

INDIVIDUAL HEALTH COVERAGE PROGRAM

CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17:1-8.1 and 15e, and 17B:27A-2 et seq.

Source and Effective Date

R.1998 d.443, effective August 7, 1998 and R.1998 d.454, effective August 13, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a);
30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 20, Individual Health Coverage Program, expires on December 31, 2005. See: 37 N.J.R. 2994(a).

Chapter Historical Note

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993 (to expire August 13, 1993). See: 25 N.J.R. 2945(a). The concurrent proposal of Chapter 20 was adopted as R.1993 d.439, effective August 13, 1993, with changes effective September 7, 1993. See: 25 N.J.R. 2945(a), 25 N.J.R. 4180(a).

Subchapter 2, Individual Health Coverage Program Temporary Plan of Operation, was adopted as R.1993 d.550, effective October 14, 1993. See: 25 N.J.R. 4707(a), 25 N.J.R. 5244(a).

Subchapter 10, Performance Standards and Reporting Requirements, was adopted as R.1994 d.142, effective February 23, 1994. See: 26 N.J.R. 1202(a), 26 N.J.R. 1351(a).

Subchapter 11, Relief from Obligations Imposed by the Individual Health Insurance Reform Act, was adopted as R.1993 d. 654, effective December 30, 1993. See: 25 N.J.R. 4459(a), 25 N.J.R. 5930(b).

Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans, was adopted as R.1994 d.54, effective December 30, 1993. See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Subchapter 13, Certification of Non-Member Status, was adopted as R.1994 d.177, effective March 10, 1994. See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Subchapter 17, Enrollment Status Report, was adopted as R.1994 d.53, effective December 30, 1993. See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, was adopted as R.1998 d. 339, effective July 6, 1998. See: 29 N.J.R. 2615(a), 30 N.J.R. 2502(a).

Pursuant to Executive Order No. 66(1978), Chapter 20, Individual Health Coverage Program, Subchapters 1 through 10, 12, 13, 17, 18 and Appendix Exhibits A through T, were readopted as R.1998 d.443, effective August 7, 1998, and Subchapter 11 was readopted as R.1998 d.454, effective August 13, 1998. Subchapter 19, Petitions for Rule-making, and Subchapter 20, Appeals from Actions of the Board, were adopted as new rules by R.1998 d.443, effective August 7, 1998. See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a); 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 20, Individual Health Coverage Program, was extended by gubernatorial directive from August 7, 2003 to 270 days following Supreme Court decision in *In re Health Coverage Program's Readoption of N.J.A.C. 11:20-1.1 et seq.* 35 N.J.R. 2898(a).

In accordance with N.J.S.A. 52:14B-5.1d, Chapter 20, Individual Health Coverage Program, expiration date was extended by gubernatorial directive from February 4, 2005 to July 4, 2005. See: 37 N.J.R. 778(a).

Subchapter 4, Standard Application Form; Subchapter 5, Standard Claim Form and Appendix Exhibits G, H, and I, expired effective July 4, 2005. See: 37 N.J.R. 2994(a).

Case Note

New Jersey Individual Health Coverage Program Board of Directors did not violate authorized procedures for adopting or amending its regulations when it readopted Individual Health Coverage Program (IHCP) regulations; Board provided notice as required by statute, received written comments regarding proposed regulations, and prepared report that summarized and responded to comments and was published in New Jersey Register. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

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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.

Petition for Rulemaking: Exhibit F.

See: 26 N.J.R. 862(a), 26 N.J.R. 1401(a), 26 N.J.R. 2488(a).

Petition for Rulemaking: Exhibit F.

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 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 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;

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:

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

“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.

“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.

“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 any payment the Health Care Financing Administration makes on behalf of Medicare Plus Choice 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.

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

“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”.

Amended by R.2001 d.55, effective January 17, 2001.

See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).

Inserted “Medicare Plus Choice”; in “Net earned premium”, inserted reference to Medicare Plus Choice enrollees; and in “Non-group persons”, inserted reference to Medicare Plus Choice contract.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Added “Basic and essential health care services plan”; in “Health benefits plan”, added new 7, recodified former 7 as 8; in “Non-group persons”, inserted “a basic and essential health care services plan pursuant to P.L. 2001, c.368” preceding “Medicare”; deleted “Reimbursement for losses”.

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.

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

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

Deleted "including individual standard health benefits plans" following "this subchapter".

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.

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

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

Inserted "plans" following "health benefits".

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.

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:

New Jersey Individual Health Coverage Program
20 West State Street, 10th Floor
PO Box 325
Trenton, NJ 08625-0325
Telephone: (609) 984-1717
Fax: (609) 633-2030

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), rewrote the introductory paragraph 2; and in (h), updated the address.

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.

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 a P.L. reference; and in (b), deleted “Basic health benefits plan”, “Deferral”, “Director”, “Financially impaired”, “HMO”, “Reasonable administrative expenses”, and “Standard health benefits plan” definitions.

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 Plan;
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 Plan;

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. Establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the IHC Program and provide for performance audits;

10. 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. Appoint from among its 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. Enter into contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Temporary Plan;

13. 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. 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. Establish rules, conditions and procedures pertaining to the sharing of IHC Program losses and administrative expenses among the members of the IHC Program;

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

18. Impose interest penalties upon members for late payment of assessments;

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

20. 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. 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 through 16;

22. 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. 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.

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

In (b), substituted "authority" for "power" in the introductory sentence, deleted a P.L. reference in 4, and rewrote 6.

11:20-2.4 Temporary Plan of Operation

(a) The Temporary Plan shall become effective upon adoption by the Commissioner and submission of final action to the Office of Administrative Law for publication. The Commissioner may amend the Temporary Plan 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.

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), substituted "the Office of Administrative Law" for "OAL"; and in (b), deleted "amend or" preceding "rescind".

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 recom-

mendation 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;

(2) A health maintenance organization;

(3) A mutual insurer of this State subject to Subtitle 3 of Title 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. 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. 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 P.L. 1993, c.164, sections 7 and 8, 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.

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.

11:20-2.6 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;

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

5. 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 ratios;
- 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 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;

2. A Legal Committee, which shall make reports to 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;
- 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 to be distributed to consumers which describes 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. An Operations 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.

(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.

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

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

Rewrote (d); and added a new (f).

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 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. 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). 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), 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.

(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, 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.

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

In (c), rewrote 2; in (d), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator"; and in (f), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator" and changed the delivery deadline from September 30 of each year beginning in 1994 to December 31 of each year beginning in 1998 in the introductory paragraph, and substituted "Board" for "Technical Advisory Committee" in 2.

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.

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 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 carriers 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:

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) 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) 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) Report and premiums earned amount set for 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) 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) 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) 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) 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.

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

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

In (a), inserted "or Operations Committee, or both Committees" following "Technical Advisory Committee" in 3; and added a new (c).

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.

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), substituted "Executive Director" for "Interim Administrator and subsequently appointed Administrator"; in (b), deleted "including rate and form filings, loss ratio filings, reports of net earned premium and reports of net paid losses" at the end of 3, deleted 8, and recodified former 9 and 10 as 8 and 9; and rewrote (c).

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 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.

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, a certification, set forth as Exhibit Q in the Appendix to this chapter, 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 a standard health benefits plan until a full schedule of corresponding rates has been filed with the Board in accordance with N.J.A.C. 11:20-6.

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.

11:20-2.11 (Reserved)

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

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

Section was "Assessment for 1992 total reimbursable net paid losses".

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

(a) 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, 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.

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.

(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) 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 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 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 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 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.

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 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.

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.

11:20-2.13 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.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Substituted "Executive Director at the address listed in N.J.A.C. 11:20-2.1(h)" for "Interim Administrator (or Administrator)".

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 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.

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); deleted former (b) through (d); and recodified former (e) as (b).

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.

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 "employee of the Board" following "Directors".

11:20-2.17 Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998

(a) The IHC Program Board may assess members for reimbursable net paid losses as may be necessary, pursuant to its authority under N.J.S.A. 17B:27A-11a and according to the procedures set forth in this Temporary Plan.

(b) The IHC Program Board shall determine the preliminary total reimbursable net paid losses, if any, for the preceding two-year calculation period based upon the information submitted by members no later than March 1 of the year immediately following each two-year calculation period to the IHC Program Board in the Carrier Market Share and Net Paid Gain (Loss) Report, set forth as Exhibit K in the Appendix to this chapter, completed in accordance with N.J.A.C. 11:20-8. Such a determination shall be made by the IHC Program Board on or about May 1 of the year immediately following each two-year calculation period.

1. The total reimbursable net paid losses of the preceding two-year calculation period shall be the aggregate of the reimbursable net paid losses for all members reporting net paid losses for that two-year calculation period.

2. Prior to receiving reimbursement for net paid losses, a member must meet the performance standards set forth at N.J.A.C. 11:20-10.

(c) The Board shall determine each member's assessment amount by multiplying the member's market share, or adjusted market share as applicable, by the total reimbursable net paid losses for the preceding two-year calculation period. The portion of assessment amounts forgiven to those members granted a final (full or pro rata) exemption shall be redistributed to carriers not receiving a final (full or pro rata) exemption as described in (c)3 below. Assessment amounts for those members granted a deferral by the Commissioner shall be redistributed as described in (c)2 below.

1. The IHC Program Board shall determine each member's market share by comparing the member's net earned premium for all health benefits plans for the preceding two-year calculation period to the net earned premium of all members for the preceding two-year calculation period as reported by each member in the Carrier Market Share and Net Paid Gain (Loss) Report, set forth as Exhibit K of the Appendix to this chapter, 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 Gain (Loss) Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program based upon the premium set forth in the member's most recent Annual Statement filed with the Department. Members' market shares shall be adjusted in consideration of the following factors, if necessary:

i. A member that has been granted a full exemption under N.J.A.C. 11:20-9.5 shall not be assessed for any portion of the total reimbursable net paid losses.

ii. A member that has been granted a pro rata exemption under N.J.A.C. 11:20-9.5 shall be liable for an assessment determined by multiplying the total amount of reimbursable losses (program losses) for the preceding two-year calculation period by the ratio of the member's net earned premium to the net earned premium of all members for the preceding two-year calculation period multiplied by a fraction, the numerator of which is the difference between the minimum number of non-group persons allocated to the member by the Board and the number of non-group persons actually enrolled or insured by the member, taking into account the limitations on counting Medicaid recipients and Medicare cost and risk lives, and the denominator of which is the minimum number of non-group persons allocated to the member by the Board. A carrier that has been granted a pro rata exemption under N.J.A.C. 11:20-9.5 shall not be liable for that portion of the loss assessment that is reapportioned as a result of the granting of final (full or pro rata) exemptions.

2. Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by a member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members based on their respective market shares as adjusted pursuant to (c)1ii above.

i. Members that have been granted a deferral shall remain liable to the IHC Program for the amount deferred and any additional amounts required by N.J.A.C. 11:20-11.6.

ii. Upon eventual payment of the deferred amount to the IHC Program, the members to whom the deferred amounts were reapportioned will be credited for those amounts previously apportioned to them.

3. Assessment amounts for members granted a final (full or pro rata) exemption by the Board shall be redistributed to the other members not receiving a final (full or pro rata) exemption. The distribution shall be based on an adjusted market share of the members not receiving a final (full or pro rata) exemption. This adjusted market share shall be the ratio of the member's net earned premium to the net earned premium of all members not receiving a final (full or pro rata) exemption for the preceding two-year calculation period. This additional redistributed portion of the assessment shall be determined by multiplying the total amount of redistributed reimbursable losses from those carriers receiving a final (full or pro rata) exemption for the preceding two-year calculation period by the carrier's market share as adjusted by this paragraph.

(d) Every member shall be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period unless the member has been granted a full exemption from assessments for the preceding two-year calculation period by the Board in accordance with N.J.A.C. 11:20-9.

1. The IHC Program Board shall provide a preliminary notice to its members in writing, on or about May 1 of the year following every two-year calculation period, of the total reimbursable net paid losses for the preceding two-year calculation period and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period.

2. On or about September 1 of the year following every two-year calculation period, the IHC Program Board shall notify each member by invoice of the dollar amount being assessed against the member for its portion of the total reimbursable net paid losses for the preceding two-year calculation period.

3. The IHC Program Board may, as necessary, make reconciliations from the preliminary notice of the assessment for reimbursable net paid losses which may include adjustments in market share and adjustments for deferrals granted.

4. Upon the resolution of all outstanding matters including audits of reimbursable losses and appeals filed pursuant thereto, the IHC Program Board shall notify each member of the final reconciliation of the assessment for reimbursable net paid losses for the appropriate two-year calculation period by invoice stating the dollar amount then due or credit, if any, against future assessments. As a result of the final reconciliation, any monies determined to be owed to or by the Board shall be calculated without provision for interest.

(e) Assessments amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, IHC Program, at the address set forth in N.J.A.C. 11:20-2.1(h).

1. 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 of the assessment amount not timely paid per month, 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 to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (e)1i above. If a carrier 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 be liable for and make payment of the full amount of the assessment invoice, 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 Procedures Act, N.J.S.A. 52:14B-1 et seq.

(f) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with 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 (e) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (g) below, pending final disposition by the Commissioner of the deferral request.

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

(g) 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. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for the two-year calculation period. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period, until such time as the dispute has been settled against the disputing member, or the deferral denied, except that any portion of an assessment not in dispute or subject to a deferral request, or

portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period year in accordance with (g) above, along with any applicable interest penalty amounts paid or interest accrued while held in escrow by the Board.

2. Upon receipt of notice that amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate the proportionate amount of interest, 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 and provide notice to the carrier of the principal amount and interest amount. The calculated amount shall be returned to the member with interest within 30 days from the date the interest has been calculated.

New Rule, R.1994 d.165, effective March 1, 1994.

See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).

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.

The Expiration date of N.J.A.C. 11:20-2.17, was extended by gubernatorial directive to December 31, 2005, in accordance with N.J.S.A. 52:14B-5.1d.

See: 37 N.J.R. 2884(a).

Case Notes

Regulation exempting health insurance carriers that met only 50% of their individual health insurance policy goals from any second-tier assessment for failing to issue minimum number of individual policies, while requiring certain carriers meeting 49% and less of their goals to meet entire cost of providing coverage, violated requirement of Individual Health Insurance Reform Act that there be an equitable sharing of Individual Health Coverage Program (IHCP) losses among all carriers. New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1, 847 A.2d 552.

Individual Health Insurance Reform Act did not authorize Individual Health Coverage Program (IHCP) regulation that completely excused carriers from second-tier assessment if they received pro rata first-tier exemptions from assessment for failing to meet Act's enrollment requirements; Act did not allow New Jersey Individual Health Coverage Program Board of Directors to further penalize carriers who were not entitled to any exemption. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

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.

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.

Amended by R.1995 d.531, effective October 2, 1995.

See: 27 N.J.R. 1127(a), 27 N.J.R. 3793(b).

Amended by R.1997 d.3, effective December 5, 1996.

See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).

Inserted new (b)2; recodified former (b)2 as (b)3; and, in (c), inserted reference to (b)2 deductible options.

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).

Substituted Plan B for Plan A as the "The Basic Health Benefits Plan" and amended deductible and copayment amounts.

Amended by R.1998 d.26, effective January 5, 1998.

See: 29 N.J.R. 1089(a), 30 N.J.R. 237(a).

Inserted (d)6.

Administrative correction.

See: 30 N.J.R. 1318(b).

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.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

In (a), substituted "Individual" for "Basic" in 2, and added 7; in (b), inserted a reference to Plan A/50, deleted a reference to Plan E, inserted a reference to Exhibit U and substituted a reference to Exhibit D for a reference to Exhibit E in the introductory paragraph, deleted a reference to Plans B and E in the introductory paragraph of 1, and inserted a reference to Plans A/50 and B in the introductory paragraph of 2; in (c), substituted a reference to Plans A/50, B, C, and D for a reference to Plans B through E in the first sentence, and added 3; and in (d), inserted a reference to Plan A/50 in the first sentence, substituted a reference to Exhibit D for a reference to Exhibit E in 2, inserted a reference to \$30.00 copayment levels in 3, and deleted ", and Plan E shall have an out-network level of 99 percent" at the end of 4. Amended by R.1999 d.131, effective March 25, 1999.

See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).

In (b)3, rewrote i and ii.

Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).

See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).

Added (b)4.

Amended by R.2002 d.331, effective October 7, 2002.

See: 34 N.J.R. 1786(a), 34 N.J.R. 3527(a).

In (b)4, substituted "may" for "shall".

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

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.

Repeal and New Rule, R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).

See: 26 N.J.R. 4884(a), 27 N.J.R. 565(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.

Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

In (a), inserted a reference to Exhibit U; and in (b), deleted a reference to Exhibit E, and substituted a reference to Exhibit D for a reference to Exhibit E.

11:20-3.3 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:20-3.2, 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 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 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 of the Appendix to this Chapter, as described in the Explanation of Brackets, Exhibit T, through the use of the Compliance and Variability Rider as set forth as Exhibit S of the Appendix.

New Rule, R.1996 d.542, effective December 2, 1996.

See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(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 (b), inserted "as described in the Explanation of Brackets, Exhibit T," following "Chapter".

Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

In (b), substituted a reference to Exhibit U for a reference to Exhibit F.

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. A specimen policy form is set forth in Appendix Exhibit V.

New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

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.

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).

See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

Administrative Correction.

See: 27 N.J.R. 1424(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.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted "and the basic and essential health care services plan with an effective date on or after January 1, 2003," following "August 1, 1993".

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.

New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

SUBCHAPTER 4. (RESERVED)

SUBCHAPTER 5. (RESERVED)

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 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.

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted "as well as the basic and essential health care services plan pursuant to P.L. 2001, c.368" following the N.J.S.A. references.

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 of these health benefits plans, an informational rate filing with the Board, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other

factors prohibited by the Act, except that the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by P.L. 2001, c.368 and N.J.A.C. 11:20-6.5;

2. 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; adult/child(ren); 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 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 rates being submitted;
 - ii. All information used in the development of the rates;
 - iii. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including historical experience, trend assumptions, plan relativity assumptions, and any other factors used in developing the anticipated loss experience; and

iv. The administrative expense, premium tax and commission payment assumptions, and other margins;

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 services 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, 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.

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.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote (a); in (b), inserted "its basic and essential health care services plan" preceding "or its community rated".

11:20-6.4 Informational rate filing procedures

(a) 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).

(b) If the Board determines that an informational filing filed pursuant to N.J.A.C. 11:20-6.3(a) or (b) 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 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 until the Board has determined that the informational filing is complete, and written notice of that fact has been provided to the member.

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).

Rewrote (a); and deleted former (e).

11:20-6.5 Permissible rate classification factors

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

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

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

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

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

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

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

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

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

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

1. Single;
2. Husband and wife;
3. Adult and child(ren); and
4. Family.

New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

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.

New Rule, R.1996 d.193, effective April 15, 1996.
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

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.

Recodified from 11:20-7.2 and amended by R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(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 (a).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), inserted references to basic and essential health care services plan preceding “in force” throughout; in (b), inserted “and the basic and essential health care services plan policy forms” preceding “written by the member”.

11:20-7.4 Contents of the Loss Ratio Report

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

1. The reporting member’s name and address;
 2. The member’s net earned premium for the preceding calendar year;
 3. A statement of the member’s total losses incurred consisting of:
 - i. Claims paid during the preceding calendar year, regardless of the year incurred;
 - ii. Less residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;
 - iii. Less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year’s Loss Ratio Report;
 - iv. Plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;
 - v. Plus residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year;
 - vi. Plus a pro rata share of the reimbursable net paid loss assessment paid by the carrier pursuant to N.J.A.C. 11:20-2.17 during the preceding calendar year, if any, determined as the member’s total net paid loss assessment multiplied by the ratio resulting from dividing the member’s net earned premium for standard health benefits plans and the basic and essential health care services plan for the preceding calendar year by the net earned premiums for all of the member’s health benefits plans for the preceding calendar year;
 4. The member’s loss ratio (determined by dividing the total losses incurred in (a)3 above by the net earned premium as determined in (a)2 above);
 5. Certification by a member of the American Academy of Actuaries that the information provided in the Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-9 in accordance with instructions; and
 6. Such other information as the Board may request.
- (b) The residual reserve reported in (a) above shall consist of either:
1. A safeharbor reserve equal to 3.3 percent of the sum of (a)3i, (a)3iii and (a)3iv above; or

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

Recodified from 11:20-7.3 and amended by R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(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 "if any," in 3vi, and inserted "in (a)3 above" in 4.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In the introductory paragraph of (a) and in 3vi, inserted "and the basic and essential health care services plan" following "health benefits plan".

11:20-7.5 Refund plan

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

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

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

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

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

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

Recodified from 11:20-7.4 and amended by R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), inserted "and net earned premium received that year on the basic and essential health care services plan" following "health benefits plan" throughout; in (b)2, inserted references to basic and essential health care plan following "health benefits plan" throughout.

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.

New Rule, R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

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.

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".

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Scope and applicability".

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 1 of the year immediately following every two-year calculation period thereafter.

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

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

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

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

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

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

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).

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Filing of the market share and net paid gain or (loss) report form".

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

(a) In Part C of the Exhibit K Assessment Report, each member shall set forth its total net earned premium from plans issued, continued or renewed for all affiliated carriers during the preceding two-year calculation period. Net earned premium reported in Part C of Exhibit K shall be consistent with the data set forth on the Exhibit K Part C Premium Data Worksheet(s).

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

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

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

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

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

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

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).

Amended by R.2001 d.55, effective January 17, 2001.

See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).

In the introductory paragraph of (a), inserted N.J.A.C. reference, and in (a)1, inserted “, but not be limited to,”.

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was “Net earned premium”.

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

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

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

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

2. In Section b of the Enrollment Data Worksheet, the carrier shall report all community rated conversion policy persons as of the last day of the end of each

calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

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

4. In Section d of the Enrollment Data Worksheet, the carrier shall report all Medicare Plus Choice and Medicare cost and risk lives 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.

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.

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was “Calculation of covered non-group persons”.

11:20-8.5 Calculating net paid losses or gains

(a) For purposes of completing Part E of the 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.

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

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

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

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

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

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

(d) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits shall report its net investment income. Net investment income shall be calculated in accordance with statutory reporting requirements. For purposes of Exhibit K reporting, and not withstanding how a carrier allocates net investment income to individual lines in other statutory reports or filings, carriers shall allocate net investment income consistent with the following basis, adjusted for the individual health benefits plans for which the report is being made as necessary.

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

2. Net investment income, after adjustment, if any, as permitted by (d)1 above, shall be distributed to major and secondary lines of business in proportion to the mean funds of each line of business, after suitable adjustment, if any, on account of policy loans, except that any miscellaneous interest income arising from policy or annuity transactions may be allocated directly to the line of business producing such income. Mean funds refers to the average net cash flow balance over the two-year calculation period for which the calculation is being made, with the average net cash flow balance determined on a monthly or quarterly basis. 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.

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.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote the section.

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 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 1 of the year following every two-year calculation period that:

1. 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.

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).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote (a); in (b)1, substituted "the assessment" for "Exhibit K" following "reported on".

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 the 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 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.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), substituted "the Assessment Report" for "market share and net paid gain (loss) report" in the introductory paragraph.

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 Assessment Report. The IHC Program Board shall choose and direct the independent auditor. The IHC Program Board and the member being audited shall share equally the cost of an independent audit.

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

New Rule, 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 (b), inserted "gain" preceding "(loss)" in the first sentence; and in (c), substituted "two-year calculation period" for "calendar year".

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (b), substituted "Assessment Report" for "market share and net paid gain (loss) report"; in (c), added the second sentence.

11:20-8.9 Hearings

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

New Rule, 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.

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.

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).
Inserted "full" preceding "or pro rata".

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

1. To enroll or insure the minimum number of non-group persons in New Jersey necessary for the member to meet its minimum enrollment share of non-group persons, allocated to it by the Board pursuant to N.J.A.C. 11:20-9.3;
2. To enroll or insure the minimum number of non-group persons in New Jersey under:
 - i. Standard health benefits plans and the basic and essential health care services plan;
 - ii. Conversion policies issued pursuant to the IHC Act;
 - iii. Medicaid contracts, if offered; and
 - iv. Medicare cost and risk contracts with the Federal government, Medicare Plus Choice and Medicare Demonstration plans with respect to Medicare recipients, if offered; and
3. Not to seek reimbursements for losses the member may incur under the standard health benefits plans 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, appeal the Board's determination and request a hearing, pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

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).
Rewrote the section.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
In (b)2, rewrote i and iv.

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, the IHC Program Board shall issue to each member its minimum enrollment share of non-group persons for that two-year calculation period which the member must agree to cover in that two-year calculation period for purposes of obtaining 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, the total number of community rated, individually enrolled or insured persons, including Medicare cost and risk lives, Medicare Plus Choice lives and Medicare Demonstration Project lives and enrolled Medicaid lives, NJ KidCare Part A lives and NJ FamilyCare Part A lives of all members subject to the Act, and all individually enrolled or insured persons covered under a basic and essential health care services plan, except for hospital and

medical service corporation carriers, covered on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, divided by eight, and multiplied by the proportion that the member's net earned premium bears to the net earned premium of all members for the preceding two-year calculation period.

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 (a) and (c).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (c), deleted 1 and recodified former 2 as new 1.

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

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

1. Standard health benefits plans and the basic and essential health care services plan;
2. Conversion policies issued pursuant to the Act; and
3. Medicare cost and risk contracts, Medicare Plus Choice contracts and Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's minimum number of non-group persons.

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

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 former 3, and recodified former 4 as 3; and in (b), substituted "(a)3" for "(a)4" following "(a)1 through".

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), rewrote 1 and 3.

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

(d) The IHC Program Board shall review, and may audit, a member's non-group persons reported pursuant to (b) 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) 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) above or as a result of the findings of an independent audit conducted pursuant to (d) above.

(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, 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.

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.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (b), inserted "Medicare Plus Choice lives and Medicare Demonstration Project lives" preceding the N.J.A.C. reference in the introductory paragraph and rewrote 2.

Case Notes

Regulation giving pro rata exemption from Individual Health Coverage Program (IHCP) assessments to health insurance carriers that fell short of writing 50% of their target goal of individual policies, so long as they engaged in good-faith marketing efforts, conflicted with assessment scheme of Individual Health Insurance Reform Act; statute's pro rata assessment provision mandated assessment based on difference between target number and actual number of policies written. New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1, 847 A.2d 552.

Good-faith marketing requirements in Individual Health Coverage Program (IHCP) regulations were within authority of New Jersey Individual Health Coverage Program Board of Directors; Board's development of a program that gave incentives and required carriers to develop that they made a good-faith effort to enroll their target amount of individual or non-group policyholders was within the Legislature's intent in establishing Individual Health Insurance Reform Act. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

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.

New Rule, R.1994 d.352, effective June 17, 1994.
See: 26 N.J.R. 2737(a), 26 N.J.R. 2904(a).
Amended by R.1994 d.509, effective September 15, 1994.
See: 26 N.J.R. 3809(a), 26 N.J.R. 4193(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).

Rewrote (a); and in (c), substituted references to New Jersey individual health benefits plans for references to health benefits plans. Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted references to basic and essential health care services plans following references to health plans throughout.

Case Notes

Regulation giving pro rata exemption from Individual Health Coverage Program (IHCP) assessments to health insurance carriers that fell short of writing 50% of their target goal of individual policies, so long as they engaged in good-faith marketing efforts, conflicted with assessment scheme of Individual Health Insurance Reform Act; statute's pro rata assessment provision mandated assessment based on difference between target number and actual number of policies written. New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1, 847 A.2d 552.

Good-faith marketing requirements in Individual Health Coverage Program (IHCP) regulations were within authority of New Jersey Individual Health Coverage Program Board of Directors; Board's development of a program that gave incentives and required carriers to prove that they made a good-faith effort to enroll their target amount of individual or non-group policyholders was within the Legislature's intent in establishing Individual Health Insurance Reform Act. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

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.

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), substituted "in the year following the two-year calculation period" for "for calendar year 1993 and thereafter".

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 1, in the year following the two-year calculation period which contains the following:

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

i. 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. 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) 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) 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.

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); and in (b), deleted "1" following "(a)"; and added a new (e).

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 final determination, pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

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.

11:20-10.5 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 law.

SUBCHAPTER 11. RELIEF FROM OBLIGATIONS IMPOSED BY THE INDIVIDUAL HEALTH INSURANCE REFORM ACT

11:20-11.1 Purpose and scope

(a) This subchapter establishes the informational and procedural requirements for members requesting relief from obligations to pay assessments pursuant to N.J.S.A. 17B:27A-12 (including assessments for IHC Program losses and administrative expenses), or to offer coverage or accept applications to provide a standard health benefits plan to eligible persons, pursuant to N.J.S.A. 17B:27A-8.

(b) This subchapter applies to all members of the IHC Program.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (a), deleted an N.J.S.A. reference.

11:20-11.2 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.

"Applicant" means the member seeking a deferral of its obligation to pay assessments or a waiver of its obligation to offer coverage and accept applications pursuant to N.J.S.A. 17B:27A-2 et seq.

"Financially impaired" means a member that is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or a member which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Relief" means a deferral of obligations imposed pursuant to N.J.S.A. 17B:27A-12, or a waiver of obligations pursuant to N.J.S.A. 17B:27A-8, as applicable.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (b), deleted "which, after December 20, 1993" following "member" in "Financially impaired" definition; and deleted an N.J.S.A. reference in "Relief" definition.

11:20-11.3 Application procedures and filing format

(a) Any member seeking relief may submit such request to the Department at any time, except that requests for relief from payment of assessments pursuant to N.J.S.A. 17B:27A-12a(3) shall be submitted to the Department no later than 15 days following the due date of payment of the assessment.

(b) All requests outlined in this subchapter shall be accompanied by a statement averring a need for relief from the obligation(s), as the case may be, including supporting documentation as set forth in N.J.A.C. 11:20-11.4, and shall specify the statutory and regulatory basis for such relief. A single filing may request relief from more than one obligation, but shall specify each obligation from which relief is sought.

(c) Each request shall be in loose leaf form inserted into standard two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in N.J.A.C. 11:20-11.4. The loose leaf sheets used in the request shall

be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(d) All members requesting relief pursuant to this subchapter shall submit five copies of each request in the format set forth in (c) above.

(e) If a request fails to materially comply with the filing format and information requirements set forth in N.J.A.C. 11:20-11.4 and this section, the Department shall notify the member that its request for relief is deficient and is denied on such grounds. The notice shall also set forth any information or other action required to cure the deficiency(s). If the member intends to pursue its request, the member shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in this section within 15 days of receipt of the Department's notice of deficiency. Failure to submit within 15 days the information necessary in the proper format to cure the deficiency shall result in the member's request being denied.

(f) All requests for relief or other information required pursuant to this subchapter shall be filed with the Department at the following address:

IHC Program
Request for Relief
New Jersey Department of Banking and Insurance
Division of Financial Solvency
PO Box 325
Trenton, NJ 08625-0325

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (a), deleted an N.J.S.A. reference; and in (f), updated the address.

11:20-11.4 Informational filing requirements

(a) When requesting relief from obligations imposed pursuant to N.J.S.A. 17B:27A-4 or 17B:27A-12, the applicant shall provide with its request the following information in a clear, concise and complete manner:

1. A cover letter stating:
 - i. The name of the applicant;
 - ii. The form of relief and, if a deferral of less than the full amount, specific amount/percentage of relief which the applicant is requesting;
 - iii. A statement of facts relied upon as the basis under which relief is sought, including the specific factor(s) upon which the Commissioner may find that the member is or would be placed in a financially impaired position as set forth in N.J.A.C. 11:2-27.3(a)1 to 29; and

- iv. The name, title, telephone number and telefax number of a contact person familiar with the filing to whom the Department may direct any additional questions;

2. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation would have on the immediate and long term financial condition of the applicant unless relief is granted as requested;

3. The most recent financial examination report, whether conducted by the applicant's state of domicile or other state;

4. A statement addressing whether the applicant is planning to modify its method of doing business in any way including, but not limited to, new acquisitions or new restructuring;

5. If the applicant is a member of a holding company system, the following shall be provided:

- i. A list of all members of the holding company system;

- ii. A list of all intercompany transactions for the period beginning January 1 in the year of the filing to the date of the quarterly statement immediately preceding the date of the filing, in the format set forth in the statutory annual statement filed by the applicant; and

- iii. A copy of the registration statement filed pursuant to N.J.S.A. 17:27A-3 and the applicant's organizational chart;

6. An actuarial opinion attesting to the adequacy of reserves specifically for all accident and health lines of business, and for all lines of business which the applicant transacts, in the format of and satisfying all requirements for the actuarial opinion and memorandum required to be submitted as a part of the annual statement filed by the applicant;

- i. If the applicant is a health maintenance organization, the applicant shall obtain and file an actuarial opinion which complies with the requirements set forth in (a)6 above;

7. A report signed by the attesting actuary referred in (a)6 above, which includes, in summary form if necessary, all data utilized, a complete explanation of methods and assumptions and sufficient additional narrative to account for any features of the data or circumstances necessary for proper interpretation;

8. A copy of the annual statement of the applicant, including all accompanying exhibits, filed with this State immediately preceding the date of the relief filing;

9. Copies of all quarterly statements for the period beginning January 1 in the year of the filing to the quarterly statement immediately preceding the date of the filing;

10. Three-year financial projections beginning with the calendar year of the date of the filing assuming relief is granted and assuming relief is denied. The projections shall include, in summary form if necessary, all data utilized, and a complete explanation of methods and assumptions utilized and relied upon by the applicant in making the projections. The projections shall include results for the applicant's operations worldwide by line of business and for the applicant's operations in New Jersey only for individual health benefits plans issued pursuant to N.J.S.A. 17B:27A-2 et seq. The projections shall assume the same rate of assessment as in the first two-year calculation period for the subsequent two-year calculation period, and shall include projections of the applicant's operating results containing the information and in the format set forth in the following:

- i. For life and health insurers, the balance sheet and summary of operations exhibits of the statutory annual statement filed by the insurer;
- ii. For property and casualty insurers, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the insurer;
- iii. For health service corporations, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the health service corporation; and
- iv. For health maintenance organizations, the balance sheet and statement of revenue, expenses and net worth of the annual statement filed by the health maintenance organization;

11. A description of any relief from obligations imposed by this State or any other state granted or in effect within the preceding 12 months, and the basis upon which such relief was granted;

12. A non-refundable filing fee of \$1,000, unless the applicant is in rehabilitation or conservation at the time of filing pursuant to N.J.S.A. 17B:32-31 et seq. or such similar law of the applicant's state of domicile; and

13. Any other information the Commissioner may deem relevant to the consideration of the request.

(b) An applicant asserting that the Department's review of its request be evaluated on a particular basis (that is, pre-pooled, post-pooled, consolidated or unconsolidated), shall submit a written statement which sets forth the specific reasons, with supporting documentation, if any, for which it believes evaluation on a particular basis is appropriate to that applicant, and the specific reasons, with supporting documentation, if any, for which evaluation on other bases would be inappropriate.

(c) All filings shall be accompanied by the following certification signed by the chief financial officer of the applicant: "I _____ certify that the attached filing complies with all requirements set forth in N.J.A.C.

11:20-11 and that all of the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of the applicant."

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (a), deleted an N.J.S.A. reference in the introductory paragraph and rewrote 10.

11:20-11.5 Confidentiality of request for relief

(a) All data or information contained in the request for relief filed pursuant to this subchapter shall be confidential and shall not be subject to public disclosure or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A-1 et seq., except for the following items, but only upon written, specified request and following 10 days written notice by the Department to the member/applicant:

1. N.J.A.C. 11:20-11.4(a)1i and ii—cover letter with name of applicant and describing relief sought;
2. N.J.A.C. 11:20-11.4(a)1iv—name, title, telephone number and telefax number of person familiar with the filing;
3. N.J.A.C. 11:20-11.4(a)3—most recent financial examination report;
4. N.J.A.C. 11:20-11.4(a)5i and ii—list of members of holding company system and intercompany transactions for period preceding date of filing;
5. N.J.A.C. 11:20-11.4(a)8—annual statement filed immediately preceding date of filing;
6. N.J.A.C. 11:20-11.4(a)12—non-refundable filing fee; and
7. N.J.A.C. 11:20-11.4(a)13—additional information required by the Commissioner to evaluate a particular filing.

11:20-11.6 Disposition of request for relief

(a) When the Commissioner determines pursuant to N.J.S.A. 17B:27A-8 or 17B:27A-12a(3), as applicable, that the member does not have the financial reserves necessary to underwrite additional coverage or is or would be placed in a financially impaired condition through fulfillment of a coverage or assessment obligation or obligations, the Commissioner shall notify the member that its duty to fulfill the applicable obligation shall be waived, or deferred in whole or in part, as appropriate. If the Commissioner defers in whole or in part a member's obligation to pay assessments pursuant to N.J.S.A. 17B:27A-12a(3), the member shall remain liable to the IHC Program for the amount deferred.

(b) The Commissioner shall find that a member is or would be financially impaired if:

1. The member has been placed in rehabilitation or conservation pursuant to N.J.S.A. 17B:32-31 et seq. or such similar law of the member's state of domicile;

2. The Commissioner finds that the member is in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2-27; or

3. The Commissioner finds that fulfillment of the obligation(s) from which relief is sought would place the member in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2-27.

(c) Any waiver or deferral from a particular obligation granted by the Commissioner pursuant to this subchapter shall be for a specified period as set forth in the notice granting the request, but shall not exceed 12 months from the date of the notice. Any member seeking to continue a waiver or deferral shall file a separate request for relief in accordance with this subchapter no later than 45 days prior to the expiration of the waiver or deferral period set forth in the original notification granting the request. Such a request shall also include a detailed explanation of all actions the applicant has taken and intends to take to cure the financial impairment. Failure to file a properly completed request for relief within the time prescribed shall result in the expiration of the waiver or deferral at the expiration of the period set forth in the original notification granting the request. Nothing herein shall be construed as limiting or prohibiting any member from applying for relief at any time in accordance with this subchapter.

(d) If the Commissioner grants a request for a deferral of payment of an assessment, the terms of the deferral shall include the requirement that the member shall pay to the Board an additional amount representing the loss to the Board of the time value of the assessment for the period of the deferral.

1. In calculating the additional amount to be paid, the member shall use the annual interest rate on one-year U.S. Treasury bills as of the date the assessment was due and payable.

2. In calculating the additional amount to be paid, the period of deferral shall begin on the date that payment of the assessment was due and payable and end on the date the amount deferred is paid to the Board.

3. The payment of the additional amount set forth in (d) above shall be in lieu of payment by the member of any interest or penalty on the amount deferred, which otherwise may be required under any other rule.

4. The requirement to pay an additional amount as provided in (d) above shall not apply when the reason for granting the deferral is that the member is in rehabilitation or conservation.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (a), inserted "does not have the financial reserves necessary to underwrite additional coverage or" in the first sentence and deleted an N.J.S.A. reference.

11:20-11.7 Hearings

(a) If the Commissioner denies a member's request for relief made pursuant to this subchapter, or if the member objects to the terms of the relief granted, the member may request a hearing on the Commissioner's determination within seven days from the date of receipt of such determination as follows:

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

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

ii. A copy of the Commissioner's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the material facts in dispute and describing the basis for which the member believes that the Commissioner's findings of fact are erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the member and such personnel of the Department as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

3. The Commissioner shall, within 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.

i. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. When the matter is determined to be a contested case, if the Commissioner finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition of the matter.

ii. If the Commissioner finds that the matter does not constitute a contested case, the Commissioner, with the approval of the Director of the Office of Administrative Law, may transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21. If the Commissioner finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition of the matter.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (a), inserted "listing the material facts in dispute and" in 1iv and added a new 3ii.

11:20-11.8 Notice of the IHC Program

Members requesting relief pursuant to this subchapter shall concurrently provide written notice of all such requests to the IHC Program through the Executive Director. Members shall also provide written notice to the IHC Program of all dispositions of such requests by the Commissioner, within 15 days of such disposition.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

Inserted "written" preceding "notice" throughout, and substituted "Executive Director" for "Interim Administrator or Administrator, as appropriate".

11:20-11.9 Exceptions for health maintenance organizations due to lack of capacity

(a) Any member health maintenance organization (HMO) asserting that it is not required to offer coverage or accept applications pursuant to the requirements of the Act because it does not have the capacity to enroll additional members, pursuant to N.J.S.A. 17B:27A-8a, shall file the following information with the Commissioner:

1. A cover letter stating:
 - i. The name of the member HMO;
 - ii. A statement that the member is not required to offer coverage or accept applications pursuant to the Act because it does not have the capacity in its facilities to enroll additional members, and the basis for that assertion, with supporting documentation, certified by the president or duly authorized officer of the member;
 - iii. The number of the member's current individual and group members, listed by provider and classified by the provider's specialty, which shall be updated annually each year the member asserts a waiver pursuant to N.J.S.A. 17B:27A-8a; and
 - iv. A certification signed by the president or duly authorized officer that the member, pursuant to N.J.S.A. 17B:27A-8a:
 - (1) Will not offer coverage to or accept any new group members. Individual additions to existing groups shall not be considered new group members; and
 - (2) Upon denying individual health benefits coverage, will not offer such coverage in the individual market for a period of 180 days after the date the coverage is denied.
- (b) The member shall concurrently file the information required pursuant to (a) above with the IHC Program.

Amended by R.1998 d.454, effective September 8, 1998.
See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).
Rewrote (a)iv.

11:20-11.10 Other actions by the Commissioner

Nothing in this subchapter shall be construed as limiting the Commissioner's authority to take such action with respect to insurers, health service corporations or health maintenance organizations as may be authorized by law, including, but not limited to, placing an insurer, health service corporation or health maintenance organization in rehabilitation, liquidation or conservation pursuant to N.J.S.A. 17B:32-31 et seq.

11:20-11.11 Penalties

Failure to comply with this subchapter, including all notice requirements set forth herein, may result in the denial of relief requested and imposition of penalties as authorized by law, including any actions that may be taken by the Board pursuant to N.J.S.A. 17B:27A-2 et seq. and the IHC Program Plan of Operation, including, but not limited to, imposition of an interest penalty for assessments due from the member and a recommendation by the Board to remove the member's authority to issue any health benefits plans in this State.

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.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted references to basic and essential health care services plan following references to health benefits plans throughout.

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 1 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.

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

In “Eligible to participate in a group health benefits plan” definition, substituted “to be eligible for coverage (often called a waiting period)” for “and the employee”; and “contractholder” for “person”; in “Group health benefits plan”, inserted “for the purpose of this subchapter” following “except that”; and deleted “Standard health benefits plan” definition.

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.

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).

See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

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).

In (b), deleted reference to persons eligible for Medicaid.

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

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

Rewrote (b) and added a new (c).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted references to basic and essential health care services plan following references to standard health benefits plan throughout.

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.

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).

In (c)1, deleted "plan E with a \$150.00 cash deductible or" following "health benefits plan, except".

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

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

In (c), substituted "other than" for "except" in 1, and deleted 2; in (h), substituted "the day before" for "30 days after" in 2; and in (i), added an N.J.S.A. reference.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a) through (c) and (h) through (i), inserted references to basic and essential health care services plan following "benefits plan" throughout.

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)3iii, 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.

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).

See: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

Administrative Correction.

See: 27 N.J.R. 1424(a).

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).

In (a), in the second sentence, deleted "30 days after" following "will terminate no later than", inserted the third sentence, and in the last sentence, inserted "that was intended to replace it"; in (b), inserted second through sixth sentences; in (d)3, added deductible amounts of \$1,500, \$2,250 and \$2,500; and in (g), deleted "30 days after" following "will terminate no later than".

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

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

In (b) and (c), substituted "31" for "30" preceding "days may choose"; and in (d), rewrote 3.

Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

In (a) and (d)3, inserted references to Plan A/50.

Amended by R.1999 d.131, effective March 25, 1999.

See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).

In (d), rewrote 3.

Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).

See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).

In (d)3, substituted "Code, \$2,500, \$5,000 or \$10,000" for "Code or \$2,500".

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), inserted references to basic and essential health care services plan following "health benefits plan" throughout; added new (e); recodified former (e) through (g) as (f) through (h); in new (h), inserted references to basic and essential health care services following "health benefits plan" throughout.

Amended by R.2005 d.160, effective April 22, 2005.

See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).

Added (i).

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 13 THROUGH 16. (RESERVED)

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.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (b), inserted "or renew" following "issue" and "or the basic and essential health care services plans" following "benefits plans".

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 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.

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

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

In (b), added new "Conversion", "Insured" or "insured individual" and "Replacement contract" definitions.

11:20-17.3 Filing requirements

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

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

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

(d) Members shall submit completed enrollment status reports to 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.

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), inserted "or renewing" following "issuing"; rewrote (b) and (c); and deleted (f).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), inserted "and the basic and essential health care services plans" following "standard health benefits plan".

11:20-17.4 Contents of the enrollment status report

(a) Members shall report the following information on a quarterly basis on the enrollment status report form set forth as Part 1 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken out into indemnity for Plan A/50, indemnity or PPO for Plan B, or indemnity, PPO and POS delivery systems for Plans C and D, the HMO plans, 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 during the period, and subtracting the number of contracts lapsed during the period.

i. New sales and conversion contracts shall be reported separately by employment status and replacement 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 status shall be separated into three categories: previously insured, previously uninsured, and unknown. Replacement status shall be obtained from the section of the application entitled, Other Health Care Coverage, and the question "Are you replacing existing 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. 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 = 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 shall be reported separately by rating category, that is: single; husband and wife (or two person); adult and child(ren); family; and child(ren) only, if applicable; and

4. In section D 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 or the required and permitted copayment options for the HMO Plan.

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

1. In section A of Part 2 of Exhibit L, Report of Inforce Contracts by Zip Code, categorized by 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.

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) and (b).

Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

In (a) and (b), inserted references to indemnity for Plan A/50 in the introductory paragraphs.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a) and (b), inserted references to indemnity or HMO coverage under the basic and essential health services plan following "HMO plans" in the introductory paragraph.

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. WITHDRAWAL OF CARRIERS FROM THE INDIVIDUAL MARKET AND 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 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: 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, 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 plan" means a plan developed by the Individual Health Coverage Program Board offered pursuant to N.J.S.A. 17B:27A-4b and the basic and essential health care services plan developed by the Legislature and offered pursuant to P.L. 2001, c.368.

"State" means the State of New Jersey.

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

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

"Plan withdraw" or "plan withdrawal" means a carrier's cessation of the issuance of one of the standard individual health benefits plans, and the nonrenewal of all in force A 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.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote "Standard individual health benefits plan".

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 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:

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.

(b) A carrier that notifies the Board under this section shall continue to renew all in force standard individual health benefits plans unless 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, 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 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 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 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 for an exemption pursuant to N.J.A.C. 11:20-9 in the

calendar year for 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. 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. 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

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

(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.

(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 above, to every 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 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 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 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 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.

(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 by interested persons for the promulgation, amendment or repeal of any 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, amend or repeal a rule shall submit to the Board, in writing, the following information:

1. Name and address of the petitioner;
2. The substance or nature of the rulemaking which is requested;
3. The reasons for the request and the petitioner's interest in the request; and
4. References to the authority of the Board to take the requested action.

(b) 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) 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 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 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; or
2. Filing a notice of proposed rule or a notice of pre-proposal for a rule with the Office of Administrative Law.

SUBCHAPTER 20. APPEALS FROM ACTIONS OF THE BOARD**11:20–20.1 Scope**

This subchapter shall apply to all appeals from determinations made by the Board under 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 member may request a hearing on the Board's determination within 20 days from the date of receipt of such determination 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 and describing the basis for which the member 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.

3. The Board shall, within 45 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 transmit the matter to the Office of Administrative Law for a hearing consistent with 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. 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.

SUBCHAPTER 21. (RESERVED)

SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

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

Source and Effective Date
R.2003 d.91, effective January 28, 2003.
Sec: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

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 other subchapters in this chapter 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 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 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;
 - 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, incorporated herein by reference. The Board has determined that the plan set forth in Exhibit V includes the coverages required for a basic and essential health care services plan.

1. Members that choose to use the plan specimen policy form as set forth in Exhibit V 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, 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 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. 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 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.

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

11:20-22.6 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 g of P.L. 2001, c.368, every member shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year, 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 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 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.

EXHIBIT I

(RESERVED)

Repeal and New Rule, R.1998 d.443, effective August 7, 1998.

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

Section was "Exhibit I".

Expired, effective July 4, 2005.

See: 37 N.J.R. 2994(a).

EXHIBIT J
Loss Ratio Report Form
New Jersey Individual Health Coverage Program

Reporting Year _____, for the Preceding
 Calendar Year Ending December 31, _____

Name of Carrier: _____ NAIC # _____

Address: _____

Carriers shall complete and file a separate Report Form for each affiliate. Note: Read the corresponding regulation, N.J.A.C. 11:20-7, before you complete this Report.

- A. Net Earned Premium for Standard Health Benefits Plans \$ _____
- B. Total Losses Incurred (1-2-3+4+5+6) = \$ _____
 - 1. Claims paid during the preceding calendar year regardless of the year incurred; \$ _____
 - 2. Residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year; \$ _____
 - 3. Claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the of the preceding calendar year as reported in the preceding calendar year's loss ratio report; \$ _____
 - 4. Claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year; \$ _____
 - 5. Residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year; \$ _____
 - 6. Pro-rata share of the reimbursable net paid loss assessment paid by the carrier during the preceding calendar year pursuant to N.J.A.C. 11:20-2.17; [i x (ii ÷ iii)] = \$ _____
 - i. Total net paid loss assessment \$ _____
 - ii. Net earned premium for standard health benefits plans \$ _____
 - iii. Net earned premium for all health benefits plans \$ _____
- C. Loss Ratio (B ÷ A) = _____ (If less than 75%, fill out D and E below)

EXHIBIT K

New Jersey Individual Health Coverage Program Assessment Report
For the Two-Year Calculation Period ____-____

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

Part A. Carrier Information

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

Part B. Information of Person Completing this Report

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

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

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

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

\$ _____; or
[] Non-member of the IHC Program with no net earned premium

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

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

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

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

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

Part F. Certification

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

Name of Officer _____ Title _____ Date _____

Exhibit K Part C Premium Data Worksheet

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

Directions:

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

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

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

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

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

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

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

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

Section 2: List of Excepted Benefits and Premium	Premium for 1st Year of 2-Year Period	Premium for 2nd Year of 2-Year Period	Total for 2-year Period
a. Medicare + Choice coverage (excepted premium amount is limited to amounts paid by federal government and does not include premium paid by insureds)	\$	\$	\$
b. contracts funded pursuant to the “Federal Employee Health Benefits Act of 1959,” 5 U.S.C. §§8901-8914	\$	\$	\$
c. excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan	\$	\$	\$
d. Medicare supplement policies or contracts	\$	\$	\$
e. non-expense incurred specified disease coverage	\$	\$	\$
f. coverage only for accident, disability income insurance, or any combination	\$	\$	\$
g. coverage issued as a supplement to liability insurance	\$	\$	\$
h. liability insurance, including general liability insurance and automobile liability insurance	\$	\$	\$
i. workers’ compensation or similar insurance	\$	\$	\$
j. automobile medical payment insurance	\$	\$	\$
k. credit-only insurance	\$	\$	\$
l. coverage for on-site medical clinics	\$	\$	\$
m. other similar insurance coverage, as specified in federal regs., under which benefits for medical care are secondary or incidental to other insurance benefits	\$	\$	\$

n. limited scope dental or vision benefits*	\$	\$	\$
o. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof *	\$	\$	\$
p. such other similar, limited benefits as are specified in federal regulations*	\$	\$	\$
q. hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same 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	\$	\$	\$
r. coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §1071 et seq.)	\$	\$	\$
s. similar supplemental coverage provided to coverage under a group health plan	\$	\$	\$
Total excepted premium:	\$	\$	\$

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

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

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

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

Carriers shall complete and return this page with Exhibit K.

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

					Total Q1-Q8
a. Persons covered under standard individual health benefits plans or basic and essential health care services plans	Q1 _____	Q2 _____	Q3 _____	Q4 _____	
	Q5 _____	Q6 _____	Q7 _____	Q8 _____	_____
b. Community rated conversion policy persons	Q1 _____	Q2 _____	Q3 _____	Q4 _____	
	Q5 _____	Q6 _____	Q7 _____	Q8 _____	_____
c. Medicaid recipients (Include NJ FamilyCare Part A, NJ KidCare Part A but no other NJ FamilyCare or NJ KidCare lives)	Q1 _____	Q2 _____	Q3 _____	Q4 _____	
	Q5 _____	Q6 _____	Q7 _____	Q8 _____	_____

- d. Medicare Plus Choice lives, Medicare Risk and Cost lives,
Medicare Demonstration Project lives (Do not include Medicare Supplement)
 - Q1 _____ Q2 _____ Q3 _____ Q4 _____
 - Q5 _____ Q6 _____ Q7 _____ Q8 _____ _____
- e. Two-Year non-group enrollment total (Total Q1-Q8 for a through d): _____
- f. Average two-year non-group enrollment to be reported on Exhibit K
Part D (line e divided by 8) _____

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Exhibit K: New Jersey Individual Health Coverage
Program; Carrier Market Share and Net Paid Gain (Loss) Report".

Carrier:
 Respondent:
 Phone:
 Fax:
 Email:

New Jersey
 Individual Health Coverage Program
 Quarterly Enrollment Report
 Part 1 of Exhibit L

	Issued Prior to 8/1/93	Standard Plans							Basic & Essential			Total Plans
		Plan A/50 Indemnity	Plan B Indemnity PPO		Plan C Indemnity PPO/POS		Plan D Indemnity PPO/POS		HMO Plans	Indemnity incl. PPO, EPO	HMO	
A. Report by Contract												
I. # of Contracts Inforce Beginning of Period	-	-	-	-	-	-	-	-	-	-	-	-
II. # of New Sales and Conversions Issued During Period												
1. # of New Contracts Issued to Employed Individuals	-	-	-	-	-	-	-	-	-	-	-	-
2. # of New Contracts Issued to Unemployed Individuals	-	-	-	-	-	-	-	-	-	-	-	-
3. # of New Contracts Issued with Unknown Employment Status	-	-	-	-	-	-	-	-	-	-	-	-
4. # of Replacement Contracts Issued to Previously Insured Individuals	-	-	-	-	-	-	-	-	-	-	-	-
5. # of Replacement Contracts Issued to Previously Uninsured Individuals	-	-	-	-	-	-	-	-	-	-	-	-
6. # of Contracts Issued with Unknown Replacement Status	-	-	-	-	-	-	-	-	-	-	-	-
III. # of Contracts Lapsed in Period	-	-	-	-	-	-	-	-	-	-	-	-
IV. # of Contracts Inforce End of Period [IV=(I+II)-III]	-	-	-	-	-	-	-	-	-	-	-	-
B. Report by Persons Insured												
I. # Insured Beginning of Period	-	-	-	-	-	-	-	-	-	-	-	-
II. # of New Insureds During Period	-	-	-	-	-	-	-	-	-	-	-	-
III. # of Insureds Lapsed During Period	-	-	-	-	-	-	-	-	-	-	-	-
IV. # Insured End of Period [IV=(I+II)-III]	-	-	-	-	-	-	-	-	-	-	-	-
C. Report of Contracts by Rating Category												
I. # of Single Contracts	-	-	-	-	-	-	-	-	-	-	-	-
II. # of Husband and Wife Contracts	-	-	-	-	-	-	-	-	-	-	-	-
III. # of Parent and Child(ren) Contracts	-	-	-	-	-	-	-	-	-	-	-	-
IV. # of Family Contracts	-	-	-	-	-	-	-	-	-	-	-	-
V. # of Child(ren) only Contracts	-	-	-	-	-	-	-	-	-	-	-	-
VI. # of Contracts Inforce End of Period [VI=I+II+III+IV+V]	-	-	-	-	-	-	-	-	-	-	-	-
D. Report of Contracts by Deductible/Copayment Option (End of Period)												
I. # of Contracts with \$10 Ccpay	-	-	-	-	-	-	-	-	-	-	-	-
II. # of Contracts with \$500 Deductible or \$15 Copay	-	-	-	-	-	-	-	-	-	-	-	-
III. # of Contracts with \$1000 Deductible or \$20 Copay	-	-	-	-	-	-	-	-	-	-	-	-
IV. # of Contracts with \$2500 Deductible or \$30 Copay	-	-	-	-	-	-	-	-	-	-	-	-
V. # of Contracts with \$1500, \$2250, \$3000, or \$4500 Deductible	-	-	-	-	-	-	-	-	-	-	-	-
VI. # of Contracts with Inflation-Adjusted Deductible	-	-	-	-	-	-	-	-	-	-	-	-
VII. # of Contracts with \$5000 Deductible	-	-	-	-	-	-	-	-	-	-	-	-
VIII. # of Contracts with \$10000 Deductible	-	-	-	-	-	-	-	-	-	-	-	-
IX. # of Contracts issued as basic & essential plan	-	-	-	-	-	-	-	-	-	-	-	-
IX. # of Contracts Inforce End of Period [IX=I+II+III+IV+V+VI+VII+VIII+IX]	-	-	-	-	-	-	-	-	-	-	-	-
% of Contracts Issued to Persons Previously Uninsured	-											

Note: A.IV=C.V=D.IX

Carrier:
 Completed By:
 Title:
 Phone:
 Fax:
 Year Ending:

New Jersey Individual Health Coverage Program
 Enrollment Status Report
 Part 2 of Exhibit L

Section A	Standard Plans								Basic & Essential		End of Quarter
	Plan A/50	Plan B		Plan C		Plan D		HMO	Indemnity	HMO	
	Indemnity	Indemnity	PPO	Indemnity	PPO/POS	Indemnity	PPO/POS	Plans	inc. PPO, EPO		
Report of Contracts by Zip Code											
Zip Code: 070-073	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 074-075	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 076	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 077	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 078	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 079	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 080-084	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 085	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 086	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 087	-	-	-	-	-	-	-	-	-	-	-
Zip Code: 088-089	-	-	-	-	-	-	-	-	-	-	-
Total # of Contracts [A12=total of A1 through A11]	-	-	-	-	-	-	-	-	-	-	-

Section B	Standard Plans								Basic & Essential		Total Plans
	Plan A/50	Plan B		Plan C		Plan D		HMO	Indemnity	HMO	
	Indemnity	Indemnity	PPO	Indemnity	PPO/POS	Indemnity	PPO/POS	Plans	inc. PPO, EPO		
Report of Insured Males by Age Group											
Age 0-20	-	-	-	-	-	-	-	-	-	-	-
Age 21-30	-	-	-	-	-	-	-	-	-	-	-
Age 31-40	-	-	-	-	-	-	-	-	-	-	-
Age 41-50	-	-	-	-	-	-	-	-	-	-	-
Age 51-60	-	-	-	-	-	-	-	-	-	-	-
Age 61-65	-	-	-	-	-	-	-	-	-	-	-
Age 66-70	-	-	-	-	-	-	-	-	-	-	-
Age 71 & Over	-	-	-	-	-	-	-	-	-	-	-
Total Insured Males [B9=total of B1 through B8]	-	-	-	-	-	-	-	-	-	-	-

Section C	Standard Plans								Basic & Essential		Total Plans
	Plan A/50	Plan B		Plan C		Plan D		HMO	Indemnity	HMO	
	Indemnity	Indemnity	PPO	Indemnity	PPO/POS	Indemnity	PPO/POS	Plans	inc. PPO, EPO		
Report of Insured Females by Age Group											
Age 0-20	-	-	-	-	-	-	-	-	-	-	-
Age 21-30	-	-	-	-	-	-	-	-	-	-	-
Age 31-40	-	-	-	-	-	-	-	-	-	-	-
Age 41-50	-	-	-	-	-	-	-	-	-	-	-
Age 51-60	-	-	-	-	-	-	-	-	-	-	-
Age 61-65	-	-	-	-	-	-	-	-	-	-	-
Age 66-70	-	-	-	-	-	-	-	-	-	-	-
Age 71 & Over	-	-	-	-	-	-	-	-	-	-	-
Total Insured Females [C9=total of C1 through C8]	-	-	-	-	-	-	-	-	-	-	-

11:20-17.5 Penalties: Failure to provide the enrollment status reports within the time and format required by this subchapter shall result in the imposition of penalties as may be provided by law.

New Rule, R.1994 d. 53, effective December 30, 1993.
See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Amended by R.1998 d.503, effective September 16, 1998 (operative
November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

Amended by R.1999 d.131, effective March 25, 1999.
See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
Amended by R.2002 d.95, effective March 18, 2002 (operative August
1, 2002).
See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

EXHIBIT P

(RESERVED)

New Rule, R.1994 d.614, effective November 17, 1994 (operative
January 1, 1995).
See: 26 N.J.R. 3356(b), 26 N.J.R. 5041(b).

Repealed by R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
Was "PPO/POS Schedule".

EXHIBIT Q

CERTIFICATION OF COMPLIANCE WITH NEW JERSEY INDIVIDUAL HEALTH BENEFITS PLANS

In accordance with N.J.A.C. 11:20-3.2 submit this form before marketing or issuing any of the standard plans, and by March 1 of every year thereafter. Submit this form to the IHC Board at the following address: 20 West State Street, PO Box-325, Trenton, New Jersey 08625. Affiliated carriers must file separate forms. Carriers must complete the certification as set forth in this Exhibit; the words in the Certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name: _____
NAIC #: _____
Respondent's Name: _____
Respondent's Title: _____
Respondent's Address: _____
Respondent's Telephone _____ FAX _____

2. COMPLIANCE

Check all appropriate responses.

(a) We are using the following forms which fully comply with the IHC Board's individual health benefits plan forms and Explanation of Brackets (Exhibit T) as set forth in the appropriate Exhibit of the Appendix to N.J.A.C. 11:20:

- Plan A Exhibit A
Plan A/50 Exhibit U
Plan B Exhibit B
Plan C Exhibit C
Plan D Exhibit D
Plan E Exhibit E
HMO Plan Exhibit F

(b) Our application form complies with the IHC Board's form as set forth in Exhibit G and Explanation of Brackets (Exhibit T) in the Appendix to N.J.A.C. 11:20.

Is the optional pre-existing conditions statement being included? Yes No

3. PLAN OPTIONS

Complete each relevant section (Please use "NA" to indicate when a section is not relevant.) Attach additional pages as necessary.

(a) Plans A/50 and A - E (To be completed by non-HMO carriers)

(1) Identify the standard plans to be offered as traditional indemnity contracts, if any.

Plan A*: Plan A/50: Plan B: Plan C Plan D: Plan E*

*As of September 1, 1997, Plan A is available only for renewals of inforce Plan A business. As of November 1, 1998, Plan E is available only for renewals of inforce Plan E business.

(2) List all plans to be offered in conjunction with a selective contracting arrangement **(defined at N.J.A.C. 11:4-37)

PPO Plans:
Plan B: Plan C Plan D: Plan E

POS Plans:
Plan C Plan D: Plan E

** A carrier must first have received approval of its selective contracting arrangement from the Departments of Health and Senior Services and Banking and Insurance before it may issue the standard individual plans through such arrangement. Note: Health Service Corporations are not subject to the statute and regulations relating to selective contracting arrangements. Such carriers should note the plans they are offering as if they were subject to selective contracting arrangements.

(3) For all plans to be offered in conjunction with a selective contracting arrangement, specify the network and out network coinsurance levels in the space provided next to the plan (Ex. Plan D: 100%/80%), the copay options, and whether the plan requires election of a primary care physician.

PPO Plans:
Plan B: Physician Copay: Hospital Copay: PCP Election:
Plan C: Physician Copay: Hospital Copay: PCP Election:

Plan D: Physician Copay: Hospital Copay: PCP Election:
Plan E: Physician Copay: Hospital Copay: PCP Election:

POS Plans:
Plan C: Physician Copay: Hospital Copay: PCP Election:

Plan D: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____
Plan E: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____

Attach copies of the schedule page for each of the PPO and POS plan options indicated above.

(4) Do the plans provide for direct payment to health care practitioners without assignment? (Note: This option is available only on health service corporation plans and other plans offered in conjunction with selective contracting arrangements.)
_____ Yes _____ No

(5) Do the plans include any of the following as set forth by the IHC Board?
Centers of Excellence Features _____ Yes _____ No
Child(ren) Only Coverage _____ Yes _____ No
Care Manager Provisions _____ Yes _____ No
High Deductible Options _____ Yes _____ No
If yes: check the Plans and individual deductibles:
_____ Plan C: _____ \$1500 _____ \$2250
_____ Plan D: _____ \$1500 _____ \$2250

(6) How are Autologous Bone Marrow Transplants offered?
_____ in the policy
_____ mandated offer rider

(7) For POS Plans, how often may a female covered person use the services of a network gynecologist for non-surgical care without referral?
_____ once per year
_____ unlimited

(b) HMO Plan

(1) Check the copayment options being offered.
_____ \$10 (Optional)
_____ \$15 (Mandatory)
_____ \$20 (Optional)
_____ \$30 (Optional)

(2) How is prescription drug coverage being provided?
_____ subject to \$15 Copayment
_____ subject to 50% Co-Insurance

(3) How are Autologous Bone Marrow Transplants offered?
_____ in the contract
_____ mandated offer rider

(4) Do the plans include any of the following as set forth by the IHC Board?
Child(ren) Only Coverage _____ Yes _____ No
Care Manager Provisions _____ Yes _____ No

(c) Compliance with Forms Changes

If this Certification is being submitted within one year of the effective date of forms changes, please complete the following:
Has the issue system been updated to reflect the changes to the policy forms which were effective during the prior year such that new plans issued on or after the effective date of the changes reflect all of the policy forms changes which were effective during the prior year ?
_____ Yes _____ No
How are inforce policies/contracts being updated to reflect the policy forms changes which were effective during the prior year?
_____ reissue policies/contracts
_____ riders mailed to policyholders/contractholders *

* NOTE: The rider option may only be used if the IHC Board stated that the compliance and variability rider would be an appropriate mechanism to update inforce plans. If the rider is permitted to be used and this option is selected, the text of the rider must be identical to the text provided by the IHC Board.

4. CERTIFICATION

I, the undersigned, certify that this completed form is true and accurate and that I am an officer of the carrier duly authorized to submit this certification.

Date

Signature

Printed Name

Title

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).
See: 26 N.J.R. 4884(a), 27 N.J.R. 565(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).
Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).
See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

EXHIBIT R

[Carrier]

MANDATED OFFER RIDER

[Policyholder]

[Policy No.]

Effective Date:

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in Plans B-E:

Item j. of the Transplant Benefits section of the COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is replaced with the following:

- j. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
- k. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in the HMO Plan:

Item 23. of the INPATIENT, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS provision of the COVERED SERVICES AND SUPPLIES section of the Contract is replaced with the following:

- 23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
- 24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plan A should use the following text:

THE COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is expanded to include the following:

Transplants: We cover Medically Necessary and Appropriate Services and Supplies for:

- a. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
- b. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.]

This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any other terms of the [Policy].

[Carrier should insert standard amendment closure and signature blocks.]

New Rule, R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).

See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).

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).

EXHIBIT S

[Carrier]
AMENDMENT
[Policyholder]
Effective Date:

[
]

This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any other terms of the [Policy].
[Carrier shall insert its standard amendment closure and signature blocks.]

New Rule, R.1996 d.542, effective December 2, 1996.

See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).

INDIVIDUAL HEALTH COVERAGE PROGRAM

EXHIBIT T

EXPLANATION OF BRACKETS FOR INDIVIDUAL HEALTH COVERAGE STANDARD PLANS AND APPLICATION

Text which is enclosed in brackets may *only* be modified as described in this Exhibit. Unless otherwise stated, carriers have the option to either include or not include the standard text.

Plans B - D and A/50

- 1) The name of the Carrier, specific dates, page numbers, deductible amounts or premium information may be inserted, as appropriate.
- 2) **Dividend** text on the face page and in the General Provisions should only be included by mutual carriers.
- 3) The definition of **Care Manager** should only be included by carriers that utilize such a provider.
- 4) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee only if the plan is issued through or in conjunction with a Selective Contracting Arrangement.
- 5) Omit the **definitions** of Network Provider, Out-Network Provider and Service Area for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.)
- 6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
- 7) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
- 8) Omit the **PPO, POS and Appeals** sections for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.).
- 9) The **Coinsurance Cap** provision in the Benefit Deductibles, Copayments and Coinsurance section should be included in plans which are *not* issued through or in conjunction with a selective Contracting Arrangement. Omit the Coinsured Charge Limit provision.
- 10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Hospital Charges** section.
- 11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available *via rider* should include the text of the first item "j" in the Transplant section. Omit the second item "j" and item "k". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item "j" in the Transplant section. Include the second item "j" and item "k".
- 12) Carriers that do not use centers of excellence should omit the **Centers of Excellence** section.
- 13) Carriers may elect to omit the **Provider Relationship** provision in the General provisions.
- 14) Omit the **Network and Out-Network Provider Relationship** provision in the General Provisions for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement (not available with Plan A/50.)
- 15) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Policy-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.
- 16) Carriers that issue Point of Service plans may elect to allow a female Covered Person to use the services of a **network gynecologist** without PCP referral for stated services on an unlimited basis, or may limit the use of a network gynecologist without PCP referral to once per year. Include only the paragraph in the Point of Service provisions which reflects the elected option (not available with Plan A/50.)

Plans issued through or in conjunction with a **Selective Contracting Arrangement** (not available with Plan A/50.)

- 1) Include the following definitions:
 - Network provider
 - Out-Network Provider
 - Service Area
- 2) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee.
- 3) Sample **Schedule** text is included for a PPO plan without copayments, a PPO plan with copayments, and a POS plan. For plans which use copayments, include only the categories of services to which a copay will apply. The dollar amounts of the copayments should be consistent with the copayment options available with the IHC HMO plan.
- 4) Include the Preferred Provider Organization section if the plan is a PPO. Include the name of the PPO wherever XYZ appears.
- 5) Include the Point of Service section if the plan is a POS. Include the name of the provider organization wherever XYZ appears.
- 6) Carriers issuing a PPO or a POS plan may include **Appeals Procedures**.
- 7) Include the **Coinsured Charge Limit** text in the Benefit Deductibles, Copayments and Coinsurance section. The Coinsurance Cap provision should be omitted.
- 8) Include the Network and Out-Network Provider relationship provision in the General Provisions.

[Plans issued with \$1500 and \$2250 High Deductible Options (that could be used in conjunction with an MSA)]For plans issued as high-deductible health plans that could be used in conjunction with an MSA or an HSA

- 1) Include only the **Schedule of Benefits** page which specifies the high deductible options **and which is labeled for use with a high-deductible health plan. Specify the specific dollar amounts for the deductible and maximum out of pocket amounts. Refer to N.J.A.C. 11:20-3.1 for permissible dollar amounts.** Omit all other schedules.
- 2) Include the **Benefit Deductibles, Copayments and Coinsurance** section which addresses the maximum out of pocket amount. Omit the corresponding section which addresses Coinsurance Cap/Coinsured Charge Limit.

HMO Plan

- 1) The name of the Carrier, specific dates, page numbers, copayment amounts or premium information may be inserted, as appropriate.

- 2) Wherever a series of terms are shown in brackets, select the term that is consistent with the carrier's terminology or practice.
- 3) Omit **Care Manager** definition if a care manager is not used.
- 4) Omit **Coinsurance** definition if prescription drugs are provided subject to a copayment.
- 5) Omit **Health Center** definition if not applicable.
- 6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
- 7) Carriers that require **that the person live, reside or work in the Service Area** as an eligibility criteria should include the bracketed text; and also include the bracketed termination text which addresses when a person no longer lives, resides or works in the Service Area.
- 8) Bracketed text is shown in the **Payment of Premiums-Grace Period** and **Termination of the Contract-Renewal Privilege** sections to accommodate termination as of the end of the grace period or as of the paid-to-date. Include appropriate bracketed text.
- 9) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
- 10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Inpatient Hospital** section.
- 11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available via *rider* should include the text of the first item "23" in the Transplant section. Omit the second item "23" and item "24". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item "23" in the Transplant section. Include the second item "23" and item "24".
- 12) The **Dispensing limits for prescription drugs** should be included in the Exclusions section by carriers that impose such limits.
- 13) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Contract-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.

Application

- 1) Omit those bracketed Instructions and bracketed text which do not apply.
- 2) Use the term Policy or Contract, as appropriate.
- 3) Use the term insured, subscriber or member, as appropriate.
- 4) If proof of full time student status or disability is not required to be attached to the application, the text which directs that proof be attached should be deleted.
- 5) In the Coverage section, carriers should include text which is consistent with the standard plan options that the carrier offers.
- 6) Omit the quarterly and/or semi-annual premium payment modes if those modes are not available.
- 7) The use of the Pre-Existing Conditions Statement is optional.
- 8) The statement regarding the selection of a PCP may be included, at the option of the carrier.
- 9) The statement regarding the option to elect coverage for ABMT should only be included by those carriers that make the benefit available via rider.
- 10) The variable text a carrier includes in the statement regarding termination in the event of falsified information should be consistent with the election of the carrier regarding termination as of the effective date, or immediately. Refer to item 15 of the explanation for Plans B - D and A/50, and item 13 of the explanation for the HMO plan.
- 11) Agent/Producer information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.

New Rule, R.1997 d.477, effective January 1, 1998.
 See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).
 Amended by R.1998 d.443, effective August 7, 1998.
 See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
 Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).
 Amended by R.1999 d.131, effective March 25, 1999.
 See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
 Amended by R.2005 d.160, effective April 22, 2005.
 See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).