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STATE OF NEW JERSEY

218th LEGISLATURE

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Sponsored by:
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District 19 (Middlesex)
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SYNOPSIS

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

CURRENT VERSION OF TEXT

As reported by the Senate Budget and Appropriations Committee on March 5, 2018, with amendments.

(Sponsorship Updated As Of: 2/16/2018)

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:

[1][**]**"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 **[2]**<u>under a health benefits plan</u>**[2]**, including a sickness and accident insurance company, a health maintenance organization, a hospital, medical or health service corporation, or any other entity providing a **[2]**<u>health benefits</u>**[2]** plan **[2]**[**]**of health insurance, 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.

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SCM committee amendments adopted February 15, 2018.
[2]Senate SBA committee amendments adopted March 5, 2018.

benefits or health services]2. 1[For purposes of this act, carriers that are affiliated companies shall be treated as one carrier.]1

"Claim" means a claim by a covered person for payment of benefits under a contract for which the financial obligation for the payment of the claim under the contract rests upon the carrier.

"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 2 of P.L.1997, c.192 (26:2S-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.

"Third party administrator" means the same as that term is defined by section 1 of P.L.2001, c.267 (C.17B:27B-1).

4. a. There is hereby established, and the 1commissioner in consultation with1 the board shall administer, the Health Insurance Premium Security Plan.

b. The 1[board] commissioner1 may apply for any available federal funding for the plan. All funds received by or appropriated to the 1[board] commissioner1 shall be deposited in the New Jersey Health Insurance Premium Security Fund.

c. The 1[board] commissioner1 shall collect data from carriers necessary to determine reinsurance payments.

d. For each applicable benefit year, the 1[board] commissioner1 shall notify carriers of 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 1[board] commissioner1 shall provide each eligible carrier with the calculation of total reinsurance payment requests.

f. By August 15 of the year following the applicable benefit year, the 1[board] commissioner1 shall disburse all applicable reinsurance payments to an eligible carrier.

g. The [1][board] commissioner[1] 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 [1][board at $50,000 or more] commissioner[1], but [1]shall[1] not [1][exceeding] exceed[1] the reinsurance cap.

i. The coinsurance rate for the plan is the rate at which the [1][board] commissioner[1] 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 [1][board at a rate between 50 and 70 percent] commissioner[1].

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 [1][board at $250,000 or less] commissioner[1].

5. a. [1][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.][1] The commissioner shall [1][review and approve] determine[1] the payment parameters [1][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][1].

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, [1][the board, in consultation with][1] the commissioner [1][,][1] shall [1][propose] revise the[1] 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 [1]⟦board⟧ commissioner[1] 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 [1]⟦board⟧ commissioner[1] 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 [1]⟦board⟧ commissioner[1] 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 [1]⟦board⟧ commissioner[1] 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 [1]⟦board⟧ commissioner[1] for approval;

(b) upon [1]⟦board⟧ the commissioner's[1] approval, implement the corrective action plan described; and

(c) provide the [1]⟦board⟧ commissioner[1] with documentation of the corrective actions taken.

8. The [1]⟦board⟧ commissioner[1] 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. [1]⟦The board⟧ If the waiver is approved [2]⟦and⟧ ,[2] the commissioner [2]⟦accepts⟧ may accept[2] the waiver [2]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.

If the commissioner accepts the waiver[2] , the commissioner[1], in consultation with the [1]⟦commissioner⟧ board[1], 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. [1]The commissioner may contract for actuarial services as necessary to implement the waiver application required pursuant to this section.[1]

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 [1]**[**subsection d. of**]**[1] 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 [1]and third party administrator[1] shall be assessed by the commissioner [1]**[**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[1] at a time and for an amount as the commissioner, in consultation with the board, finds necessary to implement this act. [1]**[**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.**]**[1] The proceeds therefrom shall be deposited into the fund [1]**[**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**]**[1]. [1]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.[1]

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 [1]**[**board**]** commissioner[1] 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 [1]⟦board⟧ commissioner[1], after receiving the completed audit, shall:

(a) provide the [1]⟦commissioner⟧ board[1] the results of the audit [1]excluding any proprietary information[1];

(b) [1]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⟧ recommends[1] 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 [1]⟦board⟧ commissioner[1] intends to correct the material weakness or significant deficiency.

[2]d. Documents, materials or other information that are in the possession or control of the commissioner and 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.[2]

[1]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]

[1]⟦12.⟧ 13.[1] The [1]⟦board and the⟧[1] commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) and in consultation with [1]⟦each other⟧ the board[1], shall [1]⟦each⟧[1] adopt such rules and regulations as may be necessary to effectuate the purposes of this act.

[1]⟦13.⟧ 14.[1] 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 [1]and accepts[1] 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.