

**SENATE, No. 2549**

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**STATE OF NEW JERSEY**

**213th LEGISLATURE**

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INTRODUCED FEBRUARY 2, 2009

**Sponsored by:**

**Senator JOSEPH F. VITALE**

**District 19 (Middlesex)**

**Senator BILL BARONI**

**District 14 (Mercer and Middlesex)**

**SYNOPSIS**

Makes technical correction to definition of “creditable coverage” in individual, small employer and larger group insurance laws.

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 2/3/2009)**

1 AN ACT concerning health insurance coverage and amending  
2 P.L.1992, c.161, P.L.1992, c.162, and P.L.1997, c.146.

3  
4 **BE IT ENACTED** by the Senate and General Assembly of the State  
5 of New Jersey:

6  
7 1. Section 1 of P.L.1992, c.161 (C.17B:27A-2) is amended to  
8 read as follows:

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

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

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

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

24 "Commissioner" means the Commissioner of Banking and  
25 Insurance.

26 "Community rating" means a rating system in which the  
27 premium for all persons covered by a contract is the same, based on  
28 the experience of all persons covered by that contract, without  
29 regard to age, sex, health status, occupation and geographical  
30 location.

31 "Creditable coverage" means, with respect to an individual,  
32 coverage of the individual under any of the following: a group  
33 health plan; a group or individual health benefits plan; Part A or  
34 Part B of Title XVIII of the federal Social Security Act (42 U.S.C.  
35 s.1395 et seq.); Title XIX of the federal Social Security Act (42  
36 U.S.C. s.1396 et seq.), other than coverage consisting solely of  
37 benefits under section 1928 of Title XIX of the federal Social  
38 Security Act (42 U.S.C.s.1396s); Chapter 55 of Title 10, United  
39 States Code (10 U.S.C. s.1071 et seq.); a medical care program of  
40 the Indian Health Service or of a tribal organization; a **[State]** state  
41 health benefits risk pool; a health plan offered under chapter 89 of  
42 Title 5, United States Code (5 U.S.C. s.8901 et seq.); a public health  
43 plan as defined by federal regulation; and a health benefits plan  
44 under section 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e));

**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.

1 or coverage under any other type of plan as set forth by the  
2 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 person, subject to applicable terms of the individual health  
19 benefits plan.

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

24 "Federally defined eligible individual" means an eligible person:  
25 (1) for whom, as of the date on which the individual seeks coverage  
26 under P.L.1992, c.161 (C.17B:27A-2 et al.), the aggregate of the  
27 periods of creditable coverage is 18 or more months; (2) whose  
28 most recent prior creditable coverage was under a group health  
29 plan, governmental plan, church plan, or health insurance coverage  
30 offered in connection with any such plan; (3) who is not eligible for  
31 coverage under a group health plan, Part A or Part B of Title XVIII  
32 of the Social Security Act (42 U.S.C.s.1395 et seq.), or a State plan  
33 under Title XIX of the Social Security Act (42 U.S.C.s.1396 et seq.)  
34 or any successor program, and who does not have another health  
35 benefits plan, or hospital or medical service plan; (4) with respect to  
36 whom the most recent coverage within the period of aggregate  
37 creditable coverage was not terminated based on a factor relating to  
38 nonpayment of premiums or fraud; (5) who, if offered the option of  
39 continuation coverage under the COBRA continuation provision or  
40 a similar State program, elected that coverage; and (6) who has  
41 elected continuation coverage described in (5) above and has  
42 exhausted that continuation coverage.

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

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

7 "Group health benefits plan" means a health benefits plan for  
8 groups of two or more persons.

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

16 "Health benefits plan" means a hospital and medical expense  
17 insurance policy; health service corporation contract; hospital  
18 service corporation contract; medical service corporation contract;  
19 health maintenance organization subscriber contract; or other plan  
20 for medical care delivered or issued for delivery in this State. For  
21 purposes of this act, health benefits plan shall not include one or  
22 more, or any combination of, the following: coverage only for  
23 accident, or disability income insurance, or any combination  
24 thereof; coverage issued as a supplement to liability insurance;  
25 liability insurance, including general liability insurance and  
26 automobile liability insurance; stop loss or excess risk insurance;  
27 workers' compensation or similar insurance; automobile medical  
28 payment insurance; credit-only insurance; coverage for on-site  
29 medical clinics; and other similar insurance coverage, as specified  
30 in federal regulations, under which benefits for medical care are  
31 secondary or incidental to other insurance benefits. Health benefits  
32 plan shall not include the following benefits if they are provided  
33 under a separate policy, certificate or contract of insurance or are  
34 otherwise not an integral part of the plan: limited scope dental or  
35 vision benefits; benefits for long-term care, nursing home care,  
36 home health care, community-based care, or any combination  
37 thereof; and such other similar, limited benefits as are specified in  
38 federal regulations. Health benefits plan shall not include hospital  
39 confinement indemnity coverage if the benefits are provided under  
40 a separate policy, certificate or contract of insurance, there is no  
41 coordination between the provision of the benefits and any  
42 exclusion of benefits under any group health benefits plan  
43 maintained by the same plan sponsor, and those benefits are paid  
44 with respect to an event without regard to whether benefits are  
45 provided with respect to such an event under any group health plan  
46 maintained by the same plan sponsor. Health benefits plan shall not  
47 include the following if it is offered as a separate policy, certificate  
48 or contract of insurance: Medicare supplemental health insurance

1 as defined under section 1882(g)(1) of the federal Social Security  
2 Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the  
3 coverage provided under chapter 55 of Title 10, United States Code  
4 (10 U.S.C. s.1071 et seq.); and similar supplemental coverage  
5 provided to coverage under a group health plan.

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

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

19 Individual health benefits plan shall not include a certificate  
20 issued under a policy or contract issued to a trust, or to the trustees  
21 of a fund, which trust or fund is an employee welfare benefit plan,  
22 to the extent the "Employee Retirement Income Security Act of  
23 1974" (29 U.S.C. s.1001 et seq.) preempts the application of  
24 P.L.1992, c.161 (C.17B:27A-2 et al.) to that plan.

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

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

32 "Member" means a carrier that issues or has in force health  
33 benefits plans in New Jersey. Member shall not include a carrier  
34 whose combined average Medicare, Medicaid, and NJ FamilyCare  
35 enrollment represents more than 75% of its average total enrollment  
36 for all health benefits plans or whose combined Medicare,  
37 Medicaid, and NJ FamilyCare net earned premium for the two-year  
38 calculation period represents more than 75% of its total net earned  
39 premium for the two-year calculation period.

40 "Modified community rating" means a rating system in which the  
41 premium for all persons covered under a policy or contract for a  
42 specific health benefits plan and a specific date of issue of that plan  
43 is the same without regard to sex, health status, occupation,  
44 geographical location or any other factor or characteristic of  
45 covered persons, other than age.

46 The rating system shall provide that the premium rate charged by  
47 the carrier for the highest rated individual or class of individuals  
48 shall not be greater than 350% of the premium rate charged for the

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

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

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

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

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

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

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

41 "Preexisting condition" means a condition that, during a  
42 specified period of not more than six months immediately preceding  
43 the effective date of coverage, had manifested itself in such a  
44 manner as would cause an ordinarily prudent person to seek medical  
45 advice, diagnosis, care or treatment, or for which medical advice,  
46 diagnosis, care or treatment was recommended or received as to that  
47 condition or as to a pregnancy existing on the effective date of  
48 coverage.

1 "Program" means the New Jersey Individual Health Coverage  
2 Program established pursuant to this act.

3 "Resident" means a person whose primary residence is in New  
4 Jersey and who is present in New Jersey for at least six months of  
5 the calendar year, or, in the case of a person who has moved to New  
6 Jersey less than six months before applying for individual health  
7 coverage, who intends to be present in New Jersey for at least six  
8 months of the calendar year.

9 "Two-year calculation period" means a two calendar year period,  
10 the first of which shall begin January 1, 1997 and end December 31,  
11 1998.

12 (cf: P.L.2008, c.38, s.9)

13

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

16 1. As used in this act:

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

25 "Anticipated loss ratio" means the ratio of the present value of  
26 the expected benefits, not including dividends, to the present value  
27 of the expected premiums, not reduced by dividends, over the entire  
28 period for which rates are computed to provide coverage. For  
29 purposes of this ratio, the present values must incorporate realistic  
30 rates of interest which are determined before federal taxes but after  
31 investment expenses.

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

33 "Carrier" means any entity subject to the insurance laws and  
34 regulations of this State, or subject to the jurisdiction of the  
35 commissioner, that contracts or offers to contract to provide,  
36 deliver, arrange for, pay for, or reimburse any of the costs of health  
37 care services, including an insurance company authorized to issue  
38 health insurance, a health maintenance organization, a hospital  
39 service corporation, medical service corporation and health service  
40 corporation, or any other entity providing a plan of health  
41 insurance, health benefits or health services. The term "carrier"  
42 shall not include a joint insurance fund established pursuant to State  
43 law. For purposes of this act, carriers that are affiliated companies  
44 shall be treated as one carrier, except that any insurance company,  
45 health service corporation, hospital service corporation, or medical  
46 service corporation that is an affiliate of a health maintenance  
47 organization located in New Jersey or any health maintenance  
48 organization located in New Jersey that is affiliated with an

1 insurance company, health service corporation, hospital service  
2 corporation, or medical service corporation shall treat the health  
3 maintenance organization as a separate carrier.

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

7 "Commissioner" means the Commissioner of Banking and  
8 Insurance.

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

15 "Creditable coverage" means, with respect to an individual,  
16 coverage of the individual under any of the following: a group  
17 health plan; a group or individual health benefits plan; Part A or  
18 part B of Title XVIII of the federal Social Security Act (42 U.S.C.  
19 s.1395 et seq.); Title XIX of the federal Social Security Act (42  
20 U.S.C. s.1396 et seq.), other than coverage consisting solely of  
21 benefits under section 1928 of Title XIX of the federal Social  
22 Security Act (42 U.S.C.s.1396s); chapter 55 of Title 10, United  
23 States Code (10 U.S.C. s.1071 et seq.); a medical care program of  
24 the Indian Health Service or of a tribal organization; a state health  
25 benefits risk pool; a health plan offered under chapter 89 of Title 5,  
26 United States Code (5 U.S.C. s.8901 et seq.); a public health plan as  
27 defined by federal regulation; a health benefits plan under section  
28 5(e) of the "Peace Corps Act" (22 U.S.C. s.2504(e)); or coverage  
29 under any other type of plan as set forth by the commissioner by  
30 regulation.

31 Creditable coverage shall not include coverage consisting solely  
32 of the following: coverage only for accident or disability income  
33 insurance, or any combination thereof; coverage issued as a  
34 supplement to liability insurance; liability insurance, including  
35 general liability insurance and automobile liability insurance;  
36 workers' compensation or similar insurance; automobile medical  
37 payment insurance; credit only insurance; coverage for on-site  
38 medical clinics; coverage, as specified in federal regulation, under  
39 which benefits for medical care are secondary or incidental to the  
40 insurance benefits; and other coverage expressly excluded from the  
41 definition of health benefits plan.

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

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



1 "Eligible employee" means a full-time employee who works a  
2 normal work week of 25 or more hours. The term includes a sole  
3 proprietor, a partner of a partnership, or an independent contractor,  
4 if the sole proprietor, partner, or independent contractor is included  
5 as an employee under a health benefits plan of a small employer,  
6 but does not include employees who work less than 25 hours a  
7 week, work on a temporary or substitute basis or are participating in  
8 an employee welfare arrangement established pursuant to a  
9 collective bargaining agreement.

10 "Enrollment date" means, with respect to a person covered under  
11 a health benefits plan, the date of enrollment of the person in the  
12 health benefits plan or, if earlier, the first day of the waiting period  
13 for such enrollment.

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

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

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

32 "Health benefits plan" means any hospital and medical expense  
33 insurance policy or certificate; health, hospital, or medical service  
34 corporation contract or certificate; or health maintenance  
35 organization subscriber contract or certificate delivered or issued  
36 for delivery in this State by any carrier to a small employer group  
37 pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). For  
38 purposes of this act, "health benefits plan" shall not include one or  
39 more, or any combination of, the following: coverage only for  
40 accident or disability income insurance, or any combination thereof;  
41 coverage issued as a supplement to liability insurance; liability  
42 insurance, including general liability insurance and automobile  
43 liability insurance; workers' compensation or similar insurance;  
44 automobile medical payment insurance; credit-only insurance;  
45 coverage for on-site medical clinics; and other similar insurance  
46 coverage, as specified in federal regulations, under which benefits  
47 for medical care are secondary or incidental to other insurance  
48 benefits. Health benefits plan shall not include the following

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

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

28 "Late enrollee" means an eligible employee or dependent who  
29 requests enrollment in a health benefits plan of a small employer  
30 following the initial minimum 30-day enrollment period provided  
31 under the terms of the health benefits plan. An eligible employee or  
32 dependent shall not be considered a late enrollee if the individual: a.  
33 was covered under another employer's health benefits plan at the  
34 time he was eligible to enroll and stated at the time of the initial  
35 enrollment that coverage under that other employer's health benefits  
36 plan was the reason for declining enrollment, but only if the plan  
37 sponsor or carrier required such a statement at that time and  
38 provided the employee with notice of that requirement and the  
39 consequences of that requirement at that time; b. has lost coverage  
40 under that other employer's health benefits plan as a result of  
41 termination of employment or eligibility, reduction in the number of  
42 hours of employment, involuntary termination, the termination of  
43 the other plan's coverage, death of a spouse, or divorce or legal  
44 separation; and c. requests enrollment within 90 days after  
45 termination of coverage provided under another employer's health  
46 benefits plan. An eligible employee or dependent also shall not be  
47 considered a late enrollee if the individual is employed by an  
48 employer which offers multiple health benefits plans and the

1 individual elects a different plan during an open enrollment period;  
2 the individual had coverage under a COBRA continuation provision  
3 and the coverage under that provision was exhausted and the  
4 employee requests enrollment not later than 30 days after the date  
5 of exhaustion of COBRA coverage; or if a court of competent  
6 jurisdiction has ordered coverage to be provided for a spouse or  
7 minor child under a covered employee's health benefits plan and  
8 request for enrollment is made within 30 days after issuance of that  
9 court order.

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

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

17 "Multiple employer arrangement" means an arrangement  
18 established or maintained to provide health benefits to employees  
19 and their dependents of two or more employers, under an insured  
20 plan purchased from a carrier in which the carrier assumes all or a  
21 substantial portion of the risk, as determined by the commissioner,  
22 and shall include, but is not limited to, a multiple employer welfare  
23 arrangement, or MEWA, multiple employer trust or other form of  
24 benefit trust.

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

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

31 "Preexisting condition exclusion" means, with respect to  
32 coverage, a limitation or exclusion of benefits relating to a  
33 condition based on the fact that the condition was present before the  
34 date of enrollment for that coverage, whether or not any medical  
35 advice, diagnosis, care, or treatment was recommended or received  
36 before that date. Genetic information shall not be treated as a  
37 preexisting condition in the absence of a diagnosis of the condition  
38 related to that information.

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

42 "Small employer" means, in connection with a group health plan  
43 with respect to a calendar year and a plan year, any person, firm,  
44 corporation, partnership, or political subdivision that is actively  
45 engaged in business that employed an average of at least two but  
46 not more than 50 eligible employees on business days during the  
47 preceding calendar year and who employs at least two employees  
48 on the first day of the plan year, and the majority of the employees

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

19 "Small employer carrier" means any carrier that offers health  
20 benefits plans covering eligible employees of one or more small  
21 employers.

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

25 "Stop loss" or "excess risk insurance" means an insurance policy  
26 designed to reimburse a self-funded arrangement of one or more  
27 small employers for catastrophic, excess or unexpected expenses,  
28 wherein neither the employees nor other individuals are third party  
29 beneficiaries under the insurance policy. In order to be considered  
30 stop loss or excess risk insurance for the purposes of P.L.1992,  
31 c.162 (C.17B:27A-17 et seq.), the policy shall establish a per person  
32 attachment point or retention or aggregate attachment point or  
33 retention, or both, which meet the following requirements:

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

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

40 "Supplemental limited benefit insurance" means insurance that is  
41 provided in addition to a health benefits plan on an indemnity non-  
42 expense incurred basis.  
43 (P.L.2008, c.38, s.20)  
44

45 3. Section 14 of P.L.1997, c.146 (C.17B:27-54) is amended to  
46 read as follows:

47 14. The provisions of sections 14 through 27 of P.L.1997, c.146  
48 (C.17B:27-54 through C.17B:27-67) shall apply to group health

1 insurance coverage that is not subject to the provisions of P.L.1992,  
2 c.161 and c.162 (C.17B:27A-2 et seq. and 17B:27A-17 et seq.). To  
3 the extent that any provision of sections 14 through 27 of P.L.1997,  
4 c.146 (C.17B:27-54 through C.17B:27-67) is inconsistent with the  
5 provisions of chapter 27 of Title 17B of the New Jersey Statutes  
6 and P.L.1973, c.337 (C.26:2J-1 et seq.), the provisions of sections  
7 14 through 27 shall supersede those laws.

8 As used in sections 14 through 27 of P.L.1997, c.146 (C.17B:27-  
9 54 through C.17B:27-67):

10 "Affiliation period" means a period which, under the terms of the  
11 group health plan offered by a health maintenance organization,  
12 begins on the enrollment date and which must expire before the  
13 health insurance becomes effective. The health maintenance  
14 organization shall not be required to provide health care services or  
15 benefits during such period and no premium shall be charged.

16 "Creditable coverage" means, with respect to an individual,  
17 coverage of the individual, other than coverage of excepted  
18 benefits, under any of the following: a group health plan; health  
19 insurance coverage; Part A or Part B of Title XVIII of the federal  
20 Social Security Act (42 U.S.C.s.1395 et seq.); Title XIX of the  
21 federal Social Security Act (42 U.S.C.s.1396 et seq.); other than  
22 coverage consisting solely of benefits under section 1928 of Title  
23 XIX of the federal Social Security Act (42 U.S.C.s.1396s); chapter  
24 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); a  
25 medical care program of the Indian Health Service of a tribal  
26 organization; a **[State]** state health benefits risk pool; a **[State]**  
27 health plan offered under chapter 89 of Title 5, United States Code  
28 (5 U.S.C. s.8901 et seq.); a public health plan; and a health benefits  
29 plan under section 5(e) of the "Peace Corps Act" (22  
30 U.S.C.s.2504(e)).

31 "Enrollment date" means, with respect to an individual covered  
32 under a group health plan or health insurance coverage, the date of  
33 enrollment of the individual in the plan or coverage or, if earlier,  
34 the first day of the waiting period for enrollment.

35 "Excepted benefits" means:

36 a. coverage only for accident or disability income insurance, or  
37 any combination thereof; coverage issued as a supplement to  
38 liability insurance; liability insurance, including general liability  
39 insurance and automobile liability insurance; workers  
40 compensation or similar insurance; automobile medical payment  
41 insurance; credit-only insurance; coverage for on-site medical  
42 clinics; and other similar insurance coverage, as specified by federal  
43 regulation, under which benefits for medical care are secondary or  
44 incidental to other insurance benefits;

45 b. when provided under a separate policy, certificate or  
46 contract of insurance or otherwise not an integral part of the group  
47 health plan: limited scope dental or vision benefits, benefits for  
48 long-term care, nursing home care, home health care, community-

1 based care, or any combination thereof, and such other similar,  
2 limited benefits as are specified by federal regulation;

3 c. when offered as independent, noncoordinated benefits:  
4 hospital indemnity or other fixed indemnity insurance;

5 d. when offered as a separate insurance policy, certificate or  
6 contract of insurance: Medicare supplemental insurance as defined  
7 under section 1882(g)(1) of the federal Social Security Act (42  
8 U.S.C. s.1395ss(g)(1))and coverage supplemental to the coverage  
9 provided under chapter 55 of Title 10, United States Code (10  
10 U.S.C.s.1071 et seq.) and similar supplemental coverage provided  
11 in addition to coverage under a group health plan.

12 "Group health plan" means an employee welfare benefit plan, as  
13 defined in Title 1 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, as defined under the terms of the plan, directly or  
18 through insurance, reimbursement or otherwise.

19 "Health insurance coverage" means benefits consisting of  
20 medical care, provided directly, through insurance or  
21 reimbursement, or otherwise, and including items and services paid  
22 for as medical care, under any hospital or medical expense policy or  
23 certificate or health maintenance organization contract offered by a  
24 health insurer.

25 "Health insurer" means an insurer licensed to sell health  
26 insurance pursuant to Title 17B of the New Jersey Statutes, a  
27 health, hospital or medical service corporation, fraternal benefit  
28 association or a health maintenance organization.

29 "Health status-related factor" means: health status; medical  
30 condition, including both physical and mental illness; claims  
31 experience; receipt of health care; medical history; genetic  
32 information; evidence of insurability, including conditions arising  
33 out of acts of domestic violence; and disability.

34 "Health maintenance organization" means a federally qualified  
35 health maintenance organization as defined in the "Health  
36 Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.  
37 s.300e et seq.), an organization authorized under P.L.1973, c.337  
38 (C.26:2J-1 et seq.), or a similar organization regulated under State  
39 law for solvency in the same manner and to the same extent as a  
40 health maintenance organization authorized to do business in this  
41 State.

42 "Late enrollee" means a participant or beneficiary who enrolls in  
43 a group health plan other than during: the first period during which  
44 the individual is eligible to enroll in the plan; or a special  
45 enrollment period.

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

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

3 "Network plan" means a group health plan offered by a health  
4 insurer under which the financing and delivery of medical care,  
5 including items and services paid for as medical care, are provided,  
6 in whole or in part, through a defined set of providers under  
7 contract with the insurer. Network plan includes a health  
8 maintenance organization or health insurance company with  
9 selective contracting arrangements.

10 "Preexisting condition" means with respect to coverage, a  
11 limitation or exclusion of benefits relating to a condition based on  
12 the fact that the condition was present before the date of enrollment  
13 for that coverage, whether or not any medical advice, diagnosis,  
14 care or treatment was recommended or received before that date.

15 "Waiting period" means with respect to a group health plan and  
16 an individual who is a potential participant or beneficiary in the  
17 plan, the period that must pass with respect to the individual before  
18 the individual is eligible to be covered for benefits under the terms  
19 of the plan.

20 (P.L.1997, c.146, s.14)

21

22 4. This act shall take effect immediately.

23

24

25 STATEMENT

26

27 This bill makes a technical correction to the definition of  
28 "creditable coverage" in the New Jersey Individual Health  
29 Coverage and the New Jersey Small Employer Health Benefits  
30 programs and the law concerning larger group insurance plans to  
31 comply with federal law.