

SENATE, No. 2145

STATE OF NEW JERSEY
219th LEGISLATURE

INTRODUCED MARCH 16, 2020

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS

Allows health maintenance organizations to include charity care assessments for purposes of meeting certain loss ratio requirements.

CURRENT VERSION OF TEXT

As introduced.



S2145 VITALE

2

1 AN ACT concerning the calculation of certain loss ratios for health
2 maintenance organizations and amending P.L.1992, c.161 and
3 P.L.1992, c.162.

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

7
8 1. Section 8 of P.L.1992, c.161 (C.17B:27A-9) is amended as
9 follows:

10 8. a. (Deleted by amendment, P.L.2008, c.38).

11 b. The board shall make application on behalf of all carriers for
12 any other subsidies, discounts, or funds that may be provided for
13 under State or federal law or regulation. A carrier may include
14 subsidies or funds granted to the board to reduce its premium rates
15 for individual health benefits plans subject to this act.

16 c. A carrier shall not issue individual health benefits plans on a
17 new contract or policy form pursuant to this act until an
18 informational filing of a full schedule of rates which applies to the
19 contract or policy form has been filed with the commissioner. The
20 commissioner shall provide a copy of the informational filing to the
21 Attorney General and the board.

22 d. A carrier desiring to increase or decrease premiums for any
23 contract or policy form may implement that increase or decrease
24 upon making an informational filing with the commissioner of that
25 increase or decrease, along with the actuarial assumptions and
26 methods used by the carrier in establishing that increase or
27 decrease. The commissioner may disapprove any informational
28 filing on a finding that it is incomplete and not in substantial
29 compliance with P.L.1992, c.161 (C.17B:27A-2 et al.), or that the
30 rates are inadequate or unfairly discriminatory.

31 e. (1) Rates shall be formulated on contracts or policies
32 required pursuant to section 3 of this act so that the anticipated
33 minimum loss ratio for a contract or policy form shall not be less
34 than 80% of the premium. The carrier shall submit with its rate
35 filing supporting data, as determined by the commissioner, and a
36 certification by a member of the American Academy of Actuaries,
37 or other individuals in a format acceptable to the commissioner, that
38 the carrier is in compliance with the provisions of this subsection.

39 (2) Each calendar year, a carrier shall return, in the form of
40 aggregate benefits for all of the policy or contract forms offered by
41 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.161
42 (C.17B:27A-4), at least 80% of the aggregate premiums collected
43 for all of the policy or contract forms during that calendar year.
44 Carriers shall annually report, no later than August 1 of each year,
45 the loss ratio calculated pursuant to this section for all of the policy

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

20 (3) Commencing with the calendar year beginning January 1,
21 2018, and in each calendar year thereafter, for the purposes of
22 complying with its 80% loss ratio requirement, a health
23 maintenance organization shall include any amounts that the health
24 maintenance organization remitted during that calendar year in the
25 form of quarterly payments to the Department of Banking and
26 Insurance as part of its annual assessment pursuant to section 3 of
27 P.L.2004, c.49 (C.26:2J-47) as an addition to aggregate benefits in
28 the numerator of its loss ratio calculation.

29 f. (Deleted by amendment, P.L.2008, c.38).

30 (cf: P.L.2008, c.38, s.16)

31

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

34 1. As used in this act:

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

43 "Anticipated loss ratio" means the ratio of the present value of
44 the expected benefits, not including dividends, to the present value
45 of the expected premiums, not reduced by dividends, over the entire
46 period for which rates are computed to provide coverage. For
47 purposes of this ratio, the present values must incorporate realistic

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1 rates of interest which are determined before federal taxes but after
2 investment expenses.

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

4 "Carrier" means any entity subject to the insurance laws and
5 regulations of this State, or subject to the jurisdiction of the
6 commissioner, that contracts or offers to contract to provide,
7 deliver, arrange for, pay for, or reimburse any of the costs of health
8 care services, including an insurance company authorized to issue
9 health insurance, a health maintenance organization, a hospital
10 service corporation, medical service corporation and health service
11 corporation, or any other entity providing a plan of health
12 insurance, health benefits or health services. The term "carrier"
13 shall not include a joint insurance fund established pursuant to State
14 law. For purposes of this act, carriers that are affiliated companies
15 shall be treated as one carrier **],** except that any insurance company,
16 health service corporation, hospital service corporation, or medical
17 service corporation that is an affiliate of a health maintenance
18 organization located in New Jersey or any health maintenance
19 organization located in New Jersey that is affiliated with an
20 insurance company, health service corporation, hospital service
21 corporation, or medical service corporation shall treat the health
22 maintenance organization as a separate carrier **].**

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

26 "Commissioner" means the Commissioner of Banking and
27 Insurance.

28 "Community rating" or "community rated" means a rating
29 methodology in which the premium charged by a carrier for all
30 persons covered by a policy or contract form is the same based upon
31 the experience of the entire pool of risks covered by that policy or
32 contract form without regard to age, gender, health status, residence
33 or occupation.

34 "Creditable coverage" means, with respect to an individual,
35 coverage of the individual under any of the following: a group
36 health plan; a group or individual health benefits plan; **[Part] part**
37 A or part B of **[Title] title** XVIII of the federal Social Security Act
38 (42 U.S.C. **[s.1395] s.1395c** et seq.); **[Title] title** XIX of the
39 federal Social Security Act (42 U.S.C. s.1396 et seq.), other than
40 coverage consisting solely of benefits under section 1928 of **[Title]**
41 **title** XIX of the federal Social Security Act (42 U.S.C. s.1396s);
42 chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et
43 seq.); a medical care program of the Indian Health Service or of a
44 tribal organization; a State health benefits risk pool; a health plan
45 offered under chapter 89 of Title 5, United States Code (5 U.S.C.
46 s.8901 et seq.); a public health plan as defined by federal
47 regulation; a health benefits plan under section 5(e) of Pub.L.87-

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1 293, the "Peace Corps Act" (22 U.S.C. s.2504(e)); or coverage
2 under any other type of plan as set forth by the commissioner by
3 regulation.

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

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

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

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

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

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

39 "Governmental plan" has the meaning given that term under
40 **【Title】** title I, section 3 of Pub.L.93-406, the "Employee Retirement
41 Income Security Act of 1974" (29 U.S.C. s.1002(32)) and any
42 governmental plan established or maintained for its employees by
43 the Government of the United States or by any agency or
44 instrumentality of that government.

45 "Group health plan" means an employee welfare benefit plan, as
46 defined in **【Title】** title I of section 3 of Pub.L.93-406, the
47 "Employee Retirement Income Security Act of 1974" (29 U.S.C.
48 s.1002(1)), to the extent that the plan provides medical care and

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

4 "Health benefits plan" means any hospital and medical expense
5 insurance policy or certificate; health, hospital, or medical service
6 corporation contract or certificate; or health maintenance
7 organization subscriber contract or certificate delivered or issued
8 for delivery in this State by any carrier to a small employer group
9 pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19). 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 thereof;
13 coverage issued as a supplement to liability insurance; liability
14 insurance, including general liability insurance and automobile
15 liability insurance; workers' compensation or similar insurance;
16 automobile medical payment insurance; credit-only insurance;
17 coverage for on-site medical clinics; and other similar insurance
18 coverage, as specified in federal regulations, under which benefits
19 for medical care are secondary or incidental to other insurance
20 benefits. Health benefits plan shall not include the following
21 benefits if they are provided under a separate policy, certificate or
22 contract of insurance or are otherwise not an integral part of the
23 plan: limited scope dental or vision benefits; benefits for long-term
24 care, nursing home care, home health care, community-based care,
25 or any combination thereof; and such other similar, limited benefits
26 as are specified in federal regulations. Health benefits plan shall
27 not include hospital confinement indemnity coverage if the benefits
28 are provided under a separate policy, certificate or contract of
29 insurance, there is no coordination between the provision of the
30 benefits and any exclusion of benefits under any group health
31 benefits plan maintained by the same plan sponsor, and those
32 benefits are paid with respect to an event without regard to whether
33 benefits are provided with respect to such an event under any group
34 health plan maintained by the same plan sponsor. Health benefits
35 plan shall not include the following if it is offered as a separate
36 policy, certificate or contract of insurance: Medicare supplemental
37 health insurance as defined under section 1882(g)(1) of the federal
38 Social Security Act (42 U.S.C. s.1395ss(g)(1)); and coverage
39 supplemental to the coverage provided under chapter 55 of Title 10,
40 United States Code (10 U.S.C. s.1071 et seq.); and similar
41 supplemental coverage provided to coverage under a group health
42 plan.

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

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

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

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

38 "Multiple employer arrangement" means an arrangement
39 established or maintained to provide health benefits to employees
40 and their dependents of two or more employers, under an insured
41 plan purchased from a carrier in which the carrier assumes all or a
42 substantial portion of the risk, as determined by the commissioner,
43 and shall include, but is not limited to, a multiple employer welfare
44 arrangement, or MEWA, multiple employer trust or other form of
45 benefit trust.

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

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

4 "Preexisting condition exclusion" means, with respect to
5 coverage, a limitation or exclusion of benefits relating to a
6 condition based on the fact that the condition was present before the
7 date of enrollment for that coverage, whether or not any medical
8 advice, diagnosis, care, or treatment was recommended or received
9 before that date. Genetic information shall not be treated as a
10 preexisting condition in the absence of a diagnosis of the condition
11 related to that information.

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

15 "Small employer" means, in connection with a group health plan
16 with respect to a calendar year and a plan year, any person, firm,
17 corporation, partnership, or political subdivision that is actively
18 engaged in business that employed an average of at least two but
19 not more than 50 eligible employees on business days during the
20 preceding calendar year and who employs at least two employees
21 on the first day of the plan year, and the majority of the employees
22 are employed in New Jersey. All persons treated as a single
23 employer under subsection (b), (c), (m) or (o) of section 414 of the
24 Internal Revenue Code of 1986 (26 U.S.C. s.414) shall be treated as
25 one employer. Subsequent to the issuance of a health benefits plan
26 to a small employer and for the purpose of determining continued
27 eligibility, the size of a small employer shall be determined
28 annually. Except as otherwise specifically provided, provisions of
29 P.L.1992, c.162 (C.17B:27A-17 et seq.) that apply to a small
30 employer shall continue to apply at least until the plan anniversary
31 following the date the small employer no longer meets the
32 requirements of this definition. In the case of an employer that was
33 not in existence during the preceding calendar year, the
34 determination of whether the employer is a small or large employer
35 shall be based on the average number of employees that it is
36 reasonably expected that the employer will employ on business
37 days in the current calendar year. Any reference in P.L.1992, c.162
38 (C.17B:27A-17 et seq.) to an employer shall include a reference to
39 any predecessor of such employer.

40 "Small employer carrier" means any carrier that offers health
41 benefits plans covering eligible employees of one or more small
42 employers.

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

46 "Stop loss" or "excess risk insurance" means an insurance policy
47 designed to reimburse a self-funded arrangement of one or more
48 small employers for catastrophic, excess or unexpected expenses,

1 wherein neither the employees nor other individuals are third party
2 beneficiaries under the insurance policy. In order to be considered
3 stop loss or excess risk insurance for the purposes of P.L.1992,
4 c.162 (C.17B:27A-17 et seq.), the policy shall establish a per person
5 attachment point or retention or aggregate attachment point or
6 retention, or both, which meet the following requirements:

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

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

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

16 (cf: P.L.2009, c.293, s.2)

17

18 3. Section 9 of P.L.1992, c.162 (C.17B:27A-25) is amended to
19 read as follows:

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

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

22 (3) (a) For all policies or contracts providing health benefits
23 plans for small employers issued pursuant to section 3 of P.L.1992,
24 c.162 (C.17B:27A-19), and including policies or contracts offered
25 by a carrier to a small employer who is a member of a Small
26 Employer Purchasing Alliance pursuant to the provisions of
27 P.L.2001, c.225 (C.17B:27A-25.1 et al.) the premium rate charged
28 by a carrier to the highest rated small group purchasing a small
29 employer health benefits plan issued pursuant to section 3 of
30 P.L.1992, c.162 (C.17B:27A-19) shall not be greater than 200% of
31 the premium rate charged for the lowest rated small group
32 purchasing that same health benefits plan; provided, however, that
33 the only factors upon which the rate differential may be based are
34 age, gender and geography. Such factors shall be applied in a
35 manner consistent with regulations adopted by the commissioner.
36 For the purposes of this paragraph (3), policies or contracts offered
37 by a carrier to a small employer who is a member of a Small
38 Employer Purchasing Alliance shall be rated separately from the
39 carrier's other small employer health benefits policies or contracts.

40 (b) A health benefits plan issued pursuant to subsection j. of
41 section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be rated in
42 accordance with the provisions of section 7 of P.L.1995, c.340
43 (C.17B:27A-19.3), for the purposes of meeting the requirements of
44 this paragraph.

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

46 (5) Any policy or contract issued after January 1, 1994 to a
47 small employer who was not previously covered by a health
48 benefits plan issued by the issuing small employer carrier, shall be

1 subject to the same premium rate restrictions as provided in
2 paragraph (3) of this subsection, which rate restrictions shall be
3 effective on the date the policy or contract is issued.

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

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

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

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

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

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

16 A carrier which provides a health benefits plan to one or more
17 small employers through a policy issued to an association or trust of
18 employers after the effective date of P.L.1992, c.162 (C.17B:27A-
19 17 et seq.), shall be required to offer small employer health benefits
20 plans to non-association or trust employers in the same manner as
21 any other small employer carrier is required pursuant to P.L.1992,
22 c.162 (C.17B:27A-17 et seq.).

23 e. Nothing contained herein shall prohibit the use of premium
24 rate structures to establish different premium rates for individuals
25 and family units.

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

37 g. (1) Beginning January 1, 1995, a carrier desiring to increase
38 or decrease premiums for any policy form or benefit rider offered
39 pursuant to subsection i. of section 3 of P.L.1992, c.162
40 (C.17B:27A-19) subject to this act may implement such increase or
41 decrease upon making an informational filing with the
42 commissioner of such increase or decrease, along with the actuarial
43 assumptions and methods used by the carrier in establishing such
44 increase or decrease, provided that the anticipated minimum loss
45 ratio for all policy forms shall not be less than 80% of the premium
46 therefor as provided in paragraph (2) of this subsection. The
47 commissioner may disapprove any informational filing on a finding
48 that it is incomplete and not in substantial compliance with

1 P.L.1992, c.162 (C.17B:27A-17 et seq.), or that the rates are
2 inadequate or unfairly discriminatory. Until December 31, 1996,
3 the informational filing shall also include the carrier's rating plan
4 and classification system in connection with such increase or
5 decrease.

6 (2) (a) Each calendar year, a carrier shall return, in the form of
7 aggregate benefits for all of the standard policy forms offered by
8 the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162
9 (C.17B:27A-19), at least 80% of the aggregate premiums collected
10 for all of the standard policy forms, other than alliance policy
11 forms, and at least 80% of the aggregate premiums collected for all
12 of the non-standard policy forms during that calendar year. A
13 carrier shall return at least 80% of the premiums collected for all of
14 the alliances during that calendar year, which loss ratio may be
15 calculated in the aggregate for all of the alliances or separately for
16 each alliance. Carriers shall annually report, no later than August
17 1st of each year, the loss ratio calculated pursuant to this section for
18 all of the standard, other than alliance policy forms, non-standard
19 policy forms and alliance policy forms for the previous calendar
20 year, provided that a carrier may annually report the loss ratio
21 calculated pursuant to this section for all of the alliances in the
22 aggregate or separately for each alliance. In each case where the
23 loss ratio fails to substantially comply with the 80% loss ratio
24 requirement, the carrier shall issue a dividend or credit against
25 future premiums for all policyholders with the standard, other than
26 alliance policy forms, nonstandard policy forms or alliance policy
27 forms, as applicable, in an amount sufficient to assure that the
28 aggregate benefits paid in the previous calendar year plus the
29 amount of the dividends and credits shall equal 80% of the
30 aggregate premiums collected for the respective policy forms in the
31 previous calendar year. All dividends and credits must be
32 distributed by December 31 of the year following the calendar year
33 in which the loss ratio requirements were not satisfied. The annual
34 report required by this paragraph shall include a carrier's calculation
35 of the dividends and credits applicable to standard, other than
36 alliance policy forms, non-standard policy forms and alliance policy
37 forms, as well as an explanation of the carrier's plan to issue
38 dividends or credits. The instructions and format for calculating
39 and reporting loss ratios and issuing dividends or credits shall be
40 specified by the commissioner by regulation. Such regulations shall
41 include provisions for the distribution of a dividend or credit in the
42 event of cancellation or termination by a policyholder. For
43 purposes of this paragraph, "alliance policy forms" means policies
44 purchased by small employers who are members of Small Employer
45 Purchasing Alliances.

46 (b) Commencing with the calendar year beginning January 1,
47 2018, and in each calendar year thereafter, for the purposes of
48 complying with its 80% loss ratio requirement, a health

1 maintenance organization shall include any amounts that the health
2 maintenance organization remitted during that calendar year in the
3 form of quarterly payments to the Department of Banking and
4 Insurance as part of its annual assessment pursuant to section 3 of
5 P.L.2004, c.49 (C.26:2J-47) as an addition to aggregate benefits in
6 the numerator of its loss ratio calculation. For purposes of including
7 these quarterly payments in the health maintenance organization's
8 loss ratio calculation, the quarterly payment amounts shall be
9 apportioned and attributed to the loss ratio requirements for
10 standard, other than alliance policy forms, non-standard policy
11 forms, and alliance policy forms in proportion to the premium
12 earned from each of these categories of policy forms.

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

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

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

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

23 k. A carrier who negotiates a reduced premium rate with a
24 Small Employer Purchasing Alliance for members of that alliance
25 shall provide a reduction in the premium rate filed in accordance
26 with paragraph (3) of subsection a. of this section, expressed as a
27 percentage, which reduction shall be based on volume or other
28 efficiencies or economies of scale and shall not be based on health
29 status-related factors.

30 (cf: P.L.2008, c.38, s.24)

31

32 4. This act shall take effect immediately.

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34

35

STATEMENT

36

37 This bill allows health maintenance organizations to include the
38 amounts that the health maintenance organizations remit as part of
39 their annual assessment for charity care in the calculation of
40 aggregate premiums returned in the form of aggregate benefits for
41 purposes of complying with their annual 80% loss ratio
42 requirements. Charity care payments are deposited in the Health
43 Care Subsidy Fund, which provides reimbursement to hospitals for
44 the care that they provide to indigent persons.

45 Currently, health maintenance organizations participating in the
46 Individual Health Coverage Program or the Small Employer Health
47 Benefits Program must ensure that at least 80% of premiums
48 collected for individual or small employer health benefits plans,

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13

1 respectively, are returned to the policy holders in the form of
2 aggregate benefits.

3 This bill provides that, commencing with the calendar year
4 beginning January 1, 2018, and in each calendar year thereafter, for
5 the purposes of complying with its 80% loss ratio requirement, a
6 health maintenance organization shall include any amounts that the
7 health maintenance organization remitted during that calendar year
8 in the form of quarterly payments to the Department of Banking and
9 Insurance as part of its annual assessment pursuant to section 3 of
10 P.L.2004, c.49 (C.26:2J-47) as an addition to aggregate benefits in
11 the numerator of its loss ratio calculation.

12 Finally, the bill modifies the definition of carrier, in the context
13 of the Small Employer Health Benefits Program, to clarify that all
14 affiliates of a carrier shall be treated as one carrier for the purpose
15 of loss ratio requirements and other statutory requirements
16 pertaining to the affiliates of carriers participating in that program.