SENATE, No. 249

STATE OF NEW JERSEY

213th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2008 SESSION

Sponsored by:
Senator JOHN H. ADLER
District 6 (Camden)
Senator JEFF VAN DREW
District 1 (Cape May, Atlantic and Cumberland)

SYNOPSIS

Creates "New Jersey Catastrophic Health Care Claims Reinsurance Program."

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel

(Sponsorship Updated As Of: 2/22/2008)

AN ACT concerning reinsurance for catastrophic health care claims, establishing the New Jersey Catastrophic Health Care Claims Reinsurance Program, and supplementing Title 17B of the New Jersey Statutes.

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

1. As used in this act:

"Board" means the board of directors of the program.

"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 an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation, and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means any person covered under an individual health benefits plan issued pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or a small employer health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

"Department" means the Department of Banking and Insurance

"Individual health benefits plan" means a health benefits plan for individuals approved by the commissioner pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.).

"Plan of operation" means the plan of operation of the program and includes the articles, bylaws and operating rules of the program that are adopted by the board.

"Program" means the New Jersey Catastrophic Health Care Claims Reinsurance Program created pursuant to section 2 of this act.

"Small employer" means a person, firm, corporation, partnership, or political subdivision that is qualified to obtain a small employer health benefits plan under P.L.1992, c.162 (C.17B:27A-17 et seq.).

"Small employer health benefits plan" means a health benefits plans for small employers approved by the commissioner pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

2. a. There is created the "New Jersey Catastrophic Health Care Claims Reinsurance Program." All carriers issuing an individual health benefits plan pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or a small employer health benefits plan pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) shall participate in the program. The program shall be administered by the board of directors established pursuant to this section.

b. Within 30 days of the effective date of this act, the commissioner shall give notice to all the participating carriers of the time and place for the initial organizational meeting which shall take place within 90 days of the effective date of this act. The board shall consist of 10 members and the commissioner or his designee who shall serve as an ex officio member. The carriers shall elect six members of the initial board, subject to the approval of the commissioner, and the Governor shall appoint four members of the board, as provided in subsections c. and d. of this section, respectively. Initially, four members of the board shall serve for three-year terms, three shall serve for two-year terms and three shall serve for one-year terms. Thereafter, all board members shall serve for a term of three years. A vacancy in the membership of the board shall be filled for an unexpired term in the manner provided for the original election or appointment, as appropriate.

c. The following categories shall be represented among the elected board members:

(1) three carriers whose principal health insurance business is in the individual or small employer market;

(2) one carrier whose principal health insurance business is in the large employer market;

(3) a health service corporation or a domestic stock insurer which converted from a health service corporation pursuant to the provisions of P.L.2001, c.131 (C.17:48E-49 et al.) and is primarily engaged in the business of issuing health benefits plans in this State; and

(4) one health maintenance organization.

No carrier shall have more than one representative on the board.

d. The board shall include four members appointed by the Governor with the advice and consent of the Senate, who shall include:

(1) one representative of organized labor;

(2) one representative of the medical provider community, such as a physician licensed to practice medicine in this State, a hospital administrator, or an advanced nurse practitioner;

(3) one representative of the general public whose only affiliation with a carrier is as a covered person who has coverage

through a individual or small employer health benefits plan provided by the carrier; and

(4) one representative of small employers.

e. The commissioner shall designate one of the members of the board to serve as the chairman. The chairman serves in that capacity at the pleasure of the commissioner.

f. If the initial board is not elected at the organizational meeting, the commissioner shall appoint the members within 15 days of the organizational meeting, in accordance with the provisions of subsections c. and d. of this section.

g. A member of the board of directors is not liable for an action or omission performed in good faith in the performance of powers and duties under this act, and no cause of action shall arise against a board member for the action or omission.

3. a. The program's initial board shall submit to the commissioner a plan of operation for the program that will assure the fair, reasonable, and equitable administration of the program.

b. In addition to the other requirements of this act, the plan of operation shall include procedures for:

(1) operating the program;

(2) creating a fund, under management of the board, for administrative expenses;

(3) handling and auditing of money and other assets of the program; and

(4) managing any other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this act.

c. After notice and a hearing, the commissioner shall approve the plan of operation if it is determined that the plan assures the fair, reasonable, and equitable administration of the program.

d. The plan of operation shall take effect on the date it is approved by the commissioner by order.

e. If the initial board fails to submit a suitable plan of operation before the 180th day following appointment of the initial board, the commissioner, after notice and hearing, shall adopt all necessary and reasonable rules to provide a plan of operation for the program. The rules adopted under this subsection shall continue in effect until the initial board submits, and the commissioner approves, a plan of operation under this section.

f. The board may amend the plan of operation as necessary to effectuate the purposes of this act, which amendments shall not become part of the plan until approved by the commissioner.

4. a. The program shall have the general powers and authority granted under the laws of New Jersey to insurance companies, health service corporations, and health maintenance organizations licensed or approved to transact business in this State, except that

the program shall not have the power to issue health benefits plans directly to either groups or individuals.

b. The board shall have the specific authority to:

(1) issue a reinsurance policy to a carrier in accordance with the requirements of this act;

(2) sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments to the program;

(3) institute any legal action necessary to avoid payment of improper claims against the program, to recover any amounts erroneously or improperly paid by the program, to recover any amount paid by the program as a mistake of fact or law, or to recover other amounts due to the program;

(4) enter into contracts as necessary to implement the provisions of this act including, with the approval of the commissioner, entering into contracts with other programs in the State for joint performance of common administrative functions;

(5) appoint appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in operating the program and performing any of the functions of the program; and

(6) employ and set the compensation of any persons necessary to assist the program in carrying out its responsibilities and functions.

c. Not later than June 1 of each year, the board shall make an annual report to the Governor, the President of the Senate, the Speaker of the General Assembly, the Chairs of the Senate Health, Human Services and Senior Citizens Committee and the Assembly Financial Institutions and Insurance Committee, or their successors, and the commissioner. The report shall summarize the activities of the program in the preceding calendar year, including information regarding the amount paid to carriers in reinsurance claims, administration expenses, and the amount assessed to carriers for that calendar year.

5. a. The program may issue a reinsurance policy to a carrier covering an individual under an individual health benefits plan pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or a small employer health benefits plan pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

b. Under a reinsurance policy, the program shall reimburse a carrier 90% of not less than $50,000 of aggregate benefit payments made by the carrier for health care services received by a covered person during a calendar year. The board may annually adjust the threshold limit of assessment payments to reflect changes in the medical component of the Consumer Price Index for All Urban Consumers, as reported by the United States Department of Labor, shown as an average index for the New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton region combined reflect increases in costs.

6. a. For the purposes of providing the funds necessary to carry-out the powers and duties of the program, the board of directors shall assess participating carriers at such time and for such amounts as the board finds necessary, but each carrier shall be assessed in an amount not to exceed $2.00 per covered person insured by each carrier per month.

b. Each carrier's assessment may be verified by the board based on annual statements and other reports deemed to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of a carrier if the specific number is unknown.

c. If the assessments exceed the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses.

d. Assessments shall be due not less than 30 days after prior written notice to the carriers of their assessment. A late payment shall accrue interest at 12% per annum on and after the due date. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any carrier that fails to pay an assessment. As an alternative, the commissioner may levy a forfeiture on any carrier that fails to pay an assessment when due. Such forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

e. The commissioner shall establish through regulation the procedures, criteria and forms necessary to implement, collect and deposit assessments made and collected under this section.

7. a. The State Auditor shall conduct annually a special audit of the program. The State Auditor's report shall include a financial audit and an economy and efficiency audit.

b. The State Auditor shall report the cost of each audit conducted under this act to the board and the Treasurer, and the board shall remit that amount to the comptroller for deposit to the General Fund.

8. Reinsurance policies under the New Jersey Catastrophic Health Care Claims Reinsurance Program shall be made available not later than June 1, 2007.

9. The commissioner may adopt rules and regulations as necessary to implement the provisions of this act pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

10. This act shall take effect immediately.

STATEMENT

This bill establishes the "New Jersey Catastrophic Health Care Claims Reinsurance Program" for carriers that participate in the New Jersey Individual Health Coverage Program and the New Jersey Small Employer Health Benefits Program.

As provided in the bill, the reinsurance program, operated by a board of directors, can issue reinsurance policies to carriers that issue individual or small employer health benefits plans in this State. Under the reinsurance policy, the program shall reimburse a carrier 90% of aggregate benefit payments of $50,000 or more for health care expenses incurred by a carrier for a covered person during a calendar year. The program is funded through an assessment of each carrier of no greater than $2.00 per covered person per month, with the actual amount to be set forth by the board of directors in the program's plan of operation. Assessment payments are due within 30 days of the board's notification to the carrier of its assessment. This bill establishes certain penalties for overdue or missing assessment payments.

The program's board of directors consists of 11 members, including the commissioner who shall serve as an ex officio member, six carrier representatives elected by the carriers subject to approval by the commissioner, and four individuals appointed by the Governor, with advice and consent from the Senate. The board shall submit a plan of operation to the commissioner for the management of the program and shall oversee the operation of the program. The board shall submit an annual report to the Governor, the leaders of the Legislature and chairs of certain committees, and the commissioner summarizing the activities of the program.

Finally, this bill directs the State Auditor to conduct a financial audit and an economy and efficiency audit of the program each year.