ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 2261

STATE OF NEW JERSEY

DATED: MAY 5, 1997

The Assembly Insurance Committee reports without recommendation the Assembly Committee Substitute for Assembly Bill No. 2261.

This committee substitute consolidates the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program under the New Jersey Health Coverage Reform Board and transfers the duties, powers and authority of the governing boards of those programs to the newly consolidated board. The bill also provides that the director of the board is to be appointed by the Commissioner of Banking and Insurance as a special deputy commissioner.

In addition, the bill also provides that the board will review any requirement for an insurer to offer or provide a mandated health benefit, and report its finding to the Legislature. Mandated benefits are defined in the bill as any mandated coverage for, or offering of, specific services, treatments or practices, and any mandated reimbursement to specific health care providers.

The bill provides for modified community rating based on age, gender and geographical location in both the individual and small employer health benefits markets on a 2 to 1 premium ratio basis.

The bill modifies current loss ratio requirements for individual and small employer health benefits plans by allowing blocks of business for all major medical and hospital expense coverages to be subject to a loss ratio requirement of 75 percent. The loss ratio is to be based on a life duration and certain expenses are permitted to be deducted before calculating the loss ratio. The bill also provides for the establishment of a premium stabilization reserve account when the actual loss ratio in a calendar year is less than 75 percent and the anticipated loss ratio is 75 percent or greater.

Other provisions of the bill: provide for periodic adjustment of the retention point amount for self-insured stop loss coverage; allow for the development of selective contracting arrangements (preferred provider organizations (PPO) and point-of-service (POS) health benefits plans) in the individual health benefits market; modify the current assessment formula; establish a process for the informational

filing of Medicare supplement rates and make technical amendments to conform current law to the provisions of the federal "Health Insurance Portability and Accountability Act of 1996."