

CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17B:27A-2 et seq.; and P.L. 2008, c. 38.

Source and Effective Date

R.2011 d.163 and d.167, effective May 12, 2011.
See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a),
43 N.J.R. 143(a), 43 N.J.R. 1359(a).

Chapter Expiration Date

Chapter 20, Individual Health Coverage Program, expires on May 12, 2018.

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.* See: 35 N.J.R. 2898(a).

Subchapter 22, Basic and Essential Health Care Services Plan, was adopted as R.2003 d.91, effective January 28, 2003. See: 34 N.J.R. 73(a), 35 N.J.R. 1290(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).

Chapter 20, Individual Health Coverage Program, Subchapters 1 through 3, 6 through 10, 12, 17 through 20, 22 and Appendix Exhibits A through F, J through L, and Q through V, were readopted as R.2006 d.15, effective December 7, 2005, and Subchapter 11 was readopted as R.2006 d.16, effective December 7, 2005. Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans and the Basic and Essential Health Care Services Plan, was repealed, and Subchapter 12. Purchase of a Standard Individual Health Benefits Plan or a Basic and Essential Healthcare Services Plan by a Person Covered under an Individual Plan or Eligible for or Covered under a Group Plan, was adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibit R, was repealed, by R.2006 d. 15, effective January 3, 2006. Subchapter 23. Rulemaking; Interested Parties; Public Notices; Interested Parties Mailing List, and Subchapter 24, Program Compliance, were adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibits A, C, E and U were repealed by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006). Exhibits A, C and E were adopted as new rules. See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 38 N.J.R. 1005(a); 37 N.J.R. 3022(a), 38 N.J.R. 332(a).

Exhibit H of the Appendix was adopted as new rules by R.2009 d.45, effective December 29, 2008. See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Subchapter 6, Individual Health Benefits Carriers Informational Rate Filing Requirement; Subchapter 7, Loss Ratio and Refund Reporting Requirements; and Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, were repealed by R.2009 d.45, effective December 29, 2008 (operative April 20, 2009). See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b), 41 N.J.R. 1875(a).

Subchapter 3A, Policy Forms; Subchapter 6, Individual Health Benefits Carriers Informational Rate Filing Requirements; Subchapter 7, Loss Ratio And Refund Reporting Requirements; and Subchapter 18, Withdrawals of Carriers from the Individual Market and the Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, were adopted as new rules by R.2009 d.128, effective April 20, 2009. See: 41 N.J.R. 73(a), 41 N.J.R. 1866(c).

Subchapter 9, Exemptions, and Subchapter 10, Performance Standards and Reporting Requirements, expired on December 7, 2010.

In accordance with N.J.S.A. 52:14B-5.1b, Subchapters 1, 2, 3, 3A, 6, 7, 8, 11, 12, 17, 18, 19, 20, 22, 23 and 24, and Appendix Exhibits A through H and J through L were scheduled to expire on June 5, 2013. See: 43 N.J.R. 1203(a).

Chapter 20, Individual Health Coverage Program, Subchapters 1, 2, 3, 8, 12, 17, 19, 20, 22, 23 and 24, and Appendix Exhibits A through D, F, G, H, K and L, were readopted as R.2011 d.163, effective May 12, 2011; and Subchapters 3A, 6, 7, 11 and 18, and Appendix Exhibits E and J, were readopted as R.2011 d.167, effective May 12, 2011. See: Source and Effective Date. See, also, section annotations.

Case Notes

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.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 11:20-1.1 Purpose and scope
- 11:20-1.2 Definitions
- 11:20-1.3 Closing of noncomplying individual health benefits plan

- 11:20-1.4 Other laws of this State
- 11:20-1.5 (Reserved)
- 11:20-1.6 Mission statement

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

- 11:20-2.1 Purpose and structure
- 11:20-2.2 Definitions
- 11:20-2.3 Powers of the IHC Program and Board
- 11:20-2.4 Plan of Operation
- 11:20-2.5 Board of Directors
- 11:20-2.6 Committees
- 11:20-2.7 Financial administration
- 11:20-2.8 Audits
- 11:20-2.9 Records
- 11:20-2.10 Standard health benefits plans
- 11:20-2.11 (Reserved)
- 11:20-2.12 Assessments for administrative expenses and organizational and operating expenses
- 11:20-2.13 (Reserved)
- 11:20-2.14 Failure to pay assessments
- 11:20-2.15 Penalties/adjustments and dispute resolutions
- 11:20-2.16 Indemnification
- 11:20-2.17 Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998 and ending with 2007 and 2008
- 11:20-2.18 Minimum assessment

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

- 11:20-3.1 The standard health benefits plans
- 11:20-3.2 (Reserved)
- 11:20-3.3 Compliance and variability rider
- 11:20-3.4 Plan update rider
- 11:20-3.5 Basic and essential health care services plan
- 11:20-3.6 Optional benefit riders to standard plans
- 11:20-3.7 Plan or plan option withdrawal by IHC Board

SUBCHAPTER 3A. POLICY FORMS

- 11:20-3A.1 Purpose and scope
- 11:20-3A.2 Certification of Compliance
- 11:20-3A.3 Basic and essential health care services plan policy form

SUBCHAPTERS 4 THROUGH 5. (RESERVED)

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

- 11:20-6.1 Purpose and scope
- 11:20-6.2 Definitions
- 11:20-6.3 Informational rate filing requirements
- 11:20-6.4 Informational rate filing procedures
- 11:20-6.5 Permissible rate classification factors

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

- 11:20-7.1 Purpose
- 11:20-7.2 Definitions
- 11:20-7.3 Filing of Loss Ratio Report
- 11:20-7.4 Contents of the Loss Ratio Report
- 11:20-7.5 Refund plan
- 11:20-7.6 Unclaimed loss ratio refunds
- 11:20-7.7 Certification of loss ratio refunds

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

- 11:20-8.1 Scope and applicability
- 11:20-8.2 Filing of the assessment report form
- 11:20-8.3 Calculation of net earned premium and determination of program membership for the two-year calculation period
- 11:20-8.4 through 8.5 (Reserved)

- 11:20-8.6 Certifications
- 11:20-8.7 Failure to file Exhibit K Assessment Report
- 11:20-8.8 through 8.9 (Reserved)

SUBCHAPTERS 9 THROUGH 10. (RESERVED)

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

- 11:20-11.1 Purpose and scope
- 11:20-11.2 Definitions
- 11:20-11.3 Application procedures and filing format
- 11:20-11.4 Informational filing requirements
- 11:20-11.5 Confidentiality of request for relief
- 11:20-11.6 Disposition of request for relief
- 11:20-11.7 Hearings
- 11:20-11.8 Notice to the IHC Program
- 11:20-11.9 Exceptions for health maintenance organizations due to lack of capacity
- 11:20-11.10 Other actions by the Commissioner
- 11:20-11.11 Penalties

SUBCHAPTER 12. PURCHASE OF A STANDARD INDIVIDUAL HEALTH BENEFITS PLAN OR A BASIC AND ESSENTIAL HEALTHCARE SERVICES PLAN BY A PERSON COVERED UNDER AN INDIVIDUAL PLAN OR ELIGIBLE FOR OR COVERED UNDER A GROUP PLAN

- 11:20-12.1 Purpose and scope
- 11:20-12.2 Definitions
- 11:20-12.3 Covered under an individual plan: replacement at any time
- 11:20-12.4 Covered under an individual plan: replacement only during Open Enrollment Period
- 11:20-12.5 Covered under or eligible to participate in a group health benefits plan

SUBCHAPTERS 13 THROUGH 16. (RESERVED)

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

- 11:20-17.1 Purpose and scope
- 11:20-17.2 Definitions
- 11:20-17.3 Filing requirements
- 11:20-17.4 Contents of the enrollment status report
- 11:20-17.5 (Reserved)

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

- 11:20-18.1 Purpose and scope
- 11:20-18.2 Definitions
- 11:20-18.3 Carrier cancellation of individual plans
- 11:20-18.4 Cessation of offer and issuance of individual plans
- 11:20-18.5 General provisions for market withdrawal
- 11:20-18.6 General provisions for withdrawal of plan, plan option, or deductible/copayment option
- 11:20-18.7 Restrictions on writings
- 11:20-18.8 Election to offer at least three plans, effect on in force-plans
- 11:20-18.9 Other policy or contractholder rights unaffected

SUBCHAPTER 19. PETITIONS FOR RULEMAKING

- 11:20-19.1 Scope
- 11:20-19.2 Procedure for petitioner
- 11:20-19.3 Procedure of the Board

SUBCHAPTER 20. APPEALS FROM ACTIONS OF THE BOARD

- 11:20-20.1 Scope
- 11:20-20.2 Appeals procedures

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

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

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

“Same as or similar to the individual plan” means the group plan under which a person is covered or eligible to participate features cost sharing provisions consistent with those in the standard individual health benefits plan or basic and essential healthcare services plan for which the person has made application.

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

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

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

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

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Added definition “Special open enrollment period”.

Amended by R.2011 d.163, effective June 6, 2011.

See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).

Deleted definition “Special open enrollment period”.

11:20-12.3 Covered under an individual plan: replacement at any time

(a) Except as stated in N.J.A.C. 11:20-12.4(c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with the same type of plan using the same or greater deductible, same or greater coinsurance or same or greater copayments from another carrier, where there is no lesser deductible, coinsurance or copayment.

(b) Except as stated in N.J.A.C. 11:20-12.4(b) or (c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with any standard individual health benefits plan or basic and essential healthcare services plan for which the filed monthly premium is less than the filed monthly premium for the existing standard individual health benefits plan.

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

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

(e) The existing standard health benefits plan, basic and essential healthcare services plan or plan issued prior to August 1, 1993 must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan as of the midnight on the day before the effective date of the new plan if the person covered under the new plan notified the existing carrier of the replacement within 30 days after the effective date of the new plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the new plan, the new plan shall be of no force and effect and premium paid shall be refunded.

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (b), inserted “filed” twice.

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

(a) A person who is covered under a standard individual health benefits plan may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or basic and essential healthcare services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan.

(b) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period to replace the HMO plan with an HMO plan featuring a lower copayment.

(c) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period to replace the HMO plan with an indemnity, preferred provider (PPO) or point of service (POS) plan. However, a person whose initial purchase in the individual market is an HMO plan may elect, at any time during the 90 days following the effective date of the individual plan, to replace the HMO plan with an indemnity, preferred provider (PPO) or point of service (POS) plan.

(d) A person who is covered under a basic and essential healthcare services plan without a rider may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a rider.

(e) A person who is covered under a standard individual health benefits plan without a rider may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan with a rider or with a basic and essential healthcare services plan with a rider.

(f) A person who is covered under a basic and essential healthcare services plan with a rider may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a different rider.

(g) The effective date of the replacement plan issued as a result of (a) through (e) above will be January 1 of the year following the Open Enrollment Period.

(h) The existing standard health benefits plan, basic and essential healthcare services plan must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan as of the midnight on the day before the effective date of the new plan if the person covered under the new plan notified the existing carrier of the replacement within 30 days after the effective date of the new plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the new plan, the new plan shall be of no force and effect and premium paid shall be refunded.

(i) Notwithstanding (a), (b), (d), (e) and (f) above, a person covered under a standard individual health benefits plan or a basic and essential health care services plan may elect to replace the standard individual health benefits plan or a basic and essential health care services plan with a standard individual health benefits plan that is a high deductible health plan sold in conjunction with a Health Savings Account, at any time during the 60 days following the date a high deductible health plan is first made available by the carrier to whom the person makes application for the high deductible health plan.

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Section was "Covered under an individual plan: replacement only during Open Enrollment Period". In (a), (b), (c) and (d), inserted "or Special Open Enrollment Period"; in (c), substituted "an indemnity, preferred provider (PPO) or point of service (POS)" for "non-HMO" and "a non-HMO"; added new (e); recodified former (e) through (h) as (f) through (i); in (f), inserted "or Special Open Enrollment Period"; in (g), deleted "items" preceding "(a)" and inserted "and no later than April 1, 2009 in the case of the Special Open Enrollment Period"; and in (i), substituted "(b), (d), (e) and (f)" for "(b) (d) and (e)".

Amended by R.2011 d.163, effective June 6, 2011.

See: 43 N.J.R. 131(a), 43 N.J.R. 1353(a).

Section was "Covered under an individual plan: replacement only during Open Enrollment Period or Special Open Enrollment Period". Deleted "or Special Open Enrollment Period" following "Open Enrollment Period" throughout; and in (g), deleted "and no later than April 1, 2009 in the case of the Special Open Enrollment Period" from the end.

11:20-12.5 Covered under or eligible to participate in a group health benefits plan

(a) A person who is covered under or eligible to participate in a group health benefits plan that is not the same as or similar to the individual plan for which application has been made may elect only during the Open Enrollment Period to be covered under a standard health benefits plan or a basic and essential healthcare services plan. The effective date of the individual plan will be January 1 of the year following the Open Enrollment Period.

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

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

(d) When an application for individual coverage is made during the Open Enrollment Period, coverage under the group plan must be terminated no later than midnight on December 31 immediately prior to the effective date of the standard individual health benefits plan or basic and essential healthcare services plan except as may be required under an extension of benefits under the group plan. The new carrier may require evidence of the termination of the existing plan.