17B:27A-10.1 to 17B:27A-10.13

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2018 **CHAPTER:** 24

NJSA: 17B:27A-10.1 to 17B:27A-10.13 ("New Jersey Health Insurance Premium Security Act;" establishes health insurance reinsurance plan)

BILL NO: S1878 (Substituted for A3379)

SPONSOR(S) Vitale and others

DATE INTRODUCED: February 15, 2018

COMMITTEE: **ASSEMBLY:** ---

SENATE: Budget and Appropriations
Commerce

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** April 12, 2018

SENATE: April 12, 2018

DATE OF APPROVAL: May 30, 2018

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Senate Committee Substitute enacted) Yes

S1878

SPONSOR'S STATEMENT:
(Begins on page 8 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes Commerce 2-15-2018
Budget and Appropriations 3-5-2018
Commerce 4-5-2018
Budget and Appropriations 4-5-2018

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes 3-20-2018
4-23-2018

A3379

SPONSOR'S STATEMENT:
(Begins on page 8 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

(continued)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS:

HEARINGS:

NEWSPAPER ARTICLES: Yes

"Starting next year, most New Jersey residents will," Burlington County Times, 5-31-2018
"State groups laud health insurance laws," NJBIZ, 5-31-2018

RWH/JA

§§1-13 -
C.17B:27A-10.1
to 17B:27A-10.13
§14 - Note

P.L. 2018, CHAPTER 24, ***approved May 30, 2018***
Senate Committee Substitute for
Senate, No. 1878

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:

"Affiliated carrier" means the same as defined in N.J.A.C.11:20-1.2.

"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 under a health benefits plan, including a sickness and accident

insurance company, a health maintenance organization, a hospital, medical or health service corporation, or any other entity providing a health benefits plan. For purposes of this act, carriers that are affiliated carriers shall be treated as one carrier.

"Paid claim" means a claim by a covered person for payment of benefits under a health benefits plan for which the financial obligation for the payment of the claim under the contract rests upon and has been paid by the carrier, excluding claims adjustment expenses.

"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 1 of P.L.1992, c.161 (C.17B:27A-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.

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

b. The board or commissioner may apply for any available federal funding for the plan. All funds received pursuant to an application for federal funding, assessed by the board pursuant this act, or otherwise dedicated to the fund shall be remitted to the State Treasurer and deposited in the fund.

c. The commissioner, in consultation with the board, shall collect data from carriers necessary to determine the reinsurance payment parameters and shall share this data with the board.

d. For each applicable benefit year, the board shall notify carriers, the commissioner, and the State Treasurer of the 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 board shall provide each eligible carrier and the commissioner with the calculation of total reinsurance payment requests.

f. By November 1 of the year following the applicable benefit year, the State Treasurer shall disburse all applicable reinsurance payments to an eligible carrier.

g. The board, subject to the disapproval of the commissioner pursuant to section 5 of this act, shall design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market by achieving between a 10% and 20% reduction in what indicated premium rates would be for the applicable benefit year without the plan;

(2) will encourage increased 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) encourage cost savings mechanisms related to the management of health care services.

h. The attachment point for the plan is the threshold amount for paid claims by an eligible carrier for an enrolled individual's covered benefits in a benefit year, beyond which the paid claims are eligible for reinsurance payments. The attachment point shall be set by the board, but shall not exceed the reinsurance cap.

i. The coinsurance rate for the plan is the rate at which the board will reimburse an eligible carrier for paid claims 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.

j. The reinsurance cap is the amount for paid claims of an eligible carrier for an enrolled individual's covered benefits, above which the paid claims for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board.

5. The board shall 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.

6. a. Each reinsurance payment shall be calculated with respect to an eligible carrier's paid claims for an individual enrollee's covered benefits in the applicable benefit year. If the paid claims do not exceed the attachment point, a reinsurance payment shall not be made. If the paid claims 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.

b. The board 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" 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 section 7 of this act.

7. a. An eligible carrier shall submit a request to the board for reinsurance payments when the eligible carrier's total amount paid for an enrollee meet the criteria for reinsurance payments.

b. An eligible carrier shall make requests for reinsurance payments in accordance with any requirements established by the board.

c. 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.

d. 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.

e. (1) At least once every five years the board shall engage an independent audit firm to audit eligible carriers that receive reinsurance payments to assess 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 or overpayment of reinsurance payments in the audited benefit years, 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 or overpayment of reinsurance payments in the audited benefit years, the eligible carrier shall:

(a) provide a written corrective action plan to the board for approval, that includes recoupment of any reinsurance overpayments;

(b) upon board approval, implement the corrective action plan described; and

(c) provide the board with documentation of the corrective actions taken.

8. The board shall keep an accounting for each benefit year, including but not limited to, the following:

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, 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 commissioner and the board 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 this act. 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 in support of this act, or monies otherwise appropriated or directed to be remitted to the fund. The establishment of this fund, the funding sources contained herein, 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 (C.42 U.S.C. 18052) and the commissioner's acceptance of any approval as provided in section 9 of 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 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.

d. The fund shall be fully funded in accordance with this section 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 this act, and in amounts sufficient to ensure funding levels as required by this act after the monies received pursuant to paragraphs (1) and (2) of this subsection, there shall be appropriated annually out of the General Fund of the State an amount as the board, in consultation with the commissioner, determines necessary to fully fund the plan to accomplish the objectives of this act. The board, in consultation with the commissioner, shall calculate the amount 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.

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

11. a. The board 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 upon request and by posting on the department's website.

b. (1) The board 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 board, after receiving the completed audit, shall:

(a) provide the commissioner the results of the audit excluding any proprietary information;

(b) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board recommends 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 board intends to correct the material weakness or significant deficiency.

c. Documents, materials or other information that are in the possession or control of the commissioner or the board and that 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.

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.).

13. The board, pursuant to section 8 of P.L.1993, c.164 (C.17B:27A-16.1), and the commissioner, pursuant to the “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.) and in consultation with each other, shall each 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 and accepts a waiver pursuant to section 9 of this act, and the commissioner and the board may take any anticipatory administrative action in advance as necessary for the implementation of this act.

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

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

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

CURRENT VERSION OF TEXT

As introduced.

(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:

"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.

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

"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 board shall administer, the Health Insurance Premium Security Plan.

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

c. The board shall collect data from carriers necessary to determine reinsurance payments.

d. For each applicable benefit year, the board 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 board 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 board shall disburse all applicable reinsurance payments to an eligible carrier.

g. The board 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, but not exceeding the reinsurance cap.

i. 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 at a rate between 50 and 70 percent.

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.

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 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 board, in consultation with the commissioner, shall propose 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 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 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 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 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 for approval;

(b) upon board approval, implement the corrective action plan described; and

(c) provide the board with documentation of the corrective actions taken.

8. The board 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. The board, 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.

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 shall be assessed by the commissioner according to an assessment methodology 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.

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 board 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 board, after receiving the completed audit, shall:

(a) provide the commissioner the results of the audit;

(b) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends 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 board intends to correct the material weakness or significant deficiency.

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

13. 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 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.

STATEMENT

This 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, 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 or a plan year beginning after January 1, 2019. The board of directors of the New Jersey Individual Health Coverage Program (the "board"), in consultation with the commissioner, is directed to 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. If the waiver is obtained, the board is directed to administer the program, which shall be overseen by the Commissioner of Banking and Insurance.

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 board is to propose payment parameters that the commissioner may approve.

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 at $50,000 or more, but not exceeding 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 at a rate between 50 and 70 percent.

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.

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.

The bill provides that, 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 board, in consultation with the commissioner, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

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

The bill creates the New Jersey Health Insurance Premium Security Fund in the State Treasury for the purposes of the bill. This fund is to 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.

For the purpose of providing the funds necessary to carry out the provisions of this act, each carrier shall be assessed by the commissioner according to such assessment methodology and at such time and for such 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 the bill.

The commissioner and 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.

It is the sponsor's intent for the State to obtain a federal waiver to support reinsurance payments to health insurance carriers with respect to claims for eligible individuals for the purpose of stabilizing premiums for health insurance coverage offered in the New Jersey individual health insurance market. However, if the State is unable to secure federal approval of a waiver, the provisions of the bill will remain inoperative. The bill's effective date reflects this intent.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 1878

with committee amendments

STATE OF NEW JERSEY

DATED: FEBRUARY 15, 2018

The Senate Commerce Committee reports favorably and with committee amendments Senate Bill No. 1878.

This amended 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, as amended, 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 after January 1, 2019. The commissioner, in consultation with the board of directors of the New Jersey Individual Health Coverage Program (the "board"), is directed to 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. If the waiver is obtained and the commissioner accepts the waiver, the commissioner is directed to administer the program. The bill allows the commissioner to contract for actuarial services as necessary to implement the waiver application required pursuant to the bill.

The bill directs the commissioner 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 commissioner, 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 commissioner.

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 commissioner.

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.

The amended bill provides that, 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, the commissioner shall revise the payment parameters within the available appropriations. The commissioner must permit an eligible carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

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

As amended, the bill creates the New Jersey Health Insurance Premium Security Fund in the State Treasury for the purposes of the bill. This fund is to be the repository for monies collected pursuant to this bill and other monies received as grants or otherwise appropriated for the purposes of the bill.

For the purpose of providing the funds necessary to carry out the provisions of this bill, each carrier and third party administrator shall be assessed by the commissioner in proportion to the claims paid by the carrier or processed by the third party administrator, as appropriate, for covered persons in this State. The proceeds therefrom are to be deposited into the fund and the amount collected is not to exceed the amount required to fund the plan, less any amounts in the fund received from other sources.

The commissioner 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 amended 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.

It is the sponsor’s intent for the State to obtain a federal waiver to support reinsurance payments to health insurance carriers with respect to claims for eligible individuals for the purpose of

stabilizing premiums for health insurance coverage offered in the New Jersey individual health insurance market. However, if the State is unable to secure federal approval of a waiver, or the commissioner does not accept the waiver, the provisions of the bill will remain inoperative. The bill's effective date reflects this intent.

COMMITTEE AMENDMENTS:

The committee amendments:

- Remove the term "affiliated company" from the definitions;
- Transfer the administration of the reinsurance plan from the Individual Health Coverage Program Board to the Commissioner of Banking and Insurance;
- Provide that the bill only takes effect if the federal waiver is, not only approved, but also accepted by the commissioner;
- Allow the commissioner to contract for actuarial services as necessary to implement the waiver application required pursuant to the bill;
- Revise the assessment provided for in the bill to provide that each carrier and third party administrator shall be assessed by the commissioner in proportion to the claims paid by the carrier or processed by the third party administrator, as appropriate, for covered persons in this State. The proceeds therefrom are to be deposited into the fund and the amount collected is not to exceed the amount required to fund the plan, less any amounts in the fund received from other sources;
- Add a penalty provision for 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's provisions.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 1878

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 5, 2018

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 1878 (1R), with committee amendments.

As amended, this 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, as amended, 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. The commissioner, in consultation with the board of directors of the New Jersey Individual Health Coverage Program (the "board"), is directed to 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. If the waiver is obtained, the commissioner may accept the waiver, so long as the commissioner determines that implementation of the plan will benefit policyholders and is expected to stabilize or reduce individual health insurance premiums. The commissioner is directed to administer the program, and is authorized to contract for actuarial services as necessary to implement the waiver application required pursuant to the bill.

The bill directs the commissioner 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 commissioner, 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 commissioner.

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 commissioner.

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.

The bill provides that, 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, the commissioner shall revise the payment parameters within the available appropriations. The commissioner must permit an eligible carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

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

The bill creates the New Jersey Health Insurance Premium Security Fund in the State Treasury for the purposes of the bill. This fund is to be the repository for monies collected pursuant to this bill and other monies received as grants or otherwise appropriated for the purposes of the bill.

For the purpose of providing the funds necessary to carry out the provisions of this bill, each carrier and third party administrator shall be assessed by the commissioner in proportion to the claims paid by the carrier or processed by the third party administrator, as appropriate, for covered persons in this State. The proceeds therefrom are to be deposited into the fund and the amount collected is not to exceed the amount required to fund the plan, less any amounts in the fund received from other sources.

The commissioner 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.

COMMITTEE AMENDMENTS:

The committee amended the bill as follows:

- Revise the definition of "carrier" to mean 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 under a health benefits plan, including a sickness and accident insurance company, a health maintenance organization, a hospital, medical or health service corporation, or any other entity providing a health benefits plan;
- Provide that the commissioner may accept the federal waiver provided for under the bill, so long as the commissioner determines that implementation of the plan: (1) will be beneficial to policyholders; and (2) is expected to stabilize or reduce premiums in the individual health insurance market; and
- Provide that 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 the bill, are 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.

FISCAL IMPACT:

The Office of Legislative Services (OLS) notes that the bill will result in a one-time indeterminate increase in State administrative expenditures. The Department of Banking and Insurance (DOBI) will incur the additional expenses in applying for a waiver from the United States Secretary of Health and Human Services whose approval would be a necessary precondition to implementing the reinsurance program envisioned by the bill.

Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the bill will have four additional indeterminate annual fiscal impacts.

First, the bill will result in an indeterminate annual increase in State administrative expenditures tied to DOBI's implementation of the program, including the cost of preparing the required annual reports. Absent information from DOBI, however, the OLS cannot anticipate the resources the department will allocate to operating the program.

Second, the bill will result in an indeterminate annual State expenditure increase equal to the amounts disbursed from the bill's New Jersey Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers. The OLS cannot quantify the amount of annual reinsurance payments because the bill grants DOBI substantial discretion in establishing payment calculation parameters and the OLS cannot anticipate the department's decisions in that regard.

Third, the bill will result in an indeterminate annual State revenue increase equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund; including collections from the annual assessment on insurance carriers and third-party administrators, any State or federal funds allocated to the reinsurance program, and any penalty payments by insurance carriers. The OLS notes that DOBI is to set the annual assessment imposed on insurance carriers and third-party administrators at a level so that fund balances from all sources will not exceed the cost of the reinsurance program. Accordingly, the bill's indeterminate annual increases in State expenditures and revenue will partially, if not fully, offset one another.

Fourth, the bill may also have an indeterminate impact on annual employee health benefits expenditures of the State and local government entities to the extent that the bill's assessment may cause insurance carriers and third-party administrators to alter the amounts they charge to the State and local government entities for their services. Given that the rate of the assessment is to be determined by DOBI, the OLS cannot determine the magnitude of any related changes in annual employee health benefit expenditures of the State and local government entities.

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.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE
SENATE, No. 1878

STATE OF NEW JERSEY

DATED: APRIL 5, 2018

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 1878 SCS.

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.

FISCAL IMPACT:

The Office of Legislative Services (OLS) notes that the bill will result in a one-time indeterminate increase in State administrative expenditures. The Department of Banking and Insurance (DOBI) will accrue the additional expenses in applying for a waiver from the United States Secretary of Health and Human Services whose approval would be a necessary precondition to implement the reinsurance program envisioned by the bill.

Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the bill will have four additional indeterminate annual fiscal impacts.

First, the bill will result in an indeterminate annual increase in State administrative expenditures tied to DOBI's implementation of the program, including the cost of preparing the required annual reports. Absent information from DOBI, however, the OLS cannot

anticipate the resources the department will allocate to operating the program.

Second, the bill will result in an indeterminate annual State expenditure increase equal to the amounts disbursed from the bill's dedicated New Jersey Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers. The OLS cannot quantify the amount of annual reinsurance payments because the bill grants DOBI substantial discretion in establishing payment calculation parameters and the OLS cannot anticipate the department's decisions in that regard.

Third, the bill will result in an indeterminate annual State revenue increase equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund including State and federal funds allocated to the reinsurance program and any penalty payments by insurance carriers.

Fourth, the bill will result in an indeterminate annual State expenditure increase equal to the amounts annually appropriated out of the General Fund as the board, in consultation with the commissioner, determines necessary to fully fund the plan to accomplish the objectives of the bill.

LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

SENATE, No. 1878

STATE OF NEW JERSEY
218th LEGISLATURE

DATED: MARCH 20, 2018

SUMMARY

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

Type of Impact: One-time State Expenditure Increase. Potential Annual State Expenditure and Revenue Increases. Potential Annual Expenditure Increase to Local Government Entities.

Agencies Affected: Department of Banking and Insurance, Department of the Treasury, and local government entities.

Office of Legislative Services Estimate

Fiscal Impact	Annual
State Expenditure Increase	Indeterminate
Potential State Revenue Increase	Indeterminate
Potential Local Expenditure Increase	Indeterminate

- The Office of Legislative Services (OLS) notes that the bill will result in a one-time indeterminate increase in State administrative expenditures. The Department of Banking and Insurance (DOBI) will accrue the additional expenses in applying for a waiver from the United States Secretary of Health and Human Services, whose approval is necessary for the implementation of the reinsurance program envisioned by the bill.

- Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the bill will have four additional indeterminate annual fiscal impacts:
  - An annual increase in State administrative expenditures tied to DOBI's implementation of the program;
  - An annual increase in State expenditures equal to the amounts disbursed from the bill's dedicated New Jersey Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers;
  - An annual increase in State revenue equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund; including collections

from the annual assessment on insurance carriers and third-party administrators, any State or federal funds allocated to the reinsurance program, and any penalty payments by insurance carriers. The OLS notes that the bill's indeterminate annual increases in State expenditures and revenue will partially, if not fully, offset one another; and

- An indeterminate impact on annual employee health benefit expenditures by State and local government entities to the extent that the bill's assessment may cause insurance carriers and third-party administrators to alter the amounts they charge to the State and local government entities for their health benefits plans and services.

BILL DESCRIPTION

This bill, entitled the "New Jersey Health Insurance Premium Security Act," directs DOBI to apply to the United States Secretary of Health and Human Services for a 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 for plan years beginning on or after January 1, 2019.

If the waiver is granted and DOBI accepts the waiver, the bill creates a reinsurance plan to be known as the Health Insurance Premium Security Plan. DOBI is to administer the reinsurance plan, a responsibility that includes the setting of specific payment calculation parameters and the exercise of certain auditing and review functions to ensure the plan operates pursuant to the bill's provisions.

In addition, the bill creates the New Jersey Health Insurance Premium Security Fund in the State Treasury as the repository for moneys collected to finance the reinsurance plan. The moneys include proceeds from an annual assessment to be imposed by DOBI on health insurance carriers and third-party administrators. DOBI is to set the rate of the assessment annually in such a manner that the amount to be collected does not exceed the amount required to fund the plan, less any amounts the New Jersey Health Insurance Premium Security Fund received from other sources.

DOBI must also publish an annual report on the department's website on 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 penalizes any carrier that violates any provision of the bill in an amount not less than $1,000 or more than $10,000 for each day of violation.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS notes that the bill will result in a one-time indeterminate increase in State administrative expenditures. DOBI will accrue the additional expenses in applying for a waiver

from the United States Secretary of Health and Human Services, whose approval is necessary for the implementation of the reinsurance program envisioned by the bill.

Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the bill will have four additional indeterminate annual fiscal impacts.

First, the bill will result in an indeterminate annual increase in State administrative expenditures tied to DOBI's implementation of the program, including the cost of preparing the required annual reports. Absent information from DOBI, however, the OLS cannot anticipate the resources the department will allocate to operating the program.

Second, the bill will result in an indeterminate annual State expenditure increase equal to the amounts disbursed from the bill's dedicated New Jersey Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers. The OLS cannot quantify the amount of annual reinsurance payments because the bill grants DOBI substantial discretion in establishing payment calculation parameters and the OLS cannot anticipate the department's decisions in that regard.

Third, the bill will result in an indeterminate annual State revenue increase equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund; including collections from the annual assessment on insurance carriers and third-party administrators, any State or federal funds allocated to the reinsurance program, and any penalty payments by insurance carriers. The OLS notes that DOBI is to set the annual assessment imposed on insurance carriers and third-party administrators at a level so that fund balances from all sources will not exceed the cost of the reinsurance program. Accordingly, the bill's indeterminate annual increases in State expenditures and revenue will partially, if not fully, offset one another.

Fourth, the bill may also have an indeterminate impact on annual employee health benefit expenditures of the State and local government entities to the extent that the bill's assessment may cause insurance carriers and third-party administrators to alter the amounts they charge to the State and local government entities for their health benefits plans and services. Given that the rate of the assessment is to be determined by DOBI, the OLS cannot determine the magnitude of any related changes in annual employee health benefit expenditures of the State and local government entities.

The OLS also notes that, assuming the waiver is granted and accepted, there may be a potential indeterminate annual reduction in State charity care disbursements to hospitals but only if the following chain of events occurs: if the bill results in lower insurance rates, then insurance coverage will become more affordable; if insurance coverage becomes more affordable, then more individuals are likely to obtain insurance coverage or better insurance coverage; if more hospital patients can pay their bills because they have insurance coverage, then hospitals have reduced outstanding uncompensated care liabilities; as hospitals have reduced outstanding uncompensated care liabilities, the State can then reduce charity care payments to hospitals.

Section:	*Commerce, Labor and Industry*
Analyst:	*Juan C. Rodriguez* *Associate Fiscal Analyst*
Approved:	*Frank W. Haines III* *Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

LEGISLATIVE FISCAL ESTIMATE

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 1878

STATE OF NEW JERSEY
218th LEGISLATURE

DATED: APRIL 23, 2018

SUMMARY

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

Type of Impact: One-time State Expenditure Increase. Potential Annual State Expenditure and Revenue Increases.

Agencies Affected: Department of Banking and Insurance, Department of the Treasury, the board of directors of the New Jersey Individual Health Coverage Program (board).

Office of Legislative Services Estimate

Fiscal Impact	Annual
State Expenditure Increase	Indeterminate
Potential State Revenue Increase	Indeterminate

- The Office of Legislative Services (OLS) notes that the bill will result in a one-time indeterminate increase in State administrative expenditures. The Department of Banking and Insurance (DOBI) will accrue the additional expenses in applying for a waiver from the United States Secretary of Health and Human Services, whose approval is necessary for the implementation of the reinsurance program envisioned by the bill.

- Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the bill will have four additional indeterminate annual fiscal impacts:
  - An annual increase in State administrative expenditures tied to DOBI's and the board's implementation of the program;
  - An annual increase in State expenditures; including amounts annually appropriated, which the board, in consultation with the commissioner, determines to be necessary to fully fund the plan to accomplish the objectives of the bill, and the amounts disbursed from the bill's dedicated New Jersey Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers; and

- An annual increase in State revenue equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund; including any federal funds allocated to the reinsurance program and any penalty payments by insurance carriers for violations of the bill.

BILL DESCRIPTION

This bill, entitled the "New Jersey Health Insurance Premium Security Act," directs DOBI to apply to the United States Secretary of Health and Human Services for a waiver of certain provisions of the Affordable Care Act to support a reinsurance program to help stabilize premiums in the individual health insurance market in New Jersey, for plan years beginning on or after January 1, 2019.

If the waiver is granted and DOBI accepts the waiver, the bill creates a reinsurance plan to be known as the Health Insurance Premium Security Plan. The board of directors of the New Jersey Individual Health Coverage Program (board), in consultation with the commissioner, is to administer the reinsurance plan, a responsibility that includes the setting of specific payment calculation parameters and the exercise of certain auditing and review functions to ensure the plan operates pursuant to the bill's provisions.

In addition, the bill creates the New Jersey Health Insurance Premium Security Fund in the State Treasury as the repository for moneys collected to finance the reinsurance plan. The moneys include: (a) proceeds from the tax penalty imposed under the "New Jersey Health Insurance Market Preservation Act," currently pending before the Legislature; (b) federal payments received as a result of the approved waiver; and (c) annual State appropriations equal to the amounts which the board, in consultation with the commissioner, determines to be necessary to fully fund the plan to accomplish the objectives of the bill.

DOBI must also publish an annual report on the department's website on 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 penalizes any carrier that violates any provision of the bill in an amount not less than $1,000 or more than $10,000 for each day of violation.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS notes that the bill will result in a one-time indeterminate increase in State administrative expenditures. DOBI will accrue the additional expenses in applying for a waiver from the United States Secretary of Health and Human Services, whose approval is necessary for the implementation of the reinsurance program envisioned by the bill. If the waiver is approved, the bill authorizes the commissioner to accept the waiver after the commissioner's determination that implementation of the bill: (1) will be beneficial to policyholders; and (2) 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.

Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the bill will have four additional indeterminate annual fiscal impacts.

First, the bill will result in an indeterminate annual increase in State administrative expenditures tied to DOBI's and the board's implementation of the program, including the cost of preparing the required annual reports. Absent information from DOBI, however, the OLS cannot anticipate the resources the department will allocate to operating the program.

Second, the bill will result in an indeterminate annual State expenditure including amounts annually appropriated out of the General Fund which the board, in consultation with the commissioner, determines to be necessary to fully fund the plan to accomplish the objectives of the bill, and amounts disbursed from the bill's dedicated New Jersey Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers. The OLS cannot quantify the amount of annual reinsurance payments because the bill grants the board substantial discretion in establishing payment calculation parameters and the OLS cannot anticipate the board's decisions in that regard.

Third, the bill will result in an indeterminate annual State revenue increase equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund, including: (a) proceeds from the tax penalty imposed under the "New Jersey Health Insurance Market Preservation Act," currently pending before the Legislature; (b) federal payments received as a result of the approved waiver; and (c) annual State appropriations equal to the amounts which the board, in consultation with the commissioner, determines to be necessary to fully fund the plan to accomplish the objectives of the bill. Accordingly, the bill's indeterminate increase in State administrative expenditures and increase in revenue will partially, if not fully, offset one another.

The bill provides that the fund should be funded to levels based upon actuarial analysis to stabilize or reduce premium rates in the individual market achieving between a 10% and 20% reduction in what indicated premium rates would be for the applicable benefit year without the plan. According to responses to FY 2018 OLS discussion points, DOBI presented tables and links with updated enrollment and premium cost information on the New Jersey individual market administered through the Individual Health Coverage Program. Using this information, a 10% to 20% reduction in premiums in the individual health insurance market may result in Gold premium rates that for 2018 range from $495.50 to $730.78 (as seen in table below), being decreased by $49.55 - $73.08 and $99.10 - $146.16, respectively from what indicated rates would be for the applicable benefit year without the plan.

NJ Individual Health Benefits Plans and Rates			
Plan Metal Level	Base Rate	10 % Savings from Current Premiums	20 % Savings from Current Premiums
Gold	$495.50 - $730.78	$49.55 - $73.08	$99.10 - $146.16
Silver	$311.86 - $795.87	$31.19 - $79.59	$62.37 - $159.17
Bronze	$251.63 - $709.49	$25.16 - $70.95	$50.33 - $141.90
Catastrophic	$180.54 - $272.04	$18.05 - $27.20	$36.11 - $54.41

The OLS also notes that, assuming the waiver is granted and accepted, there may be a potential indeterminate annual reduction in State charity care disbursements to hospitals, but only if the following chain of events occurs: if the bill results in lower insurance rates, then insurance coverage will become more affordable; if insurance coverage becomes more affordable, then more individuals are likely to obtain insurance coverage or better insurance coverage; if more hospital patients can pay their bills because they have insurance coverage, then hospitals have reduced outstanding uncompensated care liabilities; as hospitals have

reduced outstanding uncompensated care liabilities, the State can then reduce charity care payments to hospitals.

Section:	*Commerce, Labor and Industry*
Analyst:	*Juan C. Rodriguez* *Associate Fiscal Analyst*
Approved:	*Frank W. Haines III* *Legislative Budget and Finance Officer*

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

ASSEMBLY, No. 3379

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED FEBRUARY 12, 2018

Sponsored by:
Assemblyman JOHN F. MCKEON
District 27 (Essex and Morris)
Assemblywoman PAMELA R. LAMPITT
District 6 (Burlington and Camden)
Assemblywoman CAROL A. MURPHY
District 7 (Burlington)

Co-Sponsored by:
Assemblyman Mukherji and Assemblywoman Jasey

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 4/6/2018)

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:

"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.

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

"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 board shall administer, the Health Insurance Premium Security Plan.

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

c. The board shall collect data from carriers necessary to determine reinsurance payments.

d. For each applicable benefit year, the board 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 board 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 board shall disburse all applicable reinsurance payments to an eligible carrier.

g. The board 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, but not exceeding the reinsurance cap.

i. 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 at a rate between 50 and 70 percent.

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.

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 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 board, in consultation with the commissioner, shall propose 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 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 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 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 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 for approval;

(b) upon board approval, implement the corrective action plan described; and

(c) provide the board with documentation of the corrective actions taken.

8. The board 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. The board, 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.

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 shall be assessed by the commissioner according to an assessment methodology 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.

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 board 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 board, after receiving the completed audit, shall:

(a) provide the commissioner the results of the audit;

(b) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends 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 board intends to correct the material weakness or significant deficiency.

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

13. 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 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.

STATEMENT

This 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, 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 or a plan year beginning after January 1, 2019. The board of directors of the New Jersey Individual Health Coverage Program (the "board"), in consultation with the commissioner, is directed to 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. If the waiver is obtained, the board is directed to administer the program, which shall be overseen by the Commissioner of Banking and Insurance.

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 board is to propose payment parameters that the commissioner may approve.

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 at $50,000 or more, but not exceeding 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 at a rate between 50 and 70 percent.

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.

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.

The bill provides that, 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 board, in consultation with the commissioner, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

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

The bill creates the New Jersey Health Insurance Premium Security Fund in the State Treasury for the purposes of the bill. This fund is to 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.

For the purpose of providing the funds necessary to carry out the provisions of this act, each carrier shall be assessed by the commissioner according to such assessment methodology and at such time and for such 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 the bill.

The commissioner and 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.

It is the sponsor's intent for the State to obtain a federal waiver to support reinsurance payments to health insurance carriers with respect to claims for eligible individuals for the purpose of stabilizing premiums for health insurance coverage offered in the New Jersey individual health insurance market. However, if the State is unable to secure federal approval of a waiver, the provisions of the bill will remain inoperative. The bill's effective date reflects this intent.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 3379

STATE OF NEW JERSEY

DATED: APRIL 5, 2018

The Assembly Appropriations Committee reports favorably an Assembly Committee Substitute for Assembly Bill No. 3379.

This substitute, 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 substitute creates a reinsurance plan to be known as the Health Insurance Premium Security Plan.

The substitute 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 substitute. The commissioner may contract for actuarial services as necessary to implement the waiver application.

The substitute 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 substitute’s provisions.

The substitute 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 substitute 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 substitute, 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 substitute.

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 substitute, and in amounts sufficient to ensure funding levels as required by the substitute after the monies received pursuant to the substitute, 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 substitute. 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 substitute also includes a penalty provision, which penalizes any carrier that violates any provision of the substitute, in an amount not less than $1,000 nor more than $10,000 for each day the carrier is in violation of the substitute.

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 substitute will remain inoperative. The substitute's effective date reflects this provision.

FISCAL IMPACT:

The Office of Legislative Services (OLS) notes that the substitute will result in a one-time indeterminate increase in State administrative expenditures. The Department of Banking and Insurance (DOBI) will accrue the additional expenses in applying for a waiver from the United States Secretary of Health and Human Services whose approval would be a necessary precondition to implement the reinsurance program envisioned by the substitute.

Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the substitute will have four additional indeterminate annual fiscal impacts.

First, the substitute will result in an indeterminate annual increase in State administrative expenditures tied to DOBI's implementation of the program, including the cost of preparing the required annual reports. Absent information from DOBI, however, the OLS cannot anticipate the resources the department will allocate to operating the program.

Second, the substitute will result in an indeterminate annual State expenditure increase equal to the amounts disbursed from the substitute's dedicated New Jersey Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers. The OLS cannot quantify the amount of annual reinsurance payments because the substitute grants DOBI substantial discretion in establishing payment calculation parameters and the OLS cannot anticipate the department's decisions in that regard.

Third, the substitute will result in an indeterminate annual State revenue increase equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund, including State and federal funds allocated to the reinsurance program and any penalty payments by insurance carriers.

Fourth, the substitute will result in an indeterminate annual State expenditure increase equal to the amounts annually appropriated out of the General Fund as the board, in consultation with the commissioner, determines necessary to fully fund the plan to accomplish the objectives of the substitute.

LEGISLATIVE FISCAL ESTIMATE

ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, No. 3379

STATE OF NEW JERSEY
218th LEGISLATURE

DATED: APRIL 19, 2018

SUMMARY

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

Type of Impact: One-time State Expenditure Increase. Potential Annual State Expenditure and Revenue Increases.

Agencies Affected: Department of Banking and Insurance, Department of the Treasury, the board of directors of the New Jersey Individual Health Coverage Program (board).

Office of Legislative Services Estimate

Fiscal Impact	Annual
State Expenditure Increase	Indeterminate
Potential State Revenue Increase	Indeterminate

- The Office of Legislative Services (OLS) notes that the bill will result in a one-time indeterminate increase in State administrative expenditures. The Department of Banking and Insurance (DOBI) will accrue the additional expenses in applying for a waiver from the United States Secretary of Health and Human Services, whose approval is necessary for the implementation of the reinsurance program envisioned by the bill.

- Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the bill will have four additional indeterminate annual fiscal impacts:
  - An annual increase in State administrative expenditures tied to DOBI's and the board's implementation of the program;
  - An annual increase in State expenditures; including amounts annually appropriated, which the board, in consultation with the commissioner, determines to be necessary to fully fund the plan to accomplish the objectives of the bill, and the amounts disbursed from the bill's dedicated New Jersey

Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers; and

- An annual increase in State revenue equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund; including any federal funds allocated to the reinsurance program and any penalty payments by insurance carriers for violations of the bill.

BILL DESCRIPTION

This bill, entitled the "New Jersey Health Insurance Premium Security Act," directs DOBI to apply to the United States Secretary of Health and Human Services for a waiver of certain provisions of the Affordable Care Act to support a reinsurance program to help stabilize premiums in the individual health insurance market in New Jersey, for plan years beginning on or after January 1, 2019.

If the waiver is granted and DOBI accepts the waiver, the bill creates a reinsurance plan to be known as the Health Insurance Premium Security Plan. The board of directors of the New Jersey Individual Health Coverage Program (board), in consultation with the commissioner, is to administer the reinsurance plan, a responsibility that includes the setting of specific payment calculation parameters and the exercise of certain auditing and review functions to ensure the plan operates pursuant to the bill's provisions.

In addition, the bill creates the New Jersey Health Insurance Premium Security Fund in the State Treasury as the repository for moneys collected to finance the reinsurance plan. The moneys include: (a) proceeds from the tax penalty imposed under the "New Jersey Health Insurance Market Preservation Act," currently pending before the Legislature; (b) federal payments received as a result of the approved waiver; and (c) annual State appropriations equal to the amounts which the board, in consultation with the commissioner, determines to be necessary to fully fund the plan to accomplish the objectives of the bill.

DOBI must also publish an annual report on the department's website on 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 penalizes any carrier that violates any provision of the bill in an amount not less than $1,000 or more than $10,000 for each day of violation.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS notes that the bill will result in a one-time indeterminate increase in State administrative expenditures. DOBI will accrue the additional expenses in applying for a waiver from the United States Secretary of Health and Human Services, whose approval is necessary for the implementation of the reinsurance program envisioned by the bill. If the waiver is approved, the bill authorizes the commissioner to accept the waiver after the commissioner's

determination that implementation of the bill: (1) will be beneficial to policyholders; and (2) 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.

Assuming that the federal government grants the waiver and that DOBI elects to implement the reinsurance program, the bill will have four additional indeterminate annual fiscal impacts.

First, the bill will result in an indeterminate annual increase in State administrative expenditures tied to DOBI's and the board's implementation of the program, including the cost of preparing the required annual reports. Absent information from DOBI, however, the OLS cannot anticipate the resources the department will allocate to operating the program.

Second, the bill will result in an indeterminate annual State expenditure including amounts annually appropriated out of the General Fund which the board, in consultation with the commissioner, determines to be necessary to fully fund the plan to accomplish the objectives of the bill, and amounts disbursed from the bill's dedicated New Jersey Health Insurance Premium Security Fund to make reinsurance payments to eligible insurance carriers. The OLS cannot quantify the amount of annual reinsurance payments because the bill grants the board substantial discretion in establishing payment calculation parameters and the OLS cannot anticipate the board's decisions in that regard.

Third, the bill will result in an indeterminate annual State revenue increase equal to the amounts deposited into the New Jersey Health Insurance Premium Security Fund, including: (a) proceeds from the tax penalty imposed under the "New Jersey Health Insurance Market Preservation Act," currently pending before the Legislature; (b) federal payments received as a result of the approved waiver; and (c) annual State appropriations equal to the amounts which the board, in consultation with the commissioner, determines to be necessary to fully fund the plan to accomplish the objectives of the bill. Accordingly, the bill's indeterminate increase in State administrative expenditures and increase in revenue will partially, if not fully, offset one another.

The bill provides that the fund should be funded to levels based upon actuarial analysis to stabilize or reduce premium rates in the individual market achieving between a 10% and 20% reduction in what indicated premium rates would be for the applicable benefit year without the plan. According to responses to FY 2018 OLS discussion points, DOBI presented tables and links with updated enrollment and premium cost information on the New Jersey individual market administered through the Individual Health Coverage Program. Using this information, a 10% to 20% reduction in premiums in the individual health insurance market may result in Gold premium rates that for 2018 range from $495.50 to $730.78 (as seen in table below), being decreased by $49.55 - $73.08 and $99.10 - $146.16, respectively from what indicated rates would be for the applicable benefit year without the plan.

NJ Individual Health Benefits Plans and Rates			
Plan Metal Level	Base Rate	10 % Savings from Current Premiums	20 % Savings from Current Premiums
Gold	$495.50 - $730.78	$49.55 - $73.08	$99.10 - $146.16
Silver	$311.86 - $795.87	$31.19 - $79.59	$62.37 - $159.17
Bronze	$251.63 - $709.49	$25.16 - $70.95	$50.33 - $141.90
Catastrophic	$180.54 - $272.04	$18.05 - $27.20	$36.11 - $54.41

The OLS also notes that, assuming the waiver is granted and accepted, there may be a potential indeterminate annual reduction in State charity care disbursements to hospitals, but only if the following chain of events occurs: if the bill results in lower insurance rates, then insurance coverage will become more affordable; if insurance coverage becomes more

affordable, then more individuals are likely to obtain insurance coverage or better insurance coverage; if more hospital patients can pay their bills because they have insurance coverage, then hospitals have reduced outstanding uncompensated care liabilities; as hospitals have reduced outstanding uncompensated care liabilities, the State can then reduce charity care payments to hospitals.

Section:	*Commerce, Labor and Industry*
Analyst:	*Juan C. Rodriguez* *Associate Fiscal Analyst*
Approved:	*Frank W. Haines III* *Legislative Budget and Finance Officer*

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

Governor Murphy Takes Action on Legislation

05/30/2018

TRENTON – Today, Governor Phil Murphy announced that he has signed the following bills into law:

A2787 (Dancer, Andrzejczak, Houghtaling, Rooney/Cruz-Perez, Singer) – Extends pilot program authorizing special occasion events at wineries on preserved farmland; implements reporting requirement.

A3380 (McKeon, Murphy, Lampitt,Conaway/Vitale, Singleton) – "New Jersey Health Insurance Market Preservation Act."

S482 (Vitale/Vainieri Huttle, Quijano, Jasey) – Authorizes certain gestational carrier agreements.
S846 (Turner, Cruz-Perez/Pintor Marin, Mukherji, Gusciora, Jones, Sumter) – Reinstates and extends duration of certain UEZs; requires DCA to study UEZ program and report recommendations to the Legislature.

S868 (Sweeney, Vitale/Coughlin, Jasey, Schaer)– Permits candidates for school board to circulate petitions jointly and be bracketed together on ballot; permits short nonpolitical designation of principles on petitions and ballots.

S1217 (Sweeney, Smith/Mazzeo, Armato, DeAngelo) – Requires BPU consideration and approval of amended application for qualified wind energy project offshore in certain NJ territorial waters.
S1870 (Vitale, Ruiz/Speight, Quijano, McKnight) – Requires Child Fatality and Near Fatality Review Board to study racial and ethnic disparities that contribute to infant mortality.

S1876 (Ruiz, Corrado/Vainieri Huttle, Caputo, Jasey) – Requires Commissioner of Education to include data on chronic absenteeism and disciplinary suspensions on School Report Card and requires public schools to make certain efforts to combat chronic absenteeism.

S1878 (Vitale, Singleton/McKeon, Lampitt, Murphy) – "New Jersey Health Insurance Premium Security Act;" establishes health insurance reinsurance plan.

S1894 (Ruiz, Turner/Lampitt, Sumter, Barclay) – Requires "breakfast after the bell" program in all schools with 70% or more of students eligible for free or reduced price meals.

S1895 (Ruiz, Turner/Lampitt, Jones, Wimberly) – Requires certain school districts to submit report on nonparticipation in "Community Eligibility Provision" of National School Lunch and School Breakfast Programs.

S1896 (Ruiz, Turner/Lampitt, Wimberly, Jones) – Requires school district to report at least biannually to Department of Agriculture number of students who are denied school breakfast or school lunch.

S1897 (Ruiz, Turner/Lampitt, Pintor Marin, Barclay) – Expands summer meal program to all school districts with 50 percent or more of students eligible for free or reduced price meals.

S2247 (Sweeney/Burzichelli, Mukherji, Murphy) – Allows charitable assets set aside from the sale of nonprofit hospital to for-profit entity to be allocated to successor nonprofit charitable entity that is establishing and operating

equivalent nonprofit hospital.

Governor Murphy also announced that he has conditionally vetoed the following bills:

S879 (Sweeney/Burzichelli, Taliaferro, Murphy) – Amends definition of "existing major hazardous waste facility" in "Major Hazardous Waste Facilities Siting Act."

Copy of message on S879

S976 (Vitale, Bateman/Vainieri Huttle, Lagana, Mukherji) – "Revised State Medical Examiner Act"; establishes Office of the Chief State Medical Examiner in DOH.

Copy of message on S976

S1968 (Pou/Wimberly, Mukherji, Sumter) – Extends document submission deadline for certain residential and mixed use parking projects under Economic Redevelopment and Growth Grant program; increases maximum credit amounts awarded for certain residential and mixed use parking projects.

Copy of message on S1968

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