INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Proposed Repeals: N.J.A.C. 11:20-8.1, 8.2, 8.3, 8.4, 13.1, 13.2, 13.3, 13.4, 13.5 and Appendix Exhibit K

Proposed Amendments: N.J.A.C. 11:20-1.2, 3.1, 4.1, 6.1, 6.3, 7.3, 7.4, 8.1, 8.2, 8.3, 8.4, 8.5, 9.2, 9.3, 9.4, 9.5, 12.1, 12.3, 12.4, 12.5, 17.1, 17.3, 17.4, 18.2 and Appendix Exhibits G and L.

Proposed New Rules: N.J.A.C. 11:20-8.1, 8.2, 8.3, 8.4, 21.1, 21.2, 21.3, 21.4, 21.5, 21.6, 21.7, Appendix Exhibit K and Appendix Exhibit V.

Authorized By: New Jersey Individual Health Coverage Program Board, Wardell Sanders, Executive Director.

Authority: N.J.S.A. 17B:27A-2 et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2002-

Interested persons may testify with respect to the proposed specimen policy form on December 9, 2002 at 10:00 a.m. at the New Jersey Department of Banking and Insurance, 10th floor conference room, 20 West State Street, Trenton, New Jersey.

Submit written comments by January 8, 2003 to:

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The agency proposal follows:

Summary

Pursuant to P.L. 2001, c. 368, N.J.S.A. 17B:27A-4.4 through 4.7, every carrier that writes individual health benefits plans in New Jersey must offer a health benefits plan, in addition to the current standard plan options, that includes only the benefits enumerated in the new law. In enacting this law, the Legislature indicated that its intent was to have available in the individual market plans that provide for "reimbursement for basic and essential health care services but do not contain either the traditional mandated benefits to which the standard plans are subject or reimbursement for services which the consumer can more economically pay for himself, rather than having those services paid for through a third-party system, which adds significantly to the cost." To distinguish this plan from the "basic" health benefits plan originally required to be offered pursuant to N.J.S.A. 17B:27A-4c, this plan will be referred to as the "basic and essential health care services plan."

P.L. 2001, c. 368 gives the Individual Health Coverage Program Board ("Board") the responsibility for review of the policy form for such plan and for any riders that add benefits to the plan that carriers wished to offer with the plan. P.L. 2001, c. 368 further requires the Board to review rate filings and loss ratio information for this new plan. P.L. 2001, c. 368 also requires that carriers demonstrate they have marketed the new health benefits plan in good faith. The law further provides that to the extent that the provisions of P.L. 2001, c. 368 are not in conflict with the provisions of P.L. 1992, c. 161 (the Individual Health Coverage Reform Act), the provisions of P.L. 1992, c. 161 apply to the coverage offered pursuant to P.L. 2001, c. 368. One purpose of these proposed amendments and new rules is to implement P.L. 2001, c.368. The other purpose of the proposed amendments is to clarify and streamline the reporting forms that all carriers must file biennially. To that end, this proposal also repeals Subchapter 13, the Certification of Non-member Status, portions of Subchapter 8 and the entire Appendix Exhibit K, the Market Share

and Net Paid Gain (Loss) Report. The proposal includes new rules in Subchapter 8, amendments to other portions of Subchapter 8, and a new Exhibit K called the "Assessment Report." The new rules and new Exhibit K, and amendments to Subchapter 8, are designed to streamline and consolidate carrier reporting relating to the IHC assessment. The amendments to N.J.A.C. 11:20-8.5 are designed to clarify existing reporting requirements related to the calculation of net paid losses or gains. It is the Board's goal to adopt these changes for the Exhibit K filings that will be due on March 1, 2003.

Changes Required by P.L.2001, c.368

The Board proposes modifying various sections of N.J.A.C. 11:20 and Exhibits G and L in order to address the obligation of carriers to market, issue and administer a new health benefits plan consistent with the requirements set forth in P.L. 2001, c. 368.

The Board proposes amending the definition of "health benefits plan" in N.J.A.C. 11:20-1.2 to specifically include among the list of plans that are considered to be health benefits plans the basic and essential health care services plan required to be offered pursuant to P.L. 2001, c. 368. This change is necessary so that the Board may consider the premium, claims, and enrollment from the plan for calculating the assessment, for calculating non-group enrollment targets, and for determining non-group enrollment satisfaction levels for carriers seeking exemptions. The Board proposes amending the “non-group persons” definition to include non-group persons enrolled under a basic and essential health care services plan. The Board proposes deleting the definition of “reimbursement for losses” since an understanding of reimbursement for losses is best attained from a reading of subchapters 2 and 8 of N.J.A.C. 11:20.

The Board proposes amending N.J.A.C. 11:20-3 to make it clear that while the benefits, limitations and exclusions for the standard plans are set forth in Exhibits to N.J.A.C. 11:20, the

requirements for the basic and essential health care services plan are found in P.L. 2001, c. 368. The proposed change notes the existence of a specimen policy form.

The Board proposes amending N.J.A.C. 11:20-4.1 and the corresponding Exhibit G to address use of the standard application for applying for coverage under the basic and essential health care services plan.

The Board proposes amending N.J.A.C. 11:20-6.1, 6.2 and 6.3 to address the unique modified community rating requirements applicable to the basic and essential health care services plan, as set forth in P.L. 2001, c. 368. The proposed changes address the use of modified community rating for the plan as well as the rating for optional benefit riders that carriers may make available with such plan. Since P.L. 2001, c. 368 allows carriers to use modified community rating with respect to the basic and essential health care services plan, the rate filing regulation is being amended to address the permissible rating factors of age, gender and geographic location. The Board recognizes that modified community rating has been the practice for carriers selling coverage in the small employer market and that all of the carriers currently selling coverage in the individual market either have sold or do sell coverage in the small employer market. In order that the rate filing requirements be something with which carriers already have some familiarity, the Board copied sections that deal with modified community rating and the age, gender and geographic location rate classification factors from the Small Employer Health Benefits Program Board regulations, which are found at N.J.A.C. 11:21. In addition, the Board clarified the rate filing regulation as applicable to all rate filings to explicitly state that when a carrier designates an effective date in a rate filing, the carrier is expected to implement the rates as of that stated effective date.

The Board proposes amending N.J.A.C. 11:20-7.3 and 7.4 to address the inclusion of the loss ratio data associated with the basic and essential health care services plan on the loss ratio report carriers submit each year for the standard health benefits plans.

The Board proposes changes to N.J.A.C. 11:20-9.2 through 9.5 to address the inclusion of lives enrolled under the basic and essential health care services plan for purposes of seeking and obtaining an exemption and calculating non-group person targets. Lives enrolled under the new plan shall be used by the Board in setting the target and shall be counted toward the satisfaction of the non-group enrollment target for the purpose of qualifying for an exemption.

The Board proposes changes to N.J.A.C. 11:20-12.1, 12.3, 12.4 and 12.5 to address the availability of the basic and essential health care services plan to a person who either has coverage under a group plan or who is covered under another individual health benefits plan. P.L. 2001, c. 368 clearly requires carriers to make the plan available to a person that has other coverage and the proposed changes detail that availability.

The Board proposes changes to N.J.A.C. 11:20-17.1 through 17.4 and corresponding Exhibit L to include the lives enrolled under the basic and essential health care services plan on the quarterly and annual enrollment reports carriers file with the Board. P.L. 2001, c. 368 charges the Board with evaluating the effectiveness of the basic and essential health care services plan. Enrollment data such as that which is captured on Exhibit L will be invaluable in terms of evaluating effectiveness.

The Board proposes changes to N.J.A.C. 11:20-18.2 to include the basic and essential health care services plan in the definition of a "standard health benefits plan" such that the basic and essential health care services plan is included in the regulation that governs the orderly withdrawal and ensuing non-renewal of plans. The Board notes that for the purposes of withdrawal only no distinctions between the standard health benefits plans and the basic and

essential health care services plan were necessary and therefore the simplest means to address withdrawal of the basic and essential health care services plan was to consider it as a standard health benefits plan.

New section N.J.A.C. 11:20-21 and Exhibit V

The Board proposes a new subchapter that deals specifically with provisions that are unique to the basic and essential health care services plan required by P.L. 2001, c. 368. In addition, the Board proposes a specimen policy form, set forth in Appendix Exhibit V that carriers may use as a basic and essential health care services policy form.

The Board proposes N.J.A.C. 11:20-21.1 to define the purpose and scope of the new subchapter. The subchapter outlines procedures and standards that are unique to the offering of the basic and essential health care services plan while noting that carriers must continue to seek guidance in other sections of N.J.A.C. 11:20 with respect to procedures and standards that have application to standard plans as well as the new basic and essential health care services plan.

The Board proposes N.J.A.C. 11:20-21.2 to include definitions that are unique to the marketing and administration of the basic and essential health care services plan. The Board notes that while under many types of managed care plans a copayment is generally assumed to be the limit of a consumer’s liability for a service or supply, under the terms of the basic and essential health care services plan, it is possible for the consumer to be "balance billed." If the copay and the benefit paid by the carrier are less than the provider's billed charges, the provider may require the consumer to pay the difference. This is known as balanced billing.

The Board proposes N.J.A.C. 11:20-21.3 to define the obligations of carriers to offer the basic and essential health care services plan. The Board notes that pursuant to N.J.S.A. 17B:27A-2, the definition of “carrier” states that for the purposes of the Act, carriers that are affiliated companies shall be treated as one carrier. Therefore, if a carrier writes both HMO

coverage and non-HMO coverage through affiliated companies, that carrier may satisfy its obligation to market the basic and essential health care services plan by offering coverage either through the HMO company or through the non-HMO company, and need not offer coverage through both companies. In every instance of affiliated carriers the obligation to offer the basic and essential health care services plan is satisfied if at least one of the affiliated carriers offers the basic and essential health care services plan.

The Board proposes N.J.A.C. 11:20-21.4 to specify the filing requirements associated with the basic and essential health care services plan. The policy form and accompanying certification must be filed with the Board for approval. If the Board has not disapproved the filing within 30 days, the filing shall be deemed approved.

The Board notes that the majority of carriers in the individual market contacted the Board with questions regarding the benefit design described in P.L.2001, c.368. As a result of this large number of inquiries, the IHC Board is proposing a specimen basic and essential health care services policy form at proposed Exhibit V. The Board makes that policy form available for carriers to use, at their option, as their basic and essential health care services plan.

The Board proposes N.J.A.C. 11:20-21.5 to specify the filing requirements associated with the enhancements that carriers may use, subject to the Board's approval, with the basic and essential health care services plan. The Board will have 30 days in which to review the optional benefit riders. Carriers may deem the riders approved if the Board fails to respond to a filing within the 30-day period.

The Board proposes N.J.A.C. 11:20-21.6 to address the manner in which carriers are to demonstrate that they have complied with the requirements of P.L. 2001, c. 368 to make a good faith effort to market the basic and essential health care services plan. The proposed regulation offers some examples of the types of efforts carriers may employ. Each carrier may employ

whichever efforts it chooses. All carriers, regardless of how many lives they have enrolled, are required to demonstrate that they have marketed the basic and essential health care services plan in good faith. The demonstration that a carrier has marketed the basic and essential health care services plan in good faith is separate from a showing that certain carriers must make in order to qualify for an exemption from loss assessment pursuant to N.J.A.C. 11:20-9.5(f)(2) and N.J.A.C. 11:20-9.6.

As briefly discussed above, the Board proposes a new exhibit, Exhibit V. This policy form represents the nature and extent of the benefits, limitations and exclusions required for the basic and essential health care services plan under P.L. 2001, c. 368. The text of the specimen policy includes some limited variable areas in which carriers are to include their names and carrier-specific data. In some areas, variable text is included that non-HMO carriers would include to address the possibility of balance billing. Other variable text requires carriers to insert procedures that satisfy the requirements of specific laws, such as the appeals procedure and the grievance procedure. Carriers may use the specimen policy form or may develop a policy form on their own.

Subchapter 8 and Exhibit K

In past reporting periods, the IHC Board and its staff have spent a great deal of time in follow up with carriers to ensure accurate reporting on the form set forth as appendix Exhibit K and to ensure non-member status for carriers without net earned premium. To assist carriers in correctly completing Exhibit K, the Board is proposing a revised Exhibit K that provides definitions of terms used in Exhibit K on the exhibit itself. The Board proposes repealing N.J.A.C. 11:20-8.1 through 8.4 and Exhibit K and proposes new rules to replace the repealed rules. The purpose of these changes is to provide carriers with a clearer reporting format, and to ensure that the carriers have carefully considered the data that the IHC Board needs to collect in

order to administer the assessment. The Board also proposes repealing N.J.A.C. 11:20-13, the rules relating to certification of non-member status. All carriers, whether members or non-members, will be required to submit Exhibit K.

Proposed new rule N.J.A.C. 11:20-8.1 sets forth the scope and application of Subchapter 8, which requires carriers to submit Exhibit K. The new report form will be used to distinguish between members of the IHC Program subject to assessment and non-members who are not subject to the assessment.

Proposed new rule N.J.A.C. 11:20-8.2 sets forth the criteria for filing the Assessment Report form, identifies how carriers with affiliates shall report, and identifies how carriers should submit completed assessment forms.

Proposed new rule N.J.A.C. 11:20-8.3 sets forth the criteria for reporting net earned premium for the two-year calculation period on Part C of Exhibit K or for asserting non-member status if the carrier has no net earned premium as identified in N.J.A.C. 11:20-1.2. Each affiliate, if any, of a carrier will be required to submit its own Exhibit K Part C Premium Data Worksheet, which is set forth as part of Exhibit K in the Appendix to this Chapter, and will be required to aggregate all premium for all affiliates and report the premium data on one Assessment Report form. The new reporting procedures and format do not change the net earned premium data that carriers have always been required to file.

Proposed new rule N.J.A.C. 11:20-8.4 sets forth the criteria for reporting the average non-group enrollment for the two-year calculation period on Part D of Exhibit K. Each affiliate, if any, of a carrier that has enrolled any non-group persons will be required to submit the Exhibit K Part D Enrollment Data Worksheet, which is set forth as part of Exhibit K in the Appendix to this Chapter, and will be required to aggregate all average non-group enrollment and report the enrollment data on the Assessment Report form to which will be attached each affiliate's

Worksheet. The new reporting procedures and format do not change non-group enrollment data that carriers have always been required to report.

Proposed amendments to N.J.A.C. 11:20-8.5 amend the provisions that relate to the reporting of such specific information as the premium, claims, and net investment income by member carriers that issued individual health benefits coverage during the calculation period. First, the proposed amendments identify that the information requested is to be reported in Part E of the proposed new Exhibit K. Additionally, the proposed amendments at N.J.A.C. 11:20-8.5 (a) provide that information about premium, claims, and investment income relates not only to the community rated standard health benefits plans developed by the Board and the community rated guaranteed issue plans issued prior to August 1, 1993, but also to the basic and essential health care services plan, which may be rated on a modified community rated basis.

Proposed amendments to N.J.A.C. 11:20-8.5(c) also include a clarification to the reporting of claims paid. There are a number of areas where the NAIC reporting of claims may have been ambiguous. The proposed changes, which are consistent with the Board's current and past practice, permit carriers to include not only payments for covered services to providers and insureds, but also network access fees where such fees may be demonstrated to have reduced specific claim payments and where the carrier has reported such fees as claims on its annual statement, as well as fees, taxes or assessments that are directly tied to the provision of medical services such as the surcharge mandated pursuant to the New York Health Care Reform Act of 2000, P.L. 1999, c. 1, codified in New York Public Health Law, Section 2807-c through 2807-w.

Proposed amendments to N.J.A.C. 11:20-8.5(d)(2) clarify that the phrase "inception to date" in measuring a carrier's cash flow is meant to measure from the first date of the carrier's participation in the reformed individual market place until the last day of the most recent calculation period. This change is consistent with both the Board's past and current

interpretation of the existing language and is consistent with Bulletin No. 99-IHC-02 issued on July 7, 1999.

Proposed amendments to N.J.A.C. 11:20-8.6, 8.7 and 8.8 replace references to the Market Share Report and Net Paid Gain (Loss) Report with the new name of the report, the Assessment Report. Additionally, proposed amendments to N.J.A.C. 11:20-8.8, a provision addressing audits, clarifies that the Board shall adjust a carrier's net paid loss based on findings of an independent auditor that a carrier has not paid claims consistent with the terms of the applicable contract or applicable law, or collected premium consistent with the terms of the carrier informational rate filing or applicable law. For example, the Board shall adjust a carrier's net paid loss by adjusting its reported claims paid if an independent audit finds that a carrier that issued coverage to an ineligible individual or paid claims for an ineligible benefit or in excess of that for which the contract provides. Similarly, the Board shall adjust reimbursement to a carrier if an independent audit finds that a carrier did not charge premium consistent with the carrier's informational rate filing, including the effective date, or applicable law. These changes are consistent with the Board's current practice.

Proposed revised Exhibit K includes a new report format for the Assessment Report and includes the Exhibit K Part C Premium Data Worksheet and the Exhibit K Part D Enrollment Data Worksheet.

The revised report will require carriers to specifically identify coverage types and amounts that are reported on annual statement filings that are specifically excluded from the definition of a "health benefits plan." With the proposed changes it will be easier for the Board to verify whether carriers have calculated net earned premium data accurately. It is the hope of the Board that the proposed changes will make it easier for carriers to accurately complete the

forms and will reduce the follow-up with carriers that has been required in the past due to inaccurate reporting of data on Exhibit K.

The IHC Board proposes these amendments pursuant to the procedures set forth in N.J.S.A. 17B:27A-16.1, which provide a special procedure whereby the IHC Board may adopt certain actions. Pursuant to this procedure, the Board is required to publish notice of its intended action in three newspapers of general circulation, which notice shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views regarding the intended action. Notice of the intended action also is required to be sent to affected trade and professional associations, carriers, and other interested persons who may request such notice. Concurrently, the Board is required to forward the notice of the intended action to the Office of Administrative Law ("OAL") for publication in the New Jersey Register. The Board must provide a minimum 20-day period for all interested persons to submit their written comments on the intended action to the Board. However, to ensure compliance with amendments to the Administrative Procedure Act, the Board has provided a 60-day comment period for this proposal As a result, the proposal is excepted from the rulemaking calendar requirements pursuant to N.J.A.C. 1:30-3.3(a)5.

Pursuant to N.J.S.A. 17B:27A-16.1, the Board may adopt its intended action immediately upon the close of the specified comment period by submitting the adopted action to the OAL. If the Board elects to adopt the action immediately upon the close of the comment period, it shall nevertheless respond to the comments timely submitted within a reasonable period of time thereafter. The Board shall prepare a report for public distribution, and publication by the OAL in the New Jersey Register. The report shall include a list of commenters, their relevant comments, and the Board's responses.

Please note that the unique provisions of N.J.S.A. 17B:27A-16.1 may result in the publication of this rule proposal after the 60-day comment period has begun.

Social Impact

The amendments to the existing regulation and addition of new regulations are largely in response to P.L. 2001, c. 368. As stated in section 1e of the law, "It is to the interest of the State and of all health care providers that as many people have access to reasonably affordable health insurance as possible, for this reduces the amount of charity care that providers provide as well as the amount of bad debt that must be absorbed by providers each year." It is the Legislature's intention that the basic and essential health care services plan be a plan option for consumers that is more affordable than some of those currently available. Certainly, the fact that the plan does not include coverage for many services and supplies typically covered under a health benefits plan will have an impact on the cost of the coverage. In addition, the use of modified community rating based on age, gender and geography will likely be an incentive for some younger persons to explore securing coverage. While these plans may be more affordable than current options, this plan will have significant limitations in coverage that consumers will need to be aware of in making a purchase decision. The amendments and new provisions proposed herein also will affect all carriers offering coverage in the individual health benefits market. These carriers will be required to file and market a new plan. Carriers also will be responsible for educating their employees and agents, if any, regarding the new plan, and in particular noting how it differs from the more comprehensive plans currently available and for assisting insured persons.

With respect to the assessment report, by putting defined terms in the reporting format itself, the proposed amendments to N.J.A.C. 11:20-8 and Exhibit K should make it easier for carriers to complete the report form that the Board uses to calculate the assessment.

Economic Impact

The proposed amendments and new provisions should have an economic impact on persons eligible for coverage in the individual market that are looking for coverage with a lower monthly premium. In P.L.2001, c.368, the Legislature indicated that the purpose of the law is "to create a policy that is more affordable than the options that presently exist; even though the benefit package is not as rich as the existing plans, the benefit plan provided by this act will make health insurance more accessible to many individuals that do not have the economic resources to afford the existing plans while still providing essential coverage."

The proposed amendments also may have an economic impact on carriers. The Legislature believes that the new plan options could attract more consumers to obtain coverage. Thus, carriers seeking an exemption from reimbursable loss assessments would have a better opportunity to enroll non-group persons that would count toward the carrier's non-group enrollment target. This will positively affect carriers seeking and obtaining an exemption.

Carriers will experience an economic impact as they will be required to develop, file and print new policy forms. Carriers also will have to disseminate information regarding the new plan option to their employees.

The amendments to N.J.A.C. 11:20-8 and Exhibit K are intended to make the filing requirements for the assessment clearer so that carriers do not need to work with the Board and its staff in follow up to the filings to determine the accuracy of the filings. The proposed changes are not intended to change the data that the Board ultimately uses to determine net paid losses or assessment liability. A question has arisen with the Board regarding its existing interpretation of whether a carrier's reported premium should be based on its informational rate filings and whether the "inception to date" measurement of cash flow in the calculation of net investment income is measured by the date that the carrier first seeks reimbursement.

Federal Standards Statement

The standard individual health benefits plans comply with the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191. The standard plans, and the rules describing the standard plans, do not expand upon the requirements set forth in the Federal law.

Jobs Impact

The proposed amendments and new rule are not expected to result in the generation or loss of jobs in the State if they were to take effect.

Agriculture Industry Impact

The proposed amendments and new rule have no impact on the agriculture industry.

Regulatory Flexibility Analysis

The Board believes that all carriers subject to these rules have in excess of 100 employees or are located outside of the State of New Jersey. Therefore, a regulatory flexibility analysis is not required. However, to the extent that any carrier might be considered a small business under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the following analysis would apply.

The proposed amendments to Exhibits G, K, L of the Appendix to N.J.A.C. 11:20 and various changes to N.J.A.C. 11:20 will require carriers to develop a new plan, file it and adapt their operations (sales, administration, and claims handling) to the new plan. There will be capital costs involved in such compliance in terms of printing, systems programming, staff and agent training, etc., but it is unlikely that any carrier will have to contract for outside professional services in order to comply. All of the required changes to a carrier's business fall within the normal functions a carrier performs in complying with any state insurance law or regulations. An exception from the requirement to sell the basic and essential health care services plan would be inconsistent with the requirements of P.L. 2001, c. 368.

Smart Growth Impact Statement

The proposed new rules will have no impact on the achievement of smart growth and implementation of the State Plan.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

_____ Date: _____
Wardell Sanders, Executive Director

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.2 Definitions

“Act” – "Affiliated carriers" (No change.)

"Basic and essential health care services plan" means the health benefits plan pursuant to P.L.2001, c.368, N.J.S.A. 17B:27A-4.4 through 4.7.

"Basic health benefits plan" to “Group health plan” (No change.)

“Health benefits plan” means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers’ compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any

exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act (42 U.S.C.s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

The term "health benefits plan" specifically includes:

1. Standard health benefits plans as defined in this section;

2. Closed blocks of business otherwise meeting the definition of health benefits plan;

3. Executive medical plans;

4. Student coverage which provides more than accident-only coverages;

5. All prescription drug plans whether or not written on a stand alone basis;

6. Plans that cover both active employees and retirees eligible for Medicare for which separate statutory reporting is not made by the carrier; [and]

7. The basic and essential health care services plan ; and

[7.]8. All other health policies, plans or contracts not specifically excluded.

"HMO" – "Net Earned premium" (No change.)

“Non-group persons” or “non-group persons covered” means coverage by an individual health benefits plan or conversion policy or contract subject to P.L.1992, c.161 (N.J.S.A.17B:27A-2 et seq.), a basic and essential health care services plan pursuant to P.L. 2001, c. 368, Medicare cost or risk contract, Medicare Plus Choice contract, or Medicaid contract.

“Open enrollment” – “Reasonable and customary” (No change.)

["Reimbursement for losses" means reimbursements distributed through the IHC Program to cover losses, in whole or in part, incurred by members applying for reimbursements with respect to individual standard health benefits plans beginning in calendar year 1993 and thereafter.]

11:20-1.3 through -1.6 f (No change.)

SUBCHAPTER 3. [STANDARD] BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 [Benefits provided] The standard health benefits plans

(a) The standard individual health benefits plans established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, Exhibit A;
2. Plan B, "Individual Health Benefits Plan, "Exhibit B;
3. Plan C, "Individual Health Benefits Plan C," Exhibit C;
4. Plan D, "Individual Health Benefits Plan D," Exhibit D;
5. Plan E, "Individual Health Benefits Plan E," Exhibit E;
6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F; and

7. Plan A/50, "Basic Health Benefits Plan A/50, " Exhibit U.

(b) – (e) (No change.)

11:20-3.4 Basic and Essential Health Care Services Plan

The basic and essential health care services plan established by the Legislature contains the benefits, limitations and exclusions set forth in N.J.A.C. 11:20-21. A specimen policy form is set forth in Appendix Exhibit V.

SUBCHAPTER 4. STANDARD APPLICATION FORM

11:20-4.1 Standard application form

All members offering standard health benefits plans with an effective date on or after August 1, 1993, and the basic and essential health care services plan with an effective date on or after January 1, 2003 shall use the standard application form approved by the Board and specified in Exhibit G with the variable text explained on the Explanation of Brackets, Exhibit T of the Appendix to this chapter.

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

11:20-6.1 Purpose and scope

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to section 2b(1)[and] pursuant to 3 of the Act (N.J.S.A. 17B:27A-3b(1) and 17B:27A-4 as well as the basic and essential health care services plan pursuant to P.L. 2001, c. 368.

11:20-6.3 Informational rate filing requirements

(a) All members issuing standard health benefits plans on a new contract or policy form and the basic and essential health care services plan, shall make, prior to issuing any [standard] of these health benefits plans, an informational rate filing with the Board, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other factors prohibited by the Act; except that the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by P.L. 2001, c. 368 and N.J.A.C. 11:20-6.5 below.

2. Premium rates and any factors used in the calculation of the premium rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date. Unless a carrier amends the rate filing to specify an alternative effective date, carriers shall use the rates shown in the rate filing, as of the stated effective date.[, and] Rates may be developed on different rate tiers for: single, husband/wife; adult/child(ren); family; and, at the option of the carrier, [child(ren) only coverage]; and with respect to the basic and essential health care services plan, and any riders thereto, a description of the rating methodology or plan and the numerical value of the classification factors utilized in determining a policyholder's rates that addresses the use of the factors of age, gender and geography as discussed in i, ii and iii below, provided that all proposed rates applicable in the State have been filed with the Board before being used to quote new business or renewals. The filing for the basic and essential health care plan shall include:

i. the numerical value of the classification factors utilized in the calculation of an individual's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of each covered adult in accordance with the factors set forth in N.J.A.C. 11:20-6.5 below;

ii. a written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates into the rates charged for an individual policy; and

iii. a detailed example calculation, in the proposal format used by the carrier, for the basic and essential health care services plan, including any rider option(s), showing all the steps to develop premiums for a policy and demonstrating the adjustment, if any, to achieve the required 350 percent maximum ratio between premiums for the highest rated individual policyholder and the lowest rated individual policyholder in the State.

3. (No change.)

4. A certification signed by a member of the American Academy of Actuaries, which shall include the following:

i. A statement that the informational filing is complete; [and]

ii. A statement that the carrier's loss ratio is expected to be at least 75 percent; and

iii. For rates to be charged for the basic and essential health care services plan, and any optional benefit riders thereto, a statement that the rating methodology will not produce rates (for each rate tier) for the highest rated policyholder which are greater than 350 percent of the rates (for each rate tier) for the lowest rated policyholder for each basic and essential health care services plan and rider option; and

5. (No change.)

(b) Any member which seeks to change its rates for its standard health benefits plans, its basic and essential health care services plan, or its community rated health benefits plans issued prior to August 1, 1993 shall, prior to the effective date of the revised rates, submit to the Board an informational rate filing, which shall include all the supporting data set forth in (a) above.

11:20-6.5 Permissible Rate Classification Factors

(a) For a basic and essential health care services plan issued or renewed on or after January 1, 2003, a carrier shall not differentiate premium rates charged to different individuals for the basic and essential health care services plan and rider(s), if any, except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; 70 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first three digits of the U.S. Postal Service zip codes or the counties listed below. A carrier shall determine which territory applies to a policyholder on the basis of the address of the policyholder's place of residence. The six territories are the following:

i. Territory A consists of zip codes 070-073 or Essex, Hudson and Union counties;

ii. Territory B consists of zip codes 074-076 or Bergen and Passaic counties;

iii. Territory C consists of zip codes 077-079 or Monmouth, Morris, Sussex and Warren counties;

iv. Territory D consists of zip codes 088-089 or Hunterdon, Middlesex and Somerset counties;

v. Territory E consists of zip codes 081, 085-086 or Burlington, Camden and Mercer counties; and

vi. Territory F consists of zip codes 080, 082-084 and 087 or Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

(b) Notwithstanding (a) above, a carrier may differentiate premium rates on the basis of family structure according to only the following four rating tiers:

1. Single;

2. Husband and Wife;

3. Adult and child(ren); and

4. Family.

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20-7.3 Filing of Loss Ratio Report

(a) Each member that had a standard health benefits plan or a basic and essential health care services plan in force during the preceding calendar year shall file with the Board an annual Loss Ratio Report on the form appearing as Exhibit J in the Appendix to this chapter incorporated herein by reference. Affiliated carriers shall file a separate report for each carrier that had standard health benefits plans or the basic and essential health care services plan in force during the preceding calendar year plus a combined report reflecting the combined data for all affiliated carriers.

(b) The Report shall be filed on the basis of the combined total of the standard health benefits plans policy forms and the basic and essential health care services plan policy forms written by the member.

(c) The Report shall be completed and filed with the Board on or before August 15 of the reporting year for the preceding calendar year.

11:20-7.4 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form shall be completed annually by each member and shall include the following information with respect to standard health benefits plans and the basic and essential health care services plan:

1. The reporting member's name and address;

2. The member's net earned premium for the preceding calendar year;

3. A statement of the member's total losses incurred consisting of:

i. Claims paid during the preceding calendar year, regardless of the year incurred;

ii. Less residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;

iii. Less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year’s Loss Ratio Report;

iv. Plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;

v. Plus residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year;

vi. Plus a pro rata share of the reimbursable net paid loss assessment paid by the carrier pursuant to N.J.A.C. 11:20-2.17 during the preceding calendar year, if any, determined as the member's total net paid loss assessment multiplied by the ratio resulting from dividing the member's net earned premium for standard health benefits plans and the basic and essential health care services plan for the preceding calendar year by the net earned premiums for all of the member's health benefits plans for the preceding calendar year;

4. The member's loss ratio (determined by dividing the total losses incurred in (a)3 above by the net earned premium as determined in (a)2 above);

5. Certification by a member of the American Academy of Actuaries that the information provided in the Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-9 in accordance with instructions; and

6. Such other information as the Board may request.

(b) The residual reserve reported in (a) above shall consist of either:

1. A safeharbor reserve equal to 3.3 percent of the sum of (a)3i, (a)3iii and (a)3iv above; or

2. A calculated residual reserve, supported by data and assumptions demonstrating how the reserve was calculated, and an accompanying actuarial certification. A calculated residual reserve may be subject to independent audit by an actuarial firm selected by the Board. If such firm finds that the calculated residual reserve is not reasonable, supportable, or otherwise in conformance with this subchapter, the Board shall not accept the carrier's loss ratio report or approve a refund plan.

11:20-7.5 Refund plan

(a) If the loss ratio determined in N.J.A.C. 11:20-7.4 is less than 75 percent, the member shall include with the Report a plan to be approved by the Board for a prompt refund to policy and contract holders of the difference between the amount of net earned premium it received that year on the standard health benefits plans and net earned premium received that year on the basic and essential health care services plan and the amount that would have been necessary to achieve the 75 percent loss ratio.

(b) The refund plan shall conform with the following:

1. Refunds shall be made to all contract holders who were covered for any period during the preceding calendar year;

2. The refund amount per contract holder shall be determined by multiplying the earned premium from each contract holder's standard health benefits plan or basic and essential health care services plan by the percentage resulting from dividing the total refund calculated in accordance with (a) above by the carrier's total net earned premium from the standard health benefits plans and basic and essential health care services plans, or on the basis of a practical and equitable alternative formula proposed by the carrier for approval by the Board; and

3. Refund payments shall be made within 45 days of written approval by the Board of the refund plan.

(c) The Board may request that a carrier provide additional information or that a carrier make amendments to the refund plan. Carriers shall respond to such requests within the timeframes specified by the Board.

SUBCHAPTER 8. THE IHC PROGRAM [MARKET SHARE AND NET PAID GAIN (LOSS)] ASSESSMENT REPORT

Delete 11:20-8.1 through –8.4 and replace with:

11:20-8.1 Scope and applicability

(a) This subchapter sets forth reporting and certification requirements for premium and non-group enrollment data of Program members and other carriers with reportable accident and health premium in New Jersey. This subchapter also sets forth reporting and certification requirements for premium, claims, and net investment income data of Program members issuing individual health benefits plans.

(b) This subchapter shall apply to all carriers with reportable accident and health premium in New Jersey for any portion of the two-year calculation period for which reports under this subchapter are required to be filed.

11:20-8.2 Filing of the assessment report form

(a) Every carrier with reportable accident and health premium in New Jersey shall file the Exhibit K Assessment Report form, a copy of the Exhibit K Part C Premium Data Worksheet, and a copy of the Exhibit K Part D Enrollment Data Worksheet which are set forth as Exhibit K in the Appendix to this chapter on or before March 1, 2003 and on or before March 1 of the year immediately following every two-year calculation period thereafter.

(b) If a carrier with reportable accident and health premium in New Jersey is an affiliated carrier, the Exhibit K Assessment Report, the Part C Premium Data Worksheet and the Part D Enrollment Data Worksheet shall be filed as follows:

1. Each affiliated carrier shall file one copy of the Exhibit K Part C Premium Data Worksheet whether or not that affiliated carrier reported accident and health premium in New Jersey during the two-year calculation period.

2. Each affiliated carrier shall file one copy of the Exhibit K Part D Enrollment Data Worksheet if the carrier issued or renewed any of the coverages specified on the Enrollment Data Worksheet. If an affiliated carrier neither issued nor renewed any of the coverages specified on the Enrollment Data Worksheet, it is not necessary for that affiliated carrier to file the Exhibit K Part D Enrollment Data Worksheet.

3. The combined affiliated carriers, identified using a single carrier name, shall file one copy of the Exhibit K Assessment Report. The information specified on the Assessment Report shall be the aggregated information supplied on the Premium Data Worksheets for all affiliated carriers and the Enrollment Data Worksheets for those affiliated carriers with non-group person enrollment.

4. The Assessment Report along with the Premium Data Worksheet(s) and the Enrollment Data Worksheet(s) shall be filed together. For example, a carrier with three affiliates with reportable accident and health premium in New Jersey but only two of which issue non-group coverage, would file one Exhibit K with the aggregated information for all affiliated carriers, three copies of the Exhibit K Part C Premium Data Worksheet, and two copies of the Exhibit K Part D Enrollment Data Worksheet.

(c) Certified report forms shall be submitted by facsimile, with paper copy to follow by mail, or mailed or delivered to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

11:20-8.3 Calculation of net earned premium and determination of program membership for the two-year calculation period

(a) In Part C of the Exhibit K Assessment Report, each member shall set forth its total net earned premium from plans issued, continued or renewed for all affiliated carriers

during the preceding two-year calculation period. Net earned premium reported in Part C of Exhibit K shall be consistent with the data set forth on the Exhibit K Part C Premium Data Worksheet(s).

(b) In Part C of the Exhibit K Assessment Report, each carrier with no net earned premium in the preceding two-year calculation period shall assert its status as a Non-member by checking the box designated for Non-members on the assessment report form. Non-members are carriers with either no net earned premium or whose Section 3 Calculation of Net Earned Premium on the Exhibit K Part C Premium Data Worksheet is equal to 0.

(c) Every carrier, whether a member or not, shall complete an Exhibit K Part C Premium Data Worksheet for each affiliate and shall attach each Worksheet to its Exhibit K.

1. In Section 1 of the Premium Data Worksheet, the carrier shall report the total accident and health premium reported on its annual statement blank for each calendar year of the two-year calculation period.

2. In Section 2 of the Premium Data Worksheet, the carrier shall report the total net earned premium in each calendar year of the two-year calculation period for each of the excepted types of coverage which are specifically identified in section 2 of the Worksheet.

3. In Section 3 of the Premium Data Worksheet, the carrier shall calculate the affiliate’s net earned premium by subtracting the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1 of the Worksheet.

4. The carrier shall report the aggregated two-year net earned premium on Exhibit K Part C by taking the sum of each affiliate's two-year net earned premium total as calculated on the Exhibit K Part C Premium Data Worksheet.

11:20-8.4 Calculation of average non-group enrollment for the two-year calculation period

(a) In Part D of the Exhibit K Assessment Report, each carrier shall report its aggregated average non-group enrollment for all affiliates for the preceding two-year calculation period.

(b) Each carrier shall complete an Exhibit K Part D Enrollment Data Worksheet for each affiliate that issued or renewed the categories of non-group enrollment listed on the worksheet and shall attach each Worksheet to its Exhibit K.

1. In section a of the Enrollment Data Worksheet, the carrier shall report all community rated persons covered under individual health benefits plans, and all persons covered under as the basic and essential health care services plan as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters. For contracts issued prior to August 1, 1993, where a carrier's administrative systems cannot provide the number of actual covered persons, the following factors shall be used to convert contracts or subscribers to the total number of covered persons: single = 1; husband and wife = 2; adult and child(ren) = 2.8; family = 3.9. If a husband and wife category is not used, a carrier shall use a compromise factor of 3.33 in order to reflect the husband and wife category in the family factor.

2. In section b of the Enrollment Data Worksheet, the carrier shall report all community rated conversion policy persons as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

3. In section c of the Enrollment Data Worksheet, the carrier shall report all Medicaid recipients, including NJ KidCare Part A recipients and NJ FamilyCare Plan A recipients, but no recipients of any other plans through NJ KidCare or NJ FamilyCare, as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

4. In section d of the Enrollment Data Worksheet, the carrier shall report all Medicare Plus Choice and Medicare cost and risk lives as of the last day of the end of each calendar quarter during the Two-Year Calculation Period, and shall report the total of all eight quarters.

5. In section e of the Enrollment Data Worksheet, the carrier shall calculate the two-year non-group enrollment total by adding the totals from a through d of the Worksheet.

6. In section f of the Enrollment Data Worksheet, the carrier shall calculate the average two-year non-group enrollment to be reported on Exhibit K Part D by dividing the total two-year non-group enrollment total by eight.

11:20-8.5 Calculating net paid losses or gains

(a) For purposes [for] of completing [Page C3] Part E of the Assessment Report [report] form, each member[s] issuing individual health benefits plans shall provide data for [their] its individual health benefits plans issued or renewed pursuant to sections 2b(1) or 3 of the Act (N.J.S.A. 17B:27A-3b(1) or 4), or pursuant to the requirements of P.L. 2001, c. 368 for the preceding two-year calculation period.

1. All data shall be for direct business only; reinsurance accepted shall not be included, and reinsurance ceded shall not be deducted.

2. The method used by a member to allocate to sublines of the individual line shall be consistent with the method used by a member to allocate to the individual line.

(b) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report premium earned. Premium earned shall be adjusted:

1. by any changes in non-admitted premium assets consistent with statutory report requirements, except that any change in non-admitted assets associated with premium accrued shall be reported consistent with the bases, as appropriate to the member, from the member's NAIC annual statement, adjusted for the individual health benefits plan for which the report is being made, as necessary; and

2. to reflect the premium that a carrier should have earned based on charging premiums consistent with the rate filings the member filed with the board for the applicable time period.

(c) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report claims paid. Claims paid shall be reported on a basis consistent with statutory reporting, as is appropriate for the member based on the member's NAIC annual statement, adjusted as necessary for the individual health benefits plans for which the report is being made. Claims paid as reported on Exhibit K shall include reimbursement for charges made by providers for services and supplies, surcharges mandated pursuant to the New York Health Care Reform Act of 2000, P.L. 1999, c. 1, codified in the New York Public Health law, section 2807-c through 2807-w, and network access fees where such fees may be demonstrated to have reduced specific claim payments and where the carrier has reported such fees as claims on its NAIC annual statement blank. In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. Claims paid shall be adjusted to only include claims that should have been paid according to the terms and conditions of the individual health benefits policy and N.J.S.A. 17B:27A-2 et seq.

(d) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits shall report its net investment income. Net investment income shall be calculated in accordance with statutory reporting requirements. For purposes of Exhibit K reporting, and

not withstanding how a carrier allocates net investment income to individual lines in other statutory reports or filings, carriers shall allocate net investment income consistent with the following basis, adjusted for the individual health benefits plans for which the report is being made as necessary.

1. The cost of granting and servicing premium notes and policy loans and liens shall be allocated to investment expense. The resulting net income on premium notes and policy loans and liens may be distributed to those lines of business which produced such income. In making such distribution, due consideration shall be given to the variation in the interest rate and incidence of expense on such notes, loans, and liens.

2. Net investment income, after adjustment, if any, as permitted by (d)1 above, shall be distributed to major and secondary lines of business in proportion to the mean funds of each line of business, after suitable adjustment, if any, on account of policy loans, except that any miscellaneous interest income arising from policy or annuity transactions may be allocated directly to the line of business producing such income. Mean funds refers to the average net cash flow balance over the two-year calculation period for which the calculation is being made, with the average net cash flow balance determined on a monthly or quarterly basis. [Cash flow is the inception to date paid premium, plus net investment income, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid, and less paid expenses.] The average net cash flow balance is the sum of the beginning of the month or quarter and end of month or quarter cash flow balances divided by two. The cash flow balance at the beginning of the month or quarter is equal to the inception to date paid premiums, plus the net investment income at the beginning of the month or quarter, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid, and less paid expenses. The "cash flow balance" at the end of the month or quarter is equal to the inception to date paid

premiums, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid and less paid expenses, plus net investment income at the beginning of the month or quarter. Inception to date shall mean a measurement of cash flow from the first date the carrier receives premium for standard individual health benefits plans until the end of the most recent two-year calculation period.

(e) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report its net paid gain or net paid loss. The net paid gain or loss for the two-year calculation period shall be determined by taking the claims paid on individual health benefits plans (as set forth on line [C3]b in Part E of Exhibit K), less 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans (as set forth in lines [C3]a and [C3]c, respectively, in Part E of Exhibit K). If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is greater than claims paid on individual health benefits plans, the amount shown of line C3d represents a net paid gain. If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is less than claims paid on individual health benefits plans, the amount shown on line C3d represents a net paid loss.

11:20-8.6 Certifications

(a) In Part F of the Exhibit K Assessment Report, the [The] Chief Financial Officer, or other duly authorized officer of the member, shall certify that [all market share and net paid gain (loss) reports]the Assessment Report, all Exhibit K Part C Premium Data Worksheets, and all Exhibit K Part D Enrollment Data Worksheets filed with the IHC Board are accurate, complete and conform with the requirements of this subchapter. [The person certifying the

combined market share and net paid gain (loss) report of an affiliated carrier shall be the same person certifying the separate market share and net paid gain (loss) report of the member submitting the combined market share and net paid gain(loss) report for the affiliated carrier.] Every duly authorized officer who provides a certification for the reporting required under this subchapter [certifies a separate or combined market share and net paid gain (loss) report]shall be responsible for errors contained therein.

(b) The Chief Financial Officer, or other duly authorized officer, of a member which has filed for reimbursement of losses shall certify, on or before March 1 of the year following every two-year calculation period that: The net investment income reported on [Exhibit K]the Assessment Report has been allocated on a basis consistent with N.J.A.C. 11:20-8.5(d) or, if not, the changes have been outlined in detail including the impact and reason for the change.

11:20-8.7 Penalties for failure to file market share and net paid loss report

(a) Failure to file in a timely manner the Assessment Report [market share and net paid gain (loss) reports] and certifications required by this subchapter shall result in:

1. The denial of a member's application for exemption from assessments for reimbursable losses; and

2. The Board's using the premium set forth in the member's most recent Annual Statements filed with the Department as the premium base to calculate that member's market share allocation of assessments for reimbursement of losses.

11:20-8.8 Audits

(a) A member shall, upon written request of the IHC Program Board, provide additional information that the IHC Program Board may require to substantiate that the member has met the requirements in N.J.A.C. 11:20-8.6(b).

(b) The IHC Program Board shall review, and may audit, a member's reimbursable losses reported in the member's [market share and net paid gain (loss) report] Assessment Report. The IHC Program Board shall choose and direct the independent auditor. The IHC Program Board and the member being audited shall share equally the cost of an independent audit.

(c) The IHC Program Board shall adjust a member's reported net paid losses, for purposes of determining reimbursement for losses for the preceding two-year calculation period, for the member's failure to meet the certification requirements of this subchapter or as a result of the findings of an independent audit conducted pursuant to (b) above. Such findings shall include the failure of a carrier to pay claims consistent with the terms of the applicable contract or applicable law, or to collect premium consistent with the terms of its informational rate filing or applicable law.

11:20-8.9 Hearings

Any member that is denied reimbursement of losses, in whole or in part, on the grounds that the member has failed to meet the certification and reporting requirements of this subchapter, or as a result of the IHC Program Board's review of an independent audit of the member's reported net paid losses, may file an appeal of the Board’s determination and request a hearing within 20 days of the date that the IHC Program Board notifies the member of its final determination, pursuant to the procedures set forth in N.J.A.C. 11:20-20.2.

SUBCHAPTER 9. EXEMPTIONS

11:20-9.2 Filing for an exemption from assessments for reimbursements

(a) (No change.)

(b) Written requests for exemptions shall be certified by the Chief Financial Officer, or other duly authorized officer, of the member, and shall include affirmative statements that the member agrees:

1. To enroll or insure the minimum number of non-group persons in New Jersey necessary for the member to meet its minimum enrollment share of non-group persons, allocated to it by the Board pursuant to N.J.A.C. 11:20-9.3;

2. To enroll or insure the minimum number of non-group persons in New Jersey under:

i. Standard health benefits plans and the basic and essential health care services plan;

ii. Conversion policies issued pursuant to the IHC Act;

iii. Medicaid contracts, if offered; and

iv. Medicare cost and risk contracts with the Federal government, Medicare Plus Choice and Medicare Demonstration plans with respect to Medicare recipients, if offered; and

3. Not to seek reimbursements for losses the member may incur under the standard health benefits plans or the basic and essential health care services plan in that two-year calculation period for which an exemption is sought by the member.

(c) – (e) (No change.)

11:20-9.3 Minimum enrollment share

(a) – (b) (No change.)

(c) The Board shall calculate each member's minimum number of non-group persons as follows:

[1. For the first two-year calculation period, the total number of community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives of all Members subject to the Act, except for hospital and medical service corporation carriers, as of the end of the 1995 and 1996 as reported on the Market Share and Net Paid Gain (Loss) Reports, Exhibit K, submitted to the Board, divided by two, and multiplied by the proportion that the member's net earned premium bears to the net earned premium of all members for 1995 and 1996 including those members exempt from assessment.]

[2] 1. For each two-year calculation period [thereafter] beginning with 1997/1998, the total number of community rated, individually enrolled or insured persons, including Medicare cost and risk lives, Medicare Plus Choice lives and Medicare Demonstration Project lives and enrolled Medicaid lives, NJ KidCare Part A lives and NJ FamilyCare Part A lives of all members subject to the Act, and all individually enrolled or insured persons covered under a basic and essential health care services plan, except for hospital and medical service corporation carriers covered on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, divided by eight, and multiplied by the proportion that the member's net earned premium bears to the net earned premium of all members for the preceding two-year calculation period.

11:20-9.4 Satisfaction of minimum number of non-group persons

(a) Persons counted under the following may be counted by a member in meeting its minimum number of non-group persons in New Jersey:

1. Standard health benefits plans and the basic and essential health care services plan;

2. Conversion policies issued pursuant to the Act; and

3. Medicare cost and risk contracts Medicare Plus Choice contracts and Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's minimum number of non-group persons.

(b) If the member is a Federally-qualified HMO that is tax exempt pursuant to paragraph (3) of subsection (c) of Section 501 of the Federal Internal Revenue Code of 1986, 26 U.S.C. 501, the member may count persons covered under (a)1 through (a)3 above, except that in determining whether the member meets its minimum number of non-group persons, the total may include no more than one-third Medicare recipients and one-third Medicaid recipients.

11:20-9.5 Procedures for granting or denying final (full or pro rata) exemptions

(a) (No change.)

(b) So that the Board can determine whether the member has satisfied its minimum enrollment share, members seeking final (full or pro rata) exemptions shall report to the Board, on or before March 1 of the year following each two-year calculation period, the number of non-group persons covered by that member on the last day of each calendar quarter of the preceding two-year calculation period, taking into account the limitations on counting the number of Medicaid recipients and Medicare cost and risk lives Medicare Plus Choice lives and Medicare Demonstration Project lives as described in N.J.A.C. 11:20-9.4(a)3 and (b); except that members seeking final (full or pro rata) exemptions for the first two-year calculation period shall report to the Board the number of non-group persons covered by that member as of December 31

of the two preceding calendar years, taking into account the limitations on counting the number of Medicaid recipients and Medicare cost and risk lives as described in N.J.A.C. 11:20-9.4(a)3 and (b) above. The member shall report separately the number of non-group persons in each category of non-group person enumerated in N.J.A.C. 11:20-9.4. The Chief Financial Officer, or other duly authorized officer of the member, shall certify that the covered non-group persons reported therein:

1. Were counted in accordance with N.J.A.C. 11:20-9.4;

2. If covered by standard health benefits plans and conversion health benefits plans, were enrolled on an open enrolled and community rated basis or if covered under a basic and essential health care services were enrolled on an open enrolled basis;

3.- 6. (No change.)

(c) – (h) (No change.)

11:20-9.6 Good faith marketing report

(a) In order for the Board to determine whether a carrier has made a good faith marketing effort as required by N.J.A.C. 11:20-9.5(f)2, members that have received conditional exemptions from assessments for reimbursable losses and have enrolled less than 50 percent of the minimum number of non-group persons determined by the Board shall submit to the Board a marketing report on or before July 1 of the year immediately following the two-year calculation period to which the conditional exemption applies containing the following information pertaining to advertising, marketing and promotion efforts in direct support of sales of standard individual health benefits plans and basic and essential health care services plans in New Jersey during the two-year calculation period and the calendar quarter immediately preceding the two-

year calculation period to which the conditional exemption applies provided such efforts were directed toward sales during the two-year calculation period to which the exemption applies.

1. – 3. (No change.)

4. With respect to sales through producers licensed by the State of New Jersey, details of efforts to recruit and educate producers to sell standard health benefits plans and the basic and essential health care services plan; the number of producers through whom such sales were made; the total cost of commissions and other incentives paid to producers for sales of standard health benefits plans and the basic and essential health care services plan;

5. With respect to other forms of marketing or promotion of standard health benefits plans and the basic and essential health care services plan, describe the methods of media used; the frequency of use; the total cost of such efforts;

(b) Carriers required to submit the marketing report described in (a) shall send it to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

(c) The Board will review the marketing reports submitted and determined that a carrier has made a good faith marketing effort as required by N.J.A.C. 11:20-9.5(f)2 if the carrier has demonstrated that it has either:

1. Undertaken a significant media advertising or other marketing campaign, in proportion to its minimum enrollment share, in direct support of sales of standard individual health benefits plans and the basic and essential health care services plan in New Jersey; or

2. Undertaken significant efforts, in proportion to its minimum enrollment share, to educate licensed insurance producers about its standard individual health benefits plans and the basic and essential health care services plan in New Jersey and offered to pay competitive commission schedules for sales of such plans and competitive rates.

(d) A member's failure to file the marketing report described in (a) may result in the Board's denial of a final exemption from assessment for reimbursable losses.

SUBCHAPTER 12. ELIGIBILITY FOR AND REPLACEMENT OF STANDARD HEALTH BENEFITS PLANS AND THE BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

11:20-12.1 Purpose and scope

(a) This subchapter establishes the standards for determining who may be covered by a standard health benefits plan and a basic and essential health care services plan, as defined at N.J.A.C. 11:20-1.2.

(b) This subchapter sets forth the standards for obtaining a standard health benefits plan and the basic and essential health care services plan by persons covered by, or eligible for, group health benefits plans and persons covered by individual health benefits plans.

(c) This subchapter shall apply to persons applying for coverage in standard health benefits plans in New Jersey under a basic and essential health care services plan in New Jersey, all carriers which are members of the program, insurance producers selling standard health benefits plans, and employers offering group health benefits plans to their employees.

11:20-12.3 Eligibility for coverage under a standard health benefits plan or a basic and essential health care services plan

(a) The policyholder of a standard health benefits plan or a basic and essential health care services plan shall be a resident, as defined at N.J.A.C. 11:20-1.2. A carrier may require reasonable proof of residency. A dependent of the policyholder may be a nonresident, but may not reside outside of the United States.

(b) A person shall not be eligible to be covered by a standard health benefits plan or a basic and essential health care services plan, as the policyholder or a dependent, if the person is eligible for Medicare, a group health benefits plan, group health plan, governmental plan, or church plan, except as provided in N.J.A.C. 11:20-12.4, or if the person is covered by any other individual health benefits plan, except as provided in N.J.A.C. 11:20-12.5(a). After obtaining coverage under a standard health benefits plan or a basic and essential health care services plan, a covered person may elect to retain his or her coverage if he or she later becomes eligible for or covered under Medicare.

(c) A carrier shall not require a person or persons who are eligible for coverage under more than one rate tier to obtain coverage under any specific rate tier. For example, a carrier shall not require a married couple to apply for husband and wife coverage, if the husband and wife wish to obtain separate coverage.

11:20-12.4 Replacement of a group health benefits plan with a standard health benefits plan or a basic and essential health care services plan

(a) A person who is a participant, or is eligible to participate, in a group health benefits plan that does not cover general services may choose, only during the open enrollment period, to be covered by a standard health benefits plan or a basic and essential health care services plan.

(b) A person who is a participant, or is eligible to participate, in a group health benefits plan that covers general services may choose, only during the open enrollment period, to be covered by a standard health benefits plan with a higher deductible and policyholder coinsurance requirement or lower deductible and policyholder coinsurance requirement than the group health benefits plan or by the basic and essential health care services plan.

1. A standard health benefits plan shall be considered to have a higher deductible and policyholder coinsurance requirement than a group health benefits plan if the deductible is more than $100.00 higher and the policyholder coinsurance requirement is at least 10 percent higher than the group health benefits plan.

2. A standard health benefits plan shall be considered to have a lower deductible and policyholder coinsurance requirement than a group health benefits plan if the deductible is more than $100.00 lower and the policyholder coinsurance requirement is at least 10 percent lower than the group health benefits plan.

(c) With respect to coverage under an HMO contract, the following apply, notwithstanding (a) and (b) above:

1. A person who participates or is eligible to participate, only in a group health benefits plan under an HMO contract may choose, only during the open enrollment period to be covered under any standard health benefits plan or basic and essential health care services plan, other than the standard HMO benefit plan.

(d) A carrier making determinations under (b) above with respect to a person who participates, or is eligible to participate, in more than one group health benefits plan, shall decide which group health benefits plan to compare with a standard health benefits plan, as follows:

1. If a person is seeking to be covered by a standard health benefits plan with a higher deductible and policyholder coinsurance requirement than the group health benefits plan, the carrier shall compare the group health benefits plan with the higher, or highest, deductible and policyholder coinsurance requirement.

2. If a person is seeking to be covered by a standard health benefits plan with a lower deductible and policyholder coinsurance requirement than the group health benefits plan,

the carrier shall compare the group health benefits plan with the lower, or lowest, deductible and policyholder coinsurance requirement.

(e) A carrier comparing deductibles and policyholder coinsurance requirements according to (b) above shall not consider any separately applicable deductible and policyholder coinsurance requirements for specified covered services.

(f) A carrier comparing deductibles and policyholder coinsurance requirements according to (b) above, with respect to a health benefits plan delivered under a selective contracting arrangement, shall use the in-network benefit as a basis for comparison.

(g) A carrier determining whether a group health benefits plan covers general services, according to (a) and (b) above, shall not consider any limits, coinsurance, copayment or deductible requirements which may apply to a specific type of general service, (or a covered service within a type of general service) separately from the other general services (or covered services) under either the group health benefits plan or the standard health benefits plan.

(h) Notwithstanding (a), (b) and (c) above, a carrier shall not offer a person coverage by a standard health benefits plan or a basic and essential health care services plan unless:

1. The person is required to pay a portion of the premium for coverage by the group health benefits plan in which the person participates, or is eligible to participate; and

2. The person's coverage by a group health benefits plan has been terminated or will terminate no later than the day before the effective date of the standard health benefits plan or a basic and essential health care services plan, except as extension of benefits provisions under the group health benefits plan or by law may be applicable.

i. A person who is eligible only for continuation of coverage under an employer's group health benefits plan required by State or Federal law, including, but not limited to, N.J.S.A. 17B:27A-27 or the Consolidated Omnibus Budget Reconciliation Act of

1985 (COBRA) and amendments thereto, may choose to be covered by any standard health benefits plan or a basic and essential health care services plan in lieu of continuing to participate in the group health benefits plan.

11:20-12.5 Selection of a standard health benefits plan or a basic and essential health care services plan by a person covered by an individual health benefits plan

(a) A person who is covered by an individual health benefits plan other than one of the standard health benefits plans or a basic and essential health care services plan issued pursuant to this chapter may choose at any time to replace that health benefits plan with a standard health benefits plan or a basic and essential health care services plan. A carrier shall not offer a person coverage by a standard health benefits plan or a basic and essential health care services plan unless the person's coverage by the individual health benefits plan being replaced has been terminated or will terminate no later than the effective date of the standard health benefits plan or a basic and essential health care services plan. As long as the covered person notifies the carrier that issued the prior individual health benefits plan of the replacement within 30 days after the effective date of the new standard health benefits plan or a basic and essential health care services plan, the prior plan will terminate as of 12:01 A.M. on the effective date of the new standard health benefits plan or a basic and essential health care services plan, and the carrier shall refund any unearned premium. A carrier may require evidence of such termination. If a person fails to terminate a prior individual health benefits plan as required above, the standard health benefits plan or a basic and essential health care services plan that was intended to replace it shall be of no force and effect.

(b) A person who is covered by a standard health benefits plan or whose coverage by a standard health benefits plan has not lapsed for more than 31 days may choose, at any time, to

be covered by a standard health benefits plan with the same or higher deductible and the same or higher policyholder coinsurance requirement than the standard health benefits plan being replaced, except that a person who is covered by standard health benefits Plans A or A/50 may choose, only during the open enrollment period, to be covered by any other standard health benefits plan. A carrier shall not offer a person coverage by a standard health benefits plan unless the coverage by the standard health benefits plan being replaced has been terminated or will terminate no later than the effective date of the standard health benefits plan. As long as the covered person notifies the carrier that issued the prior standard health benefits plan of the replacement within 30 days after the effective date of the new standard health benefits plan the prior plan will terminate as of 12:01 A.M. on the effective date of the new standard health benefits plan, and the carrier shall refund any unearned premium. A carrier may require evidence of such termination. If a person fails to terminate the prior standard health benefits plan as required above, the prior standard health benefits plan shall nevertheless be of no force and effect as of the effective date of the standard health benefits plan. The person shall return any benefit payments to the prior carrier and the prior carrier shall refund premiums paid for the period beginning with the effective date of the new standard health benefits plan.

(c) A person who is covered by a standard health benefits plan or whose coverage by a standard health benefits plan has not lapsed for more than 31 days may choose, only during the open enrollment period, to be covered by a standard health benefits plan with a lower deductible or lower policyholder coinsurance requirement than the standard health benefits plans being replaced.

(d) The following rules apply to the HMO standard health benefits plan, notwithstanding (a), (b) and (c) above:

1. A person covered by standard health benefits plan E with a $150.00 deductible may replace that coverage, at any time, with coverage under an HMO standard health benefits plan.

2. A person covered by the HMO standard health benefits plan may replace that coverage, at any time, with coverage by an HMO standard health benefits plan with the same or higher copayment options than the HMO standard health benefits plan being replaced.

3. A person covered by standard health benefits plans A, A/50, B, C, or D or plan E with an individual deductible of $250.00, $500.00, $1,000, $1,500, $2,250 or such other amounts as are made available as a result of the inflation-adjustments made by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code or $2,500, $5,000 or $10,000 or in the case of the optional high deductible insurance plans, family unit deductible of $3,000 or $4,500, or such other amounts as are made available as a result of the inflation-adjustments made by the Federal Internal Revenue Service pursuant to §220, may replace that coverage, only during the open enrollment period, with coverage by an HMO standard health benefits plan.

4. A person covered by an HMO standard health benefits plan may replace that coverage, only during the open enrollment period, with coverage by an HMO standard health benefits plan with a lower copayment option than the HMO standard health benefits plan being replaced.

5. A person covered by a standard health benefits plan may replace that coverage at any time with coverage under a basic and essential health care services plan. A person covered under a basic and essential health care services plan may replace that coverage, only during the open enrollment period, with coverage by a standard health benefits plan or with coverage under a basic and essential health care services plan either with or without a rider.

(e) A carrier comparing deductibles or policyholder coinsurance requirements according to (b) and (c) above shall not consider any separately applicable deductible or policyholder coinsurance requirements for specific covered services.

(f) A carrier comparing deductibles or policyholder coinsurance requirements according to (b) and (c) above, with respect to individual health benefits plans delivered under selective contracting arrangements, shall use the in-network benefit as a basis for comparison.

(g) Notwithstanding (b), (c) and (d) above, a carrier shall not offer a person coverage by a standard health benefits plan or a basic and essential health care services plan unless the person's coverage by the standard health benefits plan or basic and essential health care services plan being replaced has been terminated or will terminate no later than the effective date of replacement standard health benefits plan or basic and essential health care services plan.

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

11:20-17.1 Purpose and scope

(a) This subchapter provides for the quarterly and annual submission of enrollment status reports by all members of the IHC Program, and sets forth the procedures and format for those reports.

(b) This subchapter applies to all members of the IHC Program that issue or renew standard health benefits plans or the basic and essential health care services plans to individuals.

11:20-17.3 Filing requirements

(a) Every member of the IHC Program issuing or renewing standard health benefits plans and the basic and essential health care services plan, shall complete and file with the Board the enrollment status reports required by this subchapter.

(b) Members shall file hard copy enrollment status reports on a quarterly basis reflecting the information set forth in N.J.A.C. 11:20-17.4 and in the format of Part 1 of Exhibit L which shall reflect data as of March 31, June 30, September 30 and December 31 of each year.

(c) Members shall file enrollment status reports on an annual basis reflecting the number of contracts by zip code category, and insured persons by age and sex category in the format of Part 2 of Exhibit L which shall reflect data as of December 31 of each year.

(d) Members shall submit completed enrollment status reports to Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

(e) Affiliated carriers shall submit the enrollment status reports only on a combined basis. Each affiliated carrier shall be identified on the report.

11:20-17.4 Contents of the enrollment status report

(a) Members shall report the following information on a quarterly basis on the enrollment status report form set forth as Part 1 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken out into indemnity for Plan A, and indemnity for Plan A/50, indemnity or PPO for Plan B, or indemnity, PPO and POS delivery systems for Plans C through E, the HMO plans, and indemnity or HMO coverage under the basic and essential health services plan and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. – 4. (No change.)

(b) Members shall report the following information on an annual basis on the enrollment status report form set forth at Part 2 of Exhibit L in the Appendix, cumulatively for all years to date and separately for each of the standard health benefits plans, broken down by indemnity for Plan A, and indemnity for Plan A/50, indemnity or PPO for Plan B, or indemnity

PPO and POS delivery systems for Plans C-E, the HMO plans, and the indemnity or HMO basic and essential health care services plan:

1. – 3. (No change.)

SUBCHAPTER 18. WITHDRAWALS OF CARRIERS FROM THE INDIVIDUAL MARKET AND THE WITHDRAWAL OF PLAN, PLAN OPTION, OR DEDUCTIBLE/COPAYMENT OPTION

11:20-18.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings set forth in the Act or at N.J.A.C. 11:20-1.2, unless defined below or unless the context clearly indicates otherwise:

"Cease doing business" for purposes of these rules means market withdraw or market withdrawal.

“Standard individual health benefits plan” means a plan developed by the Individual Health Coverage Program Board offered pursuant to N.J.S.A. 17B:27A-4b and the basic and essential health care services plan developed by the Legislature and offered pursuant to P.L. 2001, c. 368.

"State" means the State of New Jersey.

"Market withdraw" or "market withdrawal" means a carrier’s, or one or more affiliated carriers’, cessation of the issuance of all standard individual health benefits plans and nonrenewal of all in force standard individual health benefits plans upon their respective anniversary dates without the carrier’s offering replacement with a standard individual health benefits plan, except where such action is taken pursuant to N.J.S.A. 17B:27A-6.

"Plan option withdraw" or "plan option withdrawal" means a carrier's cessation of the issuance of a standard individual health benefits plan option, and the nonrenewal of all in force standard individual health benefits plans issued with that option upon their respective anniversary dates, except where such action is taken pursuant to N.J.S.A. 17B:27A-6 or N.J.A.C. 11:20-18.5.

"Plan withdraw" or "plan withdrawal" means a carrier's cessation of the issuance of one of the standard individual health benefits plans, and the nonrenewal of all in force standard individual health benefits plans of that type upon their respective anniversary dates, except where such action is taken pursuant to N.J.S.A. 17B:27A-6 or N.J.A.C. 11:20-18.5.

SUBCHAPTER 21. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

11:20-21.1 Purpose and Scope

(a) This subchapter implements provisions of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.4 through 4.7), an Act that supplements the Individual Health Insurance Reform Act, P.L. 1992, c. 161. This subchapter establishes procedures and standards for carriers to meet their obligations under P.L. 2001, c. 368, and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the P.L. 2001, c. 368. Carriers should consult the other subchapters in N.J.A.C. 11:20 for procedures and standards that also have application to the basic and essential health care services plan required by P.L. 2001, c. 368.

(b) The provisions of this subchapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term member is defined in N.J.A.C. 1:20-1.1.

(c) The provisions of this subchapter shall be applicable to the marketing, sale, issue and administration of all basic and essential health care services plans on or after January 1, 2003.

11:20-21.2 Definitions

Words and terms contained in N.J.S.A. 17B:27A-2 et seq., when used in this chapter, shall have the meanings as defined in the N.J.S.A. 17B:27A-2 et seq., and N.J.A.C. 11:21-1.1 unless the context clearly indicates otherwise, or as such words and terms are further defined by this subchapter.

"Copayment" means a specified dollar amount which a person covered under a basic and essential health care services plan must pay for certain charges covered under such plan. A covered person may be required to pay an amount in excess of the copayment if the charge the provider bills exceeds the reasonable and customary charge.

"Good faith effort" means the demonstrated efforts a carrier undertakes to make the basic and essential health care services plan available to residents of New Jersey, as evaluated by the Board pursuant to the standards set forth in this subchapter.

"Modified community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, except that a rate differential may be applied on the basis of age, gender and geography, as detailed in section 2.c of P.L. 2001, c. 368, and in this subchapter.

11:20-21.3 Obligation to offer a basic and essential health care services plan

(a) Every member that writes individual health benefits plans in New Jersey shall offer the basic and essential health care services plan.

(b) Members that write individual health benefits plans as HMO coverage and as indemnity coverage may choose to offer the basic and essential health care services plan as an HMO plan or as an indemnity plan and are not required to write the plan as both an HMO plan and as an indemnity plan.

11:20-21.4 Filing the basic and essential health care services plan policy form

(a) Before a member may offer or issue the basic and essential health care service plan policy form, the member shall submit the information set forth below to the Board at the address specified at N.J.A.C. 11:20-2.1(h):

1. One copy of the basic and essential health care services plan, unless filing a certification as set forth in (b)1 below;

2. A certification signed by a duly authorized officer of the member that states:

i. The member will make the basic and essential health care services plan available to eligible persons and will make a good faith effort to market the plan;

ii. Rates for the basic and essential health care services plan have been submitted pursuant to the requirements of N.J.A.C. 11:20-6;

The anticipated loss ratio for the plan; and

iv. The benefits in the form being submitted include all of the coverages enumerated in section 2.a. of P.L. 2001, c. 368, but do not include any additional benefits.

(b) The Board makes available to members a specimen basic and essential health care services plan, set forth in Exhibit V. The Board has determined that the plan set forth in Exhibit V includes the coverages required for a basic and essential health care services plan.

1. Members that choose to use the plan as set forth in Exhibit V should submit, in lieu of a copy of the basic and essential health care services policy form, a Certification, signed by a duly authorized officer of the company, stating that the Company is using the basic and essential health care services form as included in Exhibit V, including the carrier name, and similar variable text, as appropriate. The Certification regarding use of the specimen form must be submitted with the information set forth in N.J.A.C. 11:20-21.4(a).

2. Members that choose to use the plan as set forth in Exhibit V with some modifications to the text should submit the form, redlined to show any differences between the submitted form and the form as contained in Exhibit V. The redlined text of the form must be submitted with the information set forth in N.J.A.C. 11:20-21.4(a).

(c) The Board shall notify a member in writing of its determination whether the filing is approved within 30 days of the date the filing is received. If the Board does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

11:20-21.5 Riders to Amend the Basic and Essential Health Care Services Plan

(a) Members may develop optional benefit riders to amend the basic and essential health care services plan provided the riders increase the benefits provided under the basic and essential health care services plan and do not contain any feature that would represent a decrease in the coverage or the actuarial value of the plan. The enhanced or additional rider benefits must be included in a manner which will avoid adverse selection to the extent possible.

(b) Before a member may offer or issue a rider to amend the basic and essential health care service plan, the member shall file the rider with the Board for approval.

1. Submit one copy of the rider to amend the basic and essential health care services plan to the Board at the address specified at N.J.A.C. 11:20-2.1(h).

2. Submit a copy of the provision from the basic and essential health care services plan that the rider is amending, notated to highlight the area of the change.

3. Submit a certification signed by a duly authorized officer of the member that states clearly that:

i. The member will make the basic and essential health care services plan available to residents of New Jersey and will make a good faith effort to market the plan both with and without the rider;

ii. Rates for the rider amending the basic and essential health care services plan have been submitted pursuant to the requirements of N.J.A.C. 11:20-6; and

iii. The rider increases a benefit or benefits and does not decrease any benefits or the actuarial value of the basic and essential health care services plan.

(c) The Board shall notify a member in writing of its determination whether the rider filing is approved within 30 days of the date the filing is received. If the Board does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

11:20-21.6 Good Faith Effort to Market the Basic and Essential Health Care Services Plan

(a) In order for the Board to determine whether a member has made a good faith effort to market the basic and essential health care services plan, as required by section g of P.L. 2001, c. 368, every member shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year, a report detailing the activities the member undertook during the prior calendar year to market the basic and essential health care services plan.

Members may satisfy the requirement by marketing the plan as either an HMO plan or as an indemnity plan.

(b) The report should include only those marketing activities which were in direct support of the sale of the basic and essential health care services plan during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the reports submitted by each member to determine whether the member has demonstrated that it made a good faith effort to market the basic and essential health care plan and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a carrier has marketed in good faith if:

i. The carrier provides evidence that that it has included the basic and essential health care services plan on the carrier's standard application in the prior calendar year; and

ii. The carrier provides evidence that it has under taken at least one marketing effort in direct support of the sale of the basic and essential health care services plan during the prior calendar year. Examples of marketing efforts may include, but are not limited to: print media such as newspapers, magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes or other communications advising the producers of the availability of the plan; or information specific to the basic and essential health care services plan on the carrier’s web site. Members may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the basic and essential health care services plan; and

iii. The carrier certifies whether it used any New Jersey individual market marketing materials during the prior year that identified a list of plan choices. If the carrier did use any marketing materials that included a list of plan choices, the carrier shall provide evidence that the basic and essential health care services plan was listed as one of the plan choices.

2. A member will be found to have not to have made a good faith effort if the report does not meet the standards set forth above or if the member fails to submit a report by May 1 of each year.

11:20-21.7 Penalties

Members found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plan will be subject to the provisions of N.J.S. 17B:30-1.

EXHIBIT K: New Jersey Individual Health Coverage Program Assessment Report
For the Two-Year Calculation Period _____ - _____

All carriers reporting accident and health premium to the New Jersey Department of Banking and Insurance shall submit this report and attachments in accordance with the provisions of N.J.A.C. 11:20-8. Reports must be completed and returned on or before March 1, 2003 and by March 1 of the first year of each two-year calculation period thereafter, to the Executive Director, IHC Program, PO Box 325, (20 West State Street), Trenton, NJ 08625-0325.

Part A. Carrier Information

1. Carrier's name: _____ 2. NAIC Number:_____
3. Full name of all affiliated carriers reporting any accident and health premium in New Jersey

_____
_____
_____

Part B. Information of Person Completing this Report

1. Name (print or type):_____ 2. Title: _____
3. Telephone No.:_____ Facsimile No.:_____ E-mail:_____
4. Mailing Address: _____
_____

Part C. Program Membership for the Two-Year Calculation Period (Attach worksheet(s))

Members and Non-members with reportable accident and health premium in New Jersey MUST complete and return one copy of the attached "Exhibit K-Part C Premium Data Worksheet" for each of the affiliates listed above. If any of the affiliates has any net earned premium for the two-year period, the carrier is a Member and shall record the amount below. If no affiliates have net earned premium, then the carrier is a Non-member and the carrier shall check the Non-member box below.

Member's net earned premium, including all affiliates, for the two-year period:

$_____; or

€ Non-member of the IHC Program with no net earned premium

Part D. Number of Non-group Persons Enrolled by Member Carrier (Attach worksheet(s))

Members MUST complete and return one copy of the attached "Exhibit K Part D Enrollment Data Worksheet" for each of the affiliates listed above that issued or renewed non-group enrollment as listed on the attached Worksheet.

Average non-group enrollment for the two-year period: _____

Part E. Member's Net Paid Gain (Loss) for Individual Health Benefits Plans

a. PREMIUM EARNED	$_____
b. CLAIMS PAID	$_____
c. NET INVESTMENT INCOME	$_____
d. NET PAID GAIN (LOSS) [115% (a+c)]-b	$_____ _____

Part F. Certification

I certify that I am an officer of the company, that the information provided in this report and all attachments is accurate and complete, and that it has been prepared in accordance with the provisions of N.J.A.C. 11:20-8.

_____ _____ _____
Name of Officer Title Date

Exhibit K Part C Premium Data Worksheet

The purpose of this Part C Premium Data Worksheet is to demonstrate whether a carrier is a member of the IHC Program by virtue of having any "net earned premium" during the two-year calculation period. "Net earned premium" means the premiums earned in this State on "health benefits plans," less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Health benefits plans include, but may not be limited to the following coverages: health insurance for individuals or groups of any size; Medicare + Choice contracts (premium should be limited to premium from insureds); Medicare Cost and Risk; premium from Medicare Demonstration plans, Medicaid; New Jersey FamilyCare Part A and NJ KidCare Part A; accident medical; student accident and health medical if expense incurred; specified disease if expense incurred; and limited benefits if expense incurred; and Champus or TriCare. The attached report provides a carrier with a framework for accurately calculating its net earned premium. The definitions of "net earned premium" and "health benefits plans" are set forth at N.J.A.C. 11:20-1.2.

Directions:
Copy the attached worksheet, if necessary, and provide the following information for each affiliate:

- The name of the affiliate.
- Section 1: The total accident and health premium reported on the annual NAIC statement blank for both calendar years of the two-year calculation period for that affiliate.
- Section 2: The total premium amounts earned in each calendar year of the two-year calculation period for each of the excepted types of coverage listed on the worksheet for each affiliate.
- Section 3: To arrive at the net earned premium in section 3, subtract the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1. All premium that is not from some type of excepted coverage is net earned premium from health benefits plans.
- Each affiliate's worksheet shall be attached to the carrier's one-page Exhibit K.

Members shall report the combined two-year net earned premium calculated from each affiliate’s Exhibit K Part C Premium Data Worksheet on Part C of the Exhibit K Assessment Report.

If the combined two-year net earned premium total from each affiliate’s Exhibit K Part C Premium Data Worksheet is zero either because all of the premium is from excepted coverages or because the carrier had no accident and health premium, then the carrier shall assert Non-member status by checking the Non-member box on Exhibit K Part C, and completing the certification in Part F.

Exhibit K Part C Premium Data Worksheet for the Two-Year Calculation Period _____-_____

Name of Affiliate: _____ Name of Carrier on Exhibit K: _____

Carriers shall complete and return this page for each affiliate along with Exhibit K.

Section 1: Total A&H Premium	Premium for 1st Ye 2-Year Period	Premium for 2nd of 2-Year Period	Two-Year Total
Amount of Accident & Health Premium on New Jersey NAIC State Blank:			

Section 2: List of Excepted Benefits and Premium	Premium for 1 Year of 2-Yea Period	Premium for 2nd of 2-Year Period	Total for 2-year Period
a. Medicare + Choice coverage (excepted premium amount is limited to amounts paid by federal government and does not include premium paid insureds)	$	$	$
b. contracts funded pursuant to the "Federal Employee Health Benefits A 1959," 5 U.S.C. § § 8901-8914	$	$	$
c. excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan	$	$	$
d. Medicare supplement policies or contracts	$	$	$
e. non-expense incurred specified disease coverage	$	$	$
f. coverage only for accident, disability income insurance, or any combination	$	$	$
g. coverage issued as a supplement to liability insurance	$	$	$
h. liability insurance, including general liability insurance and automobi liability insurance	$	$	$
i. workers' compensation or similar insurance	$	$	$
j. automobile medical payment insurance	$	$	$
k. credit-only insurance	$	$	$
l. coverage for on- site medical clinics	$	$	$
m. other similar insurance coverage, as specified in federal regs., under which benefits for medical care are secondary or incidental to other insur benefits	$	$	$
n. limited scope dental or vision benefits*	$	$	$
o. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof *	$	$	$
p. such other similar, limited benefits as are specified in federal regulatio	$	$	$
q. hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same pla sponsor, and those benefits are paid with respect to an event without rega whether benefits are provided with respect to such an event under any gr health plan maintained by the same plan sponsor	$	$	$
r. coverage supplemental to the coverage provided under chapter 55 of T 10, United States Code (10 U.S.C. § 1071 et seq.)	$	$	$
s. similar supplemental coverage provided to coverage under a group he plan	$	$	$
Total excepted premium:	$	$	$

* Include as an excepted benefit if the coverage is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of the plan.

Section 3: Calculation of "Net Earned Premium"	Premium for 1st Year 2-Year Period	Premium for 2 Year of 2-Yea Period	2-Year Net Earned Prer Total
Net Earned Premium = (Section 1 premium – Section 2 premium))	$	$	$

Exhibit K Part D Enrollment Data Worksheet
for the Two-Year Calculation Period _____-_____

Name of Affiliate: _____ Name of Carrier on Exhibit K: _____

Carriers shall complete and return this page with Exhibit K.

For a through e below, provide the number of covered lives as of the end of each calendar quarter during the Two-Year Calculation Period for each of the categories of coverage described below, and the two-year total for each category. Non-members should be reporting no covered lives in any of the categories below because premium from all of the coverage listed below result in net earned premium.

Total Q1-Q8

a. Persons covered under standard individual health benefits plans or basic and essential health care services plans

Q1 _____ Q2 _____ Q3 _____ Q4 _____

Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____

b. Community rated conversion policy persons

Q1 _____ Q2 _____ Q3 _____ Q4 _____

Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____

c. Medicaid recipients (Include NJ FamilyCare Part A, NJ KidCare Part A but no other NJ FamilyCare or NJ KidCare lives)

Q1 _____ Q2 _____ Q3 _____ Q4 _____

Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____

d. Medicare Plus Choice lives, Medicare Risk and Cost lives, Medicare Demonstration Project lives (Do <u>not</u> include Medicare Supplement)

Q1 _____ Q2 _____ Q3 _____ Q4 _____

Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____

e. Two-Year non-group enrollment total (Total Q1-Q8 for a through d): _____

f. Average two-year non-group enrollment to be reported on Exhibit K Part D (line e divided by 8): _____

[EXHIBIT G]

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN
FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
   (a) a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; or
   (b) Medicare.
   (See item 5 below.)
4. You and any family members you wish to cover are not eligible for a standard individual health benefits plan if covered by another individual health benefits plan unless the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application was dated and premium payment is received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of your coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. [NOTE: [CARRIER'S] PARTICIPATING PROVIDERS, INCLUDING ALL [PARTICIPATING] [NETWORK] PRIMARY CARE PHYSICIANS, ARE INDEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF [CARRIER].]

COMPLETE ALL SECTIONS IF YOU ARE:
1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber] [member].
2. Changing dependent coverage.

COMPLETE SECTIONS 1, 2, 3, [AND] [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1--Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. Your social security number is for our use. The New Jersey Individual Health Coverage Program Board will not collect or use your social security number. If a dependent is a full-time college student, you must attach a current course schedule or tuition receipt. If a dependent is beyond age 19 or 23, as applicable, but is mentally or physically handicapped or developmentally disabled, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked only if you wish to add or remove a dependent from the plan.

Section 2--Complete all information.

Section 3--Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4--This information is required. Please complete all information.

[Section 5--For applicants only] From the appropriate [directory] [brochure] [ ] choose [the location number for] a Primary Care Physician [or Health Center] [and/or Gynecologist if applicable,] [for yourself and each member of your family] [required for all members]. [If you choose a Health Center, you must choose a Primary Care Physician

who services that Health Center.] [Indicate whether you are choosing [carrier's] Statewide Physician Network or Health Center.] Check the change box only if you are changing providers.

Section [5/6]--Applicant must sign this section and date this form or it will not be processed.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed [on the following page,] [on the reverse side,] I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by [carrier] after a review of the application [and receipt of payment].

2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated or developmentally disabled, who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.

3. Coverage and benefits are contingent on timely payment of premiums. Coverage may be terminated as provided in the Individual [Contract] [Policy].

4. The Individual [Contract] [Policy] will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] [member(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

5. [As a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual [Contract] [Policy] all services, in order to be covered by [Carrier], must be performed either by a Primary Care Physician or by the specialist, hospital or other provider as authorized by prior written referral from the Primary Care Physician [or Care Manager].]

6. [[If applicable,] Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual [Contract] [Policy].]

7. [Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Health Center], Primary Care Physician or other health care provider.]

8. [Applicant acknowledges that [Carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled. (Note: Dependent children may be covered under an adult-child(ren) or family contract only while unmarried and until [they attain] age 19, or 23 if full-time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.*

This section must be completed in its entirety.			BIRTHDATE			SEX	
LAST NAME	FIRST NAME	MI	MO	DAY	YR	M or F	Social Security Number
Applicant 1. o Add o Remove							__/__/__-__/__-__/__/__/
Spouse 2. o Add o Remove							__/__/__-__/__-__/__/__/
Child 3. o Add o Remove							__/__/__-__/__-__/__/__/
Child 4. o Add o Remove							__/__/__-__/__-__/__/__/
Child 5. o Add o Remove							__/__/__-__/__-__/__/__/

*Attach sheet to list additional children. [Attach proof if full-time student. Totally disabled children will be covered regardless of age. Attach proof of disability.]

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? o Yes o No

If yes, who and at what address?

_____

Explain the circumstances.

_____

If any dependent's last name is different from yours, explain the circumstances.

_____

2. PRIMARY RESIDENCE (Note: You must be a Resident, which is defined as follows: a person :
   - whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
   - in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

Street _____ Apt._____ City _____ State _____ Zip _____

[Do you live, reside or work in the [Carrier's] service area? o Yes o No]

TELEPHONE NUMBER

Home ( ) - Work ( ) - Best place to call during day: o Home o Work

Are you a resident of the State of New Jersey? o Yes o No

Do you maintain a residence in any other state? o Yes o No

If "Yes", (a) Name of state _____
(b) How much time do you spend there each year? _____

[[If you or any of your dependents are covered under an existing health benefits plan, or if you or any of your dependents had coverage which terminated within the past 31 days, please provide the following information for each person who has or had such coverage.

Name(s) of Person(s): _____

Name of Carrier: _____

Policy Number: _____

Type of Coverage: Check all that apply.

_____Group _____Individual

_____Indemnity _____HMO _____PPO _____Point of Service

_____Other (Specify)_____

Plan Information: Deductible Amount: _____

Coinsurance: _____

Copayment: _____

Initial Effective Date: _____ Termination Date:_____

If one or more of the persons are or were covered under a separate plan, please use this section to provide information concerning the coverage for those persons.

Name(s) of Person(s): _____

Name of Carrier _____

Policy Number: _____

Type of Coverage: Check all that apply.

_____Group _____Individual

_____Indemnity _____HMO _____PPO _____Point of Service

_____Other (Specify)_____

Plan Information: Deductible Amount: _____

Coinsurance: _____

Copayment: _____

Initial Effective Date: _____ Termination Date:_____]]

COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY DEPENDENTS) IN: (Only one plan and one deductible option may be selected)

[PLAN A/50 Deductible $1000 _____ $2500____
$5000 _____ $10000____

PLAN B [o Indemnity] [o Preferred Provider] Deductible $1000_____ $2500____
PLAN C [o Indemnity] [o Point of Service] [o Preferred Provider] Deductible $1000 _____ $2500____[per individual
$1500_____$2250___ per family $3000_____ $4500___]
$1650_____$2500___ per family $3300_____ $4950___]

PLAN D [o Indemnity] [o Point of Service] [o Preferred Provider] Deductible $500_____ $1000 _____ [per individual
$1500_____ $2250___per family $3000_____ $4500___]
$1650_____$2500___ per family $3300_____ $4950___]

[HMO Plan [$10] $15 [$20] [$30] copayment.] [Well Child Care Option o Yes o No]]
Basic and Essential health Care Services Plan _____
[Optional benefit Riders available with the basic and essential health care services plan (carrier should list the riders, if any)]
Type of Contract: o Single
o Family
o Adult & Child(ren)
o Husband/Wife
[o Child(ren)]
[If you selected Plan C or Plan D with a [$1500 per individual][[$[2250]2500 per individual] [$3000 per family] [$[4500]4950 per family] Deductible option, do you intend to participate in a Medical Savings Account?
o Yes o No]

Requested Effective Date - [Must be the 1st or 15th of the month]:_____

Type of Activity:

o New [Subscriber] o Name Change from _____ to _____

o Converting from existing (carrier) plan
ID #_____ [o Change of Primary Care Physician or Gynecologist]

[o Change of Health [Care] Center from _____ to _____]

o Add/Remove Dependent
Reason _____
Date of Event _____ [o Change of Primary Care Physician at Health [Care] Center]

o Withdrawal From Coverage
Date of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

o Monthly [o Quarterly] [o Semi-Annually]

[PAYMENT MODE:
o Check
o Money Order
[o Credit Card Type_____ No. _____ Exp. Date_____]
[o Automatic Bank Draft (attach voided check)]

[o Other _____ Amount $ _____]]

4. OTHER HEALTH CARE COVERAGE (Note: In some situations, if you are eligible for or have other health benefits coverage, you are not eligible for this [policy] [coverage]. If you or other dependents become eligible for or become covered under other health benefits coverage, after the date of this application, you must notify us as soon as possible, however no later than the effective date of such other coverage.)

Are you employed? o Yes o No If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? o Yes o No (i.e., coverage under your employer's health benefits coverage or Medicare).
If yes, give name and policy no. of other carrier or type of coverage.
Are other dependents eligible for coverage? If yes, specify.

Do you or other dependents currently have any other health care coverage? o Yes o No
If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy/certificate:
Are you replacing existing coverage? o Yes o No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy. If you are replacing coverage and the plan is an Individual Health Coverage (IHC) Plan or a Small Employer Health Benefits (SEH) Plan, please identify the letter of the plan being replaced._____ _____ Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? o Yes o No If "Yes", attach the Certificate of Creditable Coverage
[Have you or your dependents ever been a member of [carrier]?]
[If yes, under what name and social security no.?]
[Where? [carrier] of:]

[PRE-EXISTING CONDITIONS STATEMENT
Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 12 months. Consult the Buyer's Guide, the carrier or your agent for information concerning the application of the pre-existing conditions limitation.

1. During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

		Yes	No
a.	Alcoholism, Drug Abuse	____	____
b.	Arthritis	____	____
c.	Blood Disorder	____	____
d.	Back or Neck Disorder, Injury or Pain	____	____
e.	Cancer or Tumors	____	____
f.	Diabetes	____	____
g.	Gastro or Intestinal Disorder	____	____
h.	Heart Disorder or Condition or Chest Pain	____	____
I.	High Blood Pressure	____	____
j.	Kidney or Liver Disorder	____	____
k.	Lung or Respiratory Disorder	____	____
l.	Mental or Nervous Disorder	____	____
m.	Paralysis, Stroke or Epilepsy	____	____
n.	Does Pregnancy Exist Expected Due Date: _____	____	____

2. During the past 6 months, have you or any dependent to be covered:

		Yes	No
a.	been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	____	____
b.	been advised to have treatment or surgery or testing that has not been done?	____	____
c.	been admitted to a hospital or other health care facility as an inpatient?	____	____
d.	taken prescribed medications?	____	____

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question	Name	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name and Address of Hospitals, Practitioners
					]

[5. PROVIDER SELECTION

	FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO.	[HEALTH CENTER* (if applicable)]	[GYNECOLOGIST OFFICE NO.]	[ESTABLISHED PATIENT]	PRIMARY CARE PHYSICIAN CHANGE	[HEALTH CENTER CHANGE]
1. Applicant				o Yes o No	o	o
2. Spouse				o Yes o No	o	o
3. Child				o Yes o No	o	o
4. Child				o Yes o No	o	o
5. Child				o Yes o No	o	o]
[Statewide Physician Network o Health Center o]						

[*When selecting Health Center option, please also select a Primary Care Physician from among the Health Center doctors.]

[NOTE: A Primary Care Physician must be selected for each adult member and a Pediatrician must be selected for each child. Women over the age of 16 must also select a GYN.]

[5.][6.] AUTHORIZATION AND CERTIFICATION

I hereby apply to [carrier] for coverage for any eligible dependents listed above and myself.

[I have been offered the opportunity to add the following coverage(s) to the New Jersey Individual Health Benefits Plan and I accept or reject, as shown below: Coverage for treatment of cancer by dose intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants pursuant to New Jersey Assembly Bill 1997, P.L. 1995, c.100. o Accept o Reject]

I understand that for the 12 months following the effective date of this [policy] [contract], benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This limitation will not apply if you are a Federally Defined Eligible Individual and may not apply if the eligible person transfers from another health benefits plan.)

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, [carrier] may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to [carrier or its assignee] information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to [carrier or its assignee.]

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I state that: (a) I am a resident of New Jersey [and reside live or work within the [carrier] service area (if applicable)], (b) the information given on this application is complete to the best of my knowledge and belief and (c) that [carrier] will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application [carrier] can cancel this contract [as of the original effective date][immediately].

Applicant's Signature: _____ Date Signed _____

Spouse's Signature_____ Date Signed _____

Preparer's Signature: _____ DOBI License # _____ Date Signed _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [contract] [policy]. It becomes part of your contract with us.

For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[ ]

[[6][7] AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]]