SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 1878

STATE OF NEW JERSEY

DATED: APRIL 5, 2018

The Senate Commerce Committee reports favorably a Senate Committee Substitute for Senate Bill No. 1878.

This substitute bill, entitled the "New Jersey Health Insurance Premium Security Act," directs the Commissioner of Banking and Insurance to apply for a federal waiver of certain provisions of the Affordable Care Act to support a reinsurance program to help stabilize premiums in the New Jersey individual health insurance market. If the waiver is granted and the commissioner accepts the waiver, the bill creates a reinsurance plan to be known as the Health Insurance Premium Security Plan.

The bill directs the commissioner to apply for a waiver from the United States Secretary of Health and Human Services with respect to health insurance coverage in the State for a plan year beginning on or after January 1, 2019. 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 board and 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, and consistent with the provisions of the bill. The commissioner may contract for actuarial services as necessary to implement the waiver application.

The bill directs the board to create payment parameters, including an attachment point, reinsurance cap, and coinsurance rate, which govern the plan's operation. 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 is to be set by the board, but shall not exceed the reinsurance cap.

The coinsurance rate for the plan is the rate at which the board 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.

The reinsurance cap is the amount for paid claims of 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.

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 paid claims minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

The board is directed to 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.

The board is also directed to undertake certain auditing and review functions to ensure the plan operates pursuant to the bill’s provisions.

The bill also creates the New Jersey Health Insurance Premium Security Fund in the State Treasury for the purposes of the bill. The fund shall be the repository for monies collected pursuant to the bill and other monies received as grants in support of the bill, or monies otherwise appropriated or directed to be remitted to the fund. The establishment of this fund, the funding sources contained in the bill, 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 and the commissioner’s acceptance of any approval as provided in section 9 of the bill.

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.

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.

The fund shall be fully funded 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 the bill, and in amounts sufficient to ensure funding levels as required by the bill after the monies received pursuant to the bill, there shall be appropriated annually an amount from the General Fund which the board, in consultation with the commissioner, determines necessary to fully fund the plan to accomplish the objectives of the bill. The board, in consultation with the commissioner, shall calculate the amount of the assessment 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.

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

The board must also report on the department's website certain information regarding the operation of the plan, including the results of an audit performed by an independent certified public accountant for each benefit year.

The bill also includes a penalty provision, which penalizes any carrier that violates any provision of the bill, in an amount not less than $1,000 nor more than $10,000 for each day the carrier is in violation of the bill.

If the State does not obtain a federal waiver to support reinsurance payments to health insurance carriers with respect to claims for eligible individuals, or if the commissioner does not accept the waiver, the provisions of the bill will remain inoperative. The bill's effective date reflects this provision.