3A.2, and Exhibit J, Loss Ratio Report Form, referenced at N.J.A.C. 11:20-7.3.

The rules promulgated by the IHC Board within Subchapter 1 of N.J.A.C. 11:20 establish 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 throughout Chapter 20.

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

Subchapter 3 addresses benefits offered in the individual market. N.J.A.C. 11:20-3.1 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 at N.J.A.C. 11:20 Appendix Exhibits A and B, with variable text detailed at N.J.A.C. 11:20 Appendix Exhibit C. N.J.A.C. 11:20-3.1 provides 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. N.J.A.C. 11:20-3.1(e) sets forth the requirements for carriers that choose to make the standard plans available through or in conjunction with a selective contracting arrangement. N.J.A.C. 11:20-3.2 sets forth sample schedule language. The Compliance and Variability Rider, set forth as N.J.A.C. 11:20 Appendix Exhibit D, is the form a carrier must use if the carrier desires to implement regulatory changes to a plan without having to reissue the entire policy or contract. This rider may only be used in a manner consistent with the directions set forth at N.J.A.C. 11:20-3.3. N.J.A.C. 11:20-3.6 addresses the opportunity for carriers to create and file optional benefit riders that increase the benefits or actuarial value of the standard plans. N.J.A.C. 11:20-3.7 sets forth the provisions governing an IHC Board action to withdraw a standard plan or a plan option.

Subchapter 8 sets forth reporting and certification requirements for premium data as required of carriers with reportable accident and health premium in New Jersey. The Assessment Report is the form for reporting under this subchapter and is set forth as Exhibit K at N.J.A.C. 11:20 Appendix.

Subchapter 12 establishes the standards for determining who is eligible to be covered under standard individual health benefits plans, the standards for obtaining a standard health benefits plan by persons covered by a group health benefits plan and by persons already covered under another individual health benefits plan. This subchapter sets forth rules applicable to an annual open enrollment period as well as a special enrollment period.

Subchapter 17 establishes quarterly submissions of enrollment status reports by all carriers issuing individual health benefits plans whether through the Marketplace or directly by the carrier. The subchapter specifies the information the reports must contain.

Subchapter 19 sets forth the procedures for filing petitions for rulemaking with the IHC Board.

Subchapter 20 provides the procedures for appealing an action of the IHC Board.

Subchapter 23 addresses rulemaking notices, public notices, and the IHC Board's interested parties mailing list. N.J.A.C. 11:20-23.2 sets forth the types of notices that the IHC Board will provide when proposing rules pursuant to the Administrative Procedures Act (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 IHC Board to provide notice of new rules, amendments, repeals, or readoptions. N.J.A.C. 11:20-23.6 sets forth where the IHC Board shall provide public notice of board meetings. N.J.A.C. 11:20-23.7 sets forth the requirements for inclusion on the IHC Board's list of interested parties.

Subchapter 24 establishes certain standards that carriers issuing individual coverage must meet in offering and issuing standard health benefits plans and standard health benefits plans with riders to eligible persons off the marketplace. N.J.A.C. 11:20-24.2 sets forth standards for eligibility and issuance. N.J.A.C. 11:20-24.2A sets forth standards for triggering events that result in a special enrollment period. 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. N.J.A.C. 11:20-24.6 establishes standards for the required good faith effort to market individual plans.

These rules implement essential provisions of the Act. The Department and the IHC Board have reviewed these rules and have determined that the rules should be readopted without amendment. The rules are necessary, reasonable, and proper for the purpose for which they were originally promulgated. Therefore, pursuant to N.J.S.A. 52:14B-5.1.c(1), these rules are readopted and shall continue in effect for a seven-year period.

(a)

DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Notice of Readoption
Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations and Medical Service Corporations
Readoption: N.J.A.C. 11:24A

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 26:2J-1 et seq., 26:2S-1 et seq., and 26:2SS-1 et seq.

Authorized By: Justin Zimmerman, Commissioner, Department of Banking and Insurance.

Effective Date: December 19, 2024.
New Expiration Date: December 19, 2031.

Take notice that pursuant to the provisions at N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 11:24A were scheduled to expire on January 30, 2025. The rules in this chapter implement the provisions of the Health Care Quality Act (HCQA), P.L. 1997, c. 192 (substantially codified at N.J.S.A. 26:2S-1 et seq.). The HCQA established certain standards that must be met by various classes of carriers (insurers doing health insurance business, hospital service corporations, medical service corporations, health service corporations, and health maintenance organizations (HMOs) offering health benefits plans in New Jersey) but is primarily focused upon carriers offering managed care plans or other health benefits plans with utilization management (UM) features.

A summary of the subchapters at N.J.A.C. 11:24A follows:

N.J.A.C. 11:24A-1 sets forth the scope and purpose of the chapter, definitions used in the chapter, and compliance time frames that carriers must meet.

N.J.A.C. 11:24A-2 sets forth general provisions that are applicable to all carriers offering health benefits plans, as that term is defined. The subchapter includes the requirement that carriers submit a form, referred to as the HCQA Registration Form, to the Department of Banking and Insurance (Department) providing information about certain features that a carrier includes in all the health benefits plans that the carrier intends to offer in New Jersey. The subchapter specifies certain disclosures that all carriers are required to provide to subscribers, including descriptions of cost-sharing requirements, how services may be obtained, and use of emergency response systems in New Jersey. The subchapter includes statements that, to the extent such disclosures are contained in forms filed with the Department (such as policy forms and marketing material), such

forms will be deemed approved by the Department for purposes of compliance with the HCQA. The subchapter details certain rights that carriers must extend to covered persons and requires carriers to have policies and procedures in place to ensure that these rights are preserved and that covered persons are made aware of them. The subchapter establishes standards regarding emergency and urgent care services at various hospital settings. The subchapter also sets forth procedures regarding violations of the chapter.

N.J.A.C. 11:24A-2A, Coverage for Termination of Pregnancy, sets forth that, except in the case of a religious employer, carriers shall provide coverage, without limit or exclusion, for abortion services. A carrier may apply cost sharing, including deductible, copayment, or coinsurance, as applicable, to such services provided such cost sharing is also applied to similar services or coverages pursuant to the policy. The subchapter sets forth the rules concerning the religious employer exclusion: who may request, and when the carrier shall grant, an exclusion for abortion coverage, if the abortion coverage conflicts with the religious employer's *bona fide* religious beliefs and practices. Further, the subchapter provides that if a religious employer exclusion is granted, the carrier is not permitted to exclude coverage for care that is necessary to preserve the life or health of a covered person or member or that is the result of an act of rape or incest. In addition, a carrier that issues a policy or contract containing a religious employer exclusion shall provide written notice of such exclusion to each prospective insured or covered person, which must be provided in the certificate or evidence of coverage, the covered person or member's application or enrollment form, and all sales and marketing materials. Lastly, the subchapter provides that for each religious employer request that a carrier grants, the carrier shall make an informational filing with the Department, including a form of the written notice provided to prospective insureds.

N.J.A.C. 11:24A-3 establishes standards and procedures for carriers offering health benefits plans with UM features. The subchapter sets forth additional disclosure requirements that carriers must provide to covered persons when UM features are included in health benefits plans, particularly regarding the right of the covered person to appeal adverse UM determinations made by the carrier, including the opportunity to bring the appeal to the Independent Health Care Appeal Process (IHCAP) if the covered person continues to be dissatisfied with the outcome of the carrier's determinations of internal appeals. The subchapter sets forth a requirement that the carrier designate a physician licensed to practice medicine in New Jersey to serve as the carrier's medical director with respect to the carrier's health benefits plans with UM features and specifies the minimum activities for which the medical director is to be responsible. The subchapter requires that carriers establish a UM program that has the capacity to evaluate the effectiveness of the carrier's UM features, ensures that medical guidelines and protocols used by the carrier are consistent with generally accepted standards, and ensures that covered persons have access to UM personnel in a reasonable manner. In addition, the subchapter requires that the UM program link into a continuous quality improvement program, which should result in revised operations, policies, or procedures for the UM program, as necessary or appropriate. The subchapter establishes certain standards that a carrier's internal appeal mechanism must meet in order to address appeals of covered persons (or a health care provider acting on behalf of a covered person with the covered person's consent) regarding the carrier's adverse UM determinations. The subchapter specifies standards and procedures that carriers must meet in complying with decisions of the IHCAP.

N.J.A.C. 11:24A-4 sets forth provisions that are applicable to carriers offering managed care plans. Managed care plans essentially are network-based health benefits plans. The subchapter establishes additional disclosure requirements that carriers must provide to covered persons covered through a managed care plan, as well as to other consumers who might be interested in becoming covered through a managed care plan. These additional disclosures must include such information as the general method of compensation to health care providers, lists of in-network health care providers, and their respective certifications and affiliations. The subchapter sets forth a requirement that the carrier designate a physician licensed to practice medicine in New Jersey to serve as the carrier's medical director for the managed care plan's UM program and sets forth other duties for which the medical director, or the medical director's designee, are responsible with respect to the managed care plan. These responsibilities include overseeing medical services when the managed care plan includes a gatekeeper system, provider credentialing functions, and methods by which network health care providers may have input in the carrier's medical guidelines and protocols. The subchapter requires the carrier to establish a complaint mechanism capable of addressing and resolving complaints presented by both covered persons and health care providers. The subchapter establishes standards for carriers in terms of their handling of applications from providers interested in participation in the carrier's network. The subchapter establishes standards and procedures that carriers must employ when terminating health care providers in certain circumstances, including some details about ensuring that covered persons do not immediately lose access to terminating health care providers, particularly when the covered person is undergoing a course of treatment. The subchapter sets forth standards for network adequacy with respect to multiple categories of health care providers and certain health care services. The subchapter requires that carriers offering managed care plans have a UM program, including a UM appeal mechanism. While incorporating the same provisions applicable to HMOs at N.J.A.C. 11:24-3, with respect to the standards for the UM program and UM appeal process, the subchapter also adds specific requirements regarding access by covered members to their primary care providers. The subchapter requires carriers to have a continuous quality improvement program and incorporates substantially the provisions at N.J.A.C. 11:24A-3 with respect to this subject. However, in addition, N.J.A.C. 11:24A-4 establishes standards for carriers to obtain independent evaluations of various aspects of their operations from quality review organizations. The subchapter also requires carriers to report quality outcome measures upon the request of the Department. The subchapter establishes certain standards for contracts between carriers and health care providers, whether the contracts are written directly or through an intermediary party (vendor). The subchapter sets forth certain requirements for carriers to ensure that at least some of the managed care plans they make available in the market do not require a gatekeeper system.

N.J.A.C. 11:24A-5 sets forth general requirements for the IHCAP, focusing on the Department's operation of the IHCAP.

The rules at N.J.A.C. 11:24A continue to be necessary, reasonable, and proper for the purposes for which they were originally promulgated. Accordingly, pursuant to N.J.S.A. 52:14B-5.1.c(1), these rules are readopted and shall continue in effect for a seven-year period.

LAW AND PUBLIC SAFETY

(a)

JUVENILE JUSTICE COMMISSION

Manual of Standards for Juvenile Detention Commitment Programs

Readoption with Amendments: N.J.A.C. 13:93

Proposed: May 6, 2024, at 56 N.J.R. 755(a).

Adopted: December 4, 2024, by Executive Board of the Juvenile Justice Commission, by the Honorable Matthew J. Platkin, Attorney General and Chair, through Daniel S. Hafetz, Attorney General Designee.

Filed: December 16, 2024, as R.2025 d.013, **without change**.

Authority: N.J.S.A. 2A:4A-37, 2A:4A-43, 2A:4A-44.1, 2A:4A-60, 18A:17B-5, 47:1A-1 et seq., 52:17B-169, 52:17B-170, 52:17B-171, 52:17B-171.1, 52:17B-171.2, 52:17B-171.3, 52:17B-171.5, 52:17B-171.7, 52:17B-171.11, 52:17B-171.13, and 52:17B-176.

Effective Dates: December 16, 2024, Readoption;
January 21, 2025, Amendments.

Expiration Date: December 16, 2031.

Summary of Public Comment and Agency Response:
No comments were received.