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

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 calendar year, except that no member shall be liable for an assessment amount greater than 35 percent of the total reimbursable net paid losses for that calendar year.

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 calendar year to the net earned premium of all members for the preceding calendar year as reported by each member in the Carrier Market Share and Net Paid 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 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 final 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 calendar year by the ratio of the member's net earned premium to the net earned premium of all members for the preceding calendar year 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 and the denominator of which is the minimum number of non-group persons allocated to the member by the Board.

2. To the extent a member's assessment exceeds the 35 percent limit, the excess amount shall be apportioned to other members, except those members that received a final or pro rata exemption or that have been granted a deferral, based upon their respective adjusted market shares until such other members reach the 35 percent limit or the total reimbursable net paid losses for the preceding calendar year are fully assessed, whichever occurs first.

3. 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 adjusted market shares.

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.

(d) Every member shall be liable for a portion of the total reimbursable net paid losses for the preceding calendar year unless the member has been granted a final exemption from assessments for the preceding calendar year 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 March 14 of each year, of the total reimbursable net paid losses for the preceding calendar year and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for the preceding calendar year.

2. No later than 60 days following the preliminary notice in (d)1 above, 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 calendar year.

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

4. The IHC Program Board shall notify each member of the final reconciliation of the assessment for reimbursable net paid losses for the preceding calendar year by invoice stating the dollar amount then due or credit, if any, against future assessments on or before December 1st of the current year. 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) Assessment 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, c/o the New Jersey Department of Insurance, 20 West State Street, CN–325, Trenton, NJ 08625.

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.

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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 Interim Administrator (or Administrator) 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 preceding calendar year. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that calendar year, until such available funds have been paid out, or a member's reimbursable net paid losses for the preceding calendar year 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 calendar year, 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 the 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 calendar 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. Amounts of assessment disputed or subject to deferral wherein the dispute is settled 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 Interim Administrator (or Administrator) receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with 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.

New Rule, R.1994 d.165, effective March 1, 1994.
See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).

SUBCHAPTER 3. STANDARD BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 Benefits provided

(a) The standard individual health benefits plans 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, sections III, V, VI, VII and IX;

2. Plan B, "The Basic Health Benefits Plan", Exhibit B, sections III, V, VI, VII and IX;

3. Plan C, "Individual Health Benefits Plan C," Exhibit C, sections III, V, VI, VII and IX;

4. Plan D, "Individual Health Benefits Plan D," Exhibit D, sections III, V, VI, VII and IX;

5. Plan E, "Individual Health Benefits Plan E," Exhibit E, sections III, V, VI, VII and IX; and

6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F, sections III, V, and VI.

(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 B, C, D and E as set forth in Exhibits B through E, respectively, in the Appendix.

1. Members offering Plans B, D, and E 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 Plan 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 either or both of the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:

i. $1,500 per individual and $3,000 per family unit;

ii. $2,250 per individual and $4,500 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 B through E in (a) above. All HMO members offering the HMO Plan shall offer the following arrangements: $150.00 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.

(d) Each of the standard health benefits plans, except the deductible options listed in (b)3 above, may be offered through or in conjunction with a managed care network, and shall be subject to the following:

1. The in-network and out-network benefit level differential shall not exceed 30 percent;

2. With respect to Plans B through E set forth in Exhibits B through E of the Appendix, and notwithstanding (d)1 above, in no event shall policyholder coinsurance be greater than 40 percent;

3. The coinsurance maximum specified for the standard health benefits plan being offered through or in conjunction with a managed care network, as set forth in Exhibits A through E in the Appendix, shall be the coinsurance maximum for the in-network and out-network benefits combined;

4. The HMO Plan copayment levels of $10.00, $15.00 and $20.00 may be substituted for deductibles applicable to one or more of the in-network benefits; and

5. Notwithstanding (d)1, 2, 3 and 4 above, a carrier may submit to the Board for approval an alternative managed care delivery system which reconciles its delivery system with the standard health benefits plans.

(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 on a reasonable and customary basis as defined by the Board.

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.

11:20-3.2 Policy forms

(a) For standard health benefit plan contracts effective on or after January 1, 1995, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F.

(b) For standard health benefit plan policies with effective dates prior to January 1, 1995, members shall convert the contracts to the respective standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F on the first 12 month contract anniversary date on or after January 1, 1995.

(c) 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 Exhibit Q in conjunction with the standard policy forms set forth as Exhibits A through E.

(d) Before marketing any of the standard policy forms, a member shall file in triplicate 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 any

time a member makes any permitted changes in the standard health benefits forms being offered.

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).

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 F of the Appendix to this Chapter 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).

SUBCHAPTER 4. STANDARD APPLICATION FORM

11:20–4.1 Standard application form

(a) All members offering standard health benefits plans with an effective date on or after August 1, 1993, shall use the standard application form approved by the Board and specified in Exhibit G of the Appendix to this chapter, except as provided in (b) below.

(b) A member may submit to the Board for approval an alternative application form that differs in format but not in content from the standard form set forth in Exhibit G of the Appendix. The member may use the alternative form when submitted unless and until disapproved by the Board.

1. The alternative application form shall be submitted along with the Certification Form set forth in the Appendix to this subchapter as Exhibit Q.

2. Alternative application forms shall be submitted in triplicate to the Board at the following address:

Executive Director
New Jersey Individual Health Coverage Program
20 West State Street, 10th Floor
CN 325
Trenton, NJ 08625

3. The Board shall disapprove any alternative application form that is not consistent with the purpose of this chapter.

4. If any proposed alternative application form is disapproved, it may not be used with a policy form delivered or issued for delivery unless and until such disapproval is withdrawn.

5. Upon request by the member for a hearing, the Board's disapproval of an alternative application form shall be subject to review in accordance with 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.

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).

SUBCHAPTER 5. STANDARD CLAIM FORM

11:20–5.1 Standard Claim Form

Effective August 1, 1993, all members offering health benefits plans or other health insurance policies to individuals shall, to the extent that the member uses claims forms in its transaction of business, 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 standard claim form shall be used for all medical expenses incurred for services other than hospital inpatient services. Members shall use form UB–82 set forth as Exhibit I in the Appendix to this chapter for hospital inpatient services.

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 section 2b(1) and 3 of the Act (N.J.S.A. 17B:–27A–3b(1) and 17B:27A–4).

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 filing requirements

(a) All members issuing standard health benefits plans or conversion health benefits plans on a new contract or policy form shall make, prior to issuing any standard health benefits plan or conversion benefits plan, an informational filing with the Board, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans 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;