17B:27A-4

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(Health insurers)

NJSA: 17B:27A-4

LAWS OF: 1994 **CHAPTER:** 102

BILL NO: A1081

SPONSOR(S): Felice

DATE INTRODUCED: January 24, 1994

COMMITTEE: **ASSEMBLY:** Insurance

SENATE: ----

AMENDED DURING PASSAGE: Yes Amendments during passage denoted by superscript numbers

DATE OF PASSAGE: **ASSEMBLY:** January 27, 1994

SENATE: June 30, 1994

DATE OF APPROVAL: August 11, 1994

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:

SPONSOR STATEMENT: Yes

COMMITTEE STATEMENT: **ASSEMBLY:** Yes

SENATE: No

FISCAL NOTE: No

VETO MESSAGE: No

MESSAGE ON SIGNING: No

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

KBG:pp

[FIRST REPRINT]

ASSEMBLY, No. 1081

STATE OF NEW JERSEY

INTRODUCED JANUARY 24, 1994

By Assemblyman FELICE

AN ACT concerning individual health benefits plans and amending P.L.1992, c.161.

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

1. Section 3 of P.L.1992, c.161 (C.17B:27A-4) is amended to read as follows:

3. a. No later than 180 days after the effective date of this act, a carrier shall, as a condition of issuing health benefits plans in this State, offer individual health benefits plans. The plans shall be offered on an open enrollment, community rated basis, pursuant to the provisions of this act; except that a carrier shall be deemed to have satisfied its obligation to provide the individual health benefits plans by paying an assessment or receiving an exemption pursuant to section 11 of this act.

b. A carrier shall offer to an eligible person a choice of five individual health benefits plans, any of which may contain provisions for managed care. One plan shall be a basic health benefits plan, one plan shall be a managed care plan and three plans shall include enhanced benefits of proportionally increasing actuarial value. A carrier may elect to convert any individual [health benefits plans] <u>contract or policy forms</u> in force on the effective date of this act to any of the five benefit plans, except that <u>the carrier may not convert more than 25% of existing contracts or policies each year, and</u> the replacement plan shall be of no less actuarial value than the policy or contract being replaced.

Notwithstanding the provisions of this subsection to the contrary, at any time after three years after the effective date of this act, the board, by regulation, may reduce the number of plans required to be offered by a carrier.

Notwithstanding the provisions of this subsection to the contrary, a health maintenance organization which is a qualified health maintenance organization pursuant to the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C.§300e et seq.) shall be permitted to offer a basic health benefits plan in accordance with the provisions of that law in lieu of the five plans required pursuant to this subsection.

c. (1) A basic health benefits plan shall provide the benefits set forth in section 55 of P.L.1991, c.187 (C:17:48E-22.2), section 57 of P.L.1991, c.187 (C.17B:26B-2) or section 59 of P.L.1991, c.187 (C.26:2J-4.3), as the case may be.

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 <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
1 Assembly AIN committee amendments adopted June 13, 1994.

(2) Notwithstanding the provisions of this subsection or any other law to the contrary, a carrier may, with the approval of the board, modify the coverage provided for in sections 55, 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3, respectively) or provide alternative benefits or services from those required by this subsection if they are within the intent of this act or if the board changes the benefits included in the basic health benefits plan.

(3) A contract or policy for a basic health benefits plan provided for in this section may contain or provide for coinsurance or deductibles, or both, except that no deductible shall be payable in excess of a total of $250 by an individual or $500 by a family unit during any benefit year; and no coinsurance shall be payable in excess of a total of $500 by an individual or by a family unit during any benefit year.

(4) Notwithstanding the provisions of paragraph (3) of this subsection or any other law to the contrary, a carrier may provide for increased deductibles or coinsurance for a basic health benefits plan if approved by the board or if the board increases deductibles or coinsurance included in the basic health benefits plan.

(5) The provisions of section 13 of P.L.1985, c.236 (C:17:48E-13), N.J.S.17B:26-1, and section 8 of P.L.1973, c.337 (C.26:2J-8) with respect to the filing of policy forms shall not apply to health plans issued on or after the effective date of this act.

(6) The provisions of section 27 of P.L.1985, c.236 (C.17:48E-27) and section 7 of P.L.1988, c.71 (C.17:48E-27.1) with respect to rate filings shall not apply to individual health plans issued on or after the effective date of this act.

d. Every group conversion contract or policy issued after the effective date of this act shall be issued pursuant to this section; except that this requirement shall not apply to any group conversion contract or policy in which a portion of the premium is chargeable to, or subsidized by, the group policy from which the conversion is made.

e. If all five of the individual health benefits plans are not established by the board by the effective date of P.L.1993, c.164 (C.17B:27A-16.1 et al.), a carrier may phase-in the offering of the five health benefits plans by offering each health benefits plan as it is established by the board; however, once the board establishes all five plans, the carrier shall be required to offer the five plans in accordance with the provisions of P.L.1992, c.161 (C.17B:27A-2 et al.).

(cf: P.L.1993, c.164, s.3)

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

8. a. The board shall make application to the Hospital Rate Setting Commission on behalf of all carriers for approval of discounted or reduced rates of payment to hospitals for health care services provided under an individual health benefits plan provided pursuant to this act.

b. In addition to discounted or reduced rates of hospital payment, the board shall make application on behalf of all

carriers for any other subsidies, discounts, or funds that may be provided for under State or federal law or regulation. A carrier may include discounted or reduced rates of hospital payment and other subsidies or funds granted to the board to reduce its premium rates for individual health benefits plans subject to this act.

c. A carrier shall not issue individual health benefits plans on a new contract or policy form pursuant to this act until an informational filing of a full schedule of rates which applies to the contract or policy form has been filed with the board. The board shall forward the informational filing to the commissioner and the Public Advocate.

d. A carrier shall make an informational filing with the board of any change in its rates for individual health benefits plans pursuant to section 3 of this act prior to the date the rates become effective. The board shall file the informational filing with the commissioner and the Public Advocate. If the carrier has filed all information required by the board, the filing shall be deemed to be complete.

e. (1) Rates shall be formulated on contracts or policies required pursuant to section 3 of this act so that the anticipated minimum loss ratio for a contract or policy form shall not be less than 75% of the premium. The carrier shall submit with its rate filing supporting data, as determined by the board, and a certification by a member of the American Academy of Actuaries, or other individuals acceptable to the board and to the commissioner, that the carrier is in compliance with the provisions of this subsection.

(2) Following the close of each calendar year, if the board determines that a carrier's loss ratio was less than 75% for that calendar year, the carrier shall be required to refund to policy or contract holders the difference between the amount of net earned premium it received that year and the amount that would have been necessary to achieve the 75% loss ratio.

f. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed pursuant to this section by a carrier which insured at least 50% of the community-rated individually insured persons on the effective date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required to produce a loss ratio which when combined with the carrier's administrative costs and investment income results in self-sustaining rates prior to January 1, 1996, for individual policies or contracts issued prior to August 1, 1993. The carrier shall, not later than [1][April 1, 1994] 30 days after the effective date of P.L. , c. (C.)(pending before the Legislature as this bill)[1], file with the board for approval, a plan to achieve this objective.

(cf: P.L.1992, c.161, s.8)

3. This act shall take effect immediately.

Clarifies loss ratio requirements for certain individual insurance carriers.

carriers for any other subsidies, discounts, or funds that may be provided for under State or federal law or regulation. A carrier may include discounted or reduced rates of hospital payment and other subsidies or funds granted to the board to reduce its premium rates for individual health benefits plans subject to this act.

c. A carrier shall not issue individual health benefits plans on a new contract or policy form pursuant to this act until an informational filing of a full schedule of rates which applies to the contract or policy form has been filed with the board. The board shall forward the informational filing to the commissioner and the Public Advocate.

d. A carrier shall make an informational filing with the board of any change in its rates for individual health benefits plans pursuant to section 3 of this act prior to the date the rates become effective. The board shall file the informational filing with the commissioner and the Public Advocate. If the carrier has filed all information required by the board, the filing shall be deemed to be complete.

e. (1) Rates shall be formulated on contracts or policies required pursuant to section 3 of this act so that the anticipated minimum loss ratio for a contract or policy form shall not be less than 75% of the premium. The carrier shall submit with its rate filing supporting data, as determined by the board, and a certification by a member of the American Academy of Actuaries, or other individuals acceptable to the board and to the commissioner, that the carrier is in compliance with the provisions of this subsection.

(2) Following the close of each calendar year, if the board determines that a carrier's loss ratio was less than 75% for that calendar year, the carrier shall be required to refund to policy or contract holders the difference between the amount of net earned premium it received that year and the amount that would have been necessary to achieve the 75% loss ratio.

f. Notwithstanding the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) to the contrary, the schedule of rates filed pursuant to this section by a carrier which insured at least 50% of the community-rated individually insured persons on the effective date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required to produce a loss ratio which when combined with the carrier's administrative costs and investment income results in self-sustaining rates prior to January 1, 1996, for individual policies or contracts issued prior to August 1, 1993. The carrier shall, not later than April 1, 1994, file with the board for approval, a plan to achieve this objective.

(cf: P.L.1992, c.161, s.8)

3. This act shall take effect immediately.

STATEMENT

This bill limits an insurance carrier who choses to convert individual health insurance policies or contracts that were in effect prior to November 30, 1992 to one of the five health

benefits plans adopted by the New Jersey Individual Health Coverage Program effective August 1, 1993, to converting no more than 25% of the policies each year.

The bill also provides that for individual policies or contracts issued prior to August 1, 1993, the schedule of rates filed by a carrier which insured at least 50% of the community-rated individually insured persons on the effective date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required to produce a loss ratio which, when combined with the carrier's administrative costs and investment income, results in self-sustaining rates prior to January 1, 1996. The bill also requires a carrier to file a plan to achieve self-sustaining rates with the New Jersey Individual Health Coverage Program Board, for approval, not later than April 1, 1994.

Clarifies loss ratio requirements for certain individual insurance carriers.

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1081

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 13, 1994

The Assembly Insurance Committee reports favorably and with committee amendments Assembly Bill No. 1081.

As amended by the committee, this bill limits an insurance carrier who chooses to convert individual health insurance policies or contracts that were in effect prior to November 30, 1992 to one of the five health benefits plans adopted by the New Jersey Individual Health Coverage Program effective August 1, 1993, to converting no more than 25% of the policies each year.

The bill also provides that for individual policies or contracts issued prior to August 1, 1993, the schedule of rates filed by a carrier which insured at least 50% of the community-rated individually insured persons on the effective date of P.L.1992, c.161 (C.17B:27A-2 et seq.) shall not be required to produce a loss ratio which, when combined with the carrier's administrative costs and investment income, results in self-sustaining rates prior to January 1, 1996. The committee amended the bill to require a carrier to file a plan to achieve self-sustaining rates with the New Jersey Individual Health Coverage Program Board 30 days after the effective date of the bill. The bill originally required a carrier to file such a plan with the board by April 1, 1994. As amended, the bill is identical to Senate, No. 937.