# CHAPTER 368

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

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

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

1. The Legislature hereby finds and declares that:

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

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

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

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

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

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

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

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

Outpatient and ambulatory surgery- $250 copayment per surgery;

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

Physicians' fees connected with outpatient and ambulatory surgery;

Anesthesia and the administration of anesthesia;

Coverage for newborns;

Treatment for complications of pregnancy;

Intravenous solutions, blood and blood plasma;

Oxygen and the administration of oxygen;

Radiation and x-ray therapy;

Inpatient physical therapy and hydrotherapy;

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

Dialysis - inpatient or outpatient;

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

Laboratory fees for treatment in hospital;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Approved January 8, 2002.