SENATE, No. 3896

STATE OF NEW JERSEY

220th LEGISLATURE

INTRODUCED MAY 22, 2023

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS

Imposes certain rate filing requirements concerning certain health benefits plans available on State-based exchange.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning the review of rates and rate changes for certain health benefits plans 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 P.L. , c. (C.) (pending before the Legislature as this bill):

"Carrier" means any entity subject to the insurance laws and regulations of this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Cost sharing reduction variant" means the version of a silver plan that provides coverage offering 94% actuarial value, 87% actuarial value, 73% actuarial value, or 70% actuarial value, plus or minus de minimis variations, as defined in 45 C.F.R. s.156.400.

"Department" means the Department of Banking and Insurance.

"Individual health benefits plan" means an individual health insurance policy pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.).

"Small employer health benefits plan" means a small employer health benefits plan issued pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

"Qualified health plan" means the same as that term is defined in section 1301(a) of the federal "Patient Protection and Affordable Care Act," Pub.L.111-148 (42 U.S.C. s.18021).

2. a. The provisions of P.L. , c. (C.) (pending before the Legislature as this bill) shall apply only to rates for the following health benefits plans:

(1) individual health benefits plans issued pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.); and

(2) small employer health benefits plans issued pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.).

b. The requirements established pursuant to P.L. , c. (C.) (pending before the Legislature as this bill) shall be in addition to any other provision of law concerning health benefits plan rates.

3. The commissioner shall ensure that the process under which the commissioner reviews health benefits plan rates and rate changes complies with P.L. , c. (C.) (pending before the Legislature as this bill) and other applicable State and federal law, including sections 1201(4), 1003, and 1312 of the federal "Patient Protection and Affordable Care Act," Pub.L.111-148 (42 U.S.C. s.300gg, 42 U.S.C. 300gg-94, and 42 U.S.C. s.18032(c)) and those sections' implementing regulations, including rules establishing geographic rating areas.

4. a. The commissioner shall adopt, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), rules and regulations concerning additional requirements related to individual health benefits plans, including qualified health plans, to address the following factors:

(1) whether the carrier issuing the health benefits plan has complied with all requirements for pooling risk, as provided in 45 C.F.R. s.156.80(d), and participating in risk adjustment programs in effect under State or federal law;

(2) the covered benefits or health benefits plan design or, for a rate change, any changes to the benefits or design; and

(3) any other factor listed in 45 C.F.R. s.154.301(a)(4), as appropriate.

b. In making a determination pursuant to this section concerning a proposed rate for a qualified health plan, the commissioner shall consider, in addition to the factors under subsection a. of this section:

(1) the purchasing power of consumers who are eligible for a premium subsidy under the "Patient Protection and Affordable Care Act," Pub.L.111-148;

(2) if the plan is in the silver level, as described by section 1302 of the federal "Patient Protection and Affordable Care Act," Pub.L.111-148 (42 U.S.C. s.18022), whether the rate is appropriate for the plan in relation to the rates charged for qualified health plans offering coverage at other metal levels, taking into account any funding or lack of funding for cost sharing reductions, the covered benefits for each level of coverage, and expected service utilization by the carrier's entire individual market risk pool, if enrolled in each metal level of coverage; and

(3) whether the carrier issuing the health benefits plan utilized the induced demand factors developed by the Centers for Medicare and Medicaid Services for the risk adjustment program established under section 1343 of the federal "Patient Protection and Affordable Care Act," Pub.L.111-148 (42 U.S.C. s.18063) for the level of coverage offered by the plan, unless the department determines that the use of other factors would be more accurate in estimating the impact of cost sharing on expected utilization by the carrier's entire individual market risk pool.

c. The commissioner may consider:

(1) if the commissioner determines it appropriate for the purposes of comparison, medical claims trends reported by carriers in this State or in a region of the United States or the United States as a whole; and

(2) inflation indexes.

5. In any rate filing issued by a carrier offering a health benefits plan through the State-based exchange established pursuant to P.L.2019, c.141 (C.17B:27A-57 et seq.), the carrier shall base the price of any plan in the silver level, as described by section 1302 of

the federal "Patient Protection and Affordable Care Act," Pub.L.111-148 (42 U.S.C. s.18022), on a distribution of silver-tier enrollment among cost sharing reduction variants that:

a. for rates charged in 2024, assumes that the plan's enrollees will be distributed among cost sharing reduction variants in proportion to the total Statewide distribution of silver-tier enrollees among those variants in 2022, as estimated by the commissioner; and

b. for rates charged after 2024, assumes that the plan's enrollees will enroll in plans with an average actuarial value of 90 percent.

6. Notwithstanding the provisions of any other section of P.L. , c. (C.) (pending before the Legislature as this bill), and except as provided in section 7 of P.L. , c. (C.) (pending before the Legislature as this bill), a carrier may:

a. offer different plan designs by rating area to individuals and small employers;

b. provide network access beyond the geographic rating area; and

c. offer plan designs with deductibles, coinsurance, and other cost sharing mechanisms necessary to comply with federal actuarial values for plans issued pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.).

7. Notwithstanding the provisions of any other section of P.L. , c. (C.) (pending before the Legislature as this bill), when a carrier makes an individual or small employer health plan and provider network available in a geographic area at either the gold or silver level, the carrier shall offer the plan and provider network in that area at both the gold and silver levels.

8. The commissioner shall seek all available federal funding to cover the cost to the department of reviewing rates pursuant to P.L. , c. (C.) (pending before the Legislature as this bill).

9. Nothing in Title 17B of the New Jersey Statutes or P.L. , c. (C.) (pending before the Legislature as this bill) shall be construed to prevent a carrier from transferring a member from a plan in the silver level to a plan in the gold level, provided that:

a. before the most recent open enrollment period, the member was enrolled in a silver level plan;

b. during that open enrollment period, the member did not make an affirmative choice of plan;

c. the gold plan and the silver plan have the same product and provider network;

d. the gold plan has a higher actuarial value and a lower premium than the silver plan;

e. the member received prior and subsequent notice from the carrier describing the transfer and explaining how the member can opt out of the transfer, as prescribed by the department; and

f. the transfer is pursuant to a transfer policy of the carrier that is filed with the department and that transfers all members who meet the criteria described in subsections a. through e. of this section.

10. This act shall take effect immediately and shall apply to health benefits plans that are delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after January 1, 2024.

STATEMENT

This bill imposes certain rate filing requirements on individual health benefits plans available on New Jersey's State-based exchange, "Get Covered NJ." The legislation requires all health insurance carriers offering these plans to follow the ACA's single-risk-pool rule. The rule requires every carrier to price each plan based on projected utilization by the identical population, the entire market risk pool. Accordingly, the cost of silver and gold level plans will be priced more in line with the actuarial value of those plans.

The bill requires the Commissioner of Banking and Insurance (commissioner) to promulgate regulations imposing additional requirements for health benefits plans, including qualified health plans, to address the following factors:

(1) whether the carrier issuing the health benefits plan has complied with all requirements for pooling risk, as provided by federal regulation, and participating in risk adjustment under State or federal law;

(2) the covered benefits or health benefits plan design or, for a rate change, any changes to the benefits or design; and

(3) certain other factors enumerated by federal regulation.

The bill requires the commissioner to consider certain additional factors in making a determination concerning a proposed rate for a qualified health plan, including:

(1) the purchasing power of consumers who are eligible for a premium subsidy;

(2) if the plan is in the silver level, whether the rate is appropriate for the plan in relation to the rates charged for qualified health plans offering coverage at other metal levels, taking into account any funding or lack of funding for cost sharing reductions, the covered benefits for each level of coverage, and expected service utilization by the carrier's entire individual market risk pool, if enrolled in each metal level of coverage; and

(3) whether the carrier issuing the health benefits plan utilized the induced demand factors developed by the federal Centers for

Medicare and Medicaid Services for the risk adjustment program established under federal law for the level of coverage offered by the plan, unless the Department of Banking and Insurance determines that the use of those factors would be objectively inappropriate in estimating the impact of cost sharing on expected utilization by the carrier's entire individual market risk pool.

The bill requires carriers that make an individual or small employer health plan and provider network available in a geographic area at either the gold or silver level to offer the plan and provider network in that area at both the gold and silver levels.

The bill provides that, in any rate filing issued by a carrier offering a health benefits plan through the State-based exchange, the carrier shall base the price of any plan in the silver level on a distribution of silver-tier enrollment among cost sharing reduction variants that:

(1) for rates charged in 2024, assumes that the plan's enrollees will be distributed among cost sharing reduction variants in proportion to the total statewide distribution of silver-tier enrollees among those variants in 2022, as estimated by the commissioner; and

(2) for rates charged after 2024, assumes that the plan's enrollees will enroll in plans with an actuarial value of 90 percent.

The bill provides that nothing in current law or in the bill is to be construed to prevent a carrier from transferring a member from a plan in the silver level to a plan in the gold level, provided that:

(1) before the most recent open enrollment period, the member was enrolled in a silver level plan;

(2) during that open enrollment period, the member did not make an affirmative choice of plan;

(3) the gold plan and the silver plan have the same product and provider network;

(4) the gold plan has a higher actuarial value and a lower premium than the silver plan;

(5) the member received prior and subsequent notice from the carrier describing the transfer and explaining how the member can opt out of the transfer, as prescribed by the department; and

(6) the transfer is pursuant to a transfer policy of the carrier that is filed with the department and that transfers all members who meet the criteria described in this paragraph.