

**INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD**

Individual Health Coverage Program

Proposed Readoption with Amendments: N.J.A.C. 11:20-1, 2.1 through 2.16, 3, 6 through 10, 12, 17 through 20 and 22, and 11:20 Appendix Exhibits A through F, J, K, L and Q through V.

Proposed New Rules: N.J.A.C. 11:20-1.6, 2.18, 7.7, 23 and 24.

Proposed Readoption and Recodification with Amendments: N.J.A.C. 11:20 Appendix Exhibits B (formerly Exhibit F), D (formerly Exhibit S) and F (formerly Exhibit V)

Proposed Repeals: N.J.A.C. 11:20-1.5, 9.6, 10.5, 17.5 and 18.9, and N.J.A.C. 11:20 , Appendix Exhibits Q, R, S, T, U and V.

Proposed Repeals and New Rules: N.J.A.C. 11:20-1.6, 3.1, 3.2, and 12 and 11:20 Appendix Exhibits A, C and E.

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 an explanation of the exception to the rulemaking calendar requirements of N.J.S.A. 52:14B-3(4)(e) and N.J.A.C. 1:30-3.3.

Proposal Number: PRN 2005-285

Interested persons may testify with respect to the proposed amendments to the Plan of Operation, set forth at N.J.A.C. 11:20-2, and the standard health benefits plans, set forth in Appendix Exhibits A, B, C, D and F to N.J.A.C. 11:20, at a **public hearing** to be held on Tuesday, September 13, 2005 at 9:00 A.M. at the New Jersey Department of Banking and Insurance, Conference Room 220, 20 West State Street, Trenton, New Jersey.

Submit written comments by October 14, 2005 to:

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The agency proposal follows:

Summary

In accordance with the sunset provisions of Executive Order No. 66 (1978) and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., the New Jersey Individual Health Coverage Program Board (“IHC Board” or “Board”) has evaluated its rules at N.J.A.C. 11:20, (except for N.J.A.C. 11:20-11, a regulation promulgated by the Department of Banking and Insurance (Department)), which are scheduled to expire on December 31, 2005, pursuant to N.J.S.A. 52:14B-5.1c. This expiration date was extended twice, first by Governor McGreevey and then by Acting Governor Codey, pursuant to N.J.S.A. 52:14B-5.1d. The readoption of N.J.A.C. 11:20 is necessary because it implements the IHC Program. The IHC Board has determined that the rules are necessary, reasonable and proper for the purpose for which they were originally promulgated, with the exception of the repeals and amendments which are noted herein.

The IHC Program Board was charged by the Legislature with implementing and regulating the reformed individual health benefits coverage market pursuant to the Individual Health Insurance Reform Act, P.L. 1992, c. 161 as amended, and codified at N.J.S.A. 17B:27A-2 et seq. (the “IHC Act” or the “Act”). The IHC Board recognizes the need to modify some of its existing rules; the proposed amendments appear herein. Some of these amendments are intended to bring the rules into compliance with Federal or State law or regulations. Some amendments are substantive changes either initiated by the IHC Board or in response to suggestions by interested parties. The Board also proposes to finalize its Plan of Operation. Lastly, the IHC Board has also made many non-substantive, technical, and grammatical amendments, in order to make the rules easier to read.

The IHC Board will hold a public hearing on the proposed amendments to the Plan of Operation and the standard health benefits plans at the time and place set forth above. Written comments to any portion of this proposed readoption with amendments, including comments on the proposed amendments to the Plan of Operation and the standard health benefits plans, will be accepted until the date set forth above for receiving written comments.

Subchapter 1 of these rules establishes procedures and standards applicable for the fair, reasonable and equitable administration of the IHC Program pursuant to the Act. This subchapter also sets forth definitions of terms that are used in Chapter 20. Amendments to this subchapter include: deletion of the definition of “basic health benefits plan,” formerly known as “Plan A,” a limited benefits plan which the Board required carriers to offer but was later eliminated; amendments to the definitions of “dependent” and “family unit” so that these terms conform with the requirements of P.L. 2003, c. 246, which allows coverage for certain domestic partners; amendments to the definition of an “eligible person” to clarify that a State resident who is eligible for continuation of group coverage under COBRA or a state continuation law is still eligible for individual coverage in lieu of continuation coverage; addition of a definition of “enrollment date”; addition of a definition of “Federally defined eligible individual,” which is derived from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191, and is used in the rules; addition of a definition of “Medicare Advantage,” a new type of contract issued by carriers under Federal law; amendments to the definition of “member” to specify exceptions to “member” based on NJ FamilyCare and NJ KidCare enrollment and NJ FamilyCare and NJ KidCare net earned premium, to conform with amendments enacted in P.L. 2001, c. 349; an amendment to the definition of “net earned premium” to specifically include in the calculation of “net earned

premium” the premiums earned from NJ FamilyCare or NJ KidCare contracts; addition of definitions of “NJ FamilyCare” and “NJ KidCare”; amendments to the term “non-group persons” to add a reference to enrollment in Medicare Advantage contracts and thus include coverage under a Medicare Advantage contract which is the term that identifies a new Medicare option as used in the Medicare Modernization Act; an amendment to the term “pre-existing condition” to measure the period of time preceding coverage from the enrollment date rather than the effective date and to consider a pregnancy that exists on the enrollment date, rather than the effective date, consistent with 29 CFR Part 2590; an amendment to delete the term “reasonable and customary” from the definitions section since the definition is not necessary in light of a new section, N.J.A.C. 11:20-24.5 as included in this proposal and which addresses the payment of benefits; and an amendment to the term “resident” to conform with the requirements of HIPAA and guidance received from the Federal Centers for Medicare and Medicaid Services. The proposal deletes the penalty provision set forth at N.J.A.C. 11:20-1.5 as there was no clear source of law for the penalty set forth in that provision.

N.J.A.C. 1:30-2.9 requires agencies to provide a description of their organization, stating the general course and method of its operations. As a result, the Board is proposing a new provision, N.J.A.C. 11:20-1.6, which states the Board’s mission.

Subchapter 2, Individual Health Coverage Program Plan of Operation, sets forth the fair, reasonable and equitable manner in which the Board will administer the IHC Program. Included in this subchapter are: the powers of the Board; guidelines on election and membership of the Board; the election, membership, and responsibilities of Committees; the financial administration of the Program; provisions regarding independent audits under the Program; the recordkeeping requirements of the Board; provisions regarding the standard health benefits plans; the assessment mechanism for

administrative expenses of the IHC Program; notice requirements for carriers seeking a deferral from assessment; the consequences of a carrier's failure to pay an assessment; provisions regarding penalties and disputes arising under the Program; and a description of the assessment process for reimbursement of losses.

A number of amendments to subchapter 2 are proposed herein. Amendments throughout delete references to the "Temporary" Plan and signify that the Plan of Operation is now a permanent Plan of Operations. An amendment to N.J.A.C. 11:20-2.1(h) modifies the address for communications with the Board. The proposed deletion of N.J.A.C. 11:20-2.3(b)8, regarding the authority of the Board, removes a reference to the Board's authority to create a standard claim form. While the IHC Act specifically provided the IHC Board with such authority, another later act of the Legislature, P.L. 1999, c. 154, The Health Insurance Information Electronic Data Exchange Technology Act (HINT), required that all paper claim forms be standardized under the authority of the Department. The Department adopted N.J.A.C. 11:22-3 to address these requirements. Carriers operating in the IHC market must be guided by that subchapter, as adopted, as required by the later act of the Legislature.

Amendments to N.J.A.C. 11:20-2.5, a section addressing the Board of Directors, include updated references to categories of Board members as required by P.L. 1999, c. 367 and P.L. 2001, c. 131. The amendments remove the requirement that copies of minutes be provided to the Commissioner since the Commissioner or his or her designee sits on the Board and receives minutes as a Board member.

Amendments to N.J.A.C. 11:20-2.6, a section addressing Committees, update the functions of each of the standing committees. The name of the Operations Committee has been changed to the Operations and Audit Committee to reflect that the Committee makes recommendations to the Board regarding independent audits of the Program and of

members' net paid losses. The reference to committee members that are not members of the Board has been removed from N.J.A.C. 11:20-2.6(a), as the Board interprets N.J.S.A. 17B:27A-11k as not authorizing the Board to appoint non-Board members to committees. Since a person other than a director is not permitted to serve on a Committee, the Board proposes the deletion of N.J.A.C. 11:20-2.6(b)4 which addressed the removal of a person other than a Director from a Committee.

Amendments to N.J.A.C. 11:20-2.8, a section addressing audits, update references to the Exhibit K filing name which was changed in 2003 to the "Assessment Report."

Amendments to N.J.A.C. 11:20-2.9, a section addressing Board records, include the deletion of subsection (d) addressing dissemination of information about the Program and the mailing list for the IHC Program. Both of these are addressed more fully in a new subchapter, N.J.A.C. 11:20-24.

Amendments to N.J.A.C. 11:20-2.10, a section regarding the standard health benefits plans, modify the filing requirements for the Certification of Compliance, set forth as proposed new Exhibit E to the Appendix.

Amendments to N.J.A.C. 11:20-2.12, a section addressing assessments for administrative expenses, clarify that a reconciliation of administrative assessments shall occur within 90 days of the conclusion of all appeals and the receipt of independently audited financial statements of the Program. N.J.A.C. 11:20-2.12(a) is being amended to reference an exception for a minimum assessment, to explain that a final administrative expense reconciliation will only occur after the final audit of IHC Program financial statements and the conclusion of all administrative assessment appeals, and to address the effect of an interim assessment. New N.J.A.C. 11:20-2.12(a)4 is being added to note that the minimum assessment as set forth in N.J.A.C. 11:20-2.12 will result in some members having no liability if the amount due is less than the minimum amount. Paragraph (f)1

specifically identifies the source of law for the payment of an interest penalty for late payment. Amendments to N.J.A.C. 11:21-2.12(h)1 remove the reference to an “escrow” account, since deferred funds or disputed funds are placed by the IHC Board in an interest bearing account in the State Treasury. A true escrow of money is a deposit of funds with a neutral third part to be held until the performance of a condition. The deposit of funds in a Treasury account does not meet this definition.

An amendment to N.J.A.C. 11:20-2.13, a section addressing notice to the Board of a request for deferral with the Commissioner, to delete the phrase that indicates notice to the Board is required in order to preserve the right to monies paid. If a carrier makes an assessment payment and the Commissioner grants a deferral of all or part of that assessment obligation, the notice to the Board of a request for a deferral is not relevant for purposes of the preservation of a right to any monies paid.

Amendments to N.J.A.C. 11:20-2.16, a section addressing indemnification to delete the reference to the Department since the IHC Board does not have the authority to grant immunity to the Department.

The IHC Act and this proposed readoption with amendments also sets forth the requirements for a loss assessment mechanism. The loss reimbursement mechanism was designed to encourage carrier participation in the reformed individual health coverage market. Many states have some mechanism to compensate carriers that insure high risk individual lives, whether through a state subsidized high risk pool or carrier subsidized risk adjustment mechanism. All carriers selling some form of health coverage in New Jersey are required either to offer individual coverage and assume their fair share of the market or to pay an assessment to the IHC Program. The Program assesses carriers for reimbursable program losses on the basis of their net earned premium from health benefits plans in force in New Jersey, regardless of whether those plans are large group,

small group, or individual plans. The assessments are used to reimburse carriers for certain losses in the individual market and to pay the administrative expenses of the IHC Program. Carriers that elect to be exempt and that meet a non-group enrollment target established by the Board are exempt from paying a loss assessment, and carriers that meet a pro rata portion of their non-group enrollment target qualify for a pro rata exemption.

A section of the Board's existing rules at N.J.A.C. 11:20-2.17, which was readopted with amendments in 1998 and which covers assessment periods for 1997/1998 and thereafter, was invalidated by the Supreme Court of New Jersey in *In re New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1 et seq.*, 179 N.J. 570 (2004). Although the Court invalidated a subsection of the Board's loss assessment regulation, it did not mandate a specific assessment methodology. Taking this into consideration, and because of the litigation surrounding appeals of loss assessments and the loss assessment rule, the Board decided to receive informal public input as permitted under N.J.A.C. 1:30-5.3(a). Specifically, the Board invited interested parties to provide comments regarding both the methodology for the loss assessment and the calculation periods to which the new methodology should apply. Six parties did, in fact, present comments to the Board at its December 14, 2004 meeting. The Board subsequently voted to propose a specific methodology. In its review of the Board's draft regulations, the Governor's Office has indicated that it would like the Board to take additional time to allow further dialogue on this important issue. As a result, Acting Governor Codey, pursuant to N.J.S.A. 52:14B-5.1d, signed a letter dated July 1, 2005, extending the expiration date of N.J.A.C. 11:20-2.17 for 180 days, to December 31, 2005 (see 37 N.J.R. 2884(a)) and the Board is not including N.J.A.C. 11:20-2.17 in its proposed readoption with amendments.

The Board is proposing a new rule at N.J.A.C. 11:20-2.18, which creates a de minimis amount for payment of any assessment invoice. The Board set the amount at \$20.00, which is the amount used by the Department for purposes of the Insurance Fraud Prevention Assessment and the Special Purposes Apportionment.

Subchapter 3 addresses benefits offered in the individual market. N.J.A.C. 11:20-3.1 and 3.2 are repealed and replaced with new N.J.A.C. 11:20-3.1 and 3.2. These new sections set forth a description of the standard health benefits plans that must be offered by carriers in the individual market, as well as various options that may be offered by carriers in the individual market. Examples of these options include the option to offer high deductible health plans which meet the deductible and out of pocket requirements under federal law for use with a health savings account, and the option for an HMO plan to include deductible and coinsurance provisions. New N.J.A.C. 11:20-3.2(d) sets forth the requirements for carriers that choose to make the standard indemnity plans available through or in conjunction with a selective contracting arrangement. The Certification of Compliance with New Jersey Individual Health Coverage Plans is set forth as proposed new Exhibit E. The Compliance and Variability Rider, set forth as proposed new Appendix Exhibit D, is the form a carrier must use if the carrier desires to modify a plan without having to reissue the entire policy or contract. This rider may only be used in a manner consistent with the direction set forth in N.J.A.C. 11:20-3.3.

New N.J.A.C. 11:20-3.1(a) addresses the consolidation of the standard non-HMO plans into a single exhibit, identified as proposed new Exhibit A, which includes specified pages which are unique to Plans A/50, B, C and D.

New N.J.A.C. 11:20-3.1(b) addresses the mandatory and optional cost sharing features for Plans A/50, B, C and D. N.J.A.C. 11:20-3.1(b)1 states that carriers must offer a \$1,000 deductible with each of Plans A/50, B, C and D. N.J.A.C. 11:20-3.1(b)2,

3, and 4 identify deductibles carriers may elect to use with specified plans. With this proposed readoption with amendments, the Board is eliminating the \$500.00 deductible that had been required to be offered with Plan D. Persons who are covered under a Plan D with a \$500.00 deductible will not be permitted to renew Plan D with the \$500.00 deductible as of the first anniversary date of the existing plan following the operative date of the amendments to the standard plans, but will be given the opportunity to select a \$1,000 deductible Plan D or any other plan being offered by the same or another carrier so long as they are an “eligible individual” at the time of application for the new coverage. N.J.A.C. 11:20-3.1(b)5 addresses the calculation of the maximum out of pocket for Plans A/50, B, C and D. N.J.A.C. 11:20-3.1(b)6 and 7 address the calculation of the maximum out of pocket for high deductible health plans using Plans C and D.

New N.J.A.C. 11:20-3.1(c) addresses the mandatory and optional cost sharing features for HMO plans. N.J.A.C. 11:20-3.1(c)1i states that carriers must offer a \$15.00 copayment HMO plan. N.J.A.C. 11:20-3.1(c)1ii gives carriers the option to also offer \$30.00, \$40.00 and/or \$50.00 copayment HMO plans. With this proposed readoption with amendments the Board is eliminating the \$10.00 and \$20.00 copayment options. Persons who are covered under an HMO Plan with a \$10.00 or \$20.00 copayment will not be permitted to renew the HMO Plan with those copayment as of their first anniversary date following the operative date of the amendments to the standard plans, but will be given the opportunity to select any other available copayment or any other plan being offered by the same or another carrier so long as they are an “eligible individual” at the time of application for the new coverage. N.J.A.C. 11:20-3.1(c)2 permits HMO carriers to use deductible and coinsurance features in the HMO plan and sets forth the permissible deductible, coinsurance and maximum out of pocket amounts a carrier may include in the HMO plan.

New N.J.A.C. 11:20-3.1(d) addresses the option for carriers to offer Plans A/50, B, C and D through or in conjunction with a selective contracting arrangement and sets forth the parameters for such plan offerings.

New N.J.A.C. 11:20-3.2 addresses the filing of a Certification of Compliance, as set forth in Appendix Exhibit E. The Certification must be filed upon entry into the individual market and annually each March 1. With this proposed readoption with amendments, carriers are being afforded a wider range of options for use with the standard plans. The Certification of Compliance requires carriers to identify the options they are offering.

Amendments to N.J.A.C. 11:20-3.3 address the Compliance and Variability Rider, set forth as Appendix Exhibit D, which allows carriers to make certain changes to the text of a standard health benefits plan without necessitating the reissue of the entire policy. The Compliance and Variability Rider can also be used to include coverage required to be offered as a mandated offer pursuant to New Jersey law.

Amendments to N.J.A.C. 11:20-3.4 address the basic and essential healthcare services plan (B&E Plan), which, although not a standard plan, is a plan all carriers issuing coverage in the individual market must make available pursuant to P.L. 2001, c. 368 (N.J.S.A. 17B:27A-4 et seq.). The purpose of including a reference to the basic and essential health care services plan in this subchapter, which addresses standard plans, is to serve as a cross reference to Subchapter 22, which sets forth the rules governing the basic and essential health care services plan. A specimen policy form for a basic and essential health care services plan is set forth as proposed Appendix Exhibit F.

The Board is allowing N.J.A.C. 11:20-4 and Appendix Exhibit G to expire. Existing Subchapter 4 requires carriers to use the standard application form approved by the Board and set forth in Exhibit G in the Appendix to N.J.A.C. 11:20. Pursuant to

N.J.S.A. 17B:30-23b, the Department promulgated a new enrollment form to be used by carriers in all markets, including the individual market, which is currently set forth at N.J.A.C. 11:22-3, Appendix Exhibit 1. The Department's rule was effective on October 1, 2001.

The Board is allowing Subchapter 5 and Appendix Exhibits H and I to expire. Existing Subchapter 5 requires carriers to use the standard claim forms approved by the Board and set forth as Exhibits H and I in the Appendix to N.J.A.C. 11:20. The readoption of N.J.A.C. 11:20-5 describing the standard claim form, is no longer necessary. Pursuant to N.J.S.A. 17B:30-23b, the Department has promulgated a rule at N.J.A.C. 11:22-3.3 governing all claim forms, including those used in the individual market.

Subchapter 6 establishes the informational rate filing requirements and procedures for carriers. Amendments to N.J.A.C. 11:20-6.1 clarify that the scope of the Subchapter does not include the rate filings for pre-reform plans issued on an open enrollment, community rated basis. The filing requirements set forth at N.J.A.C. 11:20-6.3 are amended to identify the specific elements that the IHC Board requires to be included in the detailed actuarial memorandum that carriers are required to include in the rate filings. N.J.A.C. 11:20-6.3 is being expanded to include a new subsection (c) to explicitly state that carriers must use the rates in the filing as of the stated effective date unless an amended rate filing specifies an alternate date. Thus, a carrier cannot use the rates in the rate filing prior to the stated effective date, nor may a carrier delay the implementation of the rates in the rate filing until a later date. The IHC Board issued Advisory Bulletin 01-IHC-01 to clarify the required information and has been reviewing rate filings since the Bulletin was issued to ensure that they include these specific elements. N.J.A.C. 11:20-6.4 is amended to clarify the consequences to a carrier of a finding by the Board that a

rate filing is incomplete. Carriers must respond to a finding of incompleteness within 15 days. Until such time as a corrected filing has been found complete and a notice of determination of completeness has been provided to the carrier, the carrier may not use the rates from the incomplete rate filing in either the quoting or billing process. N.J.A.C. 11:20-6.5(b), as well as other rules contained in Chapter 20, are being amended to replace the reference to “husband and wife” coverage with “two adults,” in recognition of the fact that coverage may be provided for domestic partners. Included in the amendments to Subchapter 6 is a clarification that the effective date specified in a carrier’s rate filing shall be the effective date of the rates, unless the carrier amends its filing to specify a different effective date prior to implementation. This change corresponds to the requirement already set forth in N.J.A.C. 11:20-8.5(b)2, which notes that carriers reporting net paid losses shall reflect in the reporting of individual premium the amount it should have earned consistent with its rate filing.

Subchapter 7 establishes the filing requirements for loss ratio reporting and refund plans. The loss ratio report is set forth as Exhibit J to the Appendix to N.J.A.C. 11:20. N.J.A.C. 11:20-7.4(a) is being amended to include a reference to Appendix Exhibit J which is where the Loss Ratio Report form appears and to include the precise date on which the filing is due. The August 15 due date is specified elsewhere in N.J.A.C. 11:20-7.3(c). The Board proposes an amendment to N.J.A.C. 11:20-7.5(b)1 to set a de minimis standard for loss ratio refunds of \$2.00, so that carriers will not be required to issue refund checks of less than \$2.00. In addition, a new rule is proposed at N.J.A.C. 11:20-7.7 which would require carriers to provide a certification to the IHC Board after the loss ratio refunds have been provided.

Subchapter 8 sets forth the reporting, certification and audit requirements of market share data, non-group enrollment and individual market losses to determine the

total amount of losses which are reimbursable and the allocation of assessments for reimbursement of those losses, as well as a basis for determining criteria to be met by carriers requesting exemption from such assessments. The Assessment Report is the form for reporting under this subchapter and is set forth as Exhibit K in the Appendix to N.J.A.C. 11:20. This Exhibit was formerly known as the Carrier Market Share and Net Paid Gain(Loss) Report.

The amendments contained throughout Subchapter 8 include changes to standardize reference to the Exhibit K Assessment Report. The amendments also include moving the filing deadline for Exhibit K Assessment Report from March 1 for each reporting cycle to April 1. Carriers have had a difficult time submitting reports by March 1, in part, because more comprehensive annual reporting to the Department is also due on March 1. The Board anticipates that the additional time will provide carriers with a better opportunity to provide accurate and timely reports. The amendments include a clarification in N.J.A.C. 11:20-8.5 that carriers that do not have any net earned premium for standard health benefit plans or the basic and essential health care services plan during a two-year calculation period are not “issuing” coverage and thus are not eligible for reimbursement for that two-year calculation period. Such carriers, while required to submit an Exhibit K Assessment Report, are not required to complete Part E of the Exhibit K Assessment Report. The heading of N.J.A.C. 11:20-8.7 is being amended to address failure to file the Exhibit K Assessment Report, without the penalties reference, since the penalty as included in paragraph (a)1 is being deleted. N.J.A.C. 11:20-8.7(a)1 is being deleted since filing a timely Exhibit K Assessment Report is not among the criteria for the granting of an exemption. N.J.A.C. 11:20-8.7(a)2 is being amended to explain that if a carrier fails to file an Exhibit K Assessment Report the market share

derived from the annual statement premium will be used not just for assessments but also for the assignment of the minimum number of non-group persons.

An amendment to N.J.A.C. 11:20-8.8, a section addressing independent audits of carriers with net paid losses, provides that if a carrier fails to provide sufficient information to the auditor within 18 months of the auditor's first written request for records to enable the auditor to complete the audit, the costs incurred after that time shall be the sole responsibility of the carrier if it chooses to proceed with its request for reimbursement and the audit. The amendments also provide that if a carrier fails to provide sufficient information such that the audit cannot be completed within two years of the auditor's first written request for records, the Board may terminate the audit, thereby denying the carrier's request for reimbursement because their net paid losses cannot be verified. The purpose of these provisions is to provide an appropriate incentive for carriers to cooperate with the Board's auditors and work toward the timely completion of the audits. The Board's intention is not to penalize a carrier that is working in good faith with the auditor toward the completion of an audit.

N.J.A.C. 11:20-8.9 is being amended to measure the 20-day period for the filing of an appeal from the date of receipt of a final determination rather than the date the Board gives notice, and thus give the benefit of a full 20-day period.

Subchapter 9 sets forth the procedures for applying for conditional exemptions from the loss assessment, reporting and certifying the number of non-group persons, and the standards for granting final (full or pro rata) exemptions from assessment. Amendments to N.J.A.C. 11:20-9.2 and 9.3 will change the timing for the Board to provide notice to each carrier of its minimum non-group enrollment target and for carriers to file a request for a conditional exemption. In the past, the IHC Board has been unable to meet the deadlines set forth in the rules because the Board had not received

accurate and timely Exhibit K Assessment Reports from all member carriers. The amendments tie the notice of minimum non-group enrollment targets and the filing of a request for a conditional exemption to the Board's receipt of complete Exhibit K Assessment Reports from all members. The Board has also amended N.J.A.C. 11:20-9.3 and 9.4 to more clearly identify the types of coverage used in the calculation of non-group enrollment satisfaction and target setting. In N.J.A.C. 11:20-9.3(c)1 the Board is deleting the types of plans for which enrollment is considered from the body of the paragraph and instead setting the plans forth in a list in a new item N.J.A.C. 11:20-9.3(c)1. The list format in new N.J.A.C. 11:20-9.3(c)1 is thus consistently formatted with the existing list of plans in N.J.A.C. 11:20-9.4, making it easier for readers to understand the relationship between the calculation of the minimum number of non-group persons and the satisfaction. Also, in light of the Supreme Court of New Jersey's decision in *In re the New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1 et seq.*, 179 N.J. 570 (2004), the Board has eliminated all good faith marketing requirements for granting final exemptions. N.J.A.C. 11:20-9.5 is being amended to delete subsection (a) since this subsection addressed the consequences of a calculation which is described later in the section. Thus, the text addressing a full exemption is being moved such that it follows the calculation items. In new subsection (a) the Board is deleting text that explained the calculation of non-group persons in the first two-year calculation period since the methodology used in that first two-year calculation period has no usefulness beyond the 1997/1998 period. New N.J.A.C. 11:20-9.5(e) addresses the granting of a full exemption, with the placement now following the provisions that discuss the evaluation of the request for a final exemption.

Subchapter 10 establishes performance standards and reporting requirements which a member shall meet in order to receive reimbursement of losses. Amendments to N.J.A.C. 11:20-10.3 remove the requirement that a carrier seeking reimbursement of losses provide an audit statement for the preceding two-year calculation period of the member's accounts receivable, premium billing operations, and claims eligibility systems. The Board believes that this requirement is unnecessary in light of the fact that the Board engages an independent auditor to audit the net paid losses of each carrier seeking reimbursement. The date for the filing of the Performance Report is being changed from April 1 to May 1, so that it follows by one month the due date of the Exhibit K Assessment Report. As the Exhibit K Assessment Report is the basis for seeking reimbursements, a carrier will not be in a position to file a Performance Report prior to or coincident with the filing of the Exhibit K Assessment Report. N.J.A.C. 11:20-10.3(a) 2 and (b) and (c) are being deleted as no longer necessary since the Board arranges for an independent audit of carriers seeking reimbursement and thus audit information from the member's audits is not necessary.

N.J.A.C. 11:20-10.4 is being amended to measure the 20-day period in which a hearing may be requested from the date the member receives notice of the Board's determination rather than the date of board notice, thus giving members the benefit of a full 20-day period. N.J.A.C. 11:20-10.5 is being repealed because there was no clear source of law for the penalties set forth in that provision.

Subchapter 11 is a Department-promulgated subchapter and therefore is not included in this proposed readoption with amendments. The Department's notice of proposed readoption with amendments of this subchapter is published elsewhere in this issue of the New Jersey Register..

Subchapter 12 is repealed and replaced in its entirety with a new Subchapter 12. Subchapter 12 establishes the standards for determining who may be covered under standard health benefits plans, the standards for obtaining a standard plan by persons covered by, or eligible for, a group health benefits plan and by persons already covered under another individual health benefits plan. The goal of the restriction on the purchase of individual coverage by persons already with coverage in both the existing rules, and the new rules as proposed, is not only to help protect against adverse selection, but also to allow individuals to purchase coverage that better suits their needs and circumstances if it did not lead to adverse risk selection. The Board chose to revisit this issue because of changed dynamics in the market, especially with respect to the relative cost of coverage between indemnity and HMO coverage, and the inclusion of additional products in the market. The proposed new rules will allow individuals greater flexibility in purchasing individual coverage.

For purposes of determining eligibility for individual coverage by persons eligible for, or covered by, a group health benefits plan, the Board is guided by the requirements set forth in N.J.S.A. 17B:27A-3d, which prohibit such a person from obtaining coverage in the individual market which is the “same or similar” to the person’s group coverage. The rules set forth in the proposed new rule outline which types of coverage a person may obtain that are not the “same or similar.” The proposed new rules also set forth when a person can change from one individual plan to another outside of the open enrollment period, and when the person is limited to changes during the open enrollment period. The Board has also changed the open enrollment period from October of every year to November. The change is made because with an October open enrollment period consumers were asked to make changes in an open enrollment period for a January 1 effective date, when rates for January 1 were not yet available from all carriers.

Subchapter 17 establishes quarterly and annual submissions of enrollment status reports by all carriers issuing individual health benefits plans and the B&E Plan, and sets forth procedures and format for those reports. The enrollment status reports are set forth as Exhibit L, Parts 1 and 2. The amendments include the elimination of the requirement that carriers report the employment status of new enrollees on a quarterly basis. Exhibit L, Part 1 is amended accordingly. Also, the reporting format for zip code, age and gender is modified so that the age bands and zip codes correspond to the permissible ranges in N.J.A.C. 11:20-6.5, the rating rule for the B&E Plan. Lastly, the amendments reflect the new coverage options available and described in proposed N.J.A.C. 11:20-3. N.J.A.C. 11:20-17.5 is being repealed because there was no clear source of law for the penalties set forth in that provision.

Subchapter 18 establishes the requirements and procedures by which a carrier may cease doing business in the individual health benefits market in New Jersey or cease offering and renewing a specific plan or plan option. The definitions are modified to reflect the terms used in the subchapter, including the new term “individual plans,” to refer to the standard plans and the B&E Plan. The term “pre-reform plan” is added to refer to individual plans issued prior to the implementation date of the IHC Act, August 1, 1993. A carrier that issued coverage pursuant to the IHC Act that has inforce pre-reform plans, is required to nonrenew such plans in the event of market withdrawal. N.J.A.C. 11:20-18.5(c) is being amended to delete the requirement that a carrier submit an original and two copies of the withdrawal filing. A single copy is sufficient for the Board’s records. N.J.A.C. 11:20-18.5(c)11 is being deleted. Carriers that have withdrawn from the market but that have issued health benefits plans during the two-year calculation period and are eligible to seek reimbursement for any reimbursable losses. A carrier does not forfeit the opportunity to seek loss reimbursement solely by the act of

withdrawing from the market. The Board proposes an amendment to N.J.A.C. 11:20-18.5(d)3ii to conform its process for appealing from a Board denial of an application for withdrawal to the appeals provisions for all matters. The Board proposes the repeal of the penalty provision set forth at N.J.A.C. 11:20-18.9, as there was no clear source of law for the imposition of the penalty set forth in that provision.

Subchapter 19 sets forth the procedures for filing petitions for rulemaking with the Board. The Board proposes amendments to comply with the Administrative Procedure Act (APA), N.J.S.A. 52:14B-1 et seq., as amended pursuant to P.L. 2001, c. 5. This act governs the rulemaking activities of all State agencies, including the Board. The APA provides a uniform application and administration of the rulemaking process. The new requirements of the APA, codified at the Office of Administrative Law's Rules for Agency Rulemaking, N.J.A.C. 1:30, address public participation in an agency's rulemaking process. The amendments proposed here include making the terms in this subchapter reflect those used in the APA. The Board is also amending N.J.A.C. 11:20-19.3(b) to revise the timeframe from 30 to 60 days in which the Board shall respond to a petition for rulemaking. The Board is amending N.J.A.C. 11:20-19.3(c) concerning action to be taken on a petition to be consistent with the APA requirement at N.J.S.A. 52:14B-4(f).

Subchapter 20 provides the procedures for appealing an action of the Board. The Board is amending a number of provisions in this subchapter to replace the phrase "material issues in dispute" to "disputed adjudicative facts warranting a hearing" to more accurately describe the standard that determines when a contested case hearing is warranted. The Board proposes amending N.J.A.C. 11:20-20.2(a)3 to provide the Board with 30 days instead of 45 days to review a completed request for a hearing to determine whether it constitutes a contested case, consistent with the APA. The Board proposes

amending N.J.A.C. 11:20-20.2(a)3i to delete the reference to reviewing a matter on just the papers submitted, as that procedure is already addressed in N.J.A.C. 11:20-20.2(a)3iii.

Subchapter 22 implements the provisions of P.L. 2001, c. 368, which established the B&E Plan. The subchapter establishes the procedures and standards for carriers to meet their obligations under that law. The Board proposes amendments to N.J.A.C. 11:20-22.5 to modify the provisions regarding the filing of riders to the B&E Plan. In Bulletin 05-IHC-03, the Board advised carriers that the Board intended to modify this rule to ensure compliance with the statutory limitation on the filing of riders to the B&E plan. N.J.S.A. 17B:27A-4.5d provides that, “Carriers may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, **in a manner which will avoid adverse selection to the extent possible.**” [Emphasis added]. The amended rules are intended to ensure that riders filed by carriers do not lead to adverse selection in a manner which could be avoided. Because the IHC Board views this as an ongoing obligation, the amendments include a requirement that carriers that file B&E riders provide the Board with certain information on a quarterly basis, and other information on an annual basis, that is designed to evaluate over time whether the rider is leading to adverse selection. Subchapter 22 identifies the specimen policy form for the basic and essential health care services plan, which is set forth as proposed Exhibit F (recodified Exhibit V). The Board is proposing amendments to the specimen policy form to conform to changes being proposed to the standard plans. While the B&E Plan does not include many mandated benefits, certain non-benefit requirements under State and Federal law apply to the plan. If carriers are using the specimen plan, they must update their B&E Plans accordingly. Carriers that filed their own B&E Plans must file amended forms.

The Board proposes a new Subchapter 23 to address rulemaking, public notices, and its interested parties mailing list. N.J.A.C. 11:20-23.2 sets forth the types of notices which the Board will provide when proposing rules pursuant to the APA. N.J.A.C. 11:20-23.3 establishes the requirements for determining if “sufficient public interest” exists for the purposes of extending the public comment period for rulemaking. This rule is required by the APA. N.J.A.C. 11:20-23.4 sets forth the requirements for a public hearing on proposed rulemaking. N.J.A.C. 11:20-23.5 sets forth the requirements for the Board to provide notice of new rules, amendments, repeals or adoptions. N.J.A.C. 11:20-23.6 sets forth where the Board shall provide public notice of board meetings. Lastly, N.J.A.C. 11:20-23.7 sets forth the requirements for inclusion on the Board’s list of interested parties.

The Board proposes a new Subchapter 24 to establish standards that carriers issuing individual coverage must meet. N.J.A.C. 11:20-24.2 sets forth standards for eligibility and issuance. N.J.A.C. 11:20-24.3 sets forth information about the payment of premium. N.J.A.C. 11:20-24.4 establishes standards for effective dates of coverage. Previously, the only standards relating to the effective date of coverage had been included in the standard IHC application, which has been replaced by the Department’s new application form, as discussed above. The IHC application required that the effective date be no later than the first of the month following the date of the application and receipt of premium by the carrier or duly authorized agent. Proposed N.J.A.C. 11:20-24.4 would require carriers also to allow for 15th of the month effective dates in addition to first of the month effective dates. N.J.A.C. 11:20-24.5 establishes standards for the payment of benefits that are not subject to capitated or negotiated fee arrangements.

The operative date for the amendments to the standard plans will be dependent on the date that the Board adopts the readoption, and will be noted in the notice of adoption.

The Board understands that carriers need some advance notice in order to implement comprehensive changes. The proposed amendments to the standard plans would be effective upon the first renewal of the plan after the operative date of the adopted changes, rather than on a date certain.

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 the health benefit plans required to be issued. N.J.A.C. 11:20-3 identifies the standard health benefit plans, Plans A/50, B, C, D and HMO, which carriers offering coverage in the individual market must 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.

The IHC Board recognizes that it has not made significant changes to the standard health benefits plans since its 1998 readoption with amendments and that carriers have been administratively complying with the various State and Federal laws enacted since that time that impacted eligibility and coverage. The IHC Board further recognizes that nearly all carriers offering coverage in the individual market also offer coverage in the small employer market, which also requires the use of standard health benefit plans. The standard individual plans, since first proposed and adopted in 1993, have been substantially similar to the standard small employer health benefits plans in terms of benefits and exclusions, although the text used to describe the benefits and exclusions has often been phrased differently. The Small Employer Health Benefits Program Board adopted amendments to the standard Small Employer Health Benefits (SEH) Plans, operative October 1, 2004. The IHC Board recognized there would be value to both carriers and consumers if the standard plans the IHC Board included in the proposed readoption with amendments were to use were not just similar in terms of benefits and

exclusions, but also consistent in terms of the text to describe those benefits and exclusions. When carriers have to explain a benefit or an exclusion, the policy language is frequently part of the explanation. Using consistent language will help avoid misstatements of plan text. The IHC Board recognizes that consumers are not static in the individual or small employer market, but rather move between the markets, as employment circumstances change. Making the IHC plans more closely resemble the SEH plans will make it easier for those consumers to understand their benefits. Thus, rather than amending the IHC standard health benefit plans as they existed, the IHC Board is proposing the repeal of the standard plans and proposal of entirely new plans, created based on the SEH plans to replace them.

Standard Plans A/50, B, C and D will be issued using the text contained in proposed new Appendix Exhibit A, with variable text as explained by the Explanation of Brackets, in proposed new Appendix Exhibit C. The standard HMO plan will be issued using the text contained in the recodification of Exhibit B, with variable text as explained in the Explanation of Brackets, Exhibit C. The text differs from the prior text as contained in repealed Appendix Exhibits A, B, C, D, E, F and U in terms of the inclusion of benefits and provisions required by State and Federal law as well as differences related to Board decisions to modify coverage.

Compliance with State Law

As required by P.L. 1999, c. 341, Plans A/50 through D include coverage for one mammogram per year for females age 40 and over. To comply with P.L. 2004, c. 86, the plans also cover mammograms for women under age 40 who have a family history of breast cancer or other breast cancer risk factors.

As required by P.L. 2000, c. 121, Plans A/50 through D and HMO provide specific coverage for the treatment of hemophilia.

As required by P.L. 1999, c. 383, Plans A/50 through D and HMO include an exception to the exclusion of coverage for work-related injuries or illnesses for certain employees for whom worker's compensation coverage is optional.

As required by P.L. 2001, c. 361, Plans A/50 through D and HMO provide coverage for certain infant formulas.

As required by P.L. 2001, c. 295, Plans A/50 through D and HMO provide coverage for colorectal cancer screening.

As required by P.L. 2001, c. 373, Plans A/50 through D and HMO provide coverage for newborn hearing screening.

As required by P.L. 2003, c. 246, Plans A/50 through D and HMO allow coverage for domestic partners.

Consistent with N.J.A.C. 11:4-28, the Coordination of Benefits with Medicare provision in Plans A/50 through D and HMO addresses how the individual plan pays benefits as secondary to Medicare.

As required by N.J.A.C. 8:38 and 8:38A, Plans A/50 through D and HMO contain definitions, notice and disclosure as required by the Health Care Quality Act.

As required by N.J.A.C. 11:4-42.8(a)3, the penalty for failure to secure pre-approval does not exceed 50 percent.

Consistent with *Perreira v. Rediger*, 169 N.J. 399 (2001) and Bulletin 01-11 issued by the New Jersey Department of Banking and Insurance, Plans A/50 through D and HMO do not contain a Right to Recovery Third Party Liability provision.

Compliance with Federal Law

Consistent with the Federal Women's Health and Cancer Rights Act, Plans A/50 through D and HMO specify coverage for reconstructive breast surgery and physical complications of mastectomy and lymphedemas.

As required by 32 C.F.R. Section 220, Plans A/50 through D and HMO contain an exception to the exclusion for services or supplies provided by a Government or Veterans Administration Hospital to the extent they are received by a uniformed services beneficiary.

As stated in 45 C.F.R. Part 146 , Section 54.9801-4(a), the definition of Creditable Coverage includes S-CHIP coverage and for a federally defined eligible individual includes coverage under a public health plan from a foreign country. In addition, Plans A/50 through D and HMO include a definition of Enrollment Date and Pre-Existing Conditions Limitations which differ based on whether the person is a federally defined eligible individual.

Board Initiated Changes

For Plans A/50, B, C, and D, the Board is proposing the use of a maximum out of pocket rather than coinsurance cap and coinsured charge limit, as has been previously used in the plans. The maximum out of pocket includes all covered charges, with the exception of prescription drug charges. Once the maximum out of pocket has been satisfied, all further covered charges that year, other than for prescription drugs, are payable at 100 percent.

For Plans A/50, B, C, and D, the Board is proposing that carriers have greater flexibility to select the deductible amounts to offer. As stated above regarding N.J.A.C. 11:20-3.1(b)1, all carriers must offer the \$1,000 deductible. For plans other than high deductible health plans which may be used with an MSA or HSA, the Board is proposing that the family deductible continue to be calculated on a two times aggregate basis. The deductibles for high deductible health plans which could be issued or renewed in conjunction with an MSA or HSA must be calculated consistent with Federal law.

For HMO plans, the Board is proposing that the \$15.00 copayment continue to be the required offering. The Board is proposing two new higher copayment amounts that the Board believes may be attractive for persons who anticipate low frequency visits to providers.

The Board is proposing text that would allow HMO plans to use deductible and coinsurance features.

For HMO plans, the Board is proposing that carriers have the option to cover specialist services subject to the same copayment as a primary care physician visit, or subject to an increased copayment. For prenatal care, the Board is proposing that HMO carriers have the option to charge either the same copayment as for a primary care physician visit, or a flat \$25.00 copayment. For outpatient surgery, the Board is proposing that HMO carriers have the option to charge a higher copayment if the surgery is performed in a hospital outpatient department as opposed to an ambulatory surgical center.

Plans A/50 through D and HMO, as proposed, clarify that the payment of the emergency room copayment is in addition to applicable deductible, coinsurance and copayment.

Plans A/50 through D and HMO, as proposed, require pre-approval for an exchange of unused inpatient days available for non-biologically-based mental illness for additional outpatient visits.

Plans A/50 through D and HMO, as proposed, include a \$100.00 emergency room copayment, increased from the \$50.00 copayment included in the plans, as previously issued.

In the HMO plan, the Board proposes that 60-day per incident of illness or injury limit on certain therapy services as contained in the HMO plan, be replaced with a 30-visit limit per calendar year.

Plans A/50 through D, as proposed, include a preventive care allowance of \$750.00 for children through the age of one and \$500.00 per person per year for all other covered persons. Bone density testing and colorectal cancer screening have been specifically included in the definition of preventive care.

Plans A/50 through D and HMO, as proposed, specifically exclude coverage for dental implants and lasik surgery.

Plans A/50 through D and HMO, as proposed, no longer exclude coverage for methadone maintenance.

Plans A/50 through D and HMO, as proposed, specifically include coverage for intestine transplants and certain donor costs associated with any covered transplant.

As the Board has provided a 60-day comment period on this notice of proposal, this notice is exempted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

The rules proposed for readoption with amendments of N.J.A.C. 11:20 (excluding N.J.A.C. 11:20-2.17 and 11) implementing the provisions of IHC Act, will continue to affect the member carriers, producers, and individual consumers of health benefits coverage. Currently, there are approximately 90 member carriers, of which approximately 12 carriers are currently offering individual coverage. Approximately 77,000 persons are covered under individual health benefits plans.

The social impact of the rules proposed for readoption with amendments is the continued implementation of New Jersey's health insurance reforms in the individual

market. Prior to New Jersey's health insurance reform in the individual market, individuals lacked choice and access to health coverage, and there was a concentration of high-risk individuals in one carrier. The goals of reform were to make good health coverage accessible to individuals on a voluntary basis, to provide for renewability and portability of coverage, and to distribute among many carriers the concentration of high-risk individuals.

The IHC Act and the rules proposed for re Adoption with amendments provide for guaranteed access to coverage for all New Jersey residents not eligible to be covered under a group health plan or Medicare regardless of health status or any other factor of the individual. The statute and rules also provide for guaranteed renewability and portability of coverage, as well as restrictions on the use of preexisting conditions limitations. The reformed market is also characterized by standardized health benefits plans, which are designed to assist consumers in shopping for coverage. The premium for all persons covered by a contract is the same, based on the experience of all persons covered by that contract, without regard to age, gender, health status, occupation, geographical location or any other factor, except for the B&E Plans and riders, which may be rated based on age, gender, and geography up to a 3.5:1 ratio. The last key feature of the reformed market is the 75 percent loss ratio requirement, which requires carriers to pay \$.75 in benefits for every dollar collected in premium for the carrier's individual health benefits plans. If a carrier does not meet this 75 percent minimum loss ratio amount, the carrier must provide a refund to policy or contract holders.

The proposed amendments to the standard benefit plans which expand the options that may be included in the standard plans will result in more plan design choices offered to consumers when consumers purchase coverage from carriers that elect to sell plans using the new options. One of the options included in the proposal continues to allow

carriers to sell a high deductible health plan that could be purchased in conjunction with a health savings account. Many consumers have contacted the Board to inquire about the availability of such plans. Consumers will be positively affected by the continued availability of such options, if carriers chose to sell these options.

The proposed repeal of several options will affect the approximately 4200 consumers who were covered under Plan D with a \$500.00 deductible or the HMO plan with either a \$10.00 or a \$20.00 copayment option. Except as stated below, those consumers will have the option to elect coverage under another plan with the same or another carrier, and will not be required to satisfy a new preexisting conditions exclusion unless they delay applying for the replacement plan more than 31 days. The consumers may be concerned, however, with being required to make a plan change. The exception to having the option to secure coverage under another individual plan involves persons who were covered under an individual plan, subsequently became eligible for Medicare and elected to retain coverage under the individual plan. Those Medicare eligible persons do not have the opportunity to purchase coverage under another individual plan. The Board believes that persons who elected to retain individual coverage after becoming eligible for Medicare are persons who retained the individual coverage because of coverage for prescription drugs. Since the coverage for prescription drugs under the HMO plan is subject to 50 percent coinsurance, it is unlikely persons with HMO coverage retained it after becoming eligible for Medicare. Coverage under Plan D with a \$500.00 deductible, however, is very rich coverage, so it would have been economically prudent for a person with extensive prescription drug expenses to pay premiums for individual coverage. By electing Medicare Part D under the Medicare Modernization Act, however, those consumers will have the opportunity to secure coverage for prescription drugs. Thus, while those consumers will not have the opportunity to secure

another individual plan, they will have an available mechanism for coverage of prescription drug expenses.

The proposed new Subchapter 12 expands the opportunities for persons who have or are eligible for individual or group coverage to purchase an individual plan. The proposed new rule generally allows a consumer to replace an individual plan with a less expensive individual plan at any time, rather than limiting plan changes to richer plans to the open enrollment period. The proposed new rules would allow a person covered under or eligible for a group HMO plan to apply for an individual HMO plan during the open enrollment period if the networks for the group and individual plans are not the same. The proposed new rules would allow a person eligible for or covered under a non-contributory group plan to apply for individual coverage during the open enrollment period. The proposed new rules change the open enrollment period from the month of October to the month of November for January 1 effective dates which increase the opportunity for consumers to know what the rates for individual coverage might be in January when the new plan takes effect so their open enrollment decision can be made with more complete information.

The proposed amendments to Subchapter 22, particularly those related to the filing of optional benefit riders to amend the B&E Plan, will ensure that carriers file riders consistent with the requirements of P.L. 2001, c. 368 and demonstrate that adverse selection has been avoided to the extent possible. Such a demonstration will help ensure that the standard individual market is not harmed as a result of carriers offering the B&E Plans with riders. The Board believes that the interest carriers have demonstrated in offering riders to amend the B&E Plan creates greater, and potentially less expensive, choices for consumers who otherwise may have chosen to be uninsured.

The proposed new Subchapter 24 addressing program compliance will help ensure that all carriers follow the same standards for determining eligibility for coverage, issuing coverage, and paying benefits. Proposed N.J.A.C. 11:20-24.4, which addresses the effective date of coverage, expands the mandatory options for effective dates to include the 15th of the month effective date in addition to the 1st of the month effective date. Thus, an applicant will not be required to wait as long for coverage to become effective. Carriers continue to have the ability to offer other effective dates, at their discretion.

The proposed amendments and new rules will have the positive effect of providing the public with a greater opportunity to participate in the rulemaking process of the Board.

Economic Impact

The rules proposed for re adoption with amendments at N.J.A.C. 11:20 will likely have a significant economic impact on the IHC Program member carriers, brokers and consumers.

N.J.S.A. 17B:27A-2 et seq. sets forth criteria for a carrier being considered an IHC Program member carrier. As IHC Program member carriers encompass every carrier that has net earned health benefit premium in New Jersey during a two-year calculation period, the regulations will impact not just those carriers that elect to market health benefit plans to residents of New Jersey, but also those carriers that elect not to market individual coverage. Carriers that elect to market individual coverage in New Jersey will have to bear the costs associated with selling individual plans which include the creating and maintaining the provisions of the standard plans and the basic and essential health care services plan as well as rates for such plans, plan marketing, plan administration as well as reporting of enrollment, loss ratios and various certifications.

These carriers must pay the administrative assessment described in the proposed readoption with amendments and non-exempt and partially exempt carriers participate in the loss assessment mechanism. Carriers that elect not to participate in the individual market must pay the administrative assessment described in the proposed readoption with amendments as well as pay a loss assessment.

Brokers will be economically affected by the rules proposed for readoption with amendments due to the time they must take from selling to devote to reviewing and understanding the requirements set forth in the proposed readoption with amendments with respect to standard plans and the basic and essential health care services plan. Some brokers may choose to take advantage of continuing education classes discussing the proposed readoption with amendments. To the extent a broker sells coverage where the carrier pays a commission, the broker will be compensated for assisting consumers with the purchase of individual coverage.

Consumers will be economically affected by the proposed readoption with amendments. The availability of standard plans allows consumers to easily transfer from one carrier to another in order to find the lowest cost option. The requirement that standard plans be community rated makes it possible for the Board to make cost comparison information readily available to consumers.

The proposed inclusion of a de minimis assessment liability of \$20.00 will positively affect some member carriers since the proposed amendment eliminates the requirement to process checks for small amounts. Since the costs associated for processing checks for small amounts often exceed the amount of the check, some member carriers will save not just the amount of the assessment but also the costs associated with processing the check.

As discussed in the Summary, the Board is proposing a number of amendments to the standard plans. Many of those amendments will have an economic impact on consumers, brokers and carriers.

The non-HMO plans provide an increased allowance for preventive care, enabling covered persons to take advantage of a greater amount of first dollar benefits for preventive care. Carriers will be required to pay the increased benefit amount and will make any adjustment necessary in the rates to cover the cost for the increased benefit. All plans, whether non-HMO or HMO will include coverage for intestine transplants and certain donor costs for any covered transplants, not otherwise covered, allowing consumers to be covered for procedures not previously covered. Carriers will be required to pay benefits for these previously uncovered services, and will make any adjustment necessary to rate for the increased liability. With respect to HMO coverage, the proposed amendments will permit carriers to offer HMO plans using separate copayments for specialist services as contrasted to primary care physician services or a separate copayment for hospital outpatient department as contrasted to an ambulatory surgical center. Eligible persons who select a plan with any of these options will realize some rate relief.

The proposed amendments include some changes that the Board expects some eligible individuals may find economically disadvantageous. All of the plans, whether HMO or non-HMO, will include a \$100.00 emergency room copayment, an increase from the \$50.00 copayment contained in the existing standard plans. Thus, consumers who use emergency room facilities will be required to pay \$50.00 more for each visit than under the existing plans. The plans, as amended, continue to waive the application of the emergency room copayment if the patient is admitted within 24 hours. With respect to non-HMO coverage, the Board's decision to exclude prescription drug costs from the

accumulation of the maximum out of pocket will adversely affect eligible persons whose prescription drug costs exceed the maximum out of pocket. As proposed, an eligible person will continue to pay coinsurance for prescription drugs even after the maximum out of pocket has been satisfied. Under the existing plans, expenses for prescription drugs could be used to satisfy the deductible and the coinsurance cap and thereafter are covered at 100 percent. As proposed, prescription drug expenses may accumulate toward the satisfaction of the deductible, but do not accumulate toward the satisfaction of the maximum out of pocket, meaning coinsurance continues to be required even after the maximum out of pocket has been reached. The decision to exclude prescription drugs from the maximum out of pocket is generally consistent with coverage available in the small and large group markets and the Board believes was necessary to avoid further increases in rates. Additionally, the coverage for prescription drugs in a non-HMO plan will now be closer to the coverage always provided in HMO plans, namely 50 percent coinsurance that is not subject to any maximum limit on how much a person may pay as coinsurance for prescription drugs. With respect to HMO coverage, some eligible individuals may view the change in the therapy benefit limitation as having a negative economic impact. The proposed change will replace the 60-day per incident of illness or injury benefit with a 30-day per calendar year benefit. With a 60-day per incident of illness or injury benefit, a person could sustain one injury and have 60-days of physical therapy for that injury and also be eligible for 60 days of therapy for an unrelated injury. Thus, for acute injuries the 60-day limit addressed the needs for the specific injury or injuries. Under the HMO plans, as amended, a person may receive 30 visits of therapy per year, regardless of the reason therapy is needed. Thus, some persons may be required to pay for therapy services on their own if they require more than 30 visits per year. For persons with chronic illness or illnesses, or acute injuries that required greater than 60-

days of care, however, the exhaustion of benefits after only 60 days was a hardship. The amended therapy benefit will allow 30 visits per year and will provide more benefits than the prior benefit, except in the case of multiple injuries in the same year, as discussed above.

As with the additional preventive and transplant coverage the Board elected to add to the plans, the benefits that were added to comply with State and Federal laws, as described in the Summary, will have a positive economic impact on consumers who will have coverage for previously uncovered services and supplies. While carriers have provided those benefits administratively in conformity with law, the inclusion in the standard plans of specific provisions addressing the coverage will reinforce the availability of the additional benefits.

Carriers will be required to reissue all contracts upon the first renewal occurring after the operative date of the changes to the standard plans. At time of publication, there were about 58,000 contracts issued in the market, covering about 77,000 individuals. The reissuance of these contracts will be a cost for carriers.

Federal Standards Statement

The rules proposed for readoption with amendments at N.J.A.C. 11:20 (excluding N.J.A.C. 11:20-2.17 and 11) comply with the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191. The amendments do not expand upon the requirements set forth in Federal law.

The rules proposed for readoption comply with the following federal laws: Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. §1395y(b) (1994) and implementing regulations at 45 C.F.R. Part 411; the Public Health Service Act 42 U.S.C.A. §§300gg et seq., (incorporating the Federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191; the Newborns' and Mother's

Health Care Protection Act of 1998, Pub.L. 104-204, 110 Stat. 2935 (1996); and the Women's Health and Cancer Rights Act of 1998, Pub.L. 105-277, Title IX, §903, 112 Stat.) and implementing regulations at 45 C.F.R. Parts 145 and 146.

The rules do not expand upon the requirements set forth in these Federal laws. There are no other Federal laws that apply to these rules.

Jobs Impact

The IHC Board does not anticipate the creation or loss of any jobs as a result of the rules proposed for readoption with amendments and new rules.

Agriculture Industry Impact

The rules proposed for readoption with amendments and new rules will have no impact on the agriculture industry, other than the general impact felt by all industry groups and the general public.

Regulatory Flexibility Analysis

The IHC Board believes that all carriers subject to these rules have in excess of 100 full-time employees or are located outside of the State of New Jersey and, thus, are not “small businesses,” as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, a regulatory flexibility analysis is not required. Nevertheless, to the extent that there may be carriers that meet the definition of a “small business,” the following analysis would apply.

These rules may impose a greater impact in that small businesses may be required to devote proportionally more staff and financial resources to achieve compliance. The IHC Board has found, however, that any additional costs do not pose an undue burden in that the requirements herein are readily within a carrier’s ability to comply.

The development of the filings required under this chapter fall within the normal functions a carrier performs in complying with any State insurance law or regulations.

An exemption from the filing requirements would be inappropriate because the filing requirements are essential for determining a carrier's assessment liability and for protecting the individuals covered by individual health benefits plans.

The Individual Health Insurance Reform Act does not vary compliance requirements based on business size. To ensure consistency and uniformity in the market these rules now proposed for readoption provide no differentiation in compliance requirements based on business size.

Smart Growth Impact

The rules proposed for readoption with amendments and new rules have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:20-1, 2.1 through 2.16, 3, 6 through 10, 12, 17 through 20 and 22 and N.J.A.C. 11:20 Appendix Exhibits A through F, J, K, L and Q through V.

Full text of the proposed repeals may be found in the New Jersey Administrative Code at N.J.A.C. 11:20-1.5, 1.6, 3.1, 3.2, 9.6, 10.5, 12, 17.5 and 18.9 and 11:20 Appendix Exhibits A, C, E, Q, R, S, T, U and V.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets **[thus]**):

TITLE 11. DEPARTMENT OF BANKING AND INSURANCE DIVISION OF
INSURANCE

CHAPTER 20. INDIVIDUAL HEALTH COVERAGE PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.161 ([N.J.S.A. 17B:27A-2](#) et seq.), the Individual Health Insurance Reform Act, as amended. This chapter establishes procedures and standards for carriers to meet their obligations under [N.J.S.A. 17B:27A-2](#) et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to [N.J.S.A. 17B:27A-2](#) et seq.

(b) Provisions of the New Jersey Individual Health Insurance Reform Act and of this chapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term member is defined in this subchapter, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after August 1, 1993, except as the specific provisions of the statute and of this chapter state otherwise.

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.

"Act" means the Individual Health Insurance Reform Act, P.L. 1992, c.161 ([N.J.S.A. 17B:27A-2](#) through 16.5).

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another.

"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" means the health benefits plan designed by the Board in accordance with N.J.S.A. 17B:27A-4c as amended by P.L. 1993, c.164, § 3.]

"Board" means the Board of Directors of the New Jersey Individual Health Coverage Program established by the Act.

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this chapter, carriers that are affiliated carriers shall be treated as one carrier.

"Church plan" has the same meaning given that term under [Title I, section 3 of Pub.L. 93-406](#), the "Employee Retirement Income Security Act of 1974" ([29 U.S.C. § 1002\(33\)](#)).

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"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, without regard to age, sex, health status, occupation and geographical location.

"Conversion health benefits plan" means a group conversion contract or policy issued on or after August 1, 1993 that is not subsidized by either:

1. A single charge or ongoing increase in premium rates chargeable to the group policy or contract, identifiable as an excess morbidity charge in the group rating formula to cover group conversion excess morbidity costs; or

2. A reduction in dividends or returns paid to a group policy or contract holder, identifiable as a charge to or reduction in the group dividend or return formula to cover group conversion excess morbidity costs.

"Deferral" means a deferment, in whole or in part, of payment by a member of any assessment issued by the IHC Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-12a(3) and N.J.A.C. 11:20-11.

"Department" means the New Jersey Department of Banking and Insurance.

"Dependent" means the spouse **or same-gender domestic partner as that term is defined in P.L. 2003, c. 246 of the applicant**, or child of **[an eligible person] the applicant or domestic partner, [or the child of a policyholder or contractholder,]** subject to applicable terms of the individual health benefits plan.

"Director" means a Director of the Individual Health Coverage Program **Board** who, in accordance with [N.J.S.A. 17B:27A-10](#) as amended by P.L. 1993, c.164, § 5:

1. Has been elected by the members of the Individual Health Coverage Program and approved by the Commissioner;

2. Has been appointed by the Governor and confirmed by the Senate; or

3. Sits ex officio on the Board of Directors.

"Eligible person" means a person is a resident who is not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan, or Part A or Part B of Title XVIII of the Federal Social Security Act ([42 U.S.C. § § 1395](#) et seq.),

"Medicare." **An eligible person shall include a person who is a resident who is eligible for continuation of group coverage under COBRA or a state continuation law, so long as the person elects to be covered under the individual health benefits plan in lieu of continuation coverage.**

“Enrollment date” means, with respect to a federally defined eligible individual, the date the person submits a substantially complete application for coverage. With respect to all other persons, enrollment date means the effective date of coverage under the individual health benefit plan.

"Family unit" means a legally married man and woman **or person and his or her same-gender domestic partner**; a legally married man and woman **or person and his or her same-gender domestic partner** and their dependent child(ren), as the term dependent is defined in the individual health benefits plan; an adult and his or her dependent child(ren), as the term dependent is defined in the individual health benefits plan, who are members of the same household; and dependent children only who are members of the same household as the term dependent is defined in the individual health benefits plan.

"Federally defined eligible individual" means an eligible person:

1. For whom, as of the date on which the individual seeks coverage under P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months;

2. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan;

3. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) or any

successor program, and who does not have another health benefits plan, or hospital or medical service plan;

4. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

5. Who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and

6. Who has elected continuation coverage described in 5 above and has exhausted that continuation coverage.

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the "Health Maintenance Organization Act of 1973," [Pub. L. 93-222](#) ([42 U.S.C. § 300e](#) et seq.).

"Fiscal year" means the time period beginning on July 1st of each year and ending on June 30th of the following calendar year.

"Governmental plan" has the meaning given that term under [Title I, section 3 of Pub.L. 93-406](#), the "Employee Retirement Income Security Act of 1974" ([29 U.S.C. §§ 1002\(32\)](#)) and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

"Group health benefits plan" means a health benefits plan for groups of two or more persons.

"Group health plan" means an employee welfare benefit plan, as defined in [Title I, section 3 of Pub.L. 93-406](#), the "Employee Retirement Income Security Act of 1974" ([29 U.S.C. § 1002\(1\)](#)), to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

"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. § 1395ss\(g\)\(1\)](#)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code ([10 U.S.C. § § 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;
7. The basic and essential health care services plan; and
8. All other health policies, plans or contracts not specifically excluded.

"HMO" means a health maintenance organization authorized in accordance with [N.J.S.A. 26:2J-1](#) et seq.

"Hospital confinement indemnity coverage" means coverage that is provided on a stand alone basis, contains no elimination period greater than three days, provides coverage for no less than 31 days during one period of confinement for each person covered under the policy, and provides no less than \$40.00 but no more than \$250.00 in daily benefits except that the benefit for the first day of hospital confinement may exceed \$250.00 as long as the following formula is satisfied:

$$\text{1st day benefit} - \text{2nd day benefit} + \text{2nd day benefit} < \$250.00$$

"IHC Program" means the New Jersey Individual Health Coverage Program.

"Individual health benefits plan" means: (a) a health benefits plan for eligible persons and their dependents; and (b) a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy of contract pursuant to continuation of benefits provisions applicable under Federal or State law. The term "individual health benefits plan" shall include a policy, contract, or certificate evidencing coverage by a policy or contract issued to a trust or association, issued to an eligible person described in, but not limited to, the following examples: a student, except coverage issued to an institution of higher education for coverage of students and their dependents in New Jersey if such policy has been filed by the Commissioner as a discretionary group pursuant to [N.J.S.A. 17B:27-49](#), an unemployed individual or part-time employee, except as may be provided pursuant to [N.J.S.A. 17B:27A-17](#) et seq. and [N.J.A.C. 11:21-7.3](#); a self-employed person; an employer, when he or she (and dependents) is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to [N.J.S.A. 17B:27A-17](#) et seq. and [N.J.A.C. 11:21-7.6](#); any person who is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to [N.J.S.A. 17B:27A-17](#) et seq. and [N.J.A.C. 11:21-7.6](#); and an employee who is one of several employees of the same employer who are covered by certificates, contracts or policies issued by the same carrier, trust or association, if the employer does not contribute to, and remit payment for, the coverage of such employees.

The term "individual health benefits plan" shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan, to the extent the "Employee Retirement Income Security Act of 1974" ([29 U.S.C. § § 1001](#) et seq.) preempts the application of P.L. 1992, c.161 ([N.J.S.A. 17B:27A-2](#) et seq.) to that plan.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 ([N.J.S.A. 30:4D-1](#) et seq.) and amendments thereto.

"Medical care" means amounts paid:

1. For the diagnosis, care, mitigation, treatment, or prevention of a disease, illness, or medical condition or for the purpose of affecting any structure or function of the body; and
2. Transportation primarily for and essential to medical care referred to in paragraph 1 above.

"Medicare" means coverage provided pursuant to Part A or Part B of Title XVIII of the Federal Social Security Act, Pub.L. 89-97 ([42 U.S.C. § § 1395](#) et seq.) and amendments thereto.

"Medicare cost and risk contracts" means policies or contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1876 or Section 1833 of the Federal Social Security Act ([42 U.S.C. §§ 1395](#) et seq.) and amendments thereto.

"Medicare Plus Choice" means policies and contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1853 of the Federal Social Security Act ([42 U.S.C. §§ 1395](#) et seq.) and amendments thereto.

“Medicare Advantage” means policies and contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1853 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.) and any amendments thereto.

"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 **[and]**, Medicaid, **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 **[and]**, Medicaid, **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 and Medicaid 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.

"NAIC" means the National Association of Insurance Commissioners.

“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, **[or]** Medicaid, **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.

"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.).

"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.).

"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 **or Medicare Advantage contract**, Medicare Demonstration Project plan or Medicaid contract.

"Open enrollment" means the continuous offering of a health benefits plan to any eligible person on a guaranteed issue basis, except as stated in N.J.A.C. 11:20-12.

"Plan" means the plan of operation of the IHC Program.

"Plan sponsor" shall have the meaning given that term under [Title I, section 3 of Pub.L. 93-406](#), the "Employee Retirement Income Security Act of 1974" ([29 U.S.C. § 1002\(16\)\(B\)](#)).

"Pre-existing condition" means a condition that, during a specified period of not more than six months immediately preceding the **[effective] enrollment** date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the **[effective] enrollment** date of coverage.

"Premium earned" means premium received, adjusted for the changes in premium due and unpaid, and paid in advance, and unearned premium, net of refunds or dividends paid

or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.

"Program" means the New Jersey Individual Health Coverage Program established pursuant to the Act.

["Reasonable and customary" means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey, or other state where services or supplies are provided, for various medical services, published and available to carriers from the Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004-1109]

"Resident" means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of each calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of each calendar year. **For purposes of identifying a Federally defined eligible individual, actual and intended presence in the State for a minimum period may not be considered, but a carrier may require an applicant to demonstrate that New Jersey is his or her primary residence as defined by law.**

"Standard health benefits plan" means a health benefits plan, including riders, if any, adopted by the IHC Program Board.

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Individual Health Insurance Reform Act, the policy shall establish a per person

attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than \$20,000 per covered person per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

"Two-year calculation period" means a two calendar year period, the first of which shall begin January 1, 1997 and end December 31, 1998.

11:20-1.3 Closing of noncomplying individual health benefits plan

(a) All coverage under individual health benefits plans delivered or issued for delivery with an effective date of August 1, 1993 or thereafter shall comply with this chapter.

(b) Health benefits plans not subject to the Act shall remain subject to the full review and approval of the Commissioner in accordance with [N.J.S.A. 17B:26-1](#) et seq., [N.J.S.A. 17:49-1](#) et seq., [N.J.S.A. 17:48A-1](#) et seq., [N.J.S.A. 17:48E-1](#) et seq., [N.J.S.A. 26:2J-1](#) et seq. and rules promulgated pursuant thereto.

11:20-1.4 Other laws of this State

All health benefits plans delivered or issued for delivery in New Jersey, as defined by this subchapter, shall be subject to the Individual Health Insurance Reform Act, as well as all relevant statutes and rules of New Jersey not inconsistent with, amended or repealed by this Act.

11:20-1.5 [Penalties]

Failure of a carrier to comply with any provision of this chapter may result in the carrier's losing its authority to write health benefits plans in New Jersey and imposition of any and all penalties and actions available under law.

11:20-1.6] Severability

If any provision of this chapter or the application thereof to any person or circumstance is found to be invalid for any reason, the remainder of the chapter and the application thereof to other persons or circumstances shall not be affected thereby.

11:20-1.6 Mission statement

The mission of the New Jersey Individual Health Coverage Program Board is to administer the New Jersey Individual Health Coverage Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders in the marketplace and other interested persons, and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to individuals and establishing and administering assessment mechanisms. It also includes the regulation of individual health coverage carriers in conjunction with the New Jersey Department of Banking and Insurance and New Jersey Department of Health and Senior Services.

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM [TEMPORARY]

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, 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 pursuant to [N.J.S.A. 17B:27A-12](#), as amended.

(b) The Board of the IHC Program has been charged pursuant to the Act to administer the IHC Program reasonably and equitably under law.

(c) The IHC Program [**Temporary**] Plan of Operation sets forth as completely as possible the fair, reasonable and equitable manner in which the Board will administer the IHC Program under law. [**The Commissioner has adopted the Temporary Plan of Operation pursuant to N.J.S.A. 17B:27A-10e as amended by P.L. 1993, c.164, section 5 and the Temporary Plan will continue in effect until amended or rescinded by the Commissioner.**]

(d) The Board shall consist of nine directors, including the Commissioner or his or her designee, who shall serve ex officio.

(e) The Board shall appoint an insurance producer licensed to sell health insurance pursuant to [N.J.S.A. 17:22A-1](#) et seq. to advise the Board on issues related to sales of individual health benefits plans issued pursuant to the Act.

(f) Neither the [**Temporary**] Plan of Operation nor the IHC Program creates any contractual or other rights and obligations between the IHC Program and any entity or other person insured by any carrier.

(g) The IHC Program shall continue in existence subject to termination in accordance with the laws of this State or of the United States. In the event of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the IHC Program, the IHC Program shall terminate and conclude its affairs. Any funds or assets held by the IHC Program following the payment of all claims and expenses of the IHC Program shall be distributed to the member carriers at that time and in accordance with the then existing assessment formula.

(h) All documents or other communications directed to the Board shall be sent to the Executive Director of the IHC Program at the [**following**] address **set forth below.**

Communications sent by regular mail must be sent to the PO Box:

New Jersey Individual Health Coverage Program

20 West State Street, [**10th**] **11th** Floor

PO Box 325

Trenton, NJ 08625-0325

Telephone: [(**609**) **984-1717**] **(609)633-1882 x50306**

Fax: (609) 633-2030

[11:20-2.2 Definitions](#)

(a) Words and terms defined at [N.J.S.A. 17B:27A-2](#) as amended, and N.J.A.C. 11:20-1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Action" means an action by the Board adopted, in the Board's discretion, in accordance with the procedures set forth either in the Administrative Procedure Act, [N.J.S.A. 52:14B-1](#) et seq., or in sections 7 and 8 of P.L. 1993, c.164. "Action" includes, but is not limited to: the establishment and modification of health benefits plans; procedures and standards for assessment of members and the apportionment thereof, policy form filings, rate filings, evaluation of material submitted by carriers with respect to loss ratios, and establishment of refunds to policyholders or contract holders; and the promulgation or modification of policy forms. "Action" shall not include the hearing and resolution of contested cases, personnel matters or applications for exemptions.

"Plan" means the plan of operation of the IHC Program.

["Temporary Plan" means the temporary plan of operation for the IHC Program adopted by the Commissioner in accordance with [N.J.S.A. 17B:27A-10](#) as amended by P.L. 1993, c.164, section 5.]

[11:20-2.3 Powers of the IHC Program and Board](#)

(a) The IHC Program shall have the general powers and authority granted under the laws of this State to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the IHC Program shall not have the power to issue health benefits plans directly to either groups or individuals.

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

1. Define the provisions of standard health benefits plans in accordance with the requirements of the Act and **[this Temporary] the Plan of Operation**;
2. Establish benefit levels, including any optional deductibles and copayments, and exclusions and limitations for standard health benefits plans in accordance with law;
3. Establish standard policy forms for standard health benefits plans and rider packages;
4. Establish a procedure for the joint distribution of information on standard health benefits plans issued pursuant to [N.J.S.A. 17B:27A-4](#) as amended;
5. Establish reasonable guidelines for the purchase of new individual health benefits plans by persons who are already enrolled or insured by another individual health benefits plan;
6. Review rate filings and other filings submitted by carriers in accordance with the Act and rules promulgated pursuant thereto and **[this Temporary] the Plan of Operation**;
7. Establish standards for a means test for standard health benefits plans issued pursuant to [N.J.S.A. 17B:27A-4](#) as amended by P.L. 1993, c.164, section 3;
- [8. Promulgate, in conjunction with the New Jersey Small Employer Health Benefits Program, a standard claim form for the standard health benefits policies;]**
- [9.] 8.** Establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the IHC Program and provide for performance audits;

[10.] **9.** Make application on behalf of member carriers for benefits, subsidies, discounts or funds that may be provided either by any health care provider or under State or Federal law or regulation;

[11.] **10.** Appoint from among **[its] Board** members appropriate legal, actuarial and other committees necessary to provide technical and other assistance in the operation of the IHC Program, in policy and other contract design and any other functions within the authority of the Board;

[12.] **11.** Enter into contracts which are necessary or proper to carry out the provisions and purposes of the Act and **[this Temporary] the Plan of Operation**;

[13.] **12.** Employ or retain such persons, firms or corporations to perform such administrative functions as are necessary for the Board's performance of its duties;

[14.] **13.** Provide procedures for receiving oral and written comments from the public, which may include rules relating to the time and place of any public hearing, and for the length and format of testimony from individuals, groups and organizations;

[15.] **14.** Establish rules, conditions and procedures pertaining to the sharing of IHC Program losses and administrative expenses among the members of the IHC Program;

[16.] **15.** Calculate assessments and assess member carriers their proportionate share of IHC Program losses and administrative expenses in accordance with [N.J.S.A. 17B:27A-12](#) and this Plan, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses;

i. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

ii. The Board may provide for other credits against assessments as appropriate;

[17.] 16. Establish and maintain the appropriate accounts necessary to administer the IHC Program;

[18.] 17. Impose interest penalties upon members for late payment of assessments **as authorized by N.J.S.A. 17B:27A-10(f)(4);**

[19.]18. Recommend to the Commissioner that actions be instituted in accordance with the Commissioner's authority to impose penalties for violations of the Act;

[20.] 19. Sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member carrier;

[21.] 20. Pursuant to P.L. 1993, c.164, adopt "actions" necessary to execute the Board's powers pursuant to the provisions of [N.J.S.A. 17B:27A-2 et seq.](#) [through 16 **et. seq.**];

[22.] 21. Borrow money to effect the purposes of the IHC Program;

i. Any notes or other evidence of indebtedness of the Program not in default shall be legal investments for carriers and may be carried as admitted assets; and

[23.] 22. Contract for an independent actuary and any other professional services the Board deems necessary to carry out its duties under [N.J.S.A. 17B:27A-2 et seq.](#) as amended.

[11:20-2.4 \[Temporary\] Plan of Operation](#)

(a) The [Temporary] Plan **of Operation and amendments thereto** shall become effective upon [adoption] **approval** by the Commissioner and submission of final action

to the Office of Administrative Law for publication. The Commissioner may amend the [Temporary] Plan of Operation by providing written notice to the Board of amendments and their effective dates and upon adoption of amendments in accordance with applicable law.

(b) Upon the submission of a Plan by the Board and approval of the Plan by the Commissioner pursuant to [N.J.S.A. 17B:27A-10\(d\) and \(e\)](#) as amended by P.L. 1993, c.164, section 6, the Commissioner shall rescind the Temporary Plan.

[11:20-2.5 Board of Directors](#)

(a) The Board shall consist of nine Directors, including the Commissioner or his or her designee, who shall sit ex officio.

1. Four Directors shall be appointed by the Governor, with the advice and consent of the Senate.

i. One of the Governor's appointees shall be a representative of an employer, appointed upon the recommendation of a business trade association, who has experience in the management or administration of an employee health benefits plan.

One of the Governor's appointees shall be a representative of organized labor, appointed upon the recommendation of the AFL-CIO, who has experience in the management or administration of an employee health plan. Two of the Governor's appointees shall be consumers of a health benefits plan who are reflective of the population in the State.

ii. The term of the initial appointment shall be for the period as set forth in the appointment.

2. Four Directors shall represent carriers and shall be elected by the members subject to the approval of the Commissioner.

i. To the extent a Carrier elected by the members is willing to serve on the Board, a representative of each of the following types of carrier shall be elected:

(1) **[Until December 31, 1999, a health service corporation or a domestic mutual insurer which converted from a health service corporation in accordance with the provisions of sections 2 through 4 of P.L. 1995, c.196 (N.J.S.A. 17:48E-46 through 48). After that date, a domestic mutual insurer which, either directly or through a subsidiary health maintenance organization, is primarily engaged in the business of issuing health benefits plans;] A health service corporation or a domestic stock insurer which converted from a health service corporation pursuant to the provisions of P.L. 2001, c. 131 and is primarily engaged in the business of issuing health benefit plans in this State;**

(2) A health maintenance organization;

(3) **[A mutual insurer of this State subject to Subtitle 3 of Title 17B of the New Jersey Statutes;] An insurer authorized to write health insurance in this State subject to Subtitle 17B of the New Jersey Statutes; and**

(4) A foreign health insurance company authorized to do business in this State.

[ii. The initial term of Directors representing carriers shall be determined by vote of the members of the IHC Program.]

[iii.] ii. The Board shall hold a meeting, at least annually, of the members of the IHC Program for the purpose of electing Directors to fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office.

(1) On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the IHC Program members setting forth the time, date and place of the election meeting, stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

(2) Following the close of the nomination period, the Board shall determine from among the carriers nominated those carriers that are eligible and willing to serve in the position for which nominated. A carrier may be placed on the ballot for only one Board position, and may not hold more than one seat on the Board. If a carrier is nominated for two or more positions for which it is eligible, the carrier shall notify the Board before the election as to the single position for which it will accept the nomination, and be designated on the ballot.

(3) At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote via absentee ballot on or before the date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

(4) Affiliated carriers shall have no more than one vote for each position subject to vote and no two affiliated carriers shall serve on the Board at the same time.

(5) Elections shall be by the highest number of those votes properly cast in person and absentee.

(6) The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at [N.J.A.C. 11:20-2.9](#).

[**iv.** iii. Prior to the Board's annual meeting set forth at (c) below, or no later than 30 calendar days subsequent to the date of the election meeting, whichever date is later, the Board shall send a written notice to IHC Program members of the names of the Directors of the Board, their respective designees, if any[, **and the means by which Directors may be contacted during normal business hours by IHC Program members**].

3. The Commissioner shall file with the Board a letter naming his or her designee, if any.

4. A carrier elected to the Board shall file with the Board a letter naming the person authorized to vote on behalf of the carrier and may name one or more alternates.

5. Appointed Directors shall promptly notify the Board of any change in circumstance that may affect the representative capacity in which they were appointed. Upon receipt of such notice, the Board shall notify the Governor of the appointed Director's change in circumstance.

6. The Directors representing carriers on the Board shall promptly notify the Board of any change in circumstance that may affect the representative capacity of the entity elected by the members. Upon receipt of such notice, the Board shall provide notice of the same to the members of the IHC Program.

7. Directors shall serve their terms of office until their replacements are duly appointed or elected, as appropriate.

(b) The Board shall elect a Chair from among its Directors, and may elect other officers it deems appropriate. As authorized by the Board, such officers may act as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(c) The Board shall hold an annual meeting at which it shall:

1. Elect officers of the Board;
2. Appoint Directors [**and others persons**] to committees of the Board;

and

3. Take action on such other matters that it deems appropriate.

(d) A majority of the Directors shall constitute a quorum for the transaction of business.

1. Each Director shall have one vote. The acts of a majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board, except as provided in (d)2 below.

2. The affirmative votes of five Directors shall be required to act upon the following:

- i. Amendments to the Plan of Operation;
- ii. Amendments to the standard health benefits plans;
- iii. Adoption of any actions, as defined by **section 8 of** P.L. 1993, c.164, [**sections 7 and 8**] (**N.J.S.A. 17B:27A-16.1**) or amendments to the actions of the IHC Program;
- iv. Removal of any Director from membership on any committee;
- v. Recommendations by the Board to the Commissioner regarding amendments to the Act; and
- vi. An assessment or interim assessment.

(e) All meetings of the Board at which a quorum is present, including special meetings, shall be subject to the provisions of the Open Public Meetings Act, [N.J.S.A. 10:4-6](#) to 21.

(f) In addition to the annual meeting and any regularly scheduled meeting, the Board may hold special meetings upon the request of the Chair or of three or more Directors.

(g) Directors shall not receive compensation for attendance at Board and Committee meetings. Directors may be reimbursed for reasonable unreimbursed travel and other reasonable expenses incurred in attending Board and Committee meetings using the State Travel Regulations issued by the Department of the Treasury as a guide.

(h) The Board shall hold meetings either in person or by teleconference.

(i) The Board shall provide for the taking of written minutes of each Board meeting, including teleconferences and closed sessions, and distribute a copy of the minutes to the Directors [**and two copies to the Commissioner**]. The Board shall retain the original of the minutes.

1. The staff of the Board shall take and maintain the written minutes of the proceedings of the Board meetings, including teleconferences and closed sessions. Board meeting minutes shall set forth as a minimum the following:

- i. The time, date and place of the meeting;
- ii. The names of all persons attending the meeting, the organizations they represent, if any, and the identity of the person presiding;
- iii. A narrative describing what occurred at the meeting including subjects considered and actions taken;
- iv. The recorded votes of each member on each matter including abstentions;

v. The complete text of any resolutions adopted by the Board; and
vi. Any other information required to be shown in the minutes by law.

(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.

[11:20-2.6 Committees](#)

(a) The Board shall make appointments to standing and other committees from among Directors [**and IHC Program members**]. Each of the standing committees shall include no more than four Directors, but the Chair may appoint additional Directors as needed subject to ratification by the Board at the next subsequent meeting.

(b) The Board may, by resolution:

1. Determine the size of a standing committee, appoint Directors, and fill a vacancy;

2. Appoint a Director to serve as an alternate member of any standing committee to act in the absence of a committee member with all the powers of such absent member;

3. Abolish any standing committee; **and**

[4. Remove any person, other than a Director, from any standing committee at any time, with or without cause; and]

[5.] 4 Appoint or authorize the use of IHC Program staff, consultants, or other advisors to work with any standing committee.

(c) Committees may not take final action; however, within the scope of their purpose and duties, committees may make recommendations and reports to the Board for decision.

(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[s] **reports**;
- iv. A uniform Audit Program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier;
- v. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time;
- vi. Conditional and final exemptions from assessments;
- vii. Reviews of informational rate filings submitted to the Board pursuant to N.J.A.C. 11:20-6 **[and] 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. 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. A Legal Committee, which shall make **[reports] recommendations** to the Board with respect to:

- i. Rules to be promulgated by the Board pursuant to the Act;
- ii. Amendments to the Plan of Operation and the various individual health benefits plans proposed by the Board;
- iii. Any proposed amendments to the Act;
- iv. Contracts and legal documents for the IHC Program;
- v. All litigation and other disputes involving the IHC Program and its operations;
- vi. Coordination with the Office of the Attorney General on matters relating to IHC Program operations; and
- vii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member.

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

- i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of individual health benefits plans to eligible persons;
- ii. Marketing and communication plans for the IHC Program, as needed;
- iii. **[Rules to determine "good faith" marketing efforts by members applying for exemptions] Submissions by members of good faith**

marketing reports for the basic and essential health care services plan made pursuant to N.J.A.C. 11:20-22.6;

iv. The insurance producer to be appointed by the Board pursuant to N.J.S.A. 17B:27A-10g, and assist in liaison efforts between the Board and the appointed producer; and

v. **[A buyers' guide] Materials** to be distributed to consumers **or made available through the Internet** which describe[s] the individual health benefits plans available to eligible persons pursuant to the Act.

[4. A Policy Forms Committee, which shall make recommendations to the Board with respect to:

i. Changes to the Board's standard policy forms, application form and claim form and develop new forms as may be necessary from time to time; and

ii. Whether members are issuing plans in compliance with the standard health benefits plans.]

[5.] 4. An Operations **and Audit Committee, which shall make recommendations to the Board with respect to:**

i. The engagement of independent financial consultants, including, but not limited to, examiners, auditors, accountants and actuaries;

ii. The Plan of Operation and amendments thereto;

iii. Standards of acceptability for the selection of auditing firms;

iv. The review of reports prepared by independent auditors and other audit- related matters the Board deems necessary; **[and]**

v. Contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Plan **[.];**

vi. Methods for calculating assessments;

vii. Uniform audit program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier; and

viii. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time.

(e) The Board may by resolution establish and appoint other committees.

(f) All committee members[, **including those committee members who are not also members of the Board,**] 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. [**Committee members who are not also members of the Board shall be required to file a Certification, in a form to be provided by the Board, stating that they, and the respective entities and or carrier by whom they are employed, agree to be subject to all applicable terms set forth in the Code of Ethics.**]

[11:20-2.7 Financial administration](#)

(a) The fiscal year of the IHC Program shall run from July 1 to June 30 of each year.

(b) All funds of the IHC Program shall be deposited **into** and disbursements made from the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget.

1. Monies pertaining to the IHC Program shall be deposited into a dedicated account within the State's General Fund.

2. Monies may be credited from the General Fund to IHC bank accounts upon request by the Board through the Department, which request shall include justification for the request with supporting documentation, and shall be pursuant to the approval of the Director of the Division of Budget and Accounting.

(c) Bank checking accounts shall be established separately in the name of the IHC Program and shall be approved by the Board.

1. The Board shall authorize individuals to sign checks on behalf of the Board.

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law.

i. All investment income earned on administrative assessment funds shall be credited to the IHC Program and shall be applied to reduce future administrative assessments of members of IHC Program except as provided in N.J.A.C. 11:20- 2.12(h).

ii. All investment income earned on loss assessment funds shall be credited to the IHC Program and shall be applied to reduce future loss assessments of members of the IHC Program, except as provided in [N.J.A.C. 11:20-2.17\(g\)](#), **and** except that interest earned on loss assessment funds due to a carrier shall be paid to that carrier to the extent that the investment income is earned during a subsequent loss assessment cycle in which the carrier is no longer seeking reimbursement.

(d) No disbursements shall be made from IHC bank accounts without the approval of the Board, except that the Board may authorize the Executive Director to make disbursements of less than \$1,000 per disbursement for administrative purposes [**subject to such conditions as the Board may prescribe**] **as necessary for the efficient administration of the program.**

(e) All financial records shall be kept in accordance with the State's prescribed policies and procedures. The Board shall maintain the books and records of the IHC Program at a location in New Jersey in a manner so that financial statements may be prepared to satisfy the Act and other requirements of New Jersey law.

1. The receipt and disbursement of cash for the IHC Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when assets or liabilities should be realized by the IHC Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the IHC Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the IHC Program shall be calculated for each carrier either when deemed appropriate by the Board or when requested by the carrier. The Board shall maintain records of each carrier's financial transactions with the IHC Program as necessary to ensure compliance with the Act and **[this Temporary] Plan of Operation**, which records shall include at least the following:

i. Net losses of the IHC Program based upon the assessments calculated in accordance with this Plan;

ii. Any adjustments as set forth in this Plan;

iii. Adjustments to the amount due to or from the IHC Program based upon corrections to carrier submissions;

iv. Interest charges due from a carrier for late payment of amounts due to the IHC Program; and

v. Other records required by the Board.

5. The Board shall maintain a general ledger which shall be used to produce the IHC Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledger journals.

(f) The Executive Director shall prepare an annual financial report to be delivered to the Commissioner and each member of the Board by December 31 of each year beginning in 1998. The annual report shall fairly present the financial condition of the IHC Program for the preceding fiscal year.

1. All accounts shall be reconciled and trial balances shall be determined monthly.

2. Financial statements in a form approved by the Board shall be prepared and delivered to each member of the Board and the Commissioner on a quarterly basis.

11:20-2.8 Audits

(a) The Board shall have an annual audit of its operations conducted by a qualified independent certified public accountant.

1. The auditor shall be selected and approved by the Board through a competitive bidding process of certified public accountants qualified in New Jersey to perform audits of **[the type of entity] entities like the Board.**

2. The annual audit shall include the following items:

i. A review of the handling and accounting of assets and monies of the IHC Program;

ii. A determination that administrative expenses have been properly allocated and are reasonable;

iii. A review of the internal financial controls of the IHC Program;

iv. A review of the annual financial report of the IHC Program;

and

v. A review of the calculation by the IHC Program of any assessments of carriers for net losses.

3. A copy of the annual audit and related management letters shall be delivered to each Director and to the Commissioner. The annual audit report shall be reviewed by the Technical Advisory Committee or Operations **and Audit** Committee, or both Committees, which shall present its recommendations to the Board for implementation of findings and recommendations made by the auditor. The actions adopted shall be reported to the Commissioner.

(b) The Board may, from time to time, direct that a member carrier arrange, or the Board may arrange, to have an audit conducted by an independent certified public accountant and a copy of the audit report of the member carrier delivered to the Board. All information regarding an audit of a member carrier conducted pursuant to this subsection shall be confidential and protected from disclosure by the member carrier, by the auditing firm, by the Board and the Commissioner.

(c) The Board shall conduct a full or partial audit of a carrier[s] filing for reimbursement of losses. Carriers filing for reimbursement of losses shall provide, within 90 days of the Board's written request [, **the following minimum data to the Board or its appointed auditors] such information as the Board shall request, including but not limited to:**

1. With respect to information regarding premium earned:

i. Detailed electronic data files of premiums which, in total, agree to the premiums earned reported to the IHC Board on the [**IHC Program Market Share and Net Paid Gain (Loss)] Exhibit K Assessment** Report. The data file or files shall

include sufficient detail to identify the dollar amounts of premiums, by subscriber or contract number;

ii. All underwriting and premium records relating to the premiums earned on the data files, including but not limited to, subscriber applications, billing records, cash receipt and disbursement records, advance premium and premium receivable records and rate filings;

iii. A reconciliation, if necessary, between the total premiums earned per the data files requested in (c)1i above and the premium earned amount reported to the IHC Board on the **[Program Market Share and Net Paid Gain (Loss)] Exhibit K Assessment** Report, including an explanation of reconciling items; and

iv. A reconciliation, if necessary, between the premiums earned amount reported to the IHC Board on the **[Program Market Share and Net Paid Gain (Loss)] Exhibit K Assessment** Report and premiums earned amount set **[for] forth** in the Member's Annual Statement Blank filed with the Department or Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

2. With respect to claims paid:

i. Detailed electronic data files of claims paid which, in total, agree to the claims paid reported to the IHC Board on the **[Program Market Share and Net Paid Gain (Loss)] Exhibit K Assessment** Report. The data files shall include sufficient detail to identify the dollar amounts of claims paid, by claim and subscriber number, and the payment reference such as check or wire transfer number. All claim file and disbursement records relating to the claims paid on the data file, such as claims submission forms, provider invoices, pricing data, eligibility investigations, canceled checks and wire transfer documentation;

ii. A reconciliation, if necessary, between the total claims paid per the data files requested in (c)2i above and the claims paid amount reported to the IHC Board on the **[Market Share and Net Paid Gain (Loss)] Exhibit K Assessment** Report, including an explanation of reconciling items; and

iii. A reconciliation, if necessary, between the claims paid amount reported to the IHC Board on the **[Market Share and Net Paid Gain (Loss)] Exhibit K Assessment** Report and the claims paid amount set forth in the Member's Annual Statement Blank filed with the Department or the Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

3. With respect to investment income:

i. Detailed schedules of net investment income which, in total, agree to the net investment income reported to the IHC Board on the **[Program Market Share and Net Paid Gain (Loss)] Exhibit K Assessment** Report. The schedules shall set forth the Member's calculation of net investment income allocated to the New Jersey individual line of business and shall include sufficient detail to identify the nature and source of the components used to calculate net investment income; and

ii. All source documentation used in the Member's calculation of net investment income, including, but not limited to, schedules used in the calculation of mean funds by line of business, cash receipt and disbursement records used in the cash flow schedules, and calculations for the Member's investment rate of return.

11:20-2.9 Records

(a) The Board shall provide for the maintenance and retention of its official records, and may delegate this function to the Executive Director.

(b) The Board's records shall consist of the following:

1. Minutes of all Board meetings;
2. Written reports and recommendations of committees to the Board;
3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules;
4. The rulemaking file on rules proposed or adopted by the Board, including all comments received;
5. The Plan of Operation and any amendments thereto;
6. Records concerning the election of Directors and appointment of committees and committee members;
7. Determinations on requests for exemption by carriers;
8. Other actions by the Board required by the Act; and
9. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to **[the Right to Know Law,]** [N.J.S.A. 47:1A-1](#) et seq., except that information in filings determined by the Board or Department by regulation to be confidential and proprietary shall not be subject to public inspection and copying, and except that written communications of the Board, its staff, or committees, including, but not limited to, reports, opinions, and recommendations, where such communications contain discussion of litigation strategy, attorney-client advice or other privileged information, shall not be available for public inspection or copying.

[(d) For the purpose of disseminating information about the IHC Program, the Board shall maintain a mailing list of carriers and other interested parties.]

1. The mailing list of member carriers initially shall be based upon the member carriers' addresses filed with the Department pursuant to N.J.A.C. 11:1-25.

The Board may proceed to develop its own list of member carriers.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and mailing address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.]

[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. In designing and amending the standard health benefits plans, the Board shall give consideration to the types of coverage currently in force and/or available in the marketplace, individual's preferences and the evolution of the marketplace towards managed care.

2. The **[Policy Forms committee and/or the Board's staff may design or amend the standard health benefits plans, but the] Board shall discuss [the design and any changes thereto] amendments to the standard policy forms** at a meeting open to the public prior to any vote by the Board to adopt, or modify any aspect of, a standard health benefits plan design.

3. The Board shall hold a public hearing on the standard health benefits plans or any amendments thereto prior to adopting or changing a standard health benefits plan.

i. The Board shall provide to all members and interested parties reasonable advance notice of a public hearing in accordance with the procedures set forth in the Act as amended.

ii. The Board may establish procedures for a public hearing **[pursuant to Article III of this Temporary Plan]** and publish them with the notice of the public hearing.

iii. The Board shall maintain a written record of any public hearing and make it available for inspection at the office of the Executive Director.

4. The Board shall adopt or amend a standard health benefits plan in accordance with the procedures set forth in the Act, as amended, **or in accordance with the procedures set forth in the Administrative Procedures Act.**

i. In accordance with the procedures for taking action set forth in the Act, as amended, the Board may adopt a standard health benefits plan or

modifications thereto and thereafter shall address in writing such comments as were received within a reasonable period following the adoption of the proposed action. The Board shall give due consideration to all comments received. Pursuant to the Act as amended, the Board shall, within a reasonable period of time following submission of the comments, prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the Board's response to the data views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

(1) The Board shall identify whether it made a change in the action proposed at its own initiative or in response to one or more comments.

ii. Except as may be required by law, members shall implement amendments to the standard health benefits plans in the time prescribed by the Board.

5. The Board shall take action as necessary to keep the standard health benefits plans in compliance with State and Federal law.

(b) Members shall submit to the [**Board, in the care of the**] Executive Director **at the address listed in N.J.A.C. 11:20-2.1(h)**, a certification, set forth as Exhibit [Q] **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 [**and application**] forms will be used in accordance with the requirements of **N.J.A.C. 11:20-3.2 [and 4.1]**.

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

11:20-2.11 (Reserved)

11:20-2.12 Assessments for administrative expenses and organizational and operating expenses

(a) [Every] **Except as described in (a)4 below, every** member shall be liable for a portion of the administrative expenses of the IHC Program. Within 90 days of approving a final audited statement of the IHC Program **[books] financial statements and the conclusion of all appeals of assessments for administrative expenses,** the IHC Program Board shall notify each member by separate invoice of the dollar amounts being assessed against the member for its portion of the final administrative expense total for the applicable fiscal year or years. **To the extent that an interim assessment has been made for that period, the notice shall provide reconciliation between the original invoice and the final invoice.**

1. Such notice shall include a brief summary of the final administrative expenses and shall credit the member for any interim administrative expense assessments paid.

2. If a member has advanced a sum or sums of money to the IHC Program to cover some portion of the IHC Program's administrative expenses, those sums advanced shall be credited against the member's assessment amounts.

3. Each member's final assessment for administrative expenses shall be reduced by any deferral assessment paid by assessed carriers in proportion to the original assessment made to cover the deferred amount.

4. A member shall not be liable for an assessment that is less than the minimum assessment set forth in N.J.A.C. 11:20-2.18.

(b) The Board, at its discretion, may make an interim assessment on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses as well as to cover estimated losses.

(c) Through fiscal year 1997 (that is, July 1, 1996 through June 30, 1997), all members shall be assessed for a proportionate share of final administrative expenses for the fiscal year on the basis of the ratio of the member's health benefits plans net earned premiums for the calendar year which includes the first six months of the fiscal year to the total of all members health benefits plans net earned premiums for that same calendar year. Beginning with fiscal years 1998 and 1999, all members shall be assessed for a proportionate share of final administrative expenses for two-year fiscal periods on the basis of the ratio of the member's health benefits plans net earned premiums for the two-year calculation period which begins six months prior to the beginning of the first fiscal year to the total of all members' health benefits plans net earned premiums for that same two-year calculation period. Thus, for example, for fiscal years 1998 and 1999, all members will be assessed based on 1997 and 1998 net earned premium. Net earned premiums shall be determined as reported by each member to the IHC Program Board in the [**Carrier Market Share and Net Paid Gain (Loss)**] **Exhibit K Assessment** Report as set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit [**a Carrier Market Share and Net Paid Loss**] **an Exhibit K Assessment** Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement or Statements, as appropriate, filed with the Department.

(d) Interim assessments beginning with fiscal years 1998 and 1999 shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding two-year calculation period.

(e) Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by the member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members on the same basis as set forth in (c) above.

(f) Assessment amounts are due and payable upon receipt by a member of an invoice for the assessment. Payment shall be by bank draft made payable to the Treasury-State of New Jersey, IHC Program, at the address set forth in [N.J.A.C. 11:20-2.1\(h\)](#).

1. **[Members] Pursuant to N.J.S.A. 17B:27A-10(f)(4), members** shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent per month of the assessment amount or any portion thereof not timely paid, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that **[are reported] a member reports** to the Board **[by a member]** within 60 days of their occurrence shall not be subject to the interest penalty set forth in (f)1i above. If a member makes an error relating to or

involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall **identify the amount of the assessment in dispute and shall** be liable for and make payment of the full amount of the assessment invoice when due, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedure Act, [N.J.S.A. 52:14B-1](#) et seq.

(g) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with procedures established by the Commissioner, **which are set forth at N.J.A.C. 11:20-11.**

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (f) above, to be held in an interest bearing [**escrow**] account in accordance with the procedures set forth in (h) below pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (g)1 above, and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (f)1 above, accruing from the date of the invoice for the assessment.

(h) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed by the Board until such time as the dispute has been settled or concluded with the disputing member, or until final disposition of the request for deferral by the Commissioner, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed **by the Board** immediately, along with any applicable interest penalty amounts paid or interest earned while held [**in escrow**] by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, shall be returned to the appropriate members within 15 days of the date that the Executive Director receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held [**in escrow**] by the Board.

11:20-2.13 Notice of request for deferral

A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Executive Director at the address listed in [N.J.A.C. 11:20-2.1\(h\)](#) [**in order to preserve its right to any monies paid pursuant to the invoice of assessment**].

11:20-2.14 Failure to pay assessments

If a member [**is**] determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor

requested a hearing, the IHC Program Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

[11:20-2.15 Penalties/adjustments and dispute resolutions](#)

(a) A member seeking to challenge the amount of an assessment must do so within 20 days of receiving the notice of the assessment pursuant to the procedures for appeals set forth at [N.J.A.C. 11:20-20.2](#).

(b) If the Board determines that the nature or extent of errors or conduct by a member evidence activity for which penalties or sanctions are appropriate, the Board shall refer the matter to the Commissioner, Attorney General, and/or other appropriate enforcement agency, for appropriate action including the assessment of **any** penalties and sanctions as provided by the Act, as well as any other penalties permitted by law. Nothing herein shall be construed to limit the authority of the Commissioner, the Attorney General or any law enforcement agency to take appropriate regulatory or enforcement action with respect to violations of law and regulations.

[11:20-2.16 Indemnification](#)

(a) The participation in the IHC Program as a member, the establishment of rates, forms or procedures, or any other joint or collective action required by the Act shall not be the basis of any legal action, criminal or civil liability, or penalty against the IHC

Program, member of the Board of Directors, employee of the Board, or any member carrier either jointly or separately except as otherwise provided in the Act.

(b) The Board shall not be liable for any obligation of the IHC Program. No Director, officer or employee of the Board **[or the Department]** shall be individually liable and no cause of action of any nature may arise against them, for any action taken or omission made by them unless their conduct was outside the scope of their employment or constituted a crime, actual fraud, actual malice or willful misconduct.

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than \$20.00, 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) The standard individual health benefits plan 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) In accordance with [N.J.A.C. 11:20-1.3](#), members that offer individual health benefits plans in this State shall offer standard health benefits Plans A/50, B, C, and D as set forth in Exhibits U, and B through D, respectively with variable text as specified on the Explanation of Brackets, Exhibit T, in the Appendix.

1. Members offering Plan D shall offer the following annual deductible options to the policyholder for each plan:

- i. \$500.00 per individual and \$1,000 per family unit;
- ii. \$1,000 per individual and \$2,000 per family unit;

2. Members offering Plans A/50, B and , C shall offer the following annual deductible options to the policyholder for each plan:

- i. \$1,000 per individual and \$2,000 per family unit; and
- ii. \$2,500 per individual and \$5,000 per family unit.

3. Members offering Plans C and D may offer those plans, on a guaranteed issue basis, with the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:

- i. \$1,500, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to [§ 220 of the Internal Revenue Code](#) per individual or in the case of a family unit, \$3,000, or

effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to [§ 220 of the Internal Revenue Code](#) per family unit;

ii. \$2,250, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to [§ 220 of the Internal Revenue Code](#) per individual or in the case of a family unit, \$4,500, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to [§ 220 of the Internal Revenue Code](#) per family unit.

iii. in the case of single coverage, the greater of: \$1,200; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code Section 223 for the calendar year in which coverage is issued or renewed, per covered person; and in the case of other than single coverage, the greater of: \$2,400; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code Section 223 for the calendar year in which coverage is issued or renewed, per covered family;

iv. in the case of single coverage, \$2,000, and in the case of other than single coverage, \$4,000;

v. in the case of single coverage, \$2,800 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code Section 223(b)(2)(A) are permitted, per covered person; and in the case of other than single coverage, \$5,600 or the highest deductible amount for the calendar year in which coverage is issued or

renewed for which deductions under Internal Revenue Code Section 223(b)(2)(A) are permitted; and

4. Members offering Plan/A50 may offer the following annual deductible options to the policyholder for each plan:

- i. \$5,000 per individual and \$10,000 per family unit; and**
- ii. \$10,000 per individual and \$20,000 per family unit.**

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit F of the Appendix, in lieu of Plans A/50, B, C, and D in (a) above. All HMO members offering the HMO Plan shall offer the following arrangements: \$150.00 hospital inpatient copay, \$150.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 separate emergency room copay, \$25.00 maternity copay, and \$15.00 for all other copays. All HMO members choosing to offer optional health benefits plans may offer one or both of the following copayment options, provided that all options marketed shall be offered to each applicant;

1. \$250.00 hospital inpatient copay, \$200.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 emergency room copay, \$25.00 maternity copay, and \$20.00 for all other copays; and/or

2. \$100.00 hospital inpatient copay, \$100.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 emergency room copay, \$25.00 maternity copay, and \$10.00 for all other copays.

3. \$300.00 hospital patient copay, \$300.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay,

\$50.00 emergency room copay, \$25.00 maternity copay, and \$30.00 for all other copays.

(d) Each of the standard health benefits plans, except Plan A/50 and the deductible options listed in (b)3 above, may be offered through or in conjunction with a managed care network, and the standard plans may be offered as a PPO or POS plan 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 which is permitted to enter into agreements with participating providers pursuant to any statute. These plans should be subject to the following:

- 1. All of the requirements of [N.J.A.C. 11:4-37.3\(b\)6](#);**
- 2. The coinsured charge limit specified for the standard health benefits plan being offered through or in conjunction with a managed care network, as set forth in Exhibits B through D in the Appendix, shall be the maximum amount of covered charges a covered person must incur for the in-network and out-network benefits combined before benefits are paid by the carrier at 100 percent;**
- 3. The HMO Plan copayment levels of \$10.00, \$15.00, \$20.00, [and \$30.00 may be substituted for deductibles applicable to one or more of the in-network benefits; and**
- 4. The out-network benefit level shall be the coinsurance level of the standard plan. Plan B offered through or in conjunction with a managed care network shall have an out-network coinsurance amount of 60 percent, Plan C shall have an out-network level of 70 percent, and Plan D shall have an out-network level of 80 percent.**

(e) In paying benefits for covered services provided by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay

covered charges, for medical services, based on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey, or such other state where services or supplies are provided, for various medical services and supplies, published and available to carriers from the Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004-1109. Carriers shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

11:20-3.1 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 as follows:

1. Plan A/50, Appendix Exhibit A with pages identified as unique to Plan A/50;

2. Plan B, Appendix Exhibit A with pages identified as unique to Plan B;

3. Plan C, Appendix Exhibit A with pages identified as unique to Plan C;

4. Plan D, Appendix Exhibit A with pages identified as unique to Plan D; and

5. HMO Plan, Appendix Exhibit B.

(b) In accordance with N.J.A.C. 11:20-1.3, members that offer individual health benefits plans in this State shall offer standard health benefits Plans A/50, B,

C, and D 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, except as provided in (c) below.

1. Members offering Plans A/50, B, C, and D shall offer the following annual deductible provisions:

i. The per covered person annual deductible shall be \$1,000; and

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

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

i. Per covered person annual deductible equal to \$2,500, \$5,000 or \$10,000; and

ii. Per covered family annual deductible equal to two times the applicable per covered person annual deductible, satisfied on an aggregate basis.

3. Members offering Plans A/50, B, C, and D may offer one or more of the following annual deductible provisions in addition to the deductible provisions required in (b)1 above:

i. In the case of single coverage, the greater of: \$1,200; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code § 223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered person; and in the case of other than single coverage, the greater of: \$2,400; or the lowest deductible amount to qualify as a High

Deductible Health Plan under Internal Revenue Code § 223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered family, with single and other than single deductibles accumulated in accordance with the requirements of Federal law;

ii. In the case of single coverage, \$2,000, and in the case of other than single coverage, \$4,000 with single and other than single deductibles accumulated in accordance with the requirements of Federal law;

iii. In the case of single coverage, \$2,800 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code § 223(c)(2)(A) are permitted, per covered person; and in the case of other than single coverage, \$5,600 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code § 223(c)(2)(A) are permitted with single and other than single deductibles accumulated in accordance with the requirements of Federal law; and

iv. In the case of single coverage, \$5,000, and in the case of other than single coverage, \$10,000 with single and other than single deductibles accumulated in accordance with the requirements of Federal law.

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

i. \$1,500, or the lowest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to § 220(c)(2)(A) of the Internal Revenue Code per individual or in the case of a family unit, \$3,000, or the lowest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the

Federal Internal Revenue Service pursuant to § 220(c)(2)(A) of the Internal Revenue Code per family unit with single and family unit deductibles accumulated in accordance with the requirements of Federal law; and

ii. \$2,250, or the highest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to § 220(c)(2)(A) of the Internal Revenue Code per individual or in the case of a family unit, \$4,500, or the highest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to § 220(c)(2)(A) of the Internal Revenue Code per family unit with single and family unit deductibles accumulated in accordance with the requirements of Federal law.

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

i. The per covered person maximum out of pocket for Plan A/50 shall be the sum of the annual deductible and \$5,000;

ii. The per covered person maximum out of pocket for Plan B shall be the sum of the annual deductible and \$3,000;

iii. The per covered person maximum out of pocket for Plan C shall be the sum of the annual deductible and \$2,500;

iv. The per covered person maximum out of pocket for Plan D shall be the sum of the annual deductible and \$2,000;

v. The per covered family maximum out of pocket for Plans A/50, B, C and D shall be two times the per covered person maximum out of pocket, satisfied on an aggregate basis; and

vi. Coinsurance paid for covered prescription drugs under Plans A/50, B, C, and D, issued using deductibles set forth in (b)1 and 2 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. When issued using deductible provisions set forth in (b)3 above, Plans C, and D shall contain maximum out of pocket provisions as follows:

i. In the case of single coverage, the greater of \$5,100 or the highest maximum out of pocket amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted, per covered person; and

ii. In the case of other than single coverage, \$10,200 or the highest maximum out of pocket amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code § 223(c)(2)(A) are permitted.

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

i. In the case of single coverage, \$3,000 or the highest maximum out of pocket amount for the calendar year in which coverage is renewed for which deductions under Internal Revenue Code § 220(c)(2)(A) are permitted, per covered person; and

ii. In the case of other than single coverage, \$5,500 or the highest maximum out of pocket amount for the calendar year in which coverage is renewed for which deductions under Internal Revenue Code § 220(c)(2)(A) are permitted.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu 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 Plans A/50, B, C, and D in (b) above. HMO carriers offering the HMO Plan shall offer the \$15.00 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 per day hospital inpatient copayment, \$100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a \$15.00 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 per day hospital inpatient copayment, \$100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a \$30.00 copayment for all other services, except that the copayment for pre-natal care may be \$25.00 as specified in (c)3ii below;

(2) \$400.00 per day hospital inpatient copayment, \$100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a \$40.00 copayment for all other services, except that the copayment for pre-natal care may be \$25.00 as specified in (c)3ii below; and

(3) \$500.00 per day hospital inpatient copayment, \$100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a \$50.00 copayment for all other services, except that the copayment for pre-natal care may be \$25.00 as specified in (c)3ii below.

2. 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) The copayment for primary care physician services shall be: \$15.00; \$30.00; \$40.00; or \$50.00;

(2) The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care, or prescription drugs shall be \$1,000 or \$2,500 per person. The covered family deductible shall be two times the per person deductible, satisfied on an aggregate basis;

(3) The coinsurance, which shall not apply to services to which a copayment applies or to prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in 10-percent increments; and

(4) The maximum out of pocket shall be \$5,000 per person, and for a covered family two times the per person maximum out of pocket.

3. Carriers issuing HMO plans, whether with Copayment or Deductible and Coinsurance Design shall include the following features which are common to all HMO Plans:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall be \$100.00;

ii. The pre-natal care/maternity copayment, which shall only be required at the initial visit, shall be, at the option of the carrier, either \$25.00, or equal to the copayment applicable to a primary care physician visit; and

iii. Prescription drugs covered under the HMO plan shall be subject to 50 percent coinsurance. For plans that include a maximum out of pocket, coinsurance for prescription drugs shall not count toward the maximum out of pocket and must continue to be paid after the maximum out of pocket has been reached.

(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. All of the requirements of [N.J.A.C. 11:4-37.3\(b\)6](#);
2. The network annual deductible shall be \$1,000 or \$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. The HMO Plan copayment amounts for physician visits, pre-natal care and hospital confinements and the prescription drug coinsurance may be substituted for deductibles applicable to network benefits;
4. The coinsurance for network services shall be consistent with the coinsurance for one of Plans A/50, B, C, or D and the coinsurance for non-network services must be consistent with the coinsurance for one of Plans A/50, B, C, or D;
5. The network maximum out of pocket shall be \$5,000 per covered person, and for a covered family shall be \$10,000. 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. If a separate non-network deductible is included, the non-network annual deductible shall be two times or three times the network annual deductible per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis; and
7. If a separate non-network maximum out of pocket is included, the non-network maximum out of pocket shall be two times or three times the network

maximum out of pocket per covered person, and for a covered family shall equal two times the per covered person maximum out of pocket.

11:20-3.2 Policy forms

(a) For standard health benefits plans, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F and U, as may be amended by the Board.

(b) A member choosing to offer a standard health benefits plan through or in conjunction with a managed care network in accordance with [N.J.A.C. 11:20- 3.1\(d\)](#) shall use the appropriate standard language set forth in the Appendix to this subchapter as alternate text in Exhibits B, C and D as described in the Explanation of Brackets, Exhibit T, in conjunction with the standard policy forms set forth as Exhibits B through D.

(c) Before marketing, issuing or renewing any of the standard policy forms, a member shall file with the Board, the Certification Form set forth in the Appendix to this subchapter as Exhibit Q. Affiliated Carriers must file separate Certification Forms. A new Certification Form must be filed annually on or before March 1.

(d) Carriers that submit an Exhibit Q Certification Form may issue and make effective individual health benefits plans upon filing such forms with the Board, and may continue to do so until such time as the filing is disapproved in writing by the Board, following an opportunity for a hearing pursuant to the procedures set forth in [N.J.A.C. 11:20-20.2](#). The Board may disapprove an Exhibit Q Certification filing if the filing is inaccurate or incomplete.]

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 herein 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) [Notwithstanding the requirements of N.J.A.C. 11:20-3.2, members] **Members** may incorporate regulatory changes required to be made to the standard policy forms, standard HMO contract, and standard riders through the use of the Compliance and Variability Rider as set forth as Exhibit [S] **D** of the Appendix, incorporated herein by reference if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms that Compliance and Variability Riders may be used. Carriers

may only use the Compliance and Variability Rider to incorporate Board designated text for the period of time specified by the Board in the rule adoption of the regulatory changes to the standard policy forms.

(b) **[Notwithstanding the requirements of N.J.A.C. 11:20-3.2, members]**

Members may make any changes to the standard policy forms, standard HMO contract, or standard riders promulgated by the Board consistent with the permitted as variable text set forth in Exhibits **[A, B, C, D, E and U]** **A and B** of the Appendix to this Chapter, as described in the Explanation of Brackets, Exhibit **[T]** **C**, through the use of the Compliance and Variability Rider as set forth as Exhibit **[S]** **D** of the Appendix.

(c) Members may incorporate text for benefits required to be offered to the Policyholder through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms to address the mandated offer that carriers may issue the optional coverage by rider in lieu of including the coverage in the standard policy forms. For example, coverage for autologous bone marrow transplant, as required to be offered pursuant to P.L. 1995, c. 100, may be included using the Compliance and Variability Rider.

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. 11:20-22]**. **N.J.S.A. 17B:27A-4.5 Rules regarding this plan are set forth at N.J.A.C. 11:20-22.** A specimen policy form is set forth in Appendix Exhibit **[V]** **F**.

[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 5: Reserved

[SUBCHAPTER 5. STANDARD CLAIM FORM

11:20-5.1 Standard claim form

All members offering health benefits plans or other health insurance policies to individuals, to the extent that the member uses claims forms in its transaction of business (rather than an electronic billing system), shall require as a condition of payment, the standard claims form approved by the Board and set forth as Exhibit H in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions set forth in Exhibit H shall be the standard claim form for all medical expenses incurred for services other than hospital inpatient services. The form UB-92 set forth as Exhibit I shall be the standard claim form for all hospital inpatient services.]

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 [sections 2b(1) and] section 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.

11:20-6.2 Definitions

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

"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates, a certification by a member of the American Academy of Actuaries, all supporting data for the premium rates and such other information as the Board from time to time requests or requires.

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 health benefits plan, 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;

2. **[Premium] Monthly premium** rates and any factors used in the calculation of the premium rates and the effective dates for the 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. Rates may be developed on different rate tiers for: single; **[husband/wife] two adults**; adult/child(ren); **and** family; 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 (a)2i, 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 services 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 the rating tier of each covered adult in accordance with the factors set forth in N.J.A.C. 11:20-6.5;

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. A detailed actuarial memorandum, which shall include the following:

i. The **monthly** rates being submitted **for each period addressed in the rate filing along with factors or actual rates for quarterly or semi-annual modes, if such modes are available;**

ii. **Identification of the plans affected, using the alphabet name if indemnity or PPO, and the copay and coinsurance, if applicable, if HMO;**

iii. **Application of the rates to new business and renewal business;**

iv. **The duration of the rate guarantee period, and if none, so state;**

v. **A sample of the notice that will be sent to policyholders to advise them of a rate change, except that such sample notice must only be included with the first rate filing submitted on or after (the effective date of this amendment), and thereafter, whenever there is a change to the content of the notice previously submitted.**

[ii.] **vi.** All information used in the development of the rates;

[iii.] **vii.** The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including **[historical];**

(1) Historical experience, whether or not the experience is credible. At a minimum the historical experience should specify premium, claims and loss ratio data from the period used in the development of the anticipated loss ratio, where the period should be at least 12 months;

(2) [trend] Trend assumptions, if a carrier uses multiple assumptions, the average may be shown;

(3) [plan] Plan relativity assumptions, if a carrier uses plan relativity assumptions in calculating anticipated loss experience; and

(4) [any] Any other factors used in developing the anticipated loss experience; [and]

[iv.] viii. [The] Specific identification of the administrative expense, premium tax and commission payment assumptions, and other margins; and

ix. Specification of the percentage change(s) in rates as compared to the prior rating period and the average change for all plans.

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

iv. For rates to be charged for the basic and essential health care service plan, and any optional benefit riders thereto, the anticipated loss ratio for the plan; and

5. Such other information or data as may be required or requested by the Board to analyze the adequacy of the rate filing submitted.

(b) Any member which seeks to change its rates for its standard health benefits plans [, or 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.

(c) **Unless a carrier submits an amended rate filing to specify an alternate effective date, carriers shall use the rates shown in the rate filing as of the stated effective date.**

11:20-6.4 Informational rate filing procedures

(a) **[The] A member shall file one copy of the informational rate filing [filed by the member] with the [Board pursuant to N.J.A.C. 11:20-6.3(a) or (b) shall be filed in triplicate to the] Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) pursuant to N.J.A.C. 11:20-6.3(a) or (b).**

(b) If the Board determines that an informational filing filed pursuant to N.J.A.C. 11:20-6.3(a) or (b) above is incomplete, the Board shall provide written notice to the member specifying those portions of the filing which are deficient and the information required to be submitted or resubmitted by the member.

(c) **[Upon] Within 15 days of receipt of written notice in (b) above, the member shall provide the Board with the information required to complete the filing.**

(d) Upon notice that the filing is incomplete, the member shall not use the filed rates **in either the quoting or billing process** until the Board has determined that the informational filing is complete, and written notice of that **[fact] determination** has been provided to the member.

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] 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] Two adults**;
3. Adult and child(ren); and
4. Family.

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20-7.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

11:20-7.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Claims paid" means a dollar amount determined in accordance with statutory annual statement reporting and consistent with [N.J.A.C. 11:20-8.5\(c\)](#), adjusted as required by this subchapter.

"Preceding calendar year" means the calendar year immediately preceding the reporting year.

"Reporting year" means the year in which the loss ratio report is required to be filed with the Board.

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 **set forth at Appendix Exhibit J** shall be completed **[annually] by August 15 of each year** by each member and shall include the following information with respect to standard health benefits plans and **[the]** basic and essential health care services plans:

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] plus** net earned premium received that year on **[the]** basic and essential health care services plans 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 **whose refund is \$2.00 or greater;**

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.

[11:20-7.6 Unclaimed loss ratio refunds](#)

(a) Any loss ratio refund issued by a carrier to a policy or contract holder pursuant to this subchapter which remains unclaimed by that policy or contract holder shall be deemed abandoned one year from the date upon which the Board approves the refund plan.

(b) Refunds deemed abandoned pursuant to (a) above shall be subject to all applicable provisions of the Uniform Unclaimed Property Act, [N.J.S.A. 46:30B-1](#) et seq., including, but not limited to, [N.J.S.A. 46:30B-30](#), 46, 47, 49, 50 and 57. All carriers shall follow the procedures set forth in the Uniform Unclaimed Property Act with respect to the disposition of refunds deemed abandoned.

(c) Carriers which comply with the applicable provisions of the Uniform Unclaimed Property Act and this subchapter shall be relieved of liability to the extent of any unclaimed refunds upon payment of any unclaimed refunds to the State administrator designated pursuant to the Uniform Unclaimed Property Act.

11:20-7.7 Certification of loss ratio refunds

Within 15 days of providing refunds to all policy or contract holders for a specific calendar year, any carrier required to provide a loss ratio refund pursuant this subchapter shall provide a certification to the IHC Board at the address in N.J.A.C. 11:20-2.1 stating the following: "The loss ratio refund, as set forth in the [carrier name][calendar year] Loss Ratio Report, was issued by [insert carrier name] to all policy or contract holders eligible for reimbursement with refund checks mailed, or premiums credited, on [insert date or dates]."

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

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, incorporated herein by reference, on or before **[March 1, 2003 and on or before March]** April 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 **Exhibit K** 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 **Exhibit K** 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] shall** file one Exhibit K **Assessment Report** 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] Exhibit K Assessment Reports** shall be submitted **either** by facsimile, with paper copy to follow by mail, or **[mailed or delivered] by hand delivery** 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] Exhibit K Assessment Report**. **[Non-members are carriers with either] Carriers either with** 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 **are non-members**.

(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 **Assessment Report**.

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] two adults** = 2; adult and child(ren) = 2.8; family = 3.9. If a **[husband and wife] two adults** category is not used, a carrier shall use a **[compromise] composite factor** of 3.33 in order to reflect the **[husband and wife] two adults** 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 Advantage**, Medicare cost and risk lives and

Medicare Demonstration Project 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 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. **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. 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

Assessment Report 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 **Assessment Report** reporting, and **[not withstanding] notwithstanding** 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. 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 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 a and 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 d 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 d represents a net paid loss.

11:20-8.6 Certifications

(a) In Part F of the Exhibit K Assessment Report, the Chief Financial Officer, or other duly authorized officer of the carrier, shall certify that the **Exhibit K** 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 and complete and conform with the requirements of this subchapter. Every duly authorized officer who provides a certification for the reporting required under this subchapter 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]~~ April 1 of the year following every two-year calculation period that [:

1. The] the net investment income reported on the Exhibit K 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]~~ Failure to file ~~[market share and net paid loss report]~~ Exhibit K Assessment Report

(a) Failure to file in a timely manner the Exhibit K Assessment Report 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] 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 and minimum number of non-group persons.

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 **Exhibit K** 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, **except that, for loss periods beginning with 2001/2002, if the member fails to provide sufficient information to the auditor within 18 months after the auditor's first written request for records to enable the auditor to complete its audit, then the costs incurred after that time shall be the sole responsibility of carrier if the member should choose to proceed with seeking reimbursement of its losses and an audit. If a carrier fails to complete the audit within two years of the commencement of the audit, the Board may terminate the 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**] **and** applicable law, or to collect premiums consistent with the terms of its informational rate filing [**or**] **and** applicable law. **If the audit for any loss period beginning with 2001/2002 is terminated by the Board because the carrier did not cooperate in the completion of the audit within two years of the auditor's first written request for records, then the carrier shall not be entitled to reimbursement.**

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] 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](#).

SUBCHAPTER 9. EXEMPTIONS

11:20-9.1 Purpose

The purpose of this subchapter is to set forth the procedures for obtaining conditional exemptions, reporting and certifying the number of non-group persons, and the standards for granting final (full or pro rata) exemptions from assessments for reimbursement of losses in accordance with [N.J.S.A. 17B:27A-12](#).

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

(a) A member seeking to be exempted from the obligation to pay assessments for reimbursement of losses shall submit a written request for such exemption to the Board. A written request for an exemption shall be submitted **[on or before June 1 of the first year of each two-year calculation period, except that in 1998, written request for exemptions shall be submitted]** to the Board within 30 days after the date of receipt of the Board's notice of the member's minimum enrollment share for **[the 1997**

and 1998 two-year calculation period] the applicable two-year calculation period.

Written requests shall be submitted to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

(b) [Written requests] **A member's written request** for **an exemption[s]** 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, **including NJ FamilyCare Plan A contracts and NJ KidCare Plan A contracts**; and

iv. Medicare cost and risk contracts with the Federal government, Medicare Plus Choice, **Medicare Advantage** 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 in that two-year calculation period for which an exemption is sought by the member.

(c) Within 45 days of receipt of the member's written request for an exemption, the Board shall grant the member a conditional exemption, or deny the member's request for a conditional exemption in writing, specifying the reasons for the denial. If the

member's written request for an exemption is neither approved nor disapproved within 45 days of its receipt by the Board, the written request shall be deemed to be conditionally approved.

(d) Approval of a member's written request for a conditional exemption is conditioned upon the following:

1. Compliance by the member with N.J.A.C. 11:20-8 and this subchapter;
2. Compliance by the member with (b) above [**as appropriate**].

(e) Carriers denied a conditional exemption from assessments for reimbursements for losses may, within 20 days of **[the date of the Board's ruling] receipt of written notification of the Board's final determination**, appeal the Board's determination and request a hearing, pursuant to the procedures set forth at [N.J.A.C. 11:20-20.2](#).

[11:20-9.3 Minimum enrollment share](#)

(a) **[On or about August 14, 1998, and on or about May 1 of the first year of every two-year calculation period thereafter] Approximately 60 days after all IHC members have provided complete Exhibit K Assessment Reports**, the IHC Program Board shall issue to each member its minimum enrollment share of non-group persons for that two-year calculation period **[which] that** the member must agree to cover in that two-year calculation period **[for purposes of obtaining] to qualify for** an exemption from assessments for reimbursements for losses incurred in that two-year calculation period.

(b) The IHC Program Board's determination of minimum enrollment shares shall be based upon information provided by members in accordance with N.J.A.C. 11:20-8 and this subchapter.

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

1. For each two-year calculation period beginning with 1997/1998,] by adding together 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 under the plans set forth in (c)1 through 3below on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, [divided] dividing by eight, and [multiplied] 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. Standard health benefits plans and the basic and essential health care services plan, and community rated, individually enrolled or insured plans issued prior to the IHC Act;

2. Conversion policies issued pursuant to the Act; and

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. 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, **Medicare Advantage contracts**, [and] 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) 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) A member granted a conditional exemption shall be granted a full exemption from assessments for reimbursements for losses for the two-year calculation period in which the conditional exemption was granted if the Board determines that the information filed by the member pursuant to (b) below evidences that the member has enrolled or insured 100 percent of the minimum

number of non- group persons allocated to it by the Board for that two-year calculation period.]

[(b)] **(a)** So that the Board can determine whether the member has satisfied its minimum enrollment share, **[members seeking] any member that has been granted a conditional exemption and seeks a** final (full or pro rata) exemption[s] shall **[report to] file with** the Board, on or before **[March] 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)[; **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 and Medicare Plus Choice, Medicare Advantage and Medicare Demonstration Project 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 plan were enrolled on an open enrolled basis;

3. Were actual covered lives and not [estimations] estimates of covered lives based on conversion factors applied to contracts or other approximation methods;

4. Were counted consistent with N.J.S.A. 17B:27A-12d(1) and (2);

5. Do not include persons whose premium due is more than 30 days overdue; and

6. Were issued a policy that was issued, or issued for delivery, in New Jersey.

[(c)](b) 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 [(b)] (a) above.

[(d)] (c) The IHC Program Board shall review, and may audit, a member's non-group persons reported pursuant to [(b)] (a) above. 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.

[(e)] (d) The IHC Program Board shall adjust a member's reported non-group persons, for purposes of determining whether the member should receive a final (full or pro rata) exemption from assessment for reimbursable losses, for the member's failure to meet the certification requirements of [(b)] (a) above or as a result of the findings of an independent audit conducted pursuant to [(d)] (c) above.

(e) A member granted a conditional exemption shall be granted a full exemption from assessments for reimbursements for losses for the two-year calculation period in which the conditional exemption was granted if the Board determines that the information filed by the member pursuant to (a) above

demonstrates that the member has enrolled or insured at least 100 percent of the minimum number of non- group persons allocated to it by the Board for that two-year calculation period.

(f) Members receiving full exemptions from the Board shall not be liable for any portion of any assessments for reimbursements for losses for the two-year calculation period for which the full exemption is granted. The Board shall determine, in writing, whether the member is granted a final (full or pro rata) exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for that two-year calculation period.

1. A member granted a conditional exemption that enrolls or insures fewer than the minimum number of non-group persons allocated to it by the Board[, **but has enrolled or insured at least 50 percent of the minimum number of non-group persons allocated to it by the Board,**] shall be granted a pro rata exemption from assessments for reimbursements for losses based upon the percentage of the minimum number of non-group persons actually enrolled or insured by the member.

[2. A member granted a conditional exemption that enrolls or insures fewer than 50 percent of the minimum number of non-group persons allocated to it by the Board must demonstrate in writing, pursuant to [N.J.A.C. 11:20-9.6](#), that the member has made a good faith effort to enroll or insure the minimum number of non-group persons allocated to it by the Board. The member shall be granted a pro rata exemption from assessments for reimbursements for losses based upon the percentage of the minimum number of non-group persons actually enrolled or insured by the member only if the Board finds that the member has made a good faith effort to enroll or insure its minimum number of non-group persons. The Board shall not grant a pro rata exemption to the member if it finds that the

member has not made a good faith effort to enroll its minimum share, and the Board shall notify the member in writing as to its reasons for not granting the member a pro rata exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for that two- year calculation period.]

(g) Members denied a pro rata exemption from assessments for reimbursements for losses may, within 20 days of **[the date of the Board's ruling] receipt of written notification of the Board's final determination** appeal the Board's determination and request a hearing pursuant to the procedures set forth at [N.J.A.C. 11:20-20.2](#).

(h) A member requesting a hearing by the Board shall remain liable for the full amount of any assessments for reimbursements for losses issued to it by the Board, **[until and unless the Board makes a finding that the member is liable for a pro rata assessment only,] including any interest that may accrue, until and unless there has been a final adjudication finding that the member qualifies for an exemption, or until such time as the Board determines that the member's appeal should be granted.**

[\[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. With respect to print media, the names of newspapers, magazines or other print media, including billboards, in which advertising was placed; the number of times an advertisement appeared in each; the dates those advertisements appeared; the size of the advertisements in each; copies of such advertisements; the total cost of print media advertising;

2. With respect to broadcast media, the names of television stations, radio stations, or cable television franchises over which commercial advertising appeared; the number of times a commercial advertisement was broadcast or played, the time of day and the duration of each; audio or video tapes of such commercial advertisements; the total cost of such broadcast media advertising;

3. With respect to direct marketing by mail or telephone, the number of mailings distributed or calls placed; the approximate dates of the mailings or telephone calls; the geographic areas to which the mailings or calls were addressed; copies of the mailing or scripts of the telephone calls; the total cost of direct marketing through mail or telephone solicitation;

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) above 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 10. PERFORMANCE STANDARDS AND REPORTING REQUIREMENTS](#)

11:20-10.1 Purpose and scope

(a) The purpose of this subchapter is to establish performance standards and reporting requirements which a member shall meet in order to receive reimbursement for losses reported pursuant to N.J.A.C. 11:20-8 in the year following the two-year calculation period.

(b) This subchapter applies to all members that seek reimbursement for losses.

11:20-10.2 Definitions

Words and terms used in this subchapter shall have the meanings defined in N.J.S.A. 17B:27A-2 and N.J.A.C. 11:20-1.

11:20-10.3 Filing requirements and Board review

(a) Every member seeking reimbursement for losses, in accordance with N.J.A.C. 11:20- 2.17, shall provide a Performance Report to the IHC Program Board, no later than **[April] May** 1, in the year following the two-year calculation period which contains **[the following] a statement certified by member's Chief Executive Officer that:**

[1. A statement certified by the Chief Executive Officer of the member that:]

[i.] 1. The member's performance for the preceding two-year calculation period reflected good faith efforts to apply sound risk management principles in an efficient manner; and

[ii.] 2. If applicable, the member applied the same individual case management and claims handling techniques and other methods of operation to its group

and non-group business, for the same delivery system, as provided in its health benefits plan policies and contracts. [; and

2. Audit statements for the preceding two-year calculation period of the member's accounts receivable, premium billing operations, and claims eligibility systems, performed by an auditor at the member's expense.

(b) A member shall demonstrate to the IHC Program Board's satisfaction that the member has met the performance standards set forth in (a) above.

(c) The IHC Program Board shall review and may audit a member's Performance Report. The IHC Program Board shall choose and direct the independent auditor. The costs of an independent audit of a member's Performance Report shall be shared equally by the IHC Program Board and the member being audited.]

[(d)] (b) The IHC Program Board shall adjust a member's reported net paid losses to account for the member's failure to meet performance standards and filing requirements.

[(e)] (c) A carrier shall not be eligible for any reimbursement of losses until a performance report is provided pursuant to (a) above and has been found consistent with the requirements of (a) above by the IHC Board.

[11:20-10.4 Hearings](#)

Any member that is denied reimbursement for losses, in whole or in part, on the grounds that the member has failed to meet the performance standards and filing requirements of this subchapter, may appeal the Board's determination and request a hearing within 20 days of **[the date that the IHC Program Board notifies the member**

of its] receipt of written notification of the Board's final determination, pursuant to the procedures set forth at [N.J.A.C. 11:20-20.2](#).

[\[11:20-10.5 Penalties](#)

A member's failure to meet the performance standards and filing requirements set forth in this subchapter may result in the imposition of penalties provided by N.J.S.A. 17B:27A-11i.]

[\[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 under standard health benefits plans in New Jersey or a basic and essential health care

services plan in New Jersey, all carriers which are members of the program, insurance producers selling individual health benefits plans, and employers offering group health benefits plans to their employees.

11:20-12.2 Definitions

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

"Eligible to participate in a group health benefits plan" means, with respect to a group health benefits plan offered by an employer to an employee and the employee's dependents, the employee works at least the minimum number of hours required for participation in the group health benefits plan, the employee has been employed for at least the minimum period required by the employer to be eligible for coverage (often called a waiting period), and the employee's qualified dependents have satisfied all other lawful standards for participation in the group health benefits plan. With respect to a group health benefits plan under an HMO contract only, a contractholder who resides outside of the HMO's service area shall not be considered to be "eligible to participate in a group health benefits plan."

"General services" means a range of services or treatments which result in:

1. Hospital charges; and
2. Medical-surgical charges.

"Group health benefits plan" means a health benefits plan, as that term is defined at [N.J.A.C. 11:20-1.2](#), for groups of two or more persons, except that for the purpose of this subchapter, "group health benefits plan" shall also include any self-funded health benefits plan for groups of two or more persons.

"Hospital charges" means charges for care, including room and board received in or at a hospital or other facility licensed by the state in which it is located which provides mainly for the care and treatment of sick or injured persons, but does not include facilities which mainly provide convalescent or custodial care, or government hospitals which mainly provide care to military or ex-military personnel.

"Medical-surgical charges" means charges for diagnostic care and treatment rendered by a licensed health care provider acting within the scope of his or her licensure whether or not rendered in a hospital, but which, if rendered in a hospital, would not be reflected in the hospital charge.

"Open enrollment period" means the period from October through October 31 beginning in 1994 and annually thereafter. The effective date for coverage elections made during the "open enrollment period" shall be January 1 of the following year.

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 the 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 under 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](#), \$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.

(e) 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.

(f) 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.

(g) 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.

(h) Notwithstanding (b), (c) and (d) above, a carrier shall not offer a person coverage under 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 the replacement standard health benefits plan or basic and essential health care services plan.

(i) A person who is covered under a standard health benefits plan who wishes to purchase a high deductible health plan as permitted by N.J.A.C. 11:20-3.1(b)3 iii, iv, v or vi who would be required by (a) through (h) above to wait until

the open enrollment period to replace the existing coverage may purchase a high deductible plan within 60 days of the date the carrier first makes the high deductible health plans available in the individual market.

11:20-12.6 Penalties

The Board shall promptly provide the Commissioner with any information in its possession regarding possible violations of this subchapter by covered persons, employers, carriers, and insurance producers, and request that the Commissioner pursue all fines and penalties provided by law .]

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

11:20-12.1 Purpose and scope

This subchapter sets forth the standards for purchasing a standard individual health benefits plan or a basic and essential healthcare services plan by a person who is covered under an individual plan, and standards for purchasing a standard individual health benefits plan or a basic and essential healthcare services plan by a person who is either covered by or eligible to participate in a group health benefits 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.

“Covered under an individual plan” means a person is covered under a standard individual health benefits plan, or a basic and essential health care services plan or under an individual plan issued prior to August 1, 1993.

“Eligible to participate in a group health benefits plan” means, with respect to a group health benefits plan offered by an employer to an employee and to the employee’s dependents, if any, that the employee is a member of a class of persons eligible for coverage, works at least the minimum number of hours required for coverage and that the employee has been employed for at least the minimum period required by the employer to be eligible for coverage, and the employee’s dependents have satisfied all lawful standards for participation in the group health benefits plan. With respect to group coverage issued by an HMO carrier, a person who resides outside the HMO’s service area shall not be considered eligible to participate in a group health benefits plan.

“Group health benefits plan” means a health benefits plan as defined in N.J.A.C. 11:20-1.2 as well as a self-funded health benefits plan for groups of two or more persons.

“Open enrollment period” means the calendar month of November 1 through November 30 of each calendar year, beginning in 2006, and annually thereafter.

“Same as or similar to the individual plan” means the group plan under which a person is covered or eligible to participate features cost sharing provisions

consistent with those in the standard individual health benefits plan or basic and essential healthcare services plan for which the person has made application.

1. For a plan that uses coinsurance and deductible cost provisions, this means the coinsurance percentage in the group plan is identical to the coinsurance requirement in the individual plan and the deductible under the group plan differs from the deductible in the individual plan by no more than \$100. When comparing coinsurance provisions in a plan that features network and non-network benefits, the coinsurance and deductible applicable to network services and supplies must be considered. Plans that feature different cost sharing provisions, such as coinsurance and deductible in one plan and copayment in the other plan, are not the same or similar.

2. For a plan that uses copayment provisions, this means the copayment for primary care services under the group plan is either: the same as the copayment for primary care services under the individual plan; or less than \$10 more or less than the copayment for primary care services under the individual plan. When reviewing copayment provisions in a plan that features network and non-network benefits, the copayment applicable to network services and supplies must be considered. Plans that feature different cost sharing provisions, such as coinsurance and deductible in one plan and copayment in the other plan, are not the same or similar.

3. In addition to items 1 and 2 above, for contributory group plans, the group plan is only the same or similar to the individual plan if the employee's share of the cost for the group plan differs from the cost of the individual plan by \$100.00 or less per month.

4. Notwithstanding items 1 and 2 above, for group plans that are closed panel HMO plans, the group plan is not the same or similar to the individual plan if the provider network for the group plan is not the same as the provider network for the individual plan.

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 monthly premium is less than the monthly premium for the existing standard individual health benefits plan.

(c) A person who is covered under a basic and essential health care services plan without rider may elect at any time to replace the plan with a basic and essential healthcare services plan without rider.

(d) A person who is covered under an individual plan issued prior to August 1, 1993 may elect at any time to replace the plan with a standard individual health benefits plan or a basic and essential healthcare services plan.

(e) The existing standard health benefits plan, basic and essential healthcare services plan or plan issued prior to August 1, 1993 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.

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

(a) A person who is covered under a standard individual health benefits plan may only elect during the 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 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 to replace the HMO plan with non-HMO 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 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 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 basic and essential healthcare services plan with a rider may only elect during the 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) The effective date of the replacement plan issued as a result of items (a) through (e) above will be January 1 of the year following the Open Enrollment Period.

(g) 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) Notwithstanding (a), (b) (d) and (e) 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 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.

(b) A person who is covered under or eligible to participate in a group health benefits plan that is the same as or similar to the individual plan for which the person has applied is not eligible to be covered under a standard individual health benefits plan or basic and essential healthcare services plan.

(c) A person who is covered under a group plan pursuant to State or Federal continuation laws may elect at any time to be covered under a standard individual health benefits plan or basic and essential healthcare services plan.

(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. 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

11:20-17.1 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.

11:20-17.2 Definitions

(a) Words and terms defined at [N.J.S.A. 17B:27A-2](#) and N.J.A.C. 11:20-1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

["Conversion" means the first-time transfer of insurance coverage from a pre-reform plan, issued prior to August 1, 1993, to a standard plan.]

"Enrollment status report" means a complete and accurate document that is prepared and filed in accordance with the requirements of this subchapter and sets forth the information in the format of Part 1 of Exhibit L for the quarterly submission and Part 2 of Exhibit L for the annual submission in the Appendix to this chapter, which is incorporated herein by reference.

"Insured" or "insured individual" means **[the number of individuals] any individual** covered under an individual health benefits plan.

["Replacement contract" means the transfer of insurance coverage from one plan type to another with a different coinsurance, deductible or delivery system. A change in rating tier does not constitute a replacement contract.]

[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] gender** category in the format of Part 2 of Exhibit L which shall reflect data as of December 31 of **[each] the prior** year.

(d) Members shall submit completed enrollment status reports to the Executive Director at the address listed in [N.J.A.C. 11:20-2.1\(h\)](#) no later than 45 days following the end of the quarter or end of the year (for annual reporting purposes).

(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 **or PPO** for **[Plan] Plans A/50, B, [indemnity or PPO for Plan B , or indemnity, PPO and POS delivery systems for Plans] 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. In section A of Part 1 of Exhibit L, Report By Contracts shall be calculated by adding the number of contracts in force at the beginning of the period to the number of **[contracts representing new sales and conversions] contracts issued** during the period, and subtracting the number of contracts lapsed during the period.

i. **[New sales and conversion contracts] Contracts issued** shall be reported **[separately by employment status and replacement status] according to previous insured status.**

[(1) Employment status shall be separated into three categories: employed, unemployed, unknown. Employment status shall be obtained from the section of the application entitled, Other Health Care Coverage, and the

question "Are you employed?" If the response is yes, then the contract should be reported as employed. If the response is no, then the contract should be reported as unemployed. If the question has not been answered, the contract should be reported as unknown.

(2)Replacement] Previous insured status shall be separated into three categories: previously insured, previously uninsured, and unknown. [Replacement] Previous insured status shall be obtained from the section of the application [entitled, Other Health Care Coverage, and the question "Are you replacing existing coverage?"] that requires the applicant to indicate if the applicant had previous coverage. If the response is yes, then the contract shall be reported as previously insured. If the response is no, then the contract shall be reported as previously [insured] uninsured. If the question has not been answered, the contract shall be reported as unknown.

[ii. A reinstatement shall be reported by reducing the number of contracts lapsed;]

2. In section B of Part 1 of Exhibit L, Report By Persons Insured shall be calculated by adding the number of persons insured at the beginning of the period and the number of new insureds during the period, and subtracting the number of insureds lapsed during the period.

i. The number of lives insured should be reported in this section. For those members who do not maintain actual dependent data, the following factors shall be used to convert contracts to persons insured: single = 1; [husband and wife] two adults = 2; adult and child(ren) = 2.8; family = 3.9;

3. In section C of Part 1 of Exhibit L, Report of Contracts By Rating [Category] Tier shall be reported separately by rating [category] tier, that is: single;

[husband and wife (or two person)]two adults; adult and child(ren); **and** family;
[and child(ren) only, if applicable;] and

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-E] **A/50, B, C, and D** or the required and permitted copayment options for the HMO Plan. **Members issuing PPO 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, **[cumulatively for all years to date and]** separately for each of the standard health benefits plans, broken down by indemnity or PPO for Plans **A/50, B, [indemnity or PPO for Plan B, or indemnity PPO and POS delivery systems for Plans]** C and D, the HMO plans, as well as the indemnity, PPO or EPO or HMO basic and essential health care services plan, **both with and without any rider:**

1. In section A of Part 2 of Exhibit L, Report of Inforce Contracts by Zip Code, categorized by **Territory A – F** or the first three digits of the zip code**[, as of December 31 of the previous year];**

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 **[beginning with December 31, 1994];** 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 [**beginning with December 31, 1994**].

[11:20-17.5 Penalties

Failure to provide the enrollment status reports within the time and in the format required by this subchapter shall result in the imposition of penalties as may be provided by law.]

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

11:20-18.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers **issuing plans pursuant to the IHC Act** may cease doing business in the **[standard]** individual **[health benefits]** plan market in this State. Additionally, this subchapter establishes the requirements and procedures by which carriers may cease issuing **and renewing**: all **[standard]** individual **[health benefits]** plans; a specific plan, by issuing the same plan through a different delivery mechanism; a specific plan option, by offering an alternative approved plan option; or a specific deductible/copayment option that is optional pursuant to **N.J.A.C. 11:20-3.1**. This subchapter also establishes requirements for carriers in the event that the Board promulgates regulations repealing a specific plan, plan option, or deductible/copayment option.

(b) This subchapter applies to all carriers, whether or not affiliated with other carriers doing business in the [standard] individual [health benefits] plan market in New Jersey, that seek to cease offering or renewing [standard] individual [health benefits] plans issued pursuant to the IHC Act, and carriers that seek to cease issuing a specific standard plan, plan option, or deductible/copayment option as permitted herein, or as directed by the IHC Board.

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 this subchapter means market [**withdraw or market**] withdrawal.

"[Standard individual health benefits] **Individual** 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, including any rider offered with such a plan.

"Pre-reform plan" means an individual health benefits plan issued in New Jersey prior to August 1, 1993.

"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 and pre-reform plans upon their respective anniversary dates without the carrier's offering a

replacement with **[a standard] an** 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] an** 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](#).

[11:20-18.3 Carrier cancellation of **\[standard\]** individual **\[health benefits\]** plans](#)

No carrier with in force **[standard]** individual **[health benefits]** plans shall cancel **[a standard] an** individual **[health benefits]** plan, except in accordance with [N.J.S.A. 17B:27A-6](#) or, upon the plan's anniversary date, [N.J.A.C. 11:20- 18.5](#), 18.6, or 18.7.

[11:20-18.4 Cessation of offer and issuance of **\[standard\]** individual **\[health benefits\]** plans](#)

(a) No carrier with in force **[standard]** individual **[health benefits]** plans shall cease to offer and issue all of its **[standard]** individual **[health benefits]** plans to an eligible person unless the Commissioner has determined pursuant to [N.J.S.A. 17B:27A-8b](#) and [N.J.A.C. 11:20-11](#) that the carrier does not have the financial resources necessary to underwrite additional coverage, and it has **[notified] provided written notice to:**

1. The Board [**in writing,**] at least 30 days before it intends to cease offering and issuing [**standard**] individual [**health benefits**] plans. Upon receipt of such notice, the Board shall no longer distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide; and

2. Its [**standard**] individual [**health benefits**] plan policyholders, in conjunction with each notice of an adjustment of rates provided to such policyholders following the date the carrier ceases to offer and issue such plans. The notice to policyholders shall state that:

i. The carrier intends to cease [**or prior to July 6, 1998 has ceased,**] offering and issuing [**standard**] individual [**health benefits**] plans in New Jersey;

ii. The carrier will continue to renew the policyholder's health benefits plan at the policyholder's option; and

iii. The policyholder may obtain information about individual health benefits plans offered by other carriers by calling 1-800-838-0935 for a free Individual Health Coverage Program Buyer's Guide **or may obtain information on the Department of Banking and Insurance website at: www.nj.gov/dobi/reform.htm**.

(b) A carrier that notifies the Board under this section shall continue to renew all in force [**standard**] individual [**health benefits**] plans [**unless**] **until** it obtains the Board's approval for market withdrawal in accordance with [N.J.A.C. 11:20-18.5](#).

(c) A carrier that has ceased offering and issuing [**standard**] individual [**health benefits**] plans **pursuant to N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11**, but has not withdrawn from the market in accordance with [N.J.A.C. 11:20-18.5](#), may resume offering and issuing standard individual health benefits plan to an eligible person after it has notified the Board, in writing, that it intends to resume offering [**standard**] individual

[health benefits] plans. Upon receipt of such notice, the Board shall distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide.

(d) A carrier with in force **[standard]** individual **[health benefits]** plans that has ceased to offer and issue all of its **[standard]** individual **[health benefits]** plans pursuant to this section shall nevertheless continue to comply with all other provisions of the law.

11:20-18.5 General provisions for market withdrawal

(a) No carrier with in force **[standard]** individual **[health benefits]** plans, whether or not affiliated with other carriers doing business in the **[standard]** individual **[health benefits]** plan market in New Jersey, shall refuse to issue or refuse to renew a **[standard]** individual **[health benefits]** plan, except in accordance with [N.J.S.A. 17B:27A-6](#), or in accordance with [N.J.A.C. 11:20-18.4](#) or 18.6, unless the carrier receives approval from the IHC Board to withdraw all of its **[standard]** individual **[health benefits]** plans and pre-reform plans in accordance with the provisions of this subchapter.

(b) A carrier that seeks to withdraw shall file with the IHC Board an application for market withdrawal in the format described in (c) below. A carrier with more than one affiliated carrier doing business in the **[standard]** individual **[health benefits]** plan market in New Jersey may apply for market withdrawal on behalf of one or more affiliated carriers. Until the withdrawal process is complete, the withdrawing carrier shall continue to be governed by [N.J.S.A. 17B:27A-2](#) et seq. and all rules promulgated thereunder, including, but not limited to, the minimum loss ratio and policyholder refund requirements and liability for a proportionate share of assessments for reimbursable losses and administrative expenses.

(c) The application for market withdrawal shall be sent to the IHC Board at the address set forth in [N.J.A.C. 11:20-2.1](#), and shall include **[an original and two copies of]** the following information:

1. The name of the carrier seeking to withdraw;
2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for market withdrawal;
3. A statement, describing with specificity, the **carrier's** reasons for **[which the carrier is]** withdrawing from the individual market in this State;
4. A statement of the carrier's percentage market share in the **[standard]** individual **[health benefits]** plan market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;
5. A statement indicating whether the carrier has **[filed] applied** for an exemption pursuant to N.J.A.C. 11:20-9 in the **[calendar year for] two-year calculation period during** which the application for market withdrawal application was filed;
6. A copy of the carrier's most recent loss ratio filing submitted pursuant to N.J.A.C. 11:20-7;
7. A copy of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20-17;
8. A statement indicating whether the carrier has any affiliated carriers writing any health benefits plans in this State, the names of such affiliated carriers and the lines of insurance written, and whether any such affiliated carriers will continue to offer **[standard]** individual **[health benefits]** plans after the carrier's withdrawal;
9. A statement indicating whether the carrier is withdrawing from other lines of business in this State, and if so, the lines from which it is withdrawing, its authority do so, and whether it has sought and obtained approval for such withdrawal;

10. A statement indicating whether the carrier has guaranteed rates to its policyholders and for what period of time;

[11. A statement indicating whether the carrier's anticipated losses in the current calendar year, assuming no reimbursement by the IHC Program, would jeopardize its financial solvency;]

[**12.] 11.** A copy of the proposed nonrenewal notices the applicant intends to send to its policy or contractholders if the application for market withdrawal is approved. Nonrenewal notices for policy or contractholders shall contain the following information:

- i. That the carrier has elected to withdraw;
- ii. The date upon which the policy or contract shall be nonrenewed;
- iii. That the policy or contract is being nonrenewed under the authority of this subchapter;
- iv. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan nonrenewal;
- v. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan nonrenewal;
- vi. A statement that a person who fails to obtain subsequent individual coverage within 31 days of the nonrenewal may be subject to a pre-existing condition exclusion period of 12 months; and
- vii. A statement that, pursuant to [N.J.S.A. 17B:27A-6](#), all carriers offering **[standard]** individual **[health benefits]** plans must issue coverage to any individual who requests coverage, meets the eligibility requirements, and pays the required premium for the coverage;

[13] 12. Copies of the proposed nonrenewal notices the applicant intends to send to its producers if the application for market withdrawal is approved. Nonrenewal notices for producers shall contain the following information:

- i. That the carrier has elected to withdraw;
- ii. The date upon which the policy or contract shall be nonrenewed;
- iii. That the policies or contracts are being nonrenewed under the authority of this subchapter;
- iv. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the plan nonrenewal;
- v. A statement that a person who fails to obtain subsequent individual coverage within 31 days of the nonrenewal may be subject to a pre-existing conditions exclusion period of 12 months;
- vi. A statement that, pursuant to [N.J.S.A. 17B:27A-6](#), all carriers offering **[standard]** individual **[health benefits]** plans must issue coverage to any individual who requests coverage, meets the eligibility requirements, and pays the required premium for the coverage; and
- vii. The date upon which the carrier will begin to cease the issuance and to nonrenew all **[standard]** individual **[health benefits]** plans **and pre-reform plans**; and

[14.] 13. Any additional information which the carrier believes is relevant for the IHC Board to review the carrier's application for market withdrawal.

[15.]14. Any additional information that the Board believes is necessary in light of any specific circumstances of the carrier's application.

(d) The IHC Board shall not begin its evaluation of the application for market withdrawal until the applicant has complied with the requirements contained in this section for its submission.

1. Within 45 days of receipt of an application for market withdrawal or a subsequent amendment thereto, filed pursuant to (c) above, the IHC Board shall provide written notice to the carrier indicating that the filing is complete or incomplete. If the IHC Board determines that the filing is incomplete, the IHC Board's written notice shall identify the information that was not provided.

2. Following receipt of a complete application for market withdrawal filed pursuant to (c) above, the IHC Board either shall approve or disapprove the application in writing within 60 days of the date of the IHC Board's written notice to the carrier indicating that the filing is complete.

i. In determining whether to approve or disapprove a carrier's application for market withdrawal, the IHC Board shall consider the following factors:

(1) Whether a sufficient number of carriers necessary to sustain a competitive market would continue to offer individual health benefits plans following the carrier's withdrawal;

(2) Whether the withdrawing carrier's policy or contract holders would be able to replace their health benefits plan with the same or similar plan offered by another carrier at a comparable rate;

(3) Whether the withdrawing carrier reported net paid losses in the preceding calendar year;

(4) Whether a carrier's anticipated losses in the current calendar year would jeopardize its financial solvency;

(5) Whether an affiliated carrier intends to continue to offer individual health benefits plans;

(6) Whether the withdrawing carrier intends to continue to offer health benefits plans in New Jersey, or in other states; and

(7) Any other factors deemed relevant and appropriate by the Board.

3. The Board shall approve an application for market withdrawal unless it determines, based on the factors listed in (d)2i(1) through (7) above, that the carrier's withdrawal would be unjust, unfair, inequitable, or contrary to law or public policy.

i. If the Board approves an application for market withdrawal, the Board shall notify the carrier in writing and the carrier shall proceed to institute a withdrawal pursuant to (e) below.

ii. If the Board disapproves an application for market withdrawal, the Board shall provide, in writing, the reasons for the disapproval. A carrier may appeal the Board's determination [**pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1.1.] 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](#).**

(e) A carrier that has received approval of its application for market withdrawal shall:

1. Not more than 60 days after the date of the Board's approval letter, cease issuing [**standard**] individual [**health benefits**] plans;

2. Not less than 180 days in advance of the effective date of the nonrenewal on the anniversary date of the policy or contract, mail a notice, in the same format and with the same content submitted to and approved by the IHC Board pursuant

to (c)[12] **11** above, to every **individual plan and pre-reform plan** policy or contractholder, informing the policy or contractholder that the policy or contract will be nonrenewed on the anniversary date. This initial notice to each policy or contractholder shall include a copy of the Individual Health Coverage Buyer's Guide and current premium comparison chart. A carrier shall begin to send notices of nonrenewal not more than 60 days after the date of the Board's approval letter;

3. Following the initial notice to each policy or contractholder, send a subsequent notice of the nonrenewal to each **individual plan and pre-reform plan** 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;

4. Not less than 180 days in advance of the effective date of the nonrenewal on the anniversary date of the policy or contract, mail a notice, in the same format and the same content submitted to and approved by the IHC Board pursuant to (c)12 above, to the producer of record, if any, for each policy or contract; and

5. Not more than 10 days after receipt of the Board's approval letter, send a letter to the IHC Board at the address in [N.J.A.C. 11:20-2.1](#), requesting to purchase copies of the IHC Program Buyer's Guide and price comparison and requesting a quantity sufficient to comply with the requirement that each policy or contract holder receive a copy of the Buyer's Guide and current premium comparison chart with the initial notice of nonrenewal. Alternatively, the carrier may arrange to obtain from the IHC Board a copy of the Buyer's Guide and price comparison to reproduce at its own cost a sufficient quantity of copies. Carriers shall not alter the text or format of the Buyer's Guide or premium comparison chart in any way.

11:20-18.6 General provisions for withdrawal of plan, plan option, [optional rating tier,] or deductible/copayment option

(a) No carrier shall cease to issue or nonrenew **[a standard] an** individual **[health benefits]** plan, plan option, **[optional rating tier,]** or deductible/ copayment option required or permitted to be offered by [N.J.A.C. 11:20-3.1](#), except in accordance with [N.J.S.A. 17B:27A-6](#) or [N.J.A.C. 11:20-18.5](#), until the carrier submits a notice of intent to withdraw a plan, plan option, **[optional rating tier,]** or deductible/copayment option with the IHC Board in accordance with the provisions of this subchapter.

(b) A carrier may cease to issue and nonrenew **[a standard] an** individual **[health benefits]** plan pursuant to this section only if:

1. The deductible/copayment option is not required to be offered pursuant to [N.J.A.C. 11:20-3.1\(b\)](#); or

2. In the case of a deductible/copayment option required to be offered pursuant to [N.J.A.C. 11:20-3.1](#), the carrier meets its obligations to offer all **[five] four** standard individual plans and required deductible/copayment options either by offering the plans as indemnity plans or by making the plan or plans available through or in conjunction with a selective contracting arrangement to all New Jersey residents.

(c) A carrier may cease to issue and nonrenew a standard plan option pursuant to this section by offering another approved plan option. Examples of plan options include, but are not limited to, a carrier's option to offer autologous bone marrow transplant coverage in either the policy or contract or in a rider, and an HMO's option to offer **[prescription drug coverage with either a \$15.00 copayment or with 50 percent coinsurance] plans subject to deductible and coinsurance provisions.**

(d) A carrier that seeks to withdraw a plan, plan option, **[optional rating tier,]** or deductible/copayment option pursuant to this section shall provide the IHC Board with

written notification of its intent to withdraw a plan, plan option, **[optional rating tier,]** or deductible/copayment option. The notice of intent to withdraw a plan, plan option, **[optional rating tier,]** or deductible/copayment option shall be sent to the IHC Board at the address set forth in [N.J.A.C. 11:20-2.1](#), and shall include **[an original and two copies of]** the following information:

1. The name of the carrier;
2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for plan or plan option withdrawal;
3. A specific description of the reasons the carrier is withdrawing the plan, plan option, **[optional rating tier,]** or deductible/copayment option;
4. A statement of the number of in force plans affected by the withdrawal;
5. Copies of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20-17;
6. Copies of a nonrenewal notice the applicant intends to send to its policy or contractholders. Nonrenewal notices for policy or contractholders shall contain the following information:
 - i. A statement that the carrier has elected to nonrenew the plan, plan option, **[optional rating tier,]** or deductible/copayment option;
 - ii. The date upon which the plan, plan option, **[optional rating tier,]** or deductible/copayment option shall be nonrenewed;
 - iii. A statement that the plan, plan option, **[optional rating tier,]** or deductible/copayment option is being nonrenewed under the authority of this subchapter;
 - iv. A notice that the carrier shall make available a replacement plan, plan option, **[optional rating tier,]** or deductible/copayment option;

v. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option, [**optional rating tier,**] or deductible/copayment option withdrawal; and

vi. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan, plan option, [**optional rating tier,**] or deductible/ copayment option withdrawal; and

7. Copies of the proposed nonrenewal notices the applicant intends to send to its producers. Nonrenewal notices for producers shall contain the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option, [**optional rating tier,**] or deductible/copayment option;

ii. The date upon which the plan, plan option, [**optional rating tier,**] or deductible/copayment option shall be nonrenewed;

iii. That the plan, plan option, [**optional rating tier,**] or deductible/ copayment option is being nonrenewed under the authority of this subchapter;

iv. A notice that the carrier shall make available a replacement plan, plan option, [**optional rating tier,**] or deductible/copayment option;

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

vi. The date upon which the carrier will begin to cease the issuance of the plan, plan option, [**optional rating tier,**] or deductible/copayment option.

(e) The IHC Board shall review the notice of intent to withdraw a plan, plan option, [**optional rating tier,**] or deductible/copayment option to determine whether it

complies with the filing requirements of (d) above. The IHC Board shall notify the carrier, in writing, of any deficiencies and the requirements which are necessary to bring it into compliance with this section.

(f) A carrier which has submitted a notice of intent to withdraw a plan, plan option, **[optional rating tier,]** or deductible/copayment option shall:

1. Not more than 60 days after the date of notice of intent to withdraw the plan, plan option, **[optional rating tier,]** or deductible/copayment option cease issuing the **[standard]** individual **[health benefits]** plan, plan option, **[optional rating tier,]** or deductible/copayment option;

2. Not more than 60 days following the date of notice of intent to withdraw the plan, plan option, **[optional rating tier,]** 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, plan option, **[optional rating tier,]** or deductible/copayment option, mail a notice, in the same format submitted to the IHC Board pursuant to (d)6 above, to every policy or contractholder, informing the policy or contractholder that the plan, plan option, **[optional rating tier,]** or deductible/copayment option will be nonrenewed on the anniversary date;

3. Following the initial notice to each policy or contractholder, 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; and

4. Not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan or plan option, **[optional rating tier,]** or deductible/copayment option, mail a notice, in the same format submitted to the IHC

Board pursuant to (d)7 above, to the producer of record, if any, for each policy or contract.

11:20-18.7 Plan or plan option withdrawal by IHC Board

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

(b) If the IHC Board promulgates rules withdrawing a plan, plan option, [**optional rating tier,**] or deductible/copayment option, a carrier shall nonrenew that [**standard**] individual [**health benefits**] plan, plan option, [**optional rating tier,**] 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, [**optional rating tier,**] 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, [**optional rating tier,**] or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, **[optional rating tier,]** or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, **[optional rating tier,]** or deductible/copayment option is being nonrenewed under the authority of this subchapter;

4. A notice that the carrier shall make available a replacement plan, plan option, **[optional rating tier,]** 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, **[optional rating tier,]** 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, **[optional rating tier,]** 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, **[optional rating tier,]** or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, **[optional rating tier,]** or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, **[optional rating tier,]** or deductible/copayment option is being nonrenewed under the authority of this subchapter;

4. A notice that the carrier shall make available a replacement plan, plan option, **[optional rating tier,]** 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, **[optional rating tier,]** or deductible/copayment option.

11:20-18.8 Restrictions on writings

A carrier that ceases to do business pursuant to [N.J.A.C. 11:20-18.5](#) shall be prohibited from writing new **[standard]** individual **[health benefits]** plans in New Jersey for a period of five years beginning on the termination date of the last standard individual health benefits plan not renewed.

11:20-18.9 **[Penalties]**

Failure to comply with the requirements of this subchapter shall result in the imposition of any and all penalties provided by law.

11:20-18.10]Other policy or contractholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policy or contractholders concerning other obligations set forth in a policy or contract issued by a carrier.

SUBCHAPTER 19. PETITIONS FOR RULEMAKING

11:20-19.1 Scope

This subchapter shall apply to all petitions **[made] to the Board** by interested persons **[for the promulgation, amendment] to adopt a new rule, or amend** or repeal **[of] any existing** rule by the Board, pursuant to N.J.S.A. 51:14B-4(f).

11:20-19.2 Procedure for petitioner

(a) Any person who wishes to petition the Board to **[promulgate,] adopt a new rule or** amend or repeal **[a] any existing** rule shall submit to the Board, in writing, the following information:

1. Name, **[and] address, phone, fax, and email address** of the petitioner;
 2. The substance or nature of the rulemaking which is requested, **which may include suggested text of the proposed new rule, amended rule or repealed rule;**
 3. The reasons for the request and the petitioner's interest in the request;
- [and]**
4. References to the **statutory** authority of the Board to take the requested action[.] **and**
 5. **A caption at the top of the document identifying it as a petition for rulemaking pursuant to N.J.S.A. 52:14B-4(f) and this subchapter.**

(b) The petition shall be sent to the Executive Director at the address in N.J.A.C. 11:20-2.1(h).

[(b)] (c) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of

the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

[(c)] **(d)** Any document submitted to the Board which is not in substantial compliance with (a) above shall not be deemed to be a petition for **[a rule] rulemaking** requiring further Board action pursuant to [N.J.S.A. 52:14B-4\(f\)](#).

[11:20-19.3 Procedure of the Board](#)

(a) Upon receipt of a petition in compliance with [N.J.A.C. 11:20-19.2](#), the Board shall file, within 15 days, a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;
2. The substance or nature of the rulemaking action which is requested;
3. The problem or purpose which is the subject of the request; and
4. The date the petition was received.

(b) Within **[30] 60** days of receiving the petition in compliance with [N.J.A.C. 11:20-19.2](#), the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;
2. The New Jersey Register citation for the notice of petition, if that notice appeared in a previous New Jersey Register;
3. Certification by the Board that the petition was duly considered pursuant to law;
4. The nature or substance of the Board's action upon the petition; and
5. A brief statement of reasons for the Board's action.

(c) The Board's action on a petition may include:

1. Denying the petition **and providing a written statement of the Board's reasons to the petitioner, and including such reasons in its notice of action;**

[or]

2.[Filing a notice of proposed rule or a notice of pre-proposal for a rule with the Office of Administrative Law] **Granting the petition and initiating a rulemaking proceeding within 90 days of the granting of the petition[.]; or**

3. Referring the matter for further deliberations which shall be concluded within 90 days of referring the matter for further deliberations. Upon conclusion of such further deliberations, the Board shall either deny the petition and provide a written statement of its reasons or grant the petition and initiate a rulemaking proceeding within 90 days.

SUBCHAPTER 20. APPEALS FROM ACTIONS OF THE BOARD

11:20-20.1 Scope

This subchapter shall apply to all appeals from **Board** determinations [made by the Board under] **and requests for hearing as expressly provided pursuant to** this chapter [unless otherwise expressly provided].

11:20-20.2 Appeals procedures

(a) [If the Board denies a member's request for relief made pursuant to this chapter, or if the member objects to the terms of the relief granted, the] **A** member may request a hearing on [the Board's] **a final** determination **by the Board** within 20

days from the date of receipt of such **final** determination **as expressly permitted by this chapter** as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, daytime telephone number, and fax number of a contact person familiar with the matter;

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the **[material facts in dispute] disputed adjudicative facts warranting a hearing** and describing the basis for **[which]** the member's **contention** **[believes]** that the Board's findings of fact are erroneous.

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are **[material issues of fact in dispute] disputed adjudicative facts**.

3. The Board shall, within **[45] 30** days of a properly completed request for a hearing, determine whether the matter constitutes a contested case pursuant to the Administrative Procedure Act, [N.J.S.A. 52:14B-1](#) et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. If the Board finds that the matter constitutes a contested case, it **[shall] may** transmit the matter to the Office of Administrative Law for a hearing consistent with the **Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.**, and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. **[In a matter which has been determined to be a contested case, if the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents**

filed, the Board may notify the applicant in writing as to the final disposition of the matter.]

ii. If the Board finds that the matter does not constitute a contested case, it may, with the approval of the Director of the Office of Administrative Law, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21.

iii. If the Board finds that there are no good-faith **[issues of material] disputed adjudicative** facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

11:20-22.1 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] The** other subchapters in this chapter **should be consulted** 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]11:20-1.2** and **N.J.S.A. 17B:27A-2.**

(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]**.

11:20-22.2 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. 11:20-\[1.1\] 1.2](#) unless the context clearly indicates otherwise, or as such words and terms are further defined by this subchapter, as follows:

"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.

11:20-22.3 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. Carriers that choose to offer the basic and essential health care services plan as an indemnity plan may include provisions to create an indemnity-based preferred provider organization (PPO) plan or an exclusive provider organization (EPO) 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 [V]F, incorporated herein by reference. The Board has determined that the plan set forth in Exhibit [E] 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 [V]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 [V]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 [V]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 [V]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) 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. The member shall submit:

1. [One] A 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. 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; **[and]**

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

i. The member shall 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 **[.]**;

iv. The member shall offer the rider in a manner which will avoid adverse selection to the extent possible;

v. None of the ridered benefits exceed the benefits in the standard Plan A/50 through Plan D plans, or HMO plan, as applicable (benefits would include any benefits set forth in the standard Plan A/50 through Plan D

“Covered Charges” or “Charges Covered with Special Limitations” sections of the policy or set forth in the standard HMO “Covered Services and Supplies” section of the contract); and

vi. If an HMO, none of the ridered benefits are provided with a copayment that is lower than the lowest HMO copayment option allowed by the Board’s rules; and

4. A comprehensive list of benefits in the proposed rider compared with the carrier’s standard A/50 through D plan or standard HMO plan, as applicable.

(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.

(d) A member seeking to challenge the Board’s disapproval of a rider filing must do so within 20 days of receiving the notice of the disapproval pursuant to the procedures for appeals set forth at [N.J.A.C. 11:20-20.2](#).

(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 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. Earned premium for the calendar quarter;

ii. Paid claims for the calendar quarter;

iii. New business enrollment reporting both the number of contracts and number of lives for the calendar quarter, which shall include the enrollment of persons who applied for and were issued coverage, whether or not the persons were new customers to the carrier or had coverage under other plans issued by the carrier and terminated the prior plans in favor of the plan for which application was made; and

iv. Total enrollment (total inforce) reporting both number of contracts and number of lives as of the last day of the calendar quarter; and

2. For basic and essential health care services plans issued during the calendar quarter with a rider, the carrier shall submit:

i. The number of persons enrolled who were previously uninsured; and

ii. For all persons previously insured, the numbers of persons whose prior source of coverage was group; COBRA/state continuation; standard IHC plan; unridered basic and essential health care services plans plan, or other basic and essential health care services plans with rider.

(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 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. Earned premium for the calendar year; and

ii. Incurred claims for the calendar year.

(g) The Board shall evaluate the filings to determine whether the carrier has avoided adverse selection to the extent possible.

(h) If the Board finds that a carrier's rider has resulted in adverse selection, then the carrier shall cease issuing the rider within 60 days of receipt of the Board's written determination letter, but shall continue to renew the plan and rider for contractholders that had already purchased the plan with the rider.

(i) A member seeking to challenge the Board's finding that the rider has resulted in adverse selection must do so within 20 days of receiving the Board's written determination pursuant to the procedures for appeals set forth at [N.J.A.C. 11:20-20.2](#).

11:20-22.6 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 2g of P.L. 2001, c.368 ([N.J.S.A. 17B:27A-4.5g](#)), 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 [**with the first report due May 1, 2004,**] 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, **a PPO plan, an EPO plan,** or as an indemnity plan.

(b) The report shall 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 report 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;

ii. The carrier provides evidence that it has undertaken 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 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 plan; or information specific to the basic and essential health care services plan on the carrier's website. 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] provides a certification in which it certifies that it either did or did not use 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 in (c)1 above or if the member fails to submit a report by May 1 of each year.

[11:20-22.7 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.A. 17B:30-1](#).

SUBCHAPTER 23. RULEMAKING; INTERESTED PARTIES; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

11:20-23.1 Purpose and scope

(a) The purpose of N.J.A.C. 11:20-23.2 through 23.5 is to establish the procedures that the Board uses in rulemaking made pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The purpose of N.J.A.C. 11:20-23.6 is to establish procedures for public notice regarding Board meetings. The purpose of N.J.A.C. 11:20-23.7 is to establish the procedures that the Board uses in placing parties and entities on the Board's interested parties mailing list.

(b) N.J.A.C. 11:20-23.2 through 23.5 shall apply only to rulemaking of the Board made pursuant to New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and shall not apply to rules made pursuant to N.J.S.A. 17B:27A-16.1, a special rulemaking procedure set forth in the IHC Act. N.J.A.C. 11:20-23.7 shall apply to any person that wishes to be placed on the Board's interested parties mailing list.

11:20-23.2 Public notice regarding proposed rulemaking

(a) The Board shall provide the following types of public notice for rule proposals pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30:

1. The rule proposal shall be filed with the Office of Administrative Law for publication in the New Jersey Register;

2. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be posted and made available electronically on the Department of Banking and Insurance web site at: <http://www.njdoib.org> and in the Department of Banking and Insurance's Library, which is located on the 1st Floor 20 West State Street, Trenton, NJ 08625.

3. The news media maintaining a press office in the State House Complex shall be provided notice of the rule proposal, as posted and made available electronically on the New Jersey Department of Banking and Insurance web site; and

4. Notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be made available to the Board's list of interested parties by e-mail or hard copy.

11:20-23.3 Extension of the public comment period

(a) The Board, pursuant to the New Jersey Administrative Procedure

Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may extend the time for submission of public comments on a proposed rulemaking , at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall extend the time for submission of public comments for an additional 30-day period, if, within 30 days of the publication of a notice of proposal, sufficient public interest is demonstrated in an extension of time to submit comments.

(c) The Board shall determine that a sufficient public interest for the purpose of extending the public comment period has been demonstrated if any of the following has occurred:

1. Comments received indicate a previously unrecognized impact on a regulated entity or persons; or
2. Comments received raise unanticipated issues related to the notice of proposal.

11:20-23.4 Conducting a public hearing

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may conduct a public hearing on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative

Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall conduct a public hearing if sufficient public interest has been demonstrated.

(c) A person interested in having a public hearing held on a notice of proposal shall submit an application within 30 days following the publication of the notice of proposal in the New Jersey Register in a form prescribed by the Board, to the Executive Director at the address listed in N.J.A.C. 11:21-1.3. The application shall contain the following information:

1. The person's name, address, telephone number, agency or association (if applicable);
2. The citation and title of the proposed rule and the date the notice of proposal was published in the New Jersey Register; and
3. The reasons a public hearing regarding the notice of proposal is considered necessary pursuant to (d) below.

(d) The Board shall determine that sufficient public interest has been demonstrated for the purpose of holding a public hearing if the application demonstrates that additional data, findings and/or analysis regarding the notice of proposal are necessary for the Board to review prior to adoption of the proposal in order to ensure that the notice of proposal does not violate the intent of the statutory law.

11:20-23.5 Public notice of new rules, amendments, repeals or adoptions

The Board shall provide notice of new rules, amendments, repeals or adoptions by posting these rules on its website at

<http://www.nj.gov/dobi/reform.htm> and to the news media maintaining a press office in the State House complex.

11:20-23.6 Public notice regarding board meetings

(a) The Board shall adopt an annual schedule of regular meetings to be held by it the following calendar year.

(b) The Board may schedule meetings in addition to those set forth in the annual schedule.

(c) The Board shall provide public notice for all meetings by:

1. Posting a notice at the office of the Secretary of State;

2. Posting a notice at the office of the Board at the address set forth at N.J.A.C. 11:20-2.1(h);

3. Posting of a notice on the Department of Banking and Insurance web site at: <Http://www.njdobi.org>; and

4. Posting of the notice in two newspapers of general circulation designated by the Board.

11:20-23.7 Board mailing list of interested parties

(a) For the purpose of disseminating information about the IHC Program, including but not limited to information about meeting dates and rulemaking made pursuant to either the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. or N.J.S.A. 17B:27A-16.1, the Board shall maintain a mailing list of member carriers and other interested parties.

1. The mailing list of members shall be based upon the members addresses filed with its most recently filed Exhibit K Assessment Report.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided in (a)1i above, the name and mailing address of a member shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member.

2. Persons other than member carriers who wish to receive communications from the Board, including but not limited to proposed rules, actions and public notices, may send a written request to the IHC Board at the address set forth at N.J.A.C. 11:20-2.1(h) to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

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) 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 of New Jersey, 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. 11:20-12.5, 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.

(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 two adult coverage, if the husband and wife wish to obtain separate coverage.

(d) A carrier shall issue an individual health benefits plan to any eligible person who requests it and pays the premiums therefor, except that an HMO carrier may refuse to issue coverage to an eligible person that does not live in the carrier's approved service area, and except as provided in N.J.A.C. 11:20-11 and 12.

(e) Persons shall be accepted for coverage by any carrier without any restrictions or limitations on coverage related to their risk characteristics or those of their dependents, except that a carrier may exclude coverage for preexisting

conditions consistent with the applicable terms of the individual health benefits plan.

11:20-24.3 Payment of premium

(a) A carrier may offer a credit card payment option or an automatic checking withdrawal option to individuals for the monthly or quarterly payment of premiums. In the event that a carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all individuals.

(b) A carrier may offer a discount to individuals that pay premium on a quarterly basis.

(c) A carrier shall accept payment in the form of a check, a money order, a cashier's check, or cash.

11:20-24.4 Effective date of coverage

(a) A carrier, prior to issuing an individual health benefits plan, may require the following:

1. A completed individual application form;
2. Proof of the applicant's residency; and
3. Premium payment not to exceed one month's premium, which shall be refunded to the individual if the health benefits plan is not issued by the carrier.

(b) A carrier shall make coverage effective no later than the 1st or the 15th of the month, which ever comes first, after the receipt of the information set forth in (a) above that it may require. However, if a carrier allows additional effective dates and an applicant request a later effective date, a carrier shall make coverage effective no later than such requested effective date.

(c) With respect to applications submitted during the November open enrollment period, the effective date of coverage shall be January 1 of the following calendar year.

11:20-24.5 Paying benefits

(a) 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 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 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 charge shall be based on the 80th percentile of the profile.

2. Carriers shall update their databases within 60 days after receipt of periodic updates released by Ingenix.

Date

Wardell Sanders, Executive Director

