INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Proposed Amendments: N.J.A.C. 11:20-1, 2, 3, 8, 9, 12, 17, 22, 24 and N.J.A.C. 11:20 Appendix Exhibits A, B, C, F, G, K and L.

Proposed New Rules: N.J.A.C. 11:20-3.6, 3.7, 24.6 and 24.7 and Appendix Exhibit H

Proposed Repeals: N.J.A.C. 11:20-6, 7, 18 and N.J.A.C. 11:20 Appendix Exhibits E and J.

Authorized By: New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director.

Authority: N.J.S.A. 17B:27A-2 et seq., P.L. 2007, c. 345 and P.L. 2008, c. 38.

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

Proposal Number: PRN 2008-

Interested persons may testify with respect to the standard health benefits plans and specimen Basic and Essential plan, set forth in Appendix Exhibits A, B and F to N.J.A.C. 11:20 at a public hearing to be held at 9:30 a.m. on December 9, 2008 at the New Jersey Department of Banking and Insurance, Conference room 219, 20 West State Street, Trenton, New Jersey.

Submit comments by December 15, 2008 to:

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The agency proposal follows:

Summary

The purpose of this proposal is to comply with the requirements of two laws, P.L. 2007, c. 245 and P.L. 2008, c. 38. P.L. 2007, c. 245, enacted on January 13, 2008 and effective April 13, 2008 requires carriers to provide coverage for orthotic and prosthetic appliances obtained from any licensed orthotist or prosthetist or certified pedorthist as determined medically necessary by a covered person's physician. Reimbursement for orthotic and prosthetic appliances must be at the same rate as reimbursement for such appliances under the Federal Medicare reimbursement schedule. P.L. 2008, c. 38 was approved on July 8, 2008 and becomes effective January 5, 2009. Among other things, P.L. 2008, c. 38 amends N.J.S.A. 17B:27A-2 (the IHC Act), originally effective November 30, 1992, which established the New Jersey Individual Health Coverage (IHC) Program to provide requirements for the provision of the individual health coverage plans in this State. The majority of the responsibilities for the implementation of the Act were assigned to the IHC Board which adopted regulations which are codified at N.J.A.C. 11:20. P.L. 2008, c. 38 amended various sections of the IHC Act which necessitate amendments to N.J.A.C. 11:20. Further, P.L. 2008, c 38 transfers some of the responsibilities that were previously assigned to the IHC Board to the Commissioner of the Department of Banking and Insurance (Commissioner). Significant among the amendments of P.L. 2008, c. 38 are the following:

1. The definition of modified community rating is amended and allows for a 3.5:1 rate differential based on age.
2. If a carrier issues small employer coverage in New Jersey the carrier must offer individual coverage and must make a good faith effort to market the individual coverage.

3. Carriers shall offer a choice of at least three of the standard individual health benefits plans established by the Board.
4. Carriers may file optional benefit riders of increasing value to amend the standard health benefits plans**.**
5. The loss assessment for the 2007 – 2008 calculation period will be the last loss assessment. Assessments for prior years may continue even after the 2007 – 2008 calculation period. The administrative assessment continues as before.
6. The responsibility for the regulation of standard health benefit plan rates, the basic and essential health care plan and rates, loss ratios and carrier withdrawals and is transferred from the IHC Board to the Commissioner.

The IHC Board proposes to remove all references to NJ Kidcare from N.J.A.C. 11:20 and Appendix Exhibit K consistent with the deletion of all references to NJ Kidcare in P.L. 2008, c. 38.

The IHC Board proposes adding a definition of Modified Community Rated to N.J.A.C. 11:20-1, consistent with the definition set forth in amended N.J.S.A. 17B:27A-2.

The IHC Board proposes amending the definition of Net Earned Premium to delete the list of plans for which premium is to be excluded and refer to the Premium Data Worksheet which is set forth in Appendix Exhibit K for the express identification of excepted premium. The Board proposes amending such identification on Appendix Exhibit K to specifically exclude all premium from Medicare Advantage and Medicare + Choice Coverage, Medicare Demonstration and Medicare Part D Coverage as required by 42 C.F.R. 422.404.

The IHC Board proposes updating the statutory citation for NJ Family care consistent with the definition set forth in amended N.J.S.A. 17B:27A-2.

The IHC Board proposes an amendment to N.J.A.C. 11:20-2.1 and similar references to "community rated" as they appear throughout N.J.A.C. 11:20 to refer to "modified community rated" since P.L. 2008, c. 38 amends the rating requirements from community rated to modified community rated.

The IHC Board proposes an amendment to N.J.A.C. 11:20-2.1(a)2 to identify the 2007-2008 calculation period as the final period for which losses may be reimbursed consistent with amended N.J.S.A. 17B:27A-12.

The IHC Board proposes amending N.J.A.C. 11:20-2.3(b)6 to delete rate filings from the list of filings the Board will review consistent with amended N.J.S.A. 17B:27A-9.

The IHC Board proposes amending N.J.A.C. 11:20-2.5(j) and N.J.A.C. 11:20-2.6(f) to state that the IHC Board of Directors is subject to the State of New Jersey Uniform Ethics Code and any supplemental code of ethics the IHC Board may adopt, consistent with the requirements of N.J.S.A. 52:13D-23.

The IHC Board proposes amending N.J.A.C. 11:20-2.6(d) to delete the review of rate filings and loss ratio reports from among the responsibilities of the Technical Advisory Committee, consistent with amended N.J.S.A. 17B:27A-9.

The IHC Board proposes amending N.J.A.C. 11:20-2.6(d) to add a new responsibility for the Marketing and Communication Committee. Such Committee will consider the good faith marketing reports carriers must submit as required by amended N.J.S.A. 17B:27A-4.

The IHC Board proposes amending N.J.A.C. 11:2-2.10 to delete item (b) which addresses the submission of a certification of compliance to the IHC Board. Certification of compliance filings will no longer be made with the IHC Board since amended N.J.S.A. 17B:27A-7d transfers such responsibility to the Commissioner.

The IHC Board proposes amending N.J.A.C. 11:20-2.10(b)1 to state that the rate filings are made with the Department rather than the Board, as rate filing review is one of the responsibilities P.L. 2008, c. 38 transfers to the Commissioner.

The IHC Board proposes amending N.J.A.C. 11:20-2.18 to reduce the de minimus amount for a loss assessment or a combination loss and administrative assessment to $10.00 and to include a $5.00 de minimus amount for administrative only assessments. This change is being proposed in recognition of the fact that reimbursable loss amounts have been significantly lower than in the early years of the program, meaning each carrier's proportionate liability is lower. Using $10.00 as a de minimus results in an equitable distribution of liability among member carriers without requiring a member to issue a check for an amount that is lower than the cost associated with processing the check. Including $5.00 as a de minimus for administrative assessments recognizes the fact that the administrative costs associated with the IHC Program have been lower than the reimbursable losses. To ensure that member carriers are not burdened with multiple redistributions of de minimus amounts, the IHC Board selected a lower threshold amount.

The IHC Board proposes amending N.J.A.C. 11:20-3.1(b) and (c) to limit the number of plans a carrier must offer to three, consistent with amended N.J.S.A. 17B:27A-4 and to specify the cost sharing a carrier must offer in the three plans so offered by carriers. The IHC Board proposes increasing the required deductible to $2,500 and the required copay to $30.00, consistent with the plan options that have most often been selected by consumers. The amendments address options carriers may elect to offer in addition to the three plans carriers have designated as the three plans to be offered. The Board is proposing an increase in the maximum out of pocket to $7,500, consistent with the upper limit for a maximum out of pocket set forth in N.J.A.C. 11:22.5.3(a)1.

The IHC Board proposes adding a new paragraph (e) to N.J.A.C. 11:20-3.1 that would require carriers to complete an Identification of Standard Plans form set forth in proposed new Appendix Exhibit H. The purpose of the Identification of Standard Plans is to provide the Board with information regarding each carrier's selection of at least three plans.

The IHC Board proposes amending N.J.A.C. 11:20-3 to delete N.J.A.C. 11:20-3.2 which required carriers to file a Certification of Compliance with the IHC Board since P.L 2008, c. 38 transferred the responsibility for ensuring compliance with the standard plans from the Board to the Commissioner. The Commissioner will be proposing a regulation that will include a requirement to file a Certification of Compliance. The IHC Board is also proposing the repeal of Appendix Exhibit E which was the IHC Board's Certification of Compliance.

The IHC Board proposes amending N.J.A.C. 11:20-3.3 to add a new item (d) to clarify that the compliance and variability rider may not be used as the vehicle to specify amendments to the standard plans that are described in proposed new N.J.A.C. 11:20-3.6.

The IHC Board proposes amending N.J.A.C. 11:20-3.4 and Appendix Exhibit G such that the Plan Update Rider will afford cost sharing protections to covered persons whose plans are force-converted as described in N.J.A.C. 11:20-24.7.

The IHC Board proposes new N.J.A.C. 11:20-3.6 to address the filing of optional benefit riders as permitted by amended N.J.S.A. 17B:27A-4f. The proposed new rule defines "coverage" and details the information that must be included in a filing of an optional benefit rider with the IHC Board. The proposed new rule states that a plan as amended by a rider does not create a new plan. The Board proposes amending the annual enrollment report set forth at Appendix Exhibit L part 2 to report the number of plans that are issued with the optional benefit riders filed pursuant to proposed N.J.A.C. 11:20-3.6.

The IHC Board proposes new N.J.A.C. 11:20-3.7 to address the process whereby the IHC Board may eliminate a standard plan or a standard plan option. A similar provision is currently set forth in N.J.A.C. 11:18.7. As the Board is proposing the repeal of subchapter 18 in its entirety, the IHC Board is moving the discussion of the Board's option to eliminate a plan to subchapter 3.

The IHC Board proposes the repeal of N.J.A.C. 11:20-6 which addresses rate filings. P.L. 2008, c. 38 transfers the authority for governing individual rate filings from the Board to the Commissioner.

The IHC Board proposes the repeal of N.J.A.C. 11:20-7 which addresses loss ratio requirements. P.L. 2008, c. 38 transfers the authority for governing loss ratios from the Board to the Commissioner.

The IHC Board proposes amending N.J.A.C. 11:20-8.4 to explain the reporting of modified community rated lives.

The IHC Board proposes amending N.J.A.C. 11:20-8.5 to note that the final period for which loss reimbursement may be sought is the 2007-2008 calculation period, consistent with amended N.J.S.A. 17B:27A-12.

The IHC Board proposes amending N.J.A.C. 11:20-12.2, 12.4 and 12.5 to include a Special Open Enrollment Period. With the availability of modified community rates for standard health benefits plans in January 2009, the IHC Board determined it appropriate to allow consumers the opportunity to elect from among the modified community rated plans soon after such plans are available rather than requiring consumers to wait until the November open enrollment period. In 2009 there will thus be two open enrollment periods.

The IHC Board proposes amending N.J.A.C. 11:20-12.3(b) which addresses when replacement of plans can occur at any time to state that the premium used in the comparison of plans is the filed monthly premium.

The IHC Board proposes new N.J.A.C. 11:20-12.4(e) to address the operation of an open enrollment period where optional benefit riders amending a standard health benefits plan are a consideration.

The IHC Board proposes amending N.J.A.C. 11:20-17.4 to address Point of Service (POS) plans in addition to Preferred Provider Organization (PPO) plans on the enrollment status report, recognizing the possibility some carriers may elect to offer the standard plans as POS plans. The IHC Board is proposing the addition of data regarding plans issued with optional benefit riders on the annual enrollment report and is proposing corresponding amendments to Appendix Exhibit L Part 2.

The IHC Board proposes the repeal of N.J.A.C. 11:20-18. P.L. 2008, c. 38 transfers the authority for governing withdrawals from the Board to the Commissioner.

The IHC Board proposes amending the deletion of N.J.A.C. 11:20-22.4 as P.L. 2008, c. 38 transfers the authority for governing the filing of the basic and essential health care services plan from the IHC Board to the Commissioner.

The IHC Board proposes amending N.J.A.C. 11:20-22.5(e) and (f) to include standard POS plans among the plans that must be included in the information submitted by carriers that have approved riders that amend the basic and essential health care services plan.

The IHC Board proposes amending N.J.A.C. 11:20-24.2(b) to state that if a person is currently covered under an individual health benefits plan and subsequently becomes eligible for a group health plan, the person may choose to retain the individual health benefits plan. The

opportunity to retain an individual health benefits plan in such a circumstance is required by Federal law.

The IHC Board proposes amending N.J.A.C. 11:20-24.4 to add a new item (d) to address the effective date of coverage for applications submitted during the Special Open Enrollment Period.

The IHC Board proposes amending N.J.A.C. 11:20-24.5 to address the payment of benefits for prosthetics and orthotics as required by P.L. 2007, c. 345. In addition, the Board proposes revising the terminology such that "reasonable and customary" is replaced with "allowed charge" where the allowed charge for services and supplies not subject to capitated or negotiated arrangements is the actual charge or the 80th percentile of the Prevailing Healthcare Charges System profile.

The IHC Board proposes new N.J.A.C. 11:20-24.6 to specify the requirements carriers that market small employer health benefits plans must satisfy when marketing individual health benefits plans as required by amended N.J.S.A. 17B:27A-4.

The IHC Board proposes new N.J.A.C. 11:20-24.7 to address the filing required in connection with any carrier's forced conversion of existing plans, as permitted by N.J.S.A. 17B:27A-4.

Standard Health Benefits Plans

As required by N.J.S.A. 17B:27A-7, the IHC Board established the contract forms and benefit levels to be made available by all carriers for any health benefit plans the carriers elect to issue. N.J.A.C. 11:20-3 identifies the standard health benefit plans, Plans A/50, B, C, D and HMO, which are the plans from which carriers offering coverage in the individual market must select at least three plans to issue and renew. The text of the plans is set forth in Appendix Exhibits A and B, with variable text as detailed in Exhibit C.

Compliance with State Law

As required by P.L. 2007, c. 345, Plans A/50 through D and HMO would include coverage for prosthetics and orthotics.

To comply with N.J.S.A. 17B:27-46.1y regarding coverage for colorectal cancer screening and methods and frequency in accordance with the most recent published guidelines of the American Cancer Society, the colorectal cancer screening benefit in Plans A/50 through D and HMO would include stool DNA tests and computed tomography colonography.

Board Initiated Changes

The Board proposes amending Plans A/50 – D in Appendix Exhibit A to include Point of Service (POS) text for the schedule page as well as provisions discussing the operation of a POS plan. The provisions permit the point of service plan to be offered either requiring referrals or not requiring referrals.

The Board proposes replacing the term "Reasonable and Customary" with "Allowed Charge" in both the definition section of the standard plans A/50 - D in appendix Exhibit A as well as wherever the term appears in the standard plans. The IHC Board is proposing the same change in the specimen Basic and Essential Healthcare Services Plan in Appendix Exhibit F. The IHC Board proposes this change in recognition of the fact that "allowed charge" more accurately describes the amounts that are determined from use of the Prevailing Healthcare Charges System fee profile.

The Board proposes amending the HMO plan in Appendix Exhibit B to allow plans that require referral as well as plans that do not require referral. The Board proposes amending the Explanation of brackets, Appendix Exhibit C to address the optional referral provisions.

The Board proposes amending the Plan Update Rider in Appendix Exhibit G to accommodate the modifications discussed in the amendments proposed to N.J.A.C. 11:20-3.4

IHC Rulemaking Procedures

The IHC Board proposes these amendments pursuant to N.J.S.A. 17B:27A-16.1, which provides a special procedure whereby the IHC Board may adopt certain actions. Pursuant to this procedure, the IHC 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 IHC 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 IHC Board must provide a minimum 20-day period from the date of notice for all interested persons to submit their written comments on the intended action to the IHC Board. However, given the extent of the amendments proposed, the IHC Board is allowing a 45-day comment period.

Pursuant to N.J.S.A. 17B:27A-16.1, the IHC 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 IHC 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 IHC 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 IHC Board's responses.

Social Impact

The IHC Board anticipates the social impact of the proposed amendments, new rules and repeals will be positive long-term, but in the short-term, the resulting impact will be mixed for

consumers and the market generally. Increased flexibility for carriers to choose whether to offer three or more standard plans, perhaps with optional riders, on a modified community rated basis may make the market more attractive to some carriers and consumers, but confusing to other consumers because of an inability to make easy apples-to-apples comparisons among carriers and their products. In addition, the IHC Board anticipates that some carriers will elect to offer fewer standard health benefits plans than they offer now, which will have an adverse impact for some of the lives currently covered in the IHC market. As carriers pare their offerings, they will either require currently-covered individuals to actively seek or move into another plan (if the carrier withdraws a standard plan or forces the conversion of one), or allow currently-covered individuals to stay with a closed plan until rate increases force such individuals to look elsewhere for coverage.

On the other hand, the IHC Board anticipates that modified community rating of the standard plans, based on age will make pricing of the products more attractive for younger consumers, and will encourage younger consumers to elect coverage, which benefits not only the purchaser, but the carrier's line of business and the IHC market generally if the average age of enrollees is lowered.

There are possible unintended social consequences of the proposed amendments, new rules and repeals upon the IHC and Small Employer Health Benefits (SEH) Program. Because P.L. 2008, c. 38 requires carriers that offer standard plans in the SEH market to also offer standard plans in the IHC market, carriers lacking the wherewithal to do so, or that have determined the individual market is not in their business plan may choose to withdraw from the SEH market rather than offer standard health benefits plans in the IHC market, thus forcing some current small employers to seek coverage from other carriers. The IHC Board's proposed new rules are intended to mitigate the perceived downside to offering standard plans in the IHC market by establishing a modest threshold

for compliance with the good faith marketing requirement for individual standard health benefits plans. In addition, the IHC Board anticipates there may be a modest shifting of small groups and some employees away from the SEH market following the introduction of modified community rating in the IHC market. It is expected that the shift may be somewhat positive for the IHC market enrollment with a corresponding decrease for the SEH market enrollment.

Economic Impact

The IHC Board does not anticipate any direct negative economic impact for carriers as a result of these proposed amendments, new rules or repeals. The IHC Board does not believe any carrier currently offering standard health benefits plans in the IHC market will incur any significant costs related to changes in recordkeeping, reporting or other compliance requirements set forth in the proposed amendments, new rules or repeals. Indeed, some of the recordkeeping and reporting requirements would be reduced or eliminated, and consequently, may result in cost savings for some carriers. In addition, most IHC Program members currently sharing in the loss reimbursement mechanism should see a positive economic impact from the discontinuance of that mechanism after the 2007 - 2008 calculation period. Arguably, there could be a negative economic impact upon carrier(s) that have continued to seek reimbursement for losses from the IHC Program. However, both the number of carriers and the total amount of losses for which reimbursement has been sought have been substantially reduced over the years, with only two carriers seeking reimbursement for about $1,000,000 total for the 2005 - 2006 calculation period.

Depending upon a carrier's business plan, other aspects of the proposed amendments, new rules and repeals, may result in a positive economic impact for carriers. Specifically, carriers that choose to offer standard health benefits plans in the individual market should find the following to

their economic advantage: (1) the significantly enhanced flexibility carriers will have starting in 2009 to offer modified community rated policies based on age; (2) the ability of carriers to reduce the number of standard plans offered.

The economic impact for consumers will be mixed. Because carriers will be allowed to rate the standard plans based on age (subject to a 350% rate band), premiums for younger purchasers in the individual market should be more attractive in 2009 than in 2008. Conversely, premiums for older purchasers are likely to be less attractive in general. However, it should be noted that P.L. 2008, c. 38 limits the rate increases for renewing business and those aged 55 and older for four years to no more than 15%, which temporarily will mitigate the adverse impact for many people currently in the IHC market. Of course, individuals would have the opportunity to shop for other coverage in the individual market. The IHC Board anticipates the proposed changes to the IHC Plans (i.e., addition of a POS plan design option with and without required referrals, and proposed increases to the base deductible and copayment options a carrier must offer) will have both a positive and negative impact for many consumers by holding down premiums for the standard plans, while increasing out-of-pocket costs.

Professional services that will be required for carriers to comply with the proposed new rules (i.e., professional, accounting, legal, and actuarial services) are services carriers already utilize for compliance with the existing IHC Program rules, and the Board does not expect carriers to incur any substantial additional cost for these services because of the proposed amendments, new rules and repeals. The IHC Board expects a modest reduction in its administrative expenses generally: costs savings should result from the transfer of certain functions to the Commissioner, and eventually from the discontinuation of the loss assessment mechanism, while modest cost increases

are likely to result from revisions to and frequent updating of the IHC Program's informational materials (i.e., the buyer's guide and rate comparisons).

Federal Standards Statement

State agencies that adopt, readopt or amend state rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. There are Federal standards, generally set forth at 45 C.F.R. 148.101 through 148.170, applicable to individual health benefits plans. Additionally, 42 C.F.R. 422.422 prohibits imposing a tax, fee or similar assessment with respect to Medicare Advantage premium regardless of whether the premium is paid by CMS, the Medicare beneficiary or a third party on the beneficiary's behalf. To comply with this requirement, Appendix Exhibit K is being amended to expressly except all Medicare Advantage premium. However, to the extent that the proposed amendments, new rules and repeals address the same subject matter as that set forth in the Federal regulations (specifically, with respect to guaranteed renewability of coverage, and the right of an individual to maintain his or her individual coverage even if he or she becomes eligible for coverage under a group health plan as well as taxing Medicare Advantage premium), the proposed amendments, new rules and repeals do not exceed the Federal standards. Accordingly, the IHC Board does not believe a Federal standards analysis is required.

Jobs Impact

The IHC Board believes the proposed amendments, new rules and repeals would neither generate nor result in the loss of jobs. The Department invites commenters to submit any data or

studies on the potential jobs impact of the proposed new rules together with their comments on other aspects of the proposal.

Agricultural Industry Impact

The IHC Board believes the proposed amendments, new rules and repeals would have no impact upon the agriculture industry.

Regulatory Flexibility Statement

Although the proposed repeals will lessen the reporting and compliance requirements for carriers, the proposed amendments and new rules will continue or establish other reporting, recordkeeping and compliance requirements for carriers, some of which may be "small businesses" as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. As noted in the Economic Impact statement, the IHC Board does not anticipate any carrier currently operating in the IHC market will need to take on any professional services in order to comply with the proposed amendments, new rules and repeals. However, a carrier currently offering coverage in the SEH market but not offering standard plans in the IHC market will incur costs to comply with the requirement to offer IHC standard plans, or incur costs associated with withdrawal from the SEH market (whether or not specific additional professional services are needed). The requirement to offer coverage in the IHC market if offering coverage in the SEH market, and to do so in good faith (or withdraw) is set forth by P.L. 2008, c. 38. No distinction is made in the statutes based on whether a carrier constitutes a small business, and the IHC Board does not believe regulatory flexibility is warranted in this regard. However the IHC Board has proposed modest good faith marketing requirements to ease entry into the IHC market of those carriers that previously only offered standard plans in the SEH market. Finally, the goals of these proposed amendments, new

rules and repeals does not vary based on business size; accordingly, the proposed amendments, new rules and repeals provide no differentiation in compliance requirements based on business size.

Smart Growth Impact

The IHC Board believes the proposed amendments, new rules and repeals would have no impact upon the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact Analysis

In accordance with N.J.S.A. 52:14B-4.1b, a housing affordability impact analysis is required unless an agency determines that the "scope of the [proposal] is minimal, or there is an extreme unlikelihood that the [proposal] would evoke a change in the average costs associated with housing." The IHC Board has determined a housing affordability impact analysis is not required for the IHC Board's proposed amendments, new rules and repeals because the scope of the proposal is entirely unrelated to housing, and the proposed amendments, new rules and repeals are extremely unlikely to evoke a change in the average costs associating with housing.

Full text of the subchapters proposed for repeal appears in N.J.A.C. 11:20-6, 7, 18 and Appendix Exhibits E and J.

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

CHAPTER 20. INDIVIDUAL HEALTH COVERAGE PROGRAM
SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

. . .

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. A member shall not include a carrier whose combined average Medicare, Medicaid**[,]** **and** NJ FamilyCare **[and NJ KidCare]** enrollment represents more than 75 percent of its average total enrollment for all health benefits plans or whose combined Medicare, Medicaid**[,] and** NJ FamilyCare **[and NJ KidCare]** net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare, Medicaid **and** NJ FamilyCare **[and NJ Kidcare]** enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum of these enrollment figures, as measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight.

"Modified community rated" means, with respect to coverage under standard health benefit plans, a rating system in which the premium for all persons covered under a policy or contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical location or any other factor or characteristic of covered persons, other than age.

The rating system provides that the premium rate charged by a carrier for the highest rated individual or class of individuals shall not be greater than 350% of the premium rate

charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits plan shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with regulations promulgated by the commissioner, which include age classifications as set forth in N.J.A.C. 11:20-6. There may be a reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or different health benefits plans offered by a carrier.

There is a separate definition in N.J.A.C. 11:20-22.2.

"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. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid**[,]** **or** NJ FamilyCare **[or NJ KidCare]** contracts with the State or federal government, but shall not include any [**payment the Health Care Financing Administration makes on behalf of Medicare Plus Choice or Medicare Advantage enrollees, premiums earned from contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. §§8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts]** **premium associated with the benefits enumerated in Section 2 of Part C of the Premium Data Worksheet which is set forth as chapter Exhibit K, incorporated herein by reference.**

"NJ FamilyCare" means the FamilyCare Health Coverage Program established pursuant to **[P.L. 2000, c. 71 (N.J.S.A. 30:4J-1 et seq.)]** **P.L. 2005, c. 156 (C. 30:4J-8 et al.).**

["NJ KidCare" means the Children's Health Care Coverage Program established pursuant to P.L. 1997, c. 272 (N.J.S.A. 30:4I-1 et seq.).]

. . .

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

11:20-2.1. Purpose and structure

(a) The "IHC Program" created pursuant to the N.J.S.A. 17B:27A-2 to 16, as amended, has as its members all insurance companies, health service corporations, hospital service corporations, medical service corporations, and health maintenance organizations that issue or have in force health benefits plans in this State. The IHC Program's purpose is:

1. To assure the availability of standardized individual health benefits plans in New Jersey on an open enrollment, **modified** community-rated basis; and

2. To reimburse certain losses of member companies for the calendar year ending December 31, 1992 pursuant to N.J.S.A. 17B:27A-13, for each calendar year ending December 31, 1993 through December 31, 1996, and for each two-year calculation period **[thereafter]** **through the 2007-2008 calculation period** pursuant to N.J.S.A. 17B:27A-12, as amended.

(b) - (h) (No change)

11:20-2.3. Powers of the IHC Program and Board

(a) (No change)

(b) The Board shall have the authority to do the following:

1 – 5 (No change)

6. Review **[rate filings and other]**filings submitted by carriers in accordance with the Act and rules promulgated pursuant thereto and the Plan of Operation;

7 – 22 (No change)

11:20-2.5. Board of Directors

(a) – (i) (No change)

(j) All Board members shall be subject to the **[Individual Health Coverage Program Code of Ethics adopted by the Board pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D-12 et seq.]** **State of New Jersey Uniform Ethics Code and any supplemental code of ethics the Board adopts.**

11:20-2.6. Committees

(a) – (c) (No change)

(d) Standing committees shall include the following:

1. A Technical Advisory Committee, which shall make recommendations to the Board with respect to:

i. Methods for calculating assessments;

[ii. Standards for information requested for rate filings and for review of such rate filings;]

[iii. Standards for review of loss ratio reports;]

iv – vi. (Renumber as ii. – iv.)

[vii. Reviews of informational rate filings submitted to the Board pursuant to N.J.A.C. 11:20-6 to determine whether an informational rate filing is complete;]

[viii. Reviews of loss ratio reports submitted to the Board pursuant to N.J.A.C. 11:20-7;]

[ix. A member carrier's plan for refunds to policy and contract holders, if necessary;] and

[x]v. Any other reports or recommendations to the Board as may be appropriate **[regarding rates, rate filings and loss ratio reports, including, but not limited to, recommendations]** regarding the possible **[rating]** impact of suggested plan designs;

2 (No change.)

3. A Marketing and Communications Committee, which shall make recommendations to the Board with respect to:

i. – iii. (No change.)

iv. Submissions of good faith marketing reports as required by N.J.A.C. 11:20-24.6 by those members that are small employer carriers demonstrating marketing of all of the standard health benefits plans the member elects to offer.

iv - v (Renumber as v – vi.)

4. (No change.)

(e) (No change.).

(f) All committee members shall be subject to the **[Individual Health Coverage Program Code of Ethics adopted by the Board pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D-12 et seq.]** **State of New Jersey Uniform Ethics Code and any supplemental code of ethics the Board adopts.**

11:20-2.10. Standard health benefits plans

(a) The Board shall establish the policy and contract forms and benefit levels (standard health benefits plans) to be made available by members.

1. – 5. (No change.)

[(b) Members shall submit to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h), a certification, set forth as Exhibit E in the Appendix to this chapter, upon entry into the market and on March 1 of every year that sets forth that the standard policy forms will be used in accordance with the requirements of N.J.A.C. 11:20-3.2.]

[1]6. No member shall issue or renew a standard health benefits plan or the basic and essential healthcare services plan until a rate filing has been filed with the **[Board] Department** in accordance with N.J.A.C. 11:20-6.

11:20-2.18. Minimum assessment

If the total amount of a member's assessment invoice would be less than [$20.00] **$10.00 in the case of either a loss assessment or both a loss assessment and an administrative assessment, or less than $5.00 in the case of an administrative assessment only,** the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12 and 2.17 as appropriate. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12, an invoice for reimbursable net paid losses issued pursuant to N.J.A.C. 11:20-2.17, or a combined invoice for both administrative expenses and net paid losses.

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

(a) (No change)

(b) **[In accordance with N.J.A.C. 11:20-1.3, members**] **Members that offer individual health benefits plans in this State and members** that offer **small employer health benefit**

plans in this State pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21 shall offer at least three of the [individual health benefits plans in this State shall offer] standard health benefits Plans A/50, B, C, **[and] D and HMO** as set forth in chapter Appendix Exhibits A and B, incorporated herein by reference with variable text as specified on the Explanation of Brackets, which is set forth as chapter Appendix Exhibit C, incorporated herein by reference, **subject to the provisions set forth in items 1 - 9** below and except as provided in subsection (c) below.

1. Members shall offer Plan A/50 which is designated as the basic plan.

2. Members shall offer at least two of the Plans designated as Plans B, C, D and HMO.

[1]3. Members offering **[Plans] Plan** A/50, **and at least two of the plans designated as Plans** B, C, **[and]** D **and HMO** shall offer **at least two of** the **selected plans B, C and/or D if not also offering HMO, and at least one of the selected Plans B, C and/or D is offering the HMO, with the** following annual deductible provisions:

i. The per covered person annual deductible shall be **[$ 1,000] $2,500**; and

ii. The corresponding per covered family annual deductible shall be **[$2,000] $5,000**, satisfied on an aggregate basis.

[2]4. Members offering Plans A/50, B, C, **[and] and/or** D may offer **the plans with** one or more of the following annual deductible provisions in addition to the deductible provisions specified in **[(b)1] (b)3** above:

i. Per covered person annual deductible equal to **[$ 2,500] $1,000**, $ 5,000 or $10,000; and

ii. (No change.)

[3]5. Members offering Plans A/50, B, C, and D may offer **the plans with** one or more of the following annual deductible provisions in addition to the deductible

provisions required in **[(b)1] (b)3** above **such that the plans may qualify as high deductible health plans**:

i. – iv. (No change.)

[4]6. Members offering Plans C and D may renew plans that were issued with the following annual deductible provisions:

i. – ii. (No change.)

[5]7. When issued using deductible provisions set forth in **[(b)1] (b)3** and**[2]4** above, Plans A/50, B, C, and D shall contain maximum out of pocket provisions as follows:

i. –v. (No change.)

vi. Coinsurance paid for covered prescription drugs under Plans A/50, B, C, and D, issued using deductibles set forth in **[(b)1] (b)3** and **[2]4** above shall not count toward the maximum out of pocket. Coinsurance for prescription drugs must continue to be paid even after the maximum out of pocket has been reached.

[6]8. When issued using deductible provisions set forth in **[(b)3] (b)5** above, Plans C, and D shall contain maximum out of pocket provisions as follows:

i. – ii. (No change.)

[7]9. When renewed using deductible provisions set forth in [**(b)4] (b)6** above, Plans C and D shall contain maximum out of pocket provisions as follows:

i. – ii. (No change.)

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu of **offering at least three of** Plans A/50, B, C, and D in (a) above. State qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in addition to **at least two of** Plans A/50, B, C, and D in **[(b)] (a)** above. HMO carriers offering the HMO Plan shall offer the **[$ 15.00] $30.00** copayment plan design set forth

in (c)1i below and may, at the option of the HMO, also offer other copayments or may also offer the HMO plan using deductible and coinsurance provisions. All options offered by the HMO member shall be made available to every eligible individual seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (c)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (c)3 below.

1. Carriers issuing HMO plans with a Copayment Design shall use the copayments set forth below:

i. Members offering the HMO Plan shall offer the plan with a **[$ 150.00]** **$300.00** per day hospital inpatient copayment, $ 100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a **[$ 15.00]** **$30.00** copayment for all other services, except that the copayment for pre-natal care may be $ 25.00 as required by (c)3ii below;

ii. In addition to the HMO plan required by (c)1i above, members may offer one or more of the following copayment arrangements:

(1) **[$ 300.00]** **$150.00** per day hospital inpatient copayment, $ 100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a **[$ 30.00]** **$15.00** copayment for all other services, except that the copayment for pre-natal care may be $ 25.00 as specified in (c)3ii below;

(2) – (3) (No change.)

2. Carriers issuing HMO plans with a Deductible and Coinsurance Design shall use the copayments, cash deductible, coinsurance and maximum out of pocket set forth below:

i. Members offering the HMO Plan may, in addition to the HMO plan required by (c)1i above, offer HMO Plans that include deductible and coinsurance provisions, subject to the following:

(1) – (3) (No change.)

(4) The maximum out of pocket shall be **[$ 5,000]** **no greater than $7,500** per person, and for a covered family two times the per person maximum out of pocket.

3. (No change)

(d) The standard health benefits Plans A/50, B, C, and D may be offered through or in conjunction with a selective contracting arrangement approved pursuant to P.L. 1993, c. 162, §22. The standard health benefits Plans A/50, B, C, and D may be offered with the same selective contracting arrangement by a carrier that is exempt from the requirements of P.L. 1993, c. 162, §22, pursuant to N.J.A.C. 11:4-37.1(b), but is permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through or in conjunction with an approved selective contracting arrangement and plans with selective contracting arrangement features issued by an entity exempt from the requirements of P.L. 1993, c. 162, §22 shall be subject to the following:

1. (No change.)

2. The network annual deductible shall be **[$ 1,000 or]** **no greater than** $ 2,500 per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies;

3. – 4 (No change.)

5. The network maximum out of pocket shall be **[$ 5,000]** **no greater than $7,500** per covered person, and for a covered family shall be **[$ 10,000]** **no greater than two times the per covered person network maximum out of pocket**. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies;

6.- 7. (No change.)

(e) No later than July 1, 2009, each Carrier shall submit to the Board an Identification of Standard Plans set forth in the Appendix to this subchapter as Exhibit H, incorporated herein by reference, that identifies the standard health benefits plans such Carrier is offering to individual consumers. Each carrier shall file an amended Identification of Standard Plans with the Board within 60 days of any change in the plans being offered to individual consumers.

[11:20-3.2 Certification of Compliance

(a) Before marketing, issuing or renewing any of the standard policy forms, a member shall file with the Board, the Certification of Compliance set forth in the Appendix to this subchapter as Exhibit E, incorporated here by reference. Each affiliated carrier must file a separate Certification of Compliance. A Certification of Compliance must be filed upon entry into the individual market, and annually on or before March 1.

(b) Carriers that submit an Exhibit E Certification of Compliance may issue and make effective individual health benefits plans upon filing such Certification with the Board, and may continue to do so until such time as the filing is disapproved in writing by the Board.

The Board may disapprove an Exhibit E Certification of Compliance if the Certification is inaccurate or incomplete.

(c) Any carrier whose Certification of Compliance is denied may file an appeal of the Board's determination and request a hearing within 20 days of receipt of written notification of the Board's final determination, pursuant to the procedures set forth in N.J.A.C. 11:20-20.2.]

11:20-3.3 Compliance and variability rider

(a) – (c) (No change)

(d) Members may not use the Compliance and Variability rider to accomplish benefit modifications as outlined in N.J.A.C. 11:20-3.6 below.

11:20-3.4 Plan update rider

(a) Members **electing to force convert existing standard plans pursuant to N.JAC. 11:20-24.7 and issuing new [policy forms] standard plans**, as set forth in Exhibit A **or B** of the Appendix to this chapter, **[for renewal dates from July 1, 2006 through June 30, 2007,]** shall issue the Plan Update Rider, as set forth in Appendix Exhibit G, incorporated herein by reference. Such rider shall be issued to policyholders who:

1. Have coverage under [Plans A/50, B, C or D] **a plan utilizing deductible and coinsurance provisions** on the day before the plan anniversary date **[which first follows July 1, 2006] the forced conversion is effective** and

2. Elect to **[renew] enroll in the standard health benefits plan** [**Plan A/50, B, C or D, as applicable, with the same deductible amount, and copayment amount, if applicable, as issued] which is offered as a conversion plan** by the same carrier.

(b) (No change.)

11:20-3.6 Optional benefit riders to standard plans

(a) Members may offer riders that revise the coverage offered by Plans A/50, B, C, D, and HMO, subject to the provisions set forth in (a)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans A/50, B, C, D, or HMO the member shall file the rider or amendment thereof with the Board for informational purposes.

2. For purposes of optional benefit riders filed pursuant to (a)1 above "coverage" offered by Plans A/50, B, C, D, or HMO means:

i. The types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations" and "Exclusions" sections of Plans A/50, B, C, and D the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan;

ii. Deductibles, Coinsurance, Copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans A/50, B, C, D and HMO as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident; and

3. For purposes of optional benefit riders filed pursuant to (a)1 above "Coverage" offered by Plans A/50, B, C, D, or HMO does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:20-1.2, except for dental coverage where the additional dental coverage is subject to the standard plan's deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:20-1.2.

4. In addition to (a)1, 2 and 3 above, any benefit rider or amendments thereof shall be subject to the provisions of N.J.S.A. 17B:27A-4 and N.J.S.A. 17B:27A-6.

5. The inclusion of an optional benefit rider with Plan A/50, B, C, D or HMO creates Plan A/50, B, C, D or HMO as amended by the rider and the Plan continues to be Plan A/50, B, C, D or HMO. The inclusion of an optional benefit rider does not create another standard plan.

6. An individual seeking to purchase Plan A/50, B, C D or HMO must be given the opportunity to purchase Plan A/50, B, C, D or HMO without a rider or with any rider that is available to amend the plan being purchased.

7. A member making an informational filing to the Board pursuant to (a)1 above shall:

i. Submit one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:20-2.1;

ii. Submit one copy of the rider or riders which amend the standard plans, which rider or riders shall include cross-references to the standard plan provisions or sections and/or pages which are being modified;

iii. Specify whether the rider or amendment thereof is to be used in connection with standard health benefit Plans A/50, B, C, D or HMO and provide clear and conspicuous notice of such on the forms submitted for each rider;

iv. The standard plan language shall not be altered, and the benefit modifications shall appear only on the rider or riders;

v. Submit the standard plan page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

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

(1) That the rider or amendment thereof increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan A/50, B, C, D, or HMO;

(2) That the filing is complete and in accordance with all the requirements of this subsection and applicable New Jersey statutes and regulations;

(3) That the member will offer the rider or amendment thereof to any individual seeking to purchase the health benefits plan it modifies;

(4) That a rate filing for the rider has been made with the Commissioner pursuant to N.J.A.C. 11:20-6; and

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement, that the plan as

ridered continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and N.J.A.C. 11:24-14.4(c), as applicable.

8. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in compliance with the requirements of this subchapter within 45 days of the Board's receipt of the member's submission of a rider. If the Board does not notify a member of its determination with respect to an informational filing within 45 days of the Board's receipt of the submission, the informational filing shall be deemed complete and in compliance.

i. If an informational filing is incomplete or not in compliance the notification shall provide the reasons the filing is incomplete or not in compliance and what additional information needs to be submitted by the member. The member shall provide the Board with the necessary information such that the filing will be complete and in compliance. Upon receipt of notice from the Board that a filing is incomplete or not in compliance the member shall not sell the rider until the member has received written notice from the Board that the informational filing is complete and in compliance.

ii. If the Board takes no action within 45 days of receipt by the Board of a member's submission of information requested by the Board, the filing shall be deemed to be complete and in compliance.

11:20-3.7. Plan or plan option withdrawal by IHC Board

(a) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall cease issuing that plan, plan option, or deductible/copayment option within 90 days after the rules take effect.

(b) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall nonrenew that individual plan, plan option, or deductible/copayment option pursuant to the procedures set forth in (c) and (d) below.

(c) Not more than 60 days after the Board has promulgated rules withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal by mail to every policy or contractholder. Following the initial notice of nonrenewal to each policy or contractholder, the carrier shall send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium statement is transmitted, send a notice at least 30 days prior to nonrenewal. Nonrenewal notices for policy or contractholders shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this paragraph of subchapter 3;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option, or deductible/copayment option withdrawal; and

6. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the withdrawal.

(d) Not more than 60 days after the Board has promulgated regulations withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal to the producer of record, if any, for each policy or contract. Nonrenewal notices for producers shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this paragraph of subchapter 3;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the withdrawal; and

6. The date upon which the carrier will begin to cease the issuance of the plan, plan option, or deductible/copayment option.

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

(Repealed in its entirety)

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

(Repealed in its entirety)

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

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

(a) (No change.)

(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 issued prior to August 1, 1993**, **all modified community rated persons issued on or after August 1, 1993**, 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; two adults =

2; adult and child(ren) = 2.8; family = 3.9. If a two adults category is not used, a carrier shall use a composite factor of 3.33 in order to reflect the two adults category in the family factor.

2. In Section b of the Enrollment Data Worksheet, the carrier shall report all **modified** 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. – 6. (No change.)

11:20-8.5. Calculating net paid losses or gains

(a) For purposes of completing Part E of the Exhibit K Assessment Report form, each member issuing individual health benefits plans shall provide data for 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 the basic and essential health care services plan pursuant to the requirements of P.L. 2001, c.368 for the preceding two-year calculation period **up to and including the 2007 – 2008 calculation period which shall be the final period for which loss reimbursement may be sought**. For purposes of completing Part E of the Exhibit K Assessment Report, a member that does not have any net earned premium for standard individual health plans or basic and essential healthcare services plans during a two-year calculation period shall not be considered to be issuing coverage, and thus shall not complete Part E and is not eligible for reimbursement.

1. – 2. (No change.)

(b) – (e) (No change.)

SUBCHAPTER 9. EXEMPTIONS

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

(a) (No change)

(b) A member's written request for an exemption 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. (No change.)

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

i. – ii. (No change.)

iii. Medicaid contracts, if offered, including NJ FamilyCare Plan A contracts **[and NJ KidCare Plan A contracts**]; and

iv. (No change.)

3. (No change.)

(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 by adding together the total number of persons covered under the plans set forth in (c)1 through 3 below on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, dividing by eight, and multiplying 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.

1. – 2. (No change.)

3. Medicare cost and risk contracts, Medicare Plus Choice contracts, Medicare Advantage contracts, Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, including NJ FamilyCare Plan A [**and NJ KidCare Plan A contracts].**

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. – 2. (No change.)

3. 3. Medicare cost and risk contracts, Medicare Plus Choice contracts, Medicare Advantage contracts, Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, including NJ FamilyCare Plan A **[and NJ KidCare Plan A]**contracts, 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) (No change)

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

(a) So that the Board can determine whether the member has satisfied its minimum enrollment share, any member that has been granted a conditional exemption and seeks a final (full or pro rata) exemption shall file with the Board, on or before April 1 of the year following each two-year calculation period, a Certification of Non-Group Lives, in which it reports 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, Medicare Advantage lives and Medicare Demonstration Project lives as described in N.J.A.C. 11:20-9.4(a)3 and (b). 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. (No change.)

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

3. – 6. (No change.).

(b) – (h) (No change.)

SUBCHAPTER 12. PURCHASE OF A STANDARD INDIVIDUAL HEALTH BENEFITS PLAN OR A BASIC AND ESSENTIAL HEALTHCARE SERVICES PLAN BY A PERSON COVERED UNDER AN INDIVIDUAL PLAN OR ELIGIBLE FOR OR COVERED UNDER A GROUP PLAN

11:20-12.2. Definitions

For the purposes of this subchapter, words and terms used herein shall have the meanings set forth in the Act, or as may be more specifically defined in N.J.A.C. 11:20-1.2, unless otherwise defined below, or the context clearly indicates otherwise.

. . .

“Special open enrollment period” means January 5, 2009 through March 31, 2009.

11:20-12.3. Covered under an individual plan: replacement at any time

(a) Except as stated in N.J.A.C. 11:20-12.4(c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with the same type of plan using the same or greater deductible, same or greater coinsurance or same or greater copayments from another carrier, where there is no lesser deductible, coinsurance or copayment.

(b) Except as stated in N.J.A.C. 11:20-12.4(b) or (c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with any standard individual health benefits plan or basic and essential healthcare services plan for which the **filed** monthly premium is less than the **filed** monthly premium for the existing standard individual health benefits plan.

(c) – (e) (No change)

11:20-12.4. Covered under an individual plan: replacement only during Open Enrollment Period **or Special Open Enrollment Period**

(a) A person who is covered under a standard individual health benefits plan may only elect during the Open Enrollment Period **or Special Open Enrollment Period** to replace the plan with a standard individual health benefits plan or basic and essential healthcare services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan.

(b) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period **or Special Open Enrollment Period** to replace the HMO plan with an HMO plan featuring a lower copayment.

(c) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period **or Special Open Enrollment Period** to replace the HMO plan with **[non-HMO] an indemnity, preferred provider (PPO) or point of service (POS)** plan. However, a person whose initial purchase in the individual market is an HMO plan may elect, at any time during the 90 days following the effective date of the individual plan, to replace the HMO plan with a **[non-HMO] an indemnity, preferred provider (PPO) or point of service (POS)** plan.

(d) A person who is covered under a basic and essential healthcare services plan without a rider may only elect during the Open Enrollment Period **or Special Open Enrollment Period** to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a rider.

(e) A person who is covered under a standard individual health benefits plan without a rider may only elect during the Open Enrollment Period or Special Open Enrollment Period to replace the plan with a standard individual health benefits plan with a rider or with a basic and essential healthcare services plan with a rider.

[(e)] (f) A person who is covered under a basic and essential healthcare services plan with a rider may only elect during the Open Enrollment Period **or Special Open Enrollment Period** to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a different rider.

[(f)] **(g)** The effective date of the replacement plan issued as a result of items (a) though (e) above will be January 1 of the year following the Open Enrollment Period **and no later than April 1, 2009 in the case of the Special Open Enrollment Period.**

[(g)] **(h)** The existing standard health benefits plan, basic and essential healthcare services plan must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan as of the midnight on the day before the effective date of the new plan if the person covered under the new plan notified the existing carrier of the replacement within 30 days after the effective date of the new plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the new plan, the new plan shall be of no force and effect and premium paid shall be refunded.

[(h)] **(i)** Notwithstanding (a), (b)**,** (d)**,** [and] (e) **and (f)** above, a person covered under a standard individual health benefits plan or a basic and essential health care services plan may elect to replace the standard individual health benefits plan or a basic and essential health care services plan with a standard individual health benefits plan that is a high deductible health plan sold in conjunction with a Health Savings Account, at any time during the 60 days following the date a high deductible health plan is first made available by the carrier to whom the person makes application for the high deductible health plan.

11:20-12.5. Covered under or eligible to participate in a group health benefits plan

(a) A person who is covered under or eligible to participate in a group health benefits plan that is not the same as or similar to the individual plan for which application has been made may elect only during the Open Enrollment Period **or Special Open Enrollment Period** to be covered under a standard health benefits plan or a basic and essential healthcare services plan. The

effective date of the individual plan will be January 1 of the year following the Open Enrollment Period **or no later than April 1, 2009 in the case of the Special Open Enrollment Period.**

(b) – (c) (No change.)

(d) When an application for individual coverage is made during the Open Enrollment Period, coverage under the group plan must be terminated no later than midnight on December 31 immediately prior to the effective date of the standard individual health benefits plan or basic and essential healthcare services plan except as may be required under an extension of benefits under the group plan. **When an application for individual coverage is made during the Special Open Enrollment Period, coverage under the group plan must be terminated no later than midnight on the day immediately prior to the effective date of the standard individual health benefits plan or basic and essential healthcare services plan except as may be required under an extension of benefits under the group plan. The new carrier may require evidence of the termination of the existing plan**. If the effective date of the termination of coverage under the group plan is not before the effective date of the standard individual health benefits plan or basic and essential healthcare services plan, the standard individual health benefits plan or basic and essential healthcare services plan shall be of no force and effect and premium paid shall be refunded.

SUBCHAPTER 17. ENROLLMENT STATUS 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 or PPO **or POS** for Plans A/50, B, C

and D, the HMO plans reported by copay or coinsurance, as well as indemnity, PPO, EPO or HMO coverage under the basic and essential health care services plan, and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. – 3 (No change)

4. In section D of Part 1 of Exhibit L, Report of Contracts By Deductible/Copayment Option, shall be reported separately by the required and permitted deductible options for Plans A/50, B, C, and D or the required and permitted copayment options for the HMO Plan. Members issuing PPO **or POS** plans shall report according to the copayment or deductible applicable to network physician visits. Members issuing HMO plans that include deductible and coinsurance provisions shall report according to the deductible applicable to services and supplies for which coinsurance applies. Members issuing basic and essential health care plans shall report contracts for plans issued with and without riders.

(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, separately for each of the standard health benefits plans, broken down by indemnity or PPO **or POS** for Plans A/50, B, C and D, the HMO plans, as well as the indemnity, PPO**, POS** or EPO or HMO basic and essential health care services plan, both with and without any rider:

1. (No change.)

2. In section B of Part 2 of Exhibit L, Report of insured males, separated by age distribution as of December 31 of the previous year; **[and]**

3. In section C of Part 2 of Exhibit L, Report of insured females, separated by age distribution as of December 31 of the previous year**; and**

4. In section D of Part 2 of Exhibit L, Report of Contracts as amended by one or more optional benefit riders.

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

(Repealed in its entirety)

SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

[11:20-22.4 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 policy form for 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 that:

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; and

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; and

iii. The benefits in the policy 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 policy form for the basic and essential health care services plan, set forth in chapter Appendix Exhibit F, incorporated herein by reference. The Board has determined that the plan set forth in Exhibit F includes the coverages required for a basic and essential health care services plan.

1. Members that choose to use the plan specimen policy form as set forth in Exhibit F shall submit, in lieu of a copy of the basic and essential health care services plan 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 plan specimen policy form as included in Exhibit F, including the carrier name, and similar variable text, as appropriate. The Certification regarding use of the specimen policy form shall be submitted with the information set forth in N.J.A.C. 11:20-22.4(a).

2. Members that choose to use the plan specimen policy form as set forth in Exhibit F with some modifications to the text shall submit the form, redlined to show any differences between the submitted form and the form as contained in Exhibit F. The redlined text of the form shall be submitted with the information set forth in N.J.A.C. 11:20-22.4(a).

(c) The Board shall notify a member in writing of its determination whether the policy form 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.]

11:20-22.5. Riders to amend the basic and essential health care services plan

(a) – (d) (No change)

(e) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later 60 days following the close of each calendar quarter:

1. For standard indemnity plans, standard PPO plans**, standard POS plans**, standard HMO plans, basic and essential health care services plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. – iv (No change)

2. (No change.)

(f**)** A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later than 90 days following the close of the calendar year:

1. For standard indemnity plans, standard PPO plans, **standard POS plans,** standard HMO plans, basic and essential health care services plans, plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. – ii (No change.)

(g) – (j) (No change)

SUBCHAPTER 24. PROGRAM COMPLIANCE

11:20-24.1. Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering and issuing health benefits plans to any eligible person.

11:20-24.2. Eligibility and issuance

(a) (No change)

(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. 11:20-12.5, or if the person is covered by any other individual health benefits plan, except as provided in N.J.A.C. 11:20-12.3 and 12.4. 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 **or a group health plan**.

(c) –(e) (No change)

11:20-24.4. Effective date of coverage

(a) – (c) (No change)

(**d) With respect to applications submitted during the Special Open Enrollment period, the effective date of coverage shall be no later than April 1, 2009.**

11:20-24.5. Paying benefits

(a) **Except as stated in (b) below for prosthetic and orthotic appliances, [In] in** paying benefits for covered services under the terms of the individual health benefits plans provided on an out-of-network basis by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay covered charges for **[medical]** services**[, on a reasonable and**

customary basis] based on the allowed charges or actual charges**[, and, for hospital services, based on actual charges,]** except as required by applicable law including, but not limited to, N.J.A.C. 11:22-5.6(b). **[Reasonable and customary] Allowed Charge** means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

1. The maximum **[allowable] allowed** charge shall be **[based on]** the 80th percentile of the profile.

2. (No change.).

(b) In paying benefits for prosthetic and orthotic appliances as required by P.L. 2007, c. 345, reimbursement shall be at the same rate as reimbursement for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or out-of-network basis. However, if the Carrier's contract rate with a network provider of orthotic and prosthetic appliances exceeds the Medicare reimbursement rate, the carrier's contract rate should be paid.

11:20-24.6. Good faith effort to market individual health benefits plans

(a) In order for the Board to determine whether a member that is a small employer carrier as defined in N.J.S.A. 17B:27A-17 has offered and made a good faith effort to market the standard individual health benefits plans pursuant to N.J.S.A. 17B:27A-19a every small employer carrier 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 small employer carrier undertook during the prior calendar year to market at least three

of the standard health benefits plans, or in the case of a federally qualified HMO, the standard individual HMO plan. The first reports shall be due on May 1, 2010.

(b) The report shall include only those marketing activities which were in direct support of the sale of individual health benefits plans 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 report submitted by each member to determine whether the small employer carrier has demonstrated that it made a good faith effort to market the standard individual health benefits plans and provide written notice of its determination to the member within 45 days of a completed filing.

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

i. The carrier provides evidence that it listed at least three standard individual health benefits plans, or in the case of a Federally qualified HMO, the HMO plan, on the carrier's standard application for individual coverage in the prior calendar year;

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the standard individual health benefits plans during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and 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 plans; or information specific to the standard individual health benefits plans on the carrier's website. Carriers 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 standard individual health benefits plans; and

iii. The small employer carrier provides evidence that it filed rates and forms for the standard individual health benefits plans. Such evidence may be in the form of a copy of the cover letter for such rates or forms filing.

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

(d) Small employer carriers found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plans will be required to withdraw from the small employer market pursuant to N.J.A.C. 11:21-16 within 60 days following receipt of a determination from the Board that the carrier was found to have not made a good faith effort to market the standard individual health benefits plans.

11:20-24.7 Conversion of Inforce Contracts

(a) A Carrier may convert plans that were inforce as of January 5, 2009 subject to the following requirements:

(1) No more than 25% of a carrier's total inforce plans may be converted during a calendar year;

(2) The plan offered on conversion must be of equal or greater actuarial value than the plan being converted; and

(3) The selection of plans to be converted must not be based on a health status related factor of persons covered under such plans.

(b) A carrier desiring to convert inforce plans shall provide notice to the Board of its intent to convert plans at least 90 days prior to the commencement of the conversion. The notice shall:

(1) identify the plan or plans being converted;

(2) specify the plan or plans to which conversion is being made;

(3) identify the number of policies or contracts that were issued such plans and evidence that the number does not exceed 25% of the total inforce policies or contracts; and

(4) include a copy of the notice to be provided to inforce policyholders or contractholders.

(c) Conversion may only occur following at least 60 days advance notice of the conversion to each policyholder or contractholder.

(1) Carriers must provide policyholder or contractholder with a comparison of the plan being converted to the plan to which conversion is being made.

(2) Carriers must advise the policyholder or contractholder that the rate increase limitation applies to the converted plan to the same extent it would have applied to the plan that was converted

_____ _____

Date Ellen DeRosa, Executive Director