons on a quarterly  
8 basis.<sup>3</sup>

9 (cf: P.L.2005, c.375, s.7)

10

11 <sup>1</sup>[27.] <sup>3</sup>[29.<sup>1</sup>] 36.<sup>3</sup> The Commissioner of Banking and  
12 Insurance shall, pursuant to the "Administrative Procedure Act,"  
13 P.L.1968, c.410 (C.52:14B-1 et seq.), adopt regulations necessary to  
14 implement <sup>1</sup>[the provisions] sections 9 through 25<sup>1 3</sup>and sections  
15 29 through 34<sup>3</sup>of this act.

16

17 <sup>1</sup>[28.] <sup>3</sup>[30.<sup>1</sup>] 37.<sup>3</sup> Sections 1 through <sup>1</sup>[7 and 27] 8, 26  
18 through 28, 36 and this section<sup>1</sup> of this act shall take effect  
19 immediately and sections <sup>1</sup>[8] 9<sup>1</sup> through <sup>1</sup>[26] 25<sup>1 3</sup>and 29  
20 through 35<sup>3</sup>of this act shall take effect on the 180th day after  
21 enactment <sup>1</sup>[and] , except that the 80% minimum loss ratio  
22 requirements in sections 16, 19, and 24 of this bill shall take effect  
23 on January 1 next following the date of enactment. Sections 9  
24 through 25<sup>1 3</sup>and 29 through 35<sup>3</sup> shall apply to all contracts and  
25 policies that are delivered, issued, executed or renewed or approved  
26 for issuance or renewal in this State on or after the effective date  
27 provided herein,<sup>1</sup> but the Commissioner of Banking and Insurance  
28 may take such anticipatory administrative action in advance thereof  
29 as shall be necessary for the implementation of this act.