

Computerized claims data regarding health benefits paid under state plan constituted "public records". Board of Educ. of Newark v. New Jersey Dept. of Treasury, Div. of Pensions, 279 N.J.Super. 489, 653

A.2d 589 (A.D.1995), leave to appeal granted 142 N.J. 440, 663 A.2d 1351, affirmed 145 N.J. 269, 678 A.2d 660.

**17:9-1.3 Appeals from Commission decisions**

(a) Any member of the traditional plan or NJ PLUS plan who disagrees with the decision of one of the claims administrators may request that the matter be considered by the State Health Benefits Commission. Requests for consideration must be directed to the Secretary, State Health Benefits Commission, and must contain the reason for the disagreement. Appeals shall be considered at the regular monthly meetings of the Commission. It shall be the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

(b) Any member of an HMO who disagrees with a determination of medical necessity made by an HMO or any member of an HMO who feels that the HMO has violated the terms and conditions of its contract may request that the matter be considered by the State Health Benefits Commission. Such an appeal can only be considered after the member has exhausted the HMO's grievance process. Appeals shall be considered at the regular monthly meetings of the Commission.

(c) Notification of all Commission decisions will be made in writing to the member and the following statement shall be incorporated in every written notice setting forth the Commission's determination in a matter where such determination is contrary to the claim made by the claimant or his or her legal representative:

"If you disagree with the determination of the Commission in this matter, you may appeal by sending a written statement to the Commission within 45 days from the date of this letter informing the Commission of your disagreement and all of the reasons therefor. If no such written statement is received within the 45-day period, this determination shall be considered final."

(d) Any member who disagrees with the Commission's decision and submits the written statement as set forth in (c) above within 45 calendar days shall be notified of the disposition of the appeal in one of two ways:

1. The Commission shall determine whether to grant an administrative hearing on the basis of whether the matter involves contested facts or is solely a question of law. If the appeal involves solely a question of law, the Commission shall likely deny an administrative hearing request. If the request for an administrative hearing is denied, the Commission shall issue detailed findings of fact and conclusions of law. These findings and conclusions shall become the Commission's final administrative determination that may then be appealed to the Superior Court, Appellate Division.

2. If the appeal involves disputed facts, the Commission shall approve an administrative hearing request and transmit the matter to the Office of Administrative Law. Upon completion of this hearing, the Administrative Law Judge will submit to the Commission an initial decision

that the Commission may adopt, reject or modify. If the Commission rejects or modifies the initial decision, it shall issue detailed findings of fact and conclusions of law that will become the Commission's final administrative determination that may then be appealed to the Superior Court, Appellate Division.

As amended, R.1970 d.147, effective December 10, 1970.  
See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).  
Amended by R.1996 d.551, effective December 2, 1996.  
See: 28 N.J.R. 4083(b), 28 N.J.R. 5078(c).

**Case Notes**

Where the Commission has not exercised authority to regulate mental illness coverage, the Appellate Division would not defer to the Health Benefits' Commission's interpretation. *Heaton v. State Health Benefits Com'n*, 264 N.J.Super. 141, 624 A.2d 69 (A.D.1993).

Administrative remedies must be exhausted by appealing health Insurance administrators' adverse determination before commencing suit against the administrator. *Burley v. Prudential Ins. Co. of America*, 251 N.J.Super. 493, 598 A.2d 936 (A.D.1991).

**17:9-1.4 (Reserved)**

As amended, R.1971 d.21, effective February 17, 1971.  
See: 3 N.J.R. 10(a), 3 N.J.R. 52(c).  
As amended, R.1979 d.159, effective April 23, 1979.  
See: 11 N.J.R. 94(d), 11 N.J.R. 304(c).  
As amended, R.1983 d.44, effective March 7, 1983.  
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

This section formerly contained rules on local employer premium and interest.

**17:9-1.5 Voluntary termination of employer; notice**

(a) A resolution furnished by the Division of Pensions must be completed by employers who wish to voluntarily terminate their participation in the program.

(b) For purposes of local coverage, when a participating employer voluntarily terminates coverage, the coverage for the employer's active and retired employees shall terminate as of the first of the month following a 60-day period beginning with the receipt of the resolution by the Health Benefits Commission. The Commission may, from time to time, establish a re-entry application period not to exceed 30 days for those employers who have terminated coverage. During this period, an employer who has terminated coverage only once may submit a resolution for automatic re-entry. The re-entry shall be effective upon a date set by the Commission which date shall be not less than 60 days nor more than 365 days following the receipt of the resolution for re-entry. Automatic re-entry into the program will be permitted only once.

1. An employer who has terminated coverage more than once may submit a resolution for re-entry during the re-entry application period. The Commission shall consider the relevant facts accompanying the resolution, including any hardship or emergency, the impact of re-entry on the program and individual members, and whether re-entry is consistent with statutory law or judicial determinations. The Commission shall approve or disapprove

the resolution for re-entry and shall so notify the employer within 30 days following receipt of the resolution. If the Commission approves the re-entry, the re-entry shall be effective upon a date determined by the Commission, which date shall be not less than 60 days nor more than 365 days following the Commission's approval. The re-entry shall be contingent upon the employer's reimbursement to the Commission of administrative expenses reasonably based upon the approximate cost to the Commission of re-enrolling the employer.

(c) The employer shall notify all active employees of the date their coverage in the program has terminated.

(d) The Division of Pensions shall act to notify all retired employees or survivors of the termination of coverage and to send a list of the names and addresses to the terminating employer for his or her information, upon his or her request.

Amended by R.1970 d.147, effective December 10, 1970.

See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

Amended by R.1976 d.124, effective April 22, 1976.

See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).

Amended by R.1983 d.332, effective August 15, 1983.

See: 15 N.J.R. 793(a), 15 N.J.R. 1383(d).

List of names and addresses to be sent to terminating employer upon request.

Amended by R.1985 d.587, effective November 18, 1985.

See: 17 N.J.R. 1399(a), 17 N.J.R. 2784(b).

(b): Added text "for a period . . . permitted only once."

Amended by R.1993 d.269, effective June 7, 1993.

See: 25 N.J.R. 460(a), 25 N.J.R. 2505(d).

#### 17:9-1.6 Default of employer; notice

(a) For purposes of local coverage, a participating employer will be considered in default 31 days after the beginning of the coverage period for which charges were due. At that point, coverage will terminate for all employers and their dependents covered by the employer.

(b) The secretary of the commission will notify the Attorney General's office, the Division of Local Finance, the Department of Education and the carriers. The Division of Pensions will notify every participating employee, active and retired, or survivors, of the termination of coverage.

As amended, R.1970 d.147, effective December 10, 1970.

See: 2 N.J.R. 94(d), 3 N.J.R. 11(a).

As amended, R.1983 d.44, effective March 7, 1983.

See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word "premiums" was changed to "charges" and the phrase "his" to "his or her".

#### 17:9-1.7 Guidelines; local employers; purchase of contracts

Pursuant to the provisions of N.J.S.A. 52:14-17.25 et seq., it is the policy of the State Health Benefits Commission that when local governments purchase insurance contracts of health benefits, such as prescription drug, dental expense and vision care coverages, such contracts and coverage therein must adhere to the guidelines approved by the State Health Benefits Commission for such contracts or coverages, as such guidelines were transmitted to all public employers by the Division of Pensions. Local governments cannot deviate from such guidelines in purchasing such contracts or coverages without the approval of the State Health Benefits Commission.

As amended, R.1983 d.331, effective August 15, 1983.

See: 15 N.J.R. 884(a), 15 N.J.R. 1383(e).

#### 17:9-1.8 Employer incentives for non-enrollment prohibited

An employer shall not offer a financial enticement of cash or anything else of value to an employee who elects not to enroll or to terminate enrollment in the State Health Benefits Program.

#### 17:9-1.9 Definitions

The following words and terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Act" means the New Jersey State Health Benefits Program Act, P.L. 1961, c.49 (N.J.S.A. 52:14-17.25 et seq.), as amended and supplemented.

"Base salary" means an employee's annual base salary as of the first pay period of the calendar year for Federal and State income taxes.

"Category of coverage" means one of the options used for determining the rates for the premium or periodic charges for different levels of coverage under the program which include single, husband and wife, parent and child, and family coverage, with and without Medicare.

"Commission" means the State Health Benefits Commission created by Section 3 (N.J.S.A. 52:14-17.27) of the Act.

"NJ PLUS" is the name of the State managed care plan as defined in Section 2 (N.J.S.A. 52:14-17.26) of the Act.

"Participating HMO" means a health maintenance organization duly authorized to operate in the State which is under contract with the Commission to participate in the program.

"State bi-weekly sub-group" means a State payroll location or employment unit which reports to the program on a bi-weekly basis.

“State monthly sub-group” means a State payroll location or employment unit which reports to the program on a monthly basis.

New Rule, R.1996 d.298, effective June 17, 1996.  
See: 28 N.J.R. 1944(a), 28 N.J.R. 3171(a).

## SUBCHAPTER 2. COVERAGE

### 17:9-2.1 Enrollment charges

Each eligible employee shall be eligible to enroll for coverage without cost to the employee; and each employee's eligible dependents shall be eligible for enrollment for coverage provided that the additional charges for such coverage shall be paid by the employee as required by his or her employer.

As amended, R.1983 d.44, effective March 7, 1983.  
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word “premiums” was changed to “charges” and “his” to “his or her”.

### 17:9-2.2 Enrollment form

At the time each employee first becomes eligible for coverage, the employee shall complete enrollment and authorization forms indicating the employee's election to enroll or not to enroll for coverage on his or her own behalf; and the employee's election to enroll or not to enroll his or her dependents for coverage under one of the options to be provided in the commission's master contract or contracts.

As amended, R.1983 d.44, effective March 7, 1983.  
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

Added reference to female employees.

### 17:9-2.3 Annual enrollment period

(a) Any employee who shall elect not to enroll for coverage for himself or herself or for his or her dependent at the time such employee or dependent first becomes eligible for coverage shall subsequently be permitted to enroll himself or herself and his or her dependents only during the annual enrollment period, which is the month of April of each year with coverage effective for the first coverage period in July in the case of State coverage and the month of March with coverage effective July 1 in the case of local coverage.

(b) The annual enrollment period will be the annual opportunity for employees to elect participation in a health maintenance organization for themselves and their dependents. The change in the election cannot be made more frequently than once a year except where the employee moves and is no longer able to be serviced by a health maintenance organization or the health maintenance organization is terminated.

(c) The State Health Benefits Commission may, at its discretion in order to optimize benefits, establish a special enrollment period at any time it deems necessary to do so.

Amended by R.1974 d.228, effective August 19, 1974.  
See: 6 N.J.R. 156(a), 6 N.J.R. 360(c).

Amended by R.1976 d.124, effective April 22, 1976.  
See: 8 N.J.R. 85(c), 8 N.J.R. 263(a).

Amended by R.1978 d.131, effective April 18, 1978.  
See: 10 N.J.R. 80(b), 10 N.J.R. 265(b).

Amended by R.1978 d.442, effective December 26, 1978.  
See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).

Amended by R.1983 d.44, effective March 7, 1983.  
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).

The word “his” was changed to “his or her”.

Amended by R.1985 d.18, effective February 4, 1985.  
See: 16 N.J.R. 2422(a), 17 N.J.R. 320(b).

(c) added.

Amended by R.1993 d.259, effective June 7, 1993.  
See: 25 N.J.R. 4025(a), 25 N.J.R. 2506(a).

### 17:9-2.4 Coverage changes; exceptions

(a) An employee may change his or her enrollment and the enrollment of his or her dependents to any type of coverage at any time if such changes result from a change in family, dependency or employment status of the employee or his or her dependents. Such changes will be permitted under the following conditions:

1. *Marriage.* Any employee who has been enrolled for coverage and who subsequently marries may enroll the spouse and eligible dependents, if any, for any appropriate type of coverage by completing and forwarding a new enrollment form within the period beginning 60 days prior to the marriage and ending 60 days after such marriage. In the event that the spouse of such employee is already enrolled as an employee, the provisions of N.J.A.C. 17:9-3.9 shall apply to such spouse's enrollment.

2. *Divorce; separation.* Any employee who has been enrolled or has been covered as a dependent of an enrolled employee and is subsequently divorced may enroll, delete from coverage or cover any eligible dependents by completing and forwarding a new enrollment form within 60 calendar days after the divorce of such employee or dependent of an employee who was covered previously under the spouse's contract. A change of enrollment of this nature is optional in the case of separation.

3. *Death of spouse or dependent child.* Any employee, who is enrolled as the dependent of another employee who dies, may thereupon enroll as an employee, and may enroll any eligible dependents, for any appropriate coverage by completing and forwarding a new enrollment form within 60 days following the death. Any employee may, upon the death of a spouse or dependent child who is enrolled as a dependent, enroll himself or herself and any other eligible dependents for any appropriate coverage by completing and forwarding a new enrollment form.