State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
PO BOX 325
TRENTON, NJ 08625-0325
Tel (609) 292-5360

JAMES E. MCGREEVEY
Governor

HOLLY C. BAKKE
Commissioner

BULLETIN NO. 04-08

TO: **ALL NEW JERSEY HEALTH INSURANCE COMPANIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, HEALTH SERVICE CORPORATIONS, HEALTH MAINTENANCE ORGANIZATIONS, DENTAL SERVICE CORPORATIONS, DENTAL PLAN ORGANIZATIONS, AND OTHER INTERESTED PARTIES**

FROM: **HOLLY C. BAKKE, COMMISSIONER**

RE: **DOMESTIC PARTNERSHIP ACT, P.L. 2003, c. 246**

The Domestic Partnership Act, P.L. 2003, c. 246 (the Act), enacted on January 12, 2004, requires New Jersey health insurance carriers to offer policyholders the option to elect coverage for same-gender domestic partners of a covered person if the contract permits coverage for eligible dependents and is issued or renewed on or after July 10, 2004. The Department has made a preliminary determination that it is not necessary to promulgate rules to implement the Act at this time. If in the future information is received which indicates that rulemaking may be necessary, the Department will consider proposing rules at that time. The purpose of this Bulletin is to advise carriers of the Department's position concerning certain permissible and prohibited practices for coverage of domestic partners, and to address certain other issues raised by carriers concerning such coverage.

- Carriers may elect to offer opposite gender domestic partner coverage. While the Act does not require that such coverage be offered, it does not prohibit carriers from offering domestic partner coverage that is broader in scope than that required by the Act.

- Coverage must be offered for children of domestic partners. The intent of the Act is to treat domestic partners of covered persons as spouses for purposes of providing health insurance coverage. Accordingly, if a spouse's natural, adoptive or stepchildren would be covered, the domestic partner's children would also be covered. It is not necessary for the domestic partner to elect coverage in order for the domestic partner's children to be eligible for coverage.

- In the case of employer-provided coverage, carriers must make the required offer of coverage to the employer, and not to the individual covered employees. Employer-provided coverage includes coverage under a group contract between an insurer and an employer or, where permitted, a multi-employer trust or other multi-employer arrangement. Employer-provided coverage may require the employee to contribute some portion or all of the cost of the coverage.

New Jersey's law against unfair discrimination and trade practices in the business of health insurance at N.J.S.A. 17B:30-12.d states that "No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such policy or contract, or in any other manner whatever." Rates for domestic partner coverage must also meet the rating and rate filing requirements applicable to specific carriers and markets, and may not be excessive. Additionally, the stated intent of the Act is to provide eligible domestic partners with health benefits in the same manner as for spouses. Following are certain permissible and prohibited rating practices for coverage of domestic partners:

- Carriers may calculate rates for coverage of domestic partners as if the domestic partner were the spouse of the covered person by using existing rates for coverage of dependents. This method must be used in the small employer market because the Small Employer Health Benefits Law (SEH law) specifies the types of dependent coverage, and does not allow for any variation in rates other than for the type of coverage, age, gender and location.

- Carriers may use separate rating categories for dependent coverage including spouse, and for dependent coverage including domestic partners or children of domestic partners. This method is not permitted in the SEH market. Any rate difference must be reasonably related to the actual or expected difference between claims for spouses and claims for domestic partners. The Commissioner may require an explanation of any such rate difference, or a demonstration that the rate difference is not unfairly discriminatory.

- Carriers may not use a rate factor that increases the total premium under a group contract based only on the availability of domestic partner coverage.

- Carriers may not charge a higher rate for domestic partners on the basis of the cost of modifying administrative systems to accommodate the enrollment or coverage of domestic partners.

- Carriers may not charge rates for domestic partners that are excessive in relation to rates for the coverage of spouses and that would effectively negate the offer of domestic partner coverage mandated by the Act.

Questions concerning this Bulletin should be directed to:

Gale Simon, Assistant Commissioner
Life & Health
NJ Department of Banking & Insurance
P.O. Box 325
Trenton, New Jersey 08625-0325
Email: gsimon@dobi.state.nj.us
FAX: 609-633-0527

5/14/04
Date

/s/ Holly C. Bakke
Holly C. Bakke, Commissioner

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