[First Reprint]

SENATE, No. 1878

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED FEBRUARY 15, 2018

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)
Senator TROY SINGLETON
District 7 (Burlington)

SYNOPSIS

CURRENT VERSION OF TEXT
As reported by the Senate Commerce Committee on February 15, 2018, with amendments.

(Sponsorship Updated As Of: 2/16/2018)
AN ACT concerning health insurance premiums and supplementing

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 company" means a company in the same corporate
system as a parent, an industrial insured or a member organization by
virtue of common ownership, control, operation or management.1
“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, including a sickness and accident insurance company, a
health maintenance organization, a hospital, medical or health service
corporation, or any other entity providing a plan of health insurance,

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.
Matter enclosed in superscript numerals has been adopted as follows:
1Senate SCM committee amendments adopted February 15, 2018.
health benefits or health services. 1
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For purposes of this act, carriers
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that are affiliated companies shall be treated as one carrier.1
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“Claim” means a claim by a covered person for payment of
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benefits under a contract for which the financial obligation for the
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payment of the claim under the contract rests upon the carrier.
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“Coinsurance rate” means the rate as provided in subsection i. of
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section 4 of this act.
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“Commissioner” means the Commissioner of Banking and
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Insurance.
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“Department” means the Department of Banking and Insurance.
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"Eligible carrier" means a carrier that offers individual health
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benefits plans in the State.
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“Fund” means the New Jersey Health Insurance Premium Security
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Fund created pursuant to section 10 of this act.
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“Health benefits plan” means the same as that term is defined in
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"Payment parameters” means the attachment point, reinsurance
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cap, and coinsurance rate for the plan.
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“Plan” means the Health Insurance Premium Security Plan
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established pursuant to section 4 of this act.
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"Reinsurance cap” means the threshold amount as provided in
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subsection j. of section 4 of this act.
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"Reinsurance payment” means an amount paid by the board to an
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eligible carrier under the plan.
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“Third party administrator” means the same as that term is defined
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by section 1 of P.L.2001, c.267 (C.17B:27B-1).
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4.  a. There is hereby established, and the commissioner in
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consultation with the board shall administer, the Health Insurance
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Premium Security Plan.
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b. The commissioner may apply for any available
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federal funding for the plan. All funds received by or appropriated to
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the commissioner shall be deposited in the New Jersey
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Health Insurance Premium Security Fund.
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c. The commissioner shall collect data from carriers
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necessary to determine reinsurance payments.
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d. For each applicable benefit year, the commissioner shall notify carriers of reinsurance payments to be made for the
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applicable benefit year no later than June 30 of the year following the applicable benefit year.
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e. On a quarterly basis during the applicable benefit year, the
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commissioner shall provide each eligible carrier with the
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calculation of total reinsurance payment requests.
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f. By August 15 of the year following the applicable benefit year,
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the commissioner shall disburse all applicable reinsurance
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payments to an eligible carrier.
g. The [board] commissioner shall design and adjust the payment parameters to ensure the payment parameters:

1. will stabilize or reduce premium rates in the individual market;
2. will increase 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. include cost savings mechanisms related to the management of health care services.

h. The attachment point for the plan is the threshold amount for claims costs incurred by an eligible carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the [board at $50,000 or more] commission, but shall not exceed the reinsurance cap.

i. The coinsurance rate for the plan is the rate at which the [board] commissioner will reimburse an eligible carrier for claims incurred 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 at a rate between 50 and 70 percent] commissioner.

j. The reinsurance cap is the threshold amount for claims costs incurred by an eligible carrier for an enrolled individual's covered benefits, above which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the [board at $250,000 or less] commissioner.

5. a. The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall review and approve determine the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

b. If the amount in the fund is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the commissioner shall propose revise the payment parameters within the available appropriations. The commissioner shall permit an eligible carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

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

b. The °board© commissioner 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 of an
eligible claim" 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 subsection e. of section 7 of this act.

7. a. An eligible carrier shall request reinsurance payments when
the eligible carrier's claims costs for an enrollee meet the criteria for
reinsurance payments.
   b. An eligible carrier shall apply the payment parameters when
calculating amounts the carrier is eligible to receive from the plan.
   c. An eligible carrier shall make requests for reinsurance payments
in accordance with any requirements established by the board.
   d. 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.
   e. In order to receive reinsurance payments, an eligible carrier
shall provide the °board© commissioner with access to the data
within the dedicated data environment established by the eligible
carrier under the federal risk adjustment program under 42 U.S.C.
s.18063. Eligible carriers shall submit an attestation to the °board©
commissioner asserting compliance with the dedicated data
environments, data requirements, establishment and usage of masked
enrollee identification numbers, and data submission deadlines.
   f. An eligible carrier shall provide the access described in
subsection e. of this section for the applicable benefit year by April 30
of each year of the year following the end of the applicable benefit
year.
   g. 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.
   h. (1) The °board© commissioner may audit an eligible carrier
to assess its 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, 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, the eligible carrier shall:

(a) provide a written corrective action plan to the board commissioner for approval;
(b) upon the commissioner's approval, implement the corrective action plan described; and
(c) provide the commissioner with documentation of the corrective actions taken.

8. The commissioner shall keep an accounting for each benefit year of all:
   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 and the commissioner accepts the waiver, the commissioner, in consultation with the commissioner, 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. 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 or otherwise appropriated for the purposes of the 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 consist of all of the following:
(1) All moneys allocated by the State to effectuate the purposes of this act, including funds collected pursuant to subsection d. of this section; and

(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.

d. For the purpose of providing the funds necessary to carry out the provisions of this act, each carrier and third party administrator shall be assessed by the commissioner according to an assessment methodology, and in proportion to the claims paid by the carrier or processed by the third party administrator, as appropriate, for covered persons in this State and at a time and for an amount as the commissioner, in consultation with the board, finds necessary to implement this act. The commissioner may apply a uniform surcharge to all qualified health benefits plans, including plans administered by third party administrators, as the board determines necessary to effectuate the purposes of this act. The proceeds therefrom shall be deposited into the fund and be used only to pay for administrative and operational expenses that the board incurs in order to carry out its responsibilities pursuant to this act. The amount collected pursuant to this subsection shall not exceed the amount required to fund the plan, less any amounts in the fund received from other sources.

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

11. a. The commissioner 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.

b. The board shall submit to the commissioner and make available to the public an annual report summarizing the plan operations for each benefit year by posting the summary on the department website and making the summary otherwise available.

c. (1) The commissioner 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 commissioner, after receiving the completed audit, shall:
(a) provide the [commissioner] board\(^1\) the results of the audit excluding any proprietary information\(^4\);  
(b) require the board\(^1\) to identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board \(^1\) intends\(^6\) 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 \(\text{board}\) \(\text{commissioner}\)\(^4\) intends to correct the material weakness or significant deficiency.

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.).\(^1\)

13. The \(\text{board}\) \(\text{commissioner}\)\(^1\) shall 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 \(\text{and accepts}\)\(^4\) a waiver pursuant to section 9 of this act, and the commissioner may take any anticipatory administrative action in advance as necessary for the implementation of this act.