

See: 26 N.J.R. 4228(b), 26 N.J.R. 4452(d), 27 N.J.R. 1321(a).
 Petition for Rulemaking: Exhibit F.
 See: 26 N.J.R. 5119(a), 27 N.J.R. 946(d).
 Petition for Rulemaking: Exhibits A through F.
 See: 26 N.J.R. 5120(b), 27 N.J.R. 946(b).
 Petition for Rulemaking: Exhibit D.
 See: 28 N.J.R. 1315(a), 28 N.J.R. 2413(b).
 Amended by R.1998 d.443, effective August 7, 1998.
 See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), inserted "as amended" at the end of the first sentence; in (b), inserted "as the term member is defined in this subchapter" following "Coverage Program"; and in (c), substituted "August 1, 1993" for "November 30, 1992".

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 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 child of an eligible person, 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 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."

"Family unit" means a legally married man and woman: a legally married man and woman 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-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; and

7. 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:

$$\frac{\text{1st day benefit} - \text{2nd day benefit}}{5} + \text{2nd day benefit} < \$250.00$$

“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.

“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 enrollment represents more than 75 percent of its average enrollment for all health benefits plans, or whose combined Medicare and Medicaid 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 contracts with the

State or Federal government, but shall not include 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.

"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.), Medicare cost or risk contract 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 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 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.

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

"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.

"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.

Amended by R.1994 d.54, effective December 30, 1993.

See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Amended by R.1995 d.37, effective December 20, 1994.

See: 27 N.J.R. 41(b), 27 N.J.R. 371(b).

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).

See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

Amended "Eligible person" and "Family unit".

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Rewrote the section.

Amended by R.2000 d.142, effective March 6, 2000.

See: 32 N.J.R. 643(a), 32 N.J.R. 1253(c).

Rewrote "Member".

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.

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), deleted the first sentence; and in (b), inserted N.J.S.A. references.

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.

(b) This subchapter shall apply to all carriers that are or become members of the New Jersey Individual Health Coverage Program for any portion of a two-year calculation period for which reports under this subchapter are required to be filed, whether or not the carrier is a member at the time that the report is to be filed.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), deleted "annual" preceding "reporting"; and in (b), substituted "two-year calculation period" for "calendar year".

11:20-8.2 Filing of the market share and net paid gain or (loss) report form

(a) Every member of the IHC Program shall file the report form set forth as Exhibit K in the Appendix to this chapter, on or before March 1, 1999 and on or before March 1 of the year immediately following every two-year calculation period thereafter. Every member shall complete Parts A, B, C and D of the report form, whether or not the member is seeking reimbursements for losses, or exemptions from assessments for losses.

(b) Affiliated carriers shall submit a separate report for each affiliated carrier and a combined report using the report form set forth as Exhibit K in the Appendix.

1. The combined report form shall be submitted under the name of one of the affiliated carrier's members, shall list the affiliated carriers, and shall include as attachments the separate reports of each of the members of the affiliated carrier including the separate report of the member submitted the combined report form, all as one package.

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

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), changed the report filing deadlines; and rewrote (b).

11:20-8.3 Net earned premium

(a) Every member shall set forth its net earned premium for the preceding two-year calculation period ending December 31 of the second year in Part C1 of the report.

1. Net earned premium set forth in Part C1 of the report form shall include net earned premium resulting from group health benefits plans and individual health benefits plans issued, continued or renewed during the preceding two-year calculation period, including premiums from conversion health benefits plans.

2. Net earned premium reported in Part C1 of the report form shall be based upon, if not the same as, the data set forth in the member's appropriate NAIC statement blank.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a).

11:20-8.4 Calculation of covered non-group persons

Members shall report in Part C2 of the report form the total number of persons covered under individual community rated health benefits plans, conversion health benefits plans, the number of Medicaid recipients covered by the member under a contract with the State of New Jersey, and Medicare lives covered by the member under Medicare cost and risk contracts with the Federal government, as of the last day of each calendar quarter of the preceding two-year calculation period and divide the total of the eight calendar quarters by eight to determine the average non-group enrollment in the preceding two-year calculation period. For contracts issued prior to August 1, 1993, where a member's administrative systems cannot provide the number of actual covered persons, the following factors shall be used to convert contracts or subscribers to the total number of covered persons: single = 1; husband and wife = 2; adult and child(ren) = 2.8; family = 3.9. If a husband and wife category is not used, a member shall use a compromise factor of 3.33 in order to reflect the husband and wife category in the family factor.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.

11:20-8.5 Calculating net paid losses or gains

(a) For purposes for completing Page C3 of the report form, members shall provide data for their 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), for the preceding two-year calculation period.

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

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

(b) Premium earned shall be adjusted 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.

(c) In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. 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.

(d) Net investment income shall be calculated in accordance with statutory reporting requirements. For purposes of Exhibit K reporting, and 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 period for which the calculation is being made. Cash flow is the inception to date paid premium, plus net investment income, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid, and less paid expenses.

(e) The net paid gain or loss for the two-year calculation period shall be determined by taking the claims paid on individual health benefits (as set forth on line C3b 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 C3a and C3c, respectively, 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 on line C3d represents a net paid gain. If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is less than claims paid on individual health benefits plans, the amount shown on line C3d represents a net paid loss.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Rewrote the section.

11:20-8.6 Certifications

(a) The Chief Financial Officer, or other duly authorized officer of the member, shall certify that all market share and net paid gain (loss) reports filed with the IHC Board are accurate, complete and conform with the requirements of this subchapter. The person certifying the combined market share and net paid gain (loss) report of an affiliated carrier shall be the same person certifying the separate market share and net paid gain (loss) report of the member submitting the combined market share and net paid gain (loss) report for the affiliated carrier. Every duly authorized officer who certifies a separate or combined market share and net paid gain (loss) report shall be responsible for errors contained therein.

(b) The Chief Financial Officer, or other duly authorized officer, of a member which has filed for reimbursement of losses shall certify, on or before March 1 of the year following every two-year calculation period that:

1. The net investment income reported on Exhibit K 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.

Amended by R.1994 d.177, effective March 10, 1994.

See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), inserted "gain" preceding "(loss)" throughout; and rewrote (b).

Case Notes

Health insurer became member of Individual Health Coverage Program subject to assessment for share of program losses upon receiving certificate of authority to operate as health maintenance organization (HMO) in state, regardless of status of its application for approval as federally qualified HMO. Matter of Individual Health Coverage Program Final Administrative Orders Nos. 96-01 and 96-22, 302 N.J.Super. 360, 695 A.2d 371 (N.J.Super.A.D. 1997).

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

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

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

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

Amended by R.1994 d.177, effective March 10, 1994.

See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), inserted "gain" preceding "(loss)" in the introductory sentence.