ASSEMBLY, No. 1885

STATE OF NEW JERSEY

INTRODUCED MAY 6, 1996

By Assemblyman KRAMER

AN ACT concerning the New Jersey Individual Health Coverage Program and amending P.L.1992, c.161.

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

1. Section 11 of P.L.1992, c.161 (C.17B:27A-12) is amended to read as follows:

11. The board shall establish procedures for the equitable sharing of program losses among all members in accordance with their total market share as follows:

a. (1) By March 1, 1993 and following the close of each calendar year thereafter, on a date established by the board:

(a) every carrier issuing health benefits plans in this State shall file with the board its net earned premium for the preceding calendar year ending December 31; and

(b) every carrier issuing individual health benefits plans in the State shall file with the board the net earned premium on policies or contracts issued pursuant to paragraph (1) of subsection b. of section 2 and section 3 of this act and the claims paid and the administrative expenses attributable to those policies or contracts. If the claims paid and reasonable administrative expenses for that calendar year exceed the net earned premium and any investment income thereon, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this act. For the purposes of this subsection, "reasonable administrative expenses" shall be actual expenses or a maximum of 25% of premium, whichever amount is less.

(2) Every member shall be liable for an assessment to reimburse carriers issuing individual health benefits plans in this State which sustain net paid losses for the previous year, unless the member has received an exemption from the board pursuant to subsection d. of this section and has written a minimum number of non-group persons as provided for in that subsection. The assessment of each member shall be in the proportion that the net earned premium of the member for the

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

calendar year preceding the assessment bears to the net earned premium of all members for the calendar year preceding the assessment.

(3) A member that is financially impaired may seek from the commissioner a deferment in whole or in part from any assessment issued by the board. The commissioner may defer, in whole or in part, the assessment of the member if, in the opinion of the commissioner, the payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. If an assessment against a member is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessment set forth in this section. The member receiving the deferment shall remain liable to the program for the amount deferred.

b. The participation in the program as a member, the establishment of rates, forms or procedures, or any other joint or collective action required by this act shall not be the basis of any legal action, criminal or civil liability, or penalty against the program, a member of the board or a member of the program either jointly or separately except as otherwise provided in this act.

c. Payment of an assessment made under this section shall be a condition of issuing health benefits plans in the State for a carrier. Failure to pay the assessment shall be grounds for forfeiture of a carrier's authorization to issue health benefits plans of any kind in the State, as well as any other penalties permitted by law.

d. (1) Notwithstanding the provisions of this act to the contrary, a carrier may apply to the board, by a date established by the board, for an exemption from the assessment and reimbursement for losses provided for in this section. A carrier which applies for an exemption shall agree to enroll or insure a minimum number of non-group persons on an open enrollment community rated basis, under a managed care or indemnity plan, as specified in this subsection, provided that any indemnity plan so issued conforms with sections 2 through 7, inclusive, of this act. For the purposes of this subsection, non-group persons include individually enrolled persons, conversion policies issued pursuant to this act, Medicare cost and risk lives and Medicaid and HealthStart Plus recipients**[**; except that in determining whether the carrier meets the minimum number of non-group persons required pursuant to this subsection, the number of Medicaid recipients and Medicare cost and risk lives shall not exceed 50% of the total**]**.

(2) **[**Notwithstanding the provisions of paragraph (1) of this subsection to the contrary, a health maintenance organization qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub.L 93-222 (42 U.S.C.§300e et seq.) and tax exempt pursuant to paragraph (3) of subsection (c) of section 501 of the federal Internal

Revenue Code of 1986, 26 U.S.C.§501, may include up to one third Medicaid recipients and up to one third Medicare recipients in determining whether it meets its minimum number.**]**(Deleted by amendment, P.L. , c. .)

(3) The minimum number of non-group persons, as determined by the board, shall equal the total number of community rated and modified community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid and HealthStart Plus lives, of all carriers subject to this act as of the end of the calendar year, multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for that calendar year, including those carriers that are exempt from the assessment.

(4) Within 180 days after the effective date of this act and on or before March 1 of each year thereafter, every carrier seeking an exemption pursuant to this subsection shall file with the board a statement of its net earned premium for the preceding calendar year. The board shall determine each carrier's minimum number of non-group persons in accordance with this subsection.

(5) On or before March 1 of each year, every carrier that was granted an exemption for the preceding calendar year shall file with the board the number of non-group persons, by category, enrolled or insured as of December 31 of the preceding calendar year.

To the extent that the carrier has failed to enroll the minimum number of non-group persons established by the board, the carrier shall be assessed by the board on a pro rata basis for any differential between the minimum number established by the board and the actual number enrolled or insured by the carrier.

(6) A carrier that applies for the exemption shall be deemed to be in compliance with the requirements of this subsection if:

(a) by the end of calendar year 1993, it has enrolled or insured at least 40% of the minimum number of non-group persons required;

(b) by the end of calendar year 1994, it has enrolled or insured at least 75% of the minimum number of non-group persons required; and

(c) by the end of calendar year 1995, it has enrolled or insured 100% of the minimum number of non-group persons required.

(7) Any carrier that writes both managed care and indemnity business that is granted an exemption pursuant to this subsection may satisfy its obligation to write a minimum number of non-group persons by writing either managed care or indemnity business, or both.

e. Notwithstanding the provisions of this section to the contrary, no carrier shall be liable for an assessment to reimburse any carrier pursuant to this section in an amount which exceeds 35% of the aggregate net paid losses of all carriers filing pursuant to paragraph (1) of subsection a. of this section. To the extent that this limitation results in any unreimbursed paid losses to any carrier, the

unreimbursed net paid losses shall be distributed among carriers: (1) which owe assessments pursuant to paragraph (2) of subsection a. of this section; (2) whose assessments do not exceed 35% of the aggregate net paid losses of all carriers; and (3) who have not received an exemption pursuant to subsection d. of this section. For the purposes of paragraph (3) of this subsection, a carrier shall be deemed to have received an exemption notwithstanding the fact that the carrier failed to enroll or insure the minimum number of non-group persons required for that calendar year.

(cf: P.L.1992, c.161, s.11)

2. This act shall take effect immediately.

STATEMENT

Current law places restrictions on the number of Medicaid and Medicare recipients that may be counted by a carrier or federally qualified health maintenance organization in determining whether they have enrolled the minimum number of non-group persons required to qualify for an exemption from assessment under the New Jersey Individual Health Coverage Program. This bill deletes those provisions of law.

Concerns qualification for exemption from assessment under individual health coverage program.