§§1-13 -
C.17B:27A-10.1
to 17B:27A-10.13
§14 - Note

P.L. 2018, CHAPTER 24, ***approved May 30, 2018***
Senate Committee Substitute for
Senate, No. 1878

AN ACT concerning health insurance premiums and supplementing P.L.1992, c.161 (C.17B:27A-2 et seq.).

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

1. This act shall be known and may be cited as the "New Jersey Health Insurance Premium Security Act."

2. It is the intent of the Legislature to stabilize or reduce premiums in the individual health insurance market by providing reinsurance payments to health insurance carriers with respect to claims for eligible individuals. The Commissioner of Banking and Insurance, and the board of directors of the New Jersey Individual Health Coverage Program, are authorized to apply for, accept and receive federal funds to implement and sustain market stabilization programs. Preliminary planning, analysis, and implementation to effectuate the purposes of this act shall continue under the direction of the commissioner and the board.

3. For the purposes of this act:

"Affiliated carrier" means the same as defined in N.J.A.C.11:20-1.2.

"Affordable Care Act" or "PPACA" means the federal Patient Protection and Affordable Care Act, Pub.L.111-148, as amended by the federal "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, and any federal rules and regulations adopted pursuant thereto.

"Attachment point" means an amount as provided in subsection h. of section 4 of this act.

"Benefit year" means the calendar year for which an eligible carrier provides coverage through an individual health benefits plan.

"Board" means the board of directors of the New Jersey Individual Health Coverage Program established pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.).

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefits plan, including a sickness and accident

insurance company, a health maintenance organization, a hospital, medical or health service corporation, or any other entity providing a health benefits plan. For purposes of this act, carriers that are affiliated carriers shall be treated as one carrier.

"Paid claim" means a claim by a covered person for payment of benefits under a health benefits plan for which the financial obligation for the payment of the claim under the contract rests upon and has been paid by the carrier, excluding claims adjustment expenses.

"Coinsurance rate" means the rate as provided in subsection i. of section 4 of this act.

"Commissioner" means the Commissioner of Banking and Insurance.

"Department" means the Department of Banking and Insurance.

"Eligible carrier" means a carrier that offers individual health benefits plans in the State.

"Fund" means the New Jersey Health Insurance Premium Security Fund created pursuant to section 10 of this act.

"Health benefits plan" means the same as that term is defined in section 1 of P.L.1992, c.161 (C.17B:27A-2).

"Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

"Plan" means the Health Insurance Premium Security Plan established pursuant to section 4 of this act.

"Reinsurance cap" means the threshold amount as provided in subsection j. of section 4 of this act.

"Reinsurance payment" means an amount paid by the board to an eligible carrier under the plan.

4. a. There is hereby established, and the board in consultation with the commissioner shall administer, the Health Insurance Premium Security Plan.

b. The board or commissioner may apply for any available federal funding for the plan. All funds received pursuant to an application for federal funding, assessed by the board pursuant this act, or otherwise dedicated to the fund shall be remitted to the State Treasurer and deposited in the fund.

c. The commissioner, in consultation with the board, shall collect data from carriers necessary to determine the reinsurance payment parameters and shall share this data with the board.

d. For each applicable benefit year, the board shall notify carriers, the commissioner, and the State Treasurer of the reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

e. On a quarterly basis during the applicable benefit year, the board shall provide each eligible carrier and the commissioner with the calculation of total reinsurance payment requests.

f. By November 1 of the year following the applicable benefit year, the State Treasurer shall disburse all applicable reinsurance payments to an eligible carrier.

g. The board, subject to the disapproval of the commissioner pursuant to section 5 of this act, shall design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market by achieving between a 10% and 20% reduction in what indicated premium rates would be for the applicable benefit year without the plan;

(2) will encourage increased participation in the individual market;

(3) mitigate the impact high-risk individuals have on premium rates in the individual market;

(4) take into account any federal funding available for the plan;

(5) take into account the total amount available to fund the plan; and

(6) encourage cost savings mechanisms related to the management of health care services.

h. The attachment point for the plan is the threshold amount for paid claims by an eligible carrier for an enrolled individual's covered benefits in a benefit year, beyond which the paid claims are eligible for reinsurance payments. The attachment point shall be set by the board, but shall not exceed the reinsurance cap.

i. The coinsurance rate for the plan is the rate at which the board will reimburse an eligible carrier for paid claims for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board.

j. The reinsurance cap is the amount for paid claims of an eligible carrier for an enrolled individual's covered benefits, above which the paid claims for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board.

5. The board shall propose to the commissioner the payment parameters for the next benefit year by April 30 of the year before the applicable benefit year. The commissioner shall have 15 days to review the payment parameters. If the commissioner takes no affirmative action to disapprove the payment parameters within that time the proposed payment parameters are final and effective.

6. a. Each reinsurance payment shall be calculated with respect to an eligible carrier's paid claims for an individual enrollee's covered benefits in the applicable benefit year. If the paid claims do not exceed the attachment point, a reinsurance payment shall not be made. If the paid claims exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the paid claims minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

b. The board shall ensure that reinsurance payments made to eligible carriers do not exceed the total amount paid by the eligible carrier for any eligible claim. "Total amount paid" means the amount paid by the eligible carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under section 7 of this act.

7. a. An eligible carrier shall submit a request to the board for reinsurance payments when the eligible carrier's total amount paid for an enrollee meet the criteria for reinsurance payments.

b. An eligible carrier shall make requests for reinsurance payments in accordance with any requirements established by the board.

c. An eligible carrier shall calculate the premium amount the carrier would have charged for the applicable benefit year if the plan was not in effect and submit this information as part of its rate filing.

d. An eligible carrier shall maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six years. An eligible carrier shall also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

e. (1) At least once every five years the board shall engage an independent audit firm to audit eligible carriers that receive reinsurance payments to assess compliance with the requirements of this act. The eligible carrier shall cooperate with an audit. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this act or overpayment of reinsurance payments in the audited benefit years, the eligible carrier may respond to the draft audit report within 30 days of the draft audit report's issuance.

(2) Within 30 days of the issuance of the final audit report, if the final audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement of this act or overpayment of reinsurance payments in the audited benefit years, the eligible carrier shall:

(a) provide a written corrective action plan to the board for approval, that includes recoupment of any reinsurance overpayments;

(b) upon board approval, implement the corrective action plan described; and

(c) provide the board with documentation of the corrective actions taken.

8. The board shall keep an accounting for each benefit year, including but not limited to, the following:

a. funds appropriated for reinsurance payments and administrative and operational expenses;

b. requests for reinsurance payments received from eligible carriers;

c. reinsurance payments made to eligible carriers; and

d. administrative and operational expenses incurred for the plan.

9. The commissioner shall apply to the United States Secretary of Health and Human Services under 42 U.S.C. 18052 for a waiver of applicable provisions of the Affordable Care Act with respect to health insurance coverage in the State for a plan year beginning on or after January 1, 2019, to effectuate the provisions of this act. If the waiver is approved, the commissioner may accept the waiver so long as the commissioner determines that implementation of the plan:

a. will be beneficial to policyholders; and

b. is expected to stabilize or reduce premiums in the individual health insurance market through a reduction in what indicated premium rates would be without the plan.

If the commissioner accepts the waiver, the commissioner and the board shall implement the plan to meet the waiver requirements in a manner consistent with federal and State law, as approved by the United States Secretary of Health and Human Services, and consistent with the provisions of this act. The commissioner may contract for actuarial services as necessary to implement the waiver application required pursuant to this section.

10. a. The New Jersey Health Insurance Premium Security Fund is hereby created in the State Treasury for the purposes of this act. This fund shall be the repository for monies collected pursuant to this act and other monies received as grants in support of this act, or monies otherwise appropriated or directed to be remitted to the fund. The establishment of this fund, the funding sources contained herein, and the plan shall be contingent upon approval from the United States Secretary of Health and Human Services and the United States Secretary of the Treasury of a State Innovation Waiver application pursuant to section 1332 of the Affordable Care Act (C.42 U.S.C. 18052) and the commissioner's acceptance of any approval as provided in section 9 of this act.

b. All interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

c. The fund shall be funded to levels based upon actuarial analysis to stabilize or reduce premiums rates in the individual market achieving between a 10% and 20% reduction in what indicated rates would be for the applicable benefit year without the plan and to cover all necessary administrative costs of the reinsurance provided by the plan.

d. The fund shall be fully funded in accordance with this section by:

(1) All funds collected by the State pursuant to P.L. , c. (C.)(pending before the Legislature as Assembly Bill No. 3380 of 2018);

(2) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials; and

(3) For the purpose of providing the funds necessary to carry out the provisions of this act, and in amounts sufficient to ensure funding levels as required by this act after the monies received pursuant to paragraphs (1) and (2) of this subsection, there shall be appropriated annually out of the General Fund of the State an amount as the board, in consultation with the commissioner, determines necessary to fully fund the plan to accomplish the objectives of this act. The board, in consultation with the commissioner, shall calculate the amount necessary to cover the submitted reinsurance requests taking into account all federal waiver payments and other monies in the fund. The board shall issue an order memorializing those amounts and requesting the Legislature to appropriate that amount to the fund.

e. Moneys in the fund shall only be used for the purposes established in this act.

11. a. The board shall present an annual report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), which contains a summary of the operations of the Health Insurance Premium Security Plan and the impact of the plan on health insurance premiums. The report shall be made available to the public upon request and by posting on the department's website.

b. (1) The board shall engage and cooperate with an independent certified public accountant to perform an audit for each benefit year of the plan, in accordance with generally accepted auditing standards. The audit shall at a minimum:

(a) assess compliance with the requirements of this act; and

(b) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(2) The board, after receiving the completed audit, shall:

(a) provide the commissioner the results of the audit excluding any proprietary information;

(b) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board recommends to correct any such material weakness or significant deficiency in compliance with this subsection; and

(c) make available to the public a summary of the results of the audit by posting the summary on the department website and making the summary otherwise available, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency.

c. Documents, materials or other information that are in the possession or control of the commissioner or the board and that are obtained by or disclosed to the commissioner, the board, or any other person in the course of an examination or investigation made pursuant to this act shall be confidential by law and privileged and shall not be subject to disclosure or dissemination under P.L.1963, c.71 (C.47:1A-1 et seq.), or any other act. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the carrier.

12. If a carrier violates any provision of this act, the commissioner may, upon notice and hearing, assess a civil administrative penalty in an amount not less than $1,000 nor more than $10,000 for each day the carrier is in violation of this act. The penalty may be recovered in a summary proceeding pursuant to the “Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

13. The board, pursuant to section 8 of P.L.1993, c.164 (C.17B:27A-16.1), and the commissioner, pursuant to the “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.) and in consultation with each other, shall each adopt such rules and regulations as may be necessary to effectuate the purposes of this act.

14. This act shall take effect immediately, except that sections 1 through 8, 10 and 11 shall remain inoperative until the Commissioner of Banking and Insurance is granted and accepts a waiver pursuant to section 9 of this act, and the commissioner and the board may take any anticipatory administrative action in advance as necessary for the implementation of this act.

“New Jersey Health Insurance Premium Security Act;” establishes health insurance reinsurance plan.