SENATE, No. 419

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1978 SESSION

By Senators HAGEDORN, SCARDINO, DUMONT, HIRKALA, SKEVIN, VREELAND and LIPMAN

AN ACT providing equality of regulation among health insurers, and supplementing Title 17B of the New Jersey Statutes.

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

1. To provide equality of regulation among all health insurers, which shall include insurers authorized to transact the business of health insurance pursuant to Title 17B of the New Jersey Statutes and hospital service corporations authorized pursuant to P. L. 1938, c. 366 (C. 17:48–1 et seq.), in the following particulars:

a. (1) No health insurer shall issue an individual, group or blanket health insurance policy, contract or certificate unless and until a copy of the form thereof, and of all applications, riders and endorsements for use in connection therewith, shall have been submitted to and filed by the Commissioner of Insurance.

(2) The Commissioner of Insurance may disapprove such form on the ground that:

(a) It contains provisions which are unjust, unfair, inequitable, misleading or contrary to law or to the public policy of this State, or

(b) It is sold in such a manner as to mislead the public.

b. (1) Every health insurer shall, before using or applying any premium rates, file with the Commissioner of Insurance the full schedule of such rates or a copy of the rating system or formula upon which such rates are based or by which such rates are fixed or determined.

(2) The Commissioner of Insurance may disapprove a filing made pursuant to subsection b., (1) if he finds that the premium rates are excessive, inadequate or unfairly discriminatory.

(3) Whenever a rating system or formula which includes (a) a community charge, or (b) a conversion charge, or (c) a risk charge, or (d) a reserve charge, or (e) such other socioeconomic factors as the Commissioner of Insurance may consider appropriate, including, but not limited to, age, sex, geography and industry classification shall be approved by the Commissioner of Insurance, it shall be applied uniformly among all health insurers.

c. (1) Every health insurer's practices, rules and procedures involving termination or refusal to renew coverage, modification of coverage or rates in the case of persons classified as left-group, selection of risks, and underwriting classifications shall be subject to review at any time by the Commissioner of Insurance, and, upon his request for information relative to any such practice, rule or procedure, each health insurer shall furnish such information in writing without delay. If in the opinion of the Commissioner of Insurance any such practice, rule or procedure is unjust, unfair or inequitable, he shall so notify the health insurer and fix a time and place for hearing before him or his designated representative at which the health insurer may be heard. Following such hearing, the Commissioner of Insurance may make an order based on the record of the proceeding. If such order be one of disapproval, it shall be unlawful for the insurer to continue such practice, rule or procedure. Such disapproval by the Commissioner of Insurance shall be subject to review by the Superior Court in a proceeding in lieu of prerogative writ.

(2) Any order by the Commissioner of Insurance regarding selection of risks shall apply to all health insurers in the same manner and without discrimination as between carriers.

d. For policies and contracts delivered or issued for delivery in this State, each health insurer shall, on April 1 of each year, pay a general supervisory fee to the Commissioner of Insurance of $0.02 per insured covered under policies or contracts, other than group policies or contracts, at the end of the preceding year plus $0.02 per member or employee covered under group or blanket policies or contracts at the end of the preceding year, effective with the April 1 next following the effective date of this act.

2. This act shall take effect immediately.

STATEMENT

The purpose of this bill is to require equality of regulation among all health insurers in transacting the business of health insurance whether authorized pursuant to Title 17B of the New Jersey Statutes or pursuant to P. L. 1938, c. 366 (C. 17:48–1 et seq.).

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

STATEMENT TO
SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 419

STATE OF NEW JERSEY

DATED: MAY 22, 1978

The Senate Committee Substitute for Senate Bill No. 419 would allow hospital service plans to operate more competitively. A more favorable competitive climate would be fostered for Blue Cross, and other hospital service plans, by permitting the following: (1) "wrap-around" coverage; (2) reduction and minimum group contracts from 100 to 50 employees or members and incorporation of claim costs and utilization trend factors in rate formulas; and, (3) maintenance of a special contingent surplus of 5% of the yearly net premium income.

The first change would permit Blue Cross, and other hospital service plans, to offer indemnity contracts for whole or partial payment of health care services as well as the service benefit contracts now provided. In up to 20% of these indemnity contracts, deductible options may exceed $1,000.00 or such higher amount as the Commissioner of Insurance may permit by regulation and co-insurance may exceed 30% of the total amount billed for covered health care service.

The second major provision of the committee substitute reduces the size of groups contracts from 100 to 50 employees or members and allows a hospital service plan such as Blue Cross to incorporate such factors as claim costs and utilization trends as it deems necessary in determining rate formulas, provided that the rates so determined are self-supporting and that the formulas do not unduly prejudice the interests of persons who are eligible for hospital service contracts which are not experience rated. Furthermore, the Commissioner of Insurance is authorized to assure continuity of rating principles between experience rated groups of 50 to 99 and community rated and experience rated groups of 100 or more. Such authority is given to insure that rates for these two groups are not unduly disparate.

The last major provision of the substitute allows hospital service corporations to accumulate and maintain a special contingent surplus over and above its reserves and liabilities at 5% of the net premium income received during any calendar year. If such surplus shall deviate from the amount required to be maintained by more than 2% of the aggregated amount of the net premium income received during

that year, however, the Commissioner of Insurance shall approve and promulgate a plan to return such surplus to the amount required to be maintained within two years from the date of implementation of the plan. Furthermore, this section shall not take effect until January 1, 1981. The delayed effective date of implementation of the 5% surplus was adopted to allow Blue Cross to utilize the $27 million surplus accumulated this year and the $50 million surplus estimated for next year. This would minimize the possibility of an increase in Blue Cross premium rates for the first few years in which a hospital rate setting act, such as Senate Bill No. 446, would be in effect.

The committee recommends that this bill and Senate Bill No. 446 with Senate committee amendments be treated as companion measures and moved simultaneously through the Legislative process.

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 419

STATE OF NEW JERSEY

ADOPTED MAY 22, 1978

AN ACT to amend "An act concerning hospital service corporations and regulating the establishment, maintenance and operation of hospital service plans, and supplementing Title 17 of the Revised Statutes by adding thereto a new chapter entitled 'Hospital Service Corporations,'" approved June 14, 1938 (P. L. 1938, c. 366).

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

1. Section 1 of P. L. 1938, c. 366, (C. 17:48–1) is amended to read as follows:

1. A hospital service corporation is hereby declared to be any corporation organized, without capital stock and not for profit, for the purpose of establishing, maintaining and operating a non-profit hospital service plan. A hospital service plan is hereby defined as a plan **[**whereby health care services are provided by**]** *whereunder service benefit contracts are issued providing complete prepayment or postpayment of eligible health care services and supplies for a given period to persons covered under such contracts, and arrangements are made for payment for such health care services and supplies directly to the provider thereof, including but not limited to, health care facilities and other suppliers of health care services; in addition, hospital service corporations may issue contracts providing for whole or partial payment for health care services and supplies furnished to persons covered under such contracts; provided, however, that not more than 20% of persons covered by other than service benefit contracts may be covered by contracts which include deductible options exceeding $1,000.00 or such higher amount as the Commissioner of Insurance may permit by regulation, or co-insurance exceeding 30% of the total amount billed for covered health care services or supplies. Arrangements may be made for payment for such health care services and supplies directly to the provider thereof, including but not limited to, health*

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

care facilities and other suppliers of health care services, or to the subscribers under such contracts. Such providers or suppliers may include but are not limited to:

(a) A hospital service corporation*;* [or by] *(b)* a health care facility with which the corporation has a contract for such health care services *or supplies* to persons who become subscribers under contracts with the corporation[.]*;* [Health care services provided by a hospital service corporation shall include health care provided (a) through] *(c)* a health care facility which is maintained by a State or any of its political subdivisions; [(b) through] *(d)* a health care facility licensed by the Department of Health; [(c) through] *(e)* such other health care facilities as shall have been designated by the Department of Health for health care services; [(d) through] *(f)* health care facilities located in other States, which are subject to the supervision of such other States provided that such last mentioned health care facilities, if they were *to be* located in this State, would be eligible to be licensed or designated by the Department of Health; [(e) through] *or (g)* nonprofit hospital service plans of other states approved by the Commissioner of Insurance.

2. Section 1 of P. L. 1970, c. 111, (C. 17:48–6.9) is amended to read as follows:

1. Any group contract, covering at least [100] *50* employees or members, may provide for the adjustment of the rate of premium at the end of the first year or any subsequent year of insurance thereunder based on the experience thereunder both past and contemplated. No hospital service corporation shall use any form of experience rating plan until it shall have filed with the commissioner the formulas to be used and the classes of groups to which they are to apply. The commissioner may disapprove the formulas or classes at any time if he finds that the rates produced thereby are excessive, inadequate or unfairly discriminatory or that the formulas or classes are such as to prejudice the interests of persons who are eligible for hospital services under contracts with the hospital service corporation which are not subject to experience rating.

Excluding those rating formulas applicable to groups the employees or members of which are located in more than one state and which are underwritten in participation with other corporation(s) of other state(s), no rating formula shall be approved by the commissioner unless it provides that the experience rated groups will be assessed a reasonable community charge. Any such

rating formula may provide for the allowance of an equitable discount in the event the policyholder agrees to perform certain administrative and record keeping functions in connection with the routine maintenance of the group account.

Nothing in this section shall preclude the hospital service corporation from incorporating in the rate formula such claim cost and utilization trend factors as it deems necessary in its discretion so long as the rates produced are self-supporting and the formulas for classes do not prejudice the interests of persons who are eligible for hospital services under contracts with the hospital service corporation which are not subject to experience rating.

For experience rated groups of 50 to 99 employees or members, the commissioner will have the authority to determine that rates charged depart from community rates in such a way as to assure continuity of rating principles with the community rated and experience rated groups of 100 or more.

3. Section 10 of P. L. 1938, c. 366, (C. 17:48–10) is amended to read as follows:

10. No corporation subject to the provisions of this chapter shall during any one year disburse more than 10% of the aggregate amount of the payments received from subscribers during that year as expenditures for the soliciting of subscribers, except that during the first year after the issuance of a certificate of authority such corporation may so disburse not more than 20% of such amount and during the second year not more than 15%.

No such corporation shall, during any one year, disburse a sum greater than 20% of the payments received from subscribers during that year as administrative expenses. The term, "administrative expenses," as used in this section, shall include all expenditures for nonprofessional services and in general all expenses not directly connected with the furnishing of hospital services, but not including expenses of soliciting subscribers.

The funds of any hospital service corporation may be invested only in accordance with the requirements now or hereafter provided by law for the investment of funds of life insurance companies. Every hospital service corporation after the first full calendar year of doing business after the effective date of this chapter, shall accumulate and maintain a special contingent surplus over and above its reserves and liabilities at the rate of 2% annually of its net premium income until such surplus shall be not less than $100,000.00 [except that no such corporation shall be required to maintain a special contingent surplus exceeding 55% of its average

annual premiums for the previous 5 years]. *Thereafter for any subsequent calendar year, such special contingent surplus shall be maintained at 5% of the net premium income received during that year as determined by reference to the statement of financial condition filed pursuant to R. S. 17:48–11. The special contingent surplus as herein provided shall be contributed by each of the following two categories: 1) community rated, excluding open enrollment and conversion groups; and 2) experience rated subscribers, in the ratio that the net premium income of each category bears to the total net premium income of the corporation and by contributions from the category that gives rise to a diminution of the surplus required to be maintained under this act. Whenever it shall appear that such special contingent surplus has deviated from the amount required to be maintained by more than 2% of the aggregate amount of the net premium income received during that year, the Commissioner of Insurance shall approve and promulgate a plan reasonably calculated to return such special contingent surplus to the amount required to be maintained, within 2 years from the date of implementation of the plan specified above. Approved and promulgation of said plan by the Commisisoner of Insurance shall not abrogate the responsibilities of corporate officers with regard to the reporting of financial conditons pursuant to section 11 of the act which this act amends.*

4. Sections 1 and 2 of this act shall take effect immediately; section 3 shall take effect on January 1, 1981.

SENATE AMENDMENT TO
SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 419

STATE OF NEW JERSEY

ADOPTED JUNE 8, 1978

Amend page 4, section 3, line 29, omit "5%", insert "2½%".

CHAPTER 94 LAWS OF N. J. 1978
APPROVED 8-2-78

[OFFICIAL COPY REPRINT]
SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 419

STATE OF NEW JERSEY

ADOPTED MAY 22, 1978

AN ACT to amend "An act concerning hospital service corporations and regulating the establishment, maintenance and operation of hospital service plans, and supplementing Title 17 of the Revised Statutes by adding thereto a new chapter entitled 'Hospital Service Corporations,' " approved June 14, 1938 (P. L. 1938, c. 366).

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care facilities and other suppliers of health care services, or to the subscribers under such contracts. Such providers or suppliers may include but are not limited to:

(a) A hospital service corporation*;* [or by] *(b)* a health care facility with which the corporation has a contract for such health care services *or supplies* to persons who become subscribers under contracts with the corporation[.]*;* [Health care services provided by a hospital service corporation shall include health care provided (a) through] *(c)* a health care facility which is maintained by a State or any of its political subdivisions; [(b) through] *(d)* a health care facility licensed by the Department of Health; [(c) through] *(e)* such other health care facilities as shall have been designated by the Department of Health for health care services; [(d) through] *(f)* health care facilities located in other States, which are subject to the supervision of such other States provided that such last mentioned health care facilities, if they were *to be* located in this State, would be eligible to be licensed or designated by the Department of Health; [(e) through] *or (g)* nonprofit hospital service plans of other states approved by the Commissioner of Insurance.

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1. Any group contract, covering at least [100] *50* employees or members, may provide for the adjustment of the rate of premium at the end of the first year or any subsequent year of insurance thereunder based on the experience thereunder both past and contemplated. No hospital service corporation shall use any form of experience rating plan until it shall have filed with the commissioner the formulas to be used and the classes of groups to which they are to apply. The commissioner may disapprove the formulas or classes at any time if he finds that the rates produced thereby are excessive, inadequate or unfairly discriminatory or that the formulas or classes are such as to prejudice the interests of persons who are eligible for hospital services under contracts with the hospital service corporation which are not subject to experience rating.

Excluding those rating formulas applicable to groups the employees or members of which are located in more than one state and which are underwritten in participation with other corporation(s) of other state(s), no rating formula shall be approved by the commissioner unless it provides that the experience rated groups will be assessed a reasonable community charge. Any such

rating formula may provide for the allowance of an equitable discount in the event the policyholder agrees to perform certain administrative and record keeping functions in connection with the routine maintenance of the group account.

Nothing in this section shall preclude the hospital service corporation from incorporating in the rate formula such claim cost and utilization trend factors as it deems necessary in its discretion so long as the rates produced are self-supporting and the formulas for classes do not prejudice the interests of persons who are eligible for hospital services under contracts with the hospital service corporation which are not subject to experience rating.

For experience rated groups of 50 to 99 employees or members, the commissioner will have the authority to determine that rates charged depart from community rates in such a way as to assure continuity of rating principles with the community rated and experience rated groups of 100 or more.

3. Section 10 of P. L. 1938, c. 366, (C. 17:48–10) is amended to read as follows:

10. No corporation subject to the provisions of this chapter shall during any one year disburse more than 10% of the aggregate amount of the payments received from subscribers during that year as expenditures for the soliciting of subscribers, except that during the first year after the issuance of a certificate of authority such corporation may so disburse not more than 20% of such amount and during the second year not more than 15%.

No such corporation shall, during any one year, disburse a sum greater than 20% of the payments received from subscribers during that year as administrative expenses. The term, "administrative expenses," as used in this section, shall include all expenditures for nonprofessional services and in general all expenses not directly connected with the furnishing of hospital services, but not including expenses of soliciting subscribers.

The funds of any hospital service corporation may be invested only in accordance with the requirements now or hereafter provided by law for the investment of funds of life insurance companies. Every hospital service corporation after the first full calendar year of doing business after the effective date of this chapter, shall accumulate and maintain a special contingent surplus over and above its reserves and liabilities at the rate of 2% annually of its net premium income until such surplus shall be not less than $100,000.00 [except that no such corporation shall be required to maintain a special contingent surplus exceeding 55% of its average

annual premiums for the previous 5 years]. *Thereafter for any subsequent calendar year, such special contingent surplus shall be maintained at* *[*5%*]* **2 1/2%** *of the net premium income received during that year as determined by reference to the statement of financial condition filed pursuant to R. S. 17:48–11. The special contingent surplus as herein provided shall be contributed by each of the following two categories: 1) community rated, excluding open enrollment and conversion groups; and 2) experience rated subscribers, in the ratio that the net premium income of each category bears to the total net premium income of the corporation and by contributions from the category that gives rise to a diminution of the surplus required to be maintained under this act. Whenever it shall appear that such special contingent surplus has deviated from the amount required to be maintained by more than 2% of the aggregate amount of the net premium income received during that year, the Commissioner of Insurance shall approve and promulgate a plan reasonably calculated to return such special contingent surplus to the amount required to be maintained, within 2 years from the date of implementation of the plan specified above. Approval and promulgation of said plan by the Commissioner of Insurance shall not abrogate the responsibilities of corporate officers with regard to the reporting of financial conditons pursuant to section 11 of the act which this act amends.*

4. Sections 1 and 2 of this act shall take effect immediately; section 3 shall take effect on January 1, 1981.

ASSEMBLY INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 419

STATE OF NEW JERSEY

DATED: JUNE 19, 1978

The committee agrees with the provisions of the Senate Committee Substitute for Senate Bill No. 419. This bill would allow Blue Cross to: (1) have greater underwriting flexibility; (2) have group enrollment reduced to 50 members as well as the incorporation of claim costs and utilization trend factors in rate formulas; and, (3) maintain a special contingent surplus of 2½% of the yearly net premium income.

The committee has closely followed this legislation and its companion measure, Senate Bill No. 446, when it was in the Senate Institutions, Health and Welfare Committee. The committee released this bill without amendment.

FROM THE OFFICE OF THE GOVERNOR

FOR RELEASE IMMEDIATELY

AUGUST 4, 1978

FOR FURTHER INFORMATION

ANNE BURNS

Governor Brendan Byrne has signed into law the Senate Committee Substitute for S-419, sponsored by Senator Garrett Hagedorn (R-Bergen) which allows hospital service plans to operate more competitively.

Prior to the enactment of the hospital rate-setting bill, Blue Cross paid hospital rates which were 26 percent lower than rates paid by commercial insurers. With the enactment of the rate-setting legislation, this discount was substantially reduced. S-419 makes three changes in the functioning of hospital service plans to allow them to remain competitive with commercial insurers.

The first change permits Blue Cross and other hospital service plans to offer indemnity contracts for whole or partial payment of health care services as well as the service benefits contracts now provided.

The second provision reduces the minimum size of group contracts from 100 to 50 employees. It also allows hospital service plans to incorporate factors such as claim costs and utilization trends in determining rate formulas.

The last major provision of the bill permits hospital service corporations to accumulate and maintain a special contingent surplus over and above its reserves and liabilities at a rate of 2.5 percent of the net premium income received during any calendar year. This section of the legislation will take effect January 1, 1981.

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11 erage for profit;

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