

In (b), deleted "Effective on the fiscal quarter ending on September 30, 1994," at the beginning; deleted a former (d); and recodified former (e) as (d).

11:21-7.13 Paying benefits

(a) In paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services, on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, incorporated herein by reference published and available from the Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004-1109.

1. The maximum allowable charge shall be based on the 80th percentile of the profile.

2. Carriers shall use the profile effective as of July 1993, and shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

Recodified from 11:21-7.14 by R.1997 d.62, effective February 3, 1997. See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Former section recodified to N.J.A.C. 11:21-7.12.

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

In (a), rewrote the introductory paragraph.

11:21-7.14 Permissible rate classification factors

(a) For health benefits plans issued or renewed on or after September 11, 1994, a carrier shall not differentiate premium rates charged to different small employers for the same health benefits plan 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 small employer on the basis of the address of the small employer's principal place of business. 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 charged to different small employers for the same standard health benefits plan, whether it be A, B, C, D, E or HMO, on the basis of family structure according to only the following four rating tiers:

1. Employee only;
2. Employee and spouse;
3. Employee and child(ren); and
4. Family.

New Rule, R.1994 d.418, effective July 15, 1994 (operative September 11, 1994).

See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).

Recodified from 11:21-7.15 by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Former section recodified to N.J.A.C. 11:21-7.13.

11:21-7.15 (Reserved)

Recodified to 11:21-7.14 by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

SUBCHAPTER 7A. LOSS RATIO REPORTS; DIVIDENDS AND CREDITS

11:21-7A.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

11:21-7A.2 Definitions

The following terms, when used in this subchapter, shall have the following meanings:

"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 Department.

"Total employee months exposed" means the sum of the number of months that each employee was covered during the preceding calendar year. For example, if 40 employees were covered for three months, five employees were covered for 10 months and 12 employees were covered for 12 months, then the total employee months exposed would be 314 ($\{40 \times 3\} + \{5 \times 10\} + \{12 \times 12\}$).

11:21-7A.3 Filing of loss ratio reports

(a) Each carrier having the five standard health benefit plan policy forms, non-standard policy forms or HMO plans in force at any time during the preceding calendar year shall file with the Department, for each standard plan including any standard and non-standard riders thereto and for all non-standard plans combined, an annual loss ratio report on the form appearing as Exhibit GG in the Appendix to this chapter, incorporated herein by reference.

(b) The loss ratio report shall be completed and filed with the Department on or before August 1 of the reporting year for the preceding calendar year; except that loss ratio reports for calendar year 1994, including any refund plans, shall be filed no later than June 5, 1996.

(c) Loss ratio reports submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Loss Ratio Report Filings
Office of the Life and Health Actuary
New Jersey Department of Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

11:21-7A.4 Contents of the loss ratio report

(a) A loss ratio report filed pursuant to N.J.A.C. 11:21-7A.3 shall include the following information:

1. The reporting carrier's name and address;
2. The carrier's earned premiums before refunds or credits applicable to prior years, and claims for the preceding calendar year;
3. The carrier's loss ratio determined by dividing the claims by the premiums;
4. The carrier's calculation of the dividends and credits to be issued pursuant to N.J.S.A. 17B:27A-25g(2). (A credit is a dividend paid in the form of a reduction in a current premium due, as distinguished from dividends paid in cash.);
5. An explanation of the carrier's plan to issue dividends and credits;
6. An explanation of the carrier's plan to distribute a dividend in the event of cancellation or termination by a policyholder;
7. Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-25g(2), N.J.A.C. 11:21-7A and instructions; and
8. Such other information as the Department may request.

11:21-7A.5 Refund plan

(a) If the preceding calendar year loss ratio is less than 75 percent, the carrier shall include with the loss ratio report a plan to be approved by the Department for the distribution of all dividends and credits against future premiums for all policyholders with that policy form in the preceding calendar year in an amount sufficient to assure that the claims in the preceding calendar year plus the amount of the dividends and credits shall equal 75 percent of the premiums for the policy form in the preceding calendar year.

(b) Standard plans having total employee months exposed of less than 10,000 shall be combined for refund purposes.

(c) All non-standard plans, regardless of total employee months exposed, shall be combined for refund purposes. Standard plans shall not be combined with non-standard plans.

(d) The dividends or credits shall be issued to each policyholder who was covered for any period in the preceding calendar year.

(e) The dividend or credit amount per policyholder shall be determined by multiplying the premium for each policyholder by the percentage calculated by dividing the total refund by the total premium or on the basis of a practical and equitable alternate methodology filed by the carrier in accordance with (a) above.

(f) All dividends and credits shall be distributed by December 31 of the reporting year; except that refunds based on 1994 experience shall be made no later than 60 days following the Department's approval thereof and shall be limited to the payment of dividends—no credits will be permitted for that year.

SUBCHAPTER 8. CARRIER CERTIFICATION OF NON-MEMBER STATUS
11:21-8.1 Purpose and scope

(a) The purpose of this subchapter is to establish which carriers are not members of the SEH Program and how those carriers may be certified as non-members.

(b) This subchapter applies to any carrier which files Annual Statements with the Department evidencing premium earned on group health insurance.

Amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

In (a), deleted reference to "other entities"; and in (b), deleted reference to accident insurance.

11:21-8.2 Definitions

Words and terms used in this subchapter shall have the meanings set forth in the Act or N.J.A.C. 11:21-1.2, unless the context indicates otherwise.

Amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Amended "Group health benefits plan" and "Small employer".

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

Rewrote the section.

11:21-8.3 Non-member status

(a) A carrier shall be a non-member of the SEH Program for the calendar year for which it submits a completed request for non-member certification unless the non-member certification is disapproved in writing by the Board. A carrier shall use the "Carrier Request for Non-Member Certification in the New Jersey Small Employer Health Benefits Program" form provided as Exhibit KK of these rules.

(b) A request for non-member certification shall state that:

1. The carrier neither issued nor had in force a group health benefits plan covering New Jersey small employers during the calendar year for which certification is submitted;
2. Other reasons which under law permit a carrier or entity to be certified a non-member.

Amended by R.1994 d.583, effective October 27, 1994.

See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).

Amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Substantially amended section.

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

In (a), substituted "shall" for "may" following "carrier" in the second sentence.

11:21-8.4 Non-member certification requests

(a) To be considered a non-member in any calendar year, a carrier or entity shall file with the Board a completed request for non-member certification no later than March 1 of the following calendar year. Such request shall be sent to the SEH Program Administrator or Executive Director as specified at N.J.A.C. 11:21-1.3.

(b) All requests for non-member certification shall contain the statements required in N.J.A.C. 11:21-8.3 and be certified by a duly authorized officer of the carrier.

(c) A copy of such request also shall be filed by the carrier or other entity with the Commissioner as follows:

Attn: SEH Annual Certification of Non-Member Status

Life/Health Actuarial Services

New Jersey Department of Banking and Insurance

PO Box 325

Trenton, NJ 08625-0325

Amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

In (a), deleted reference to non-members for calendar year 1993; and in (b), inserted reference to statements required by N.J.A.C. 11:21-8.3.

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

In (a), inserted a reference to the Executive Director in the second sentence.

11:21-8.5 Decisions on filings by the Board

The Board shall, if it determines that a carrier's non-member certification is incomplete, incorrect, or not in substantial compliance with this subchapter or other law, deny a request for non-member certification in writing, stating the reasons for the determination, after review of a carrier's filing. A copy of such decision shall be sent to the carrier and to the Commissioner.

Amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Substantially amended section.

11:21-8.6 Review

(a) A carrier which has been denied non-member certification may contest that determination by filing an appeal with the Board no later than 20 calendar days after receiving the written determination from the Board.

(b) The appeal shall specify the reasons why the Board's determination is inaccurate and shall include all documentation that supports or tends to support the carrier's or entity's position. The carrier or entity also shall specify whether a hearing is requested.

(c) Within 45 days of its receipt of a request for a hearing, the Board shall determine whether bona fide issues of material fact exist such that a hearing shall be conducted. If bona fide factual issues do not exist, the Board shall review the challenge itself and may delegate this review to an appropriate Board committee to make a recommendation to the Board. If a hearing is appropriate, the Board shall determine whether to hear the matter itself or refer it to the Office of Administrative Law for a hearing 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.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

In (c), substituted a reference to 45 days for a reference to 30 days in the first sentence.

**SUBCHAPTER 9. INFORMATIONAL RATE FILING
REQUIREMENTS PURSUANT TO THE
SMALL EMPLOYER HEALTH BENEFITS
PROGRAM**

11:21-9.1 Purpose and scope

(a) The purpose of this subchapter is to establish informational rate filing requirements and procedures applicable to health benefits plans, including riders or endorsements, issued, renewed, reinstated or continued pursuant to the Act.

(b) This subchapter applies to all carriers issuing, renewing, reinstating or continuing health benefits plans to small employers pursuant to the Act.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21-9.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A-17 or N.J.A.C. 11:21-1.2 unless defined below or the context clearly indicates otherwise.

“Classification factor” means a factor used to vary rates based upon characteristics of the employee, employer or policyholder.

“Health benefits plan” means any standard health benefits plan or nonstandard health benefits plan including any rider or endorsement thereto.

“Nonstandard health benefits plan” means a health benefits plan issued prior to January 1, 1994, which was in effect on February 28, 1994, and which has been reinstated, renewed or continued at the option of a small employer pursuant to the requirements of the Act.

“Nonstandard rider” means a rider or endorsement developed by a carrier to be offered with one or more of the standard health benefits plans.

“Plan” means a policy or contract form under which policies, contracts or certificates are issued evidencing benefits for expenses incurred or coverage of services rendered when referring to a type of health benefits plan.

“Standard health benefits plan” means a health benefits plan promulgated by the SEH Board subject to the review and approval of the Commissioner.

“Standard rider” means a rider or endorsement promulgated by the SEH Board to be offered with one or more of the standard health benefits plans.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

**11:21-9.3 Informational rate filing requirements for
health benefits plans renewed between January
1, 1994 and January 1, 1997**

(a) All carriers issuing policies, contracts or certificates under standard health benefits plans, including any standard or nonstandard rider option, on or before September 11, 1994, prior to issuing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the following data:

1. A schedule of premiums specifying the standard health benefits plans offered, indicating the delivery system for each plan, describing the benefit differentials for the in-network and out-of-network benefits for selective contracting arrangements and listing the premium rates to be charged;

2. A description of the rating methodology or plan and the numerical value of the classification factors utilized in the calculation of a group's premium rate or rates, including but not limited to: age, gender, industry, geographic location, effective date, and rating categories (for example, standard and substandard) resulting from underwriting rules (for example, medical and non-medical);

3. A detailed actuarial memorandum setting forth the assumptions and methods used in the development of the rates, which shall include:
 - i. Recent claim cost experience, a description of the source of the claim costs and the time period for which the claim costs were calculated;

ii. The assumptions used in developing the anticipated loss experience, including trend, plan relativity assumptions and the anticipated distribution of business by rating classification described in (a)2 above and any other factors used; and

iii. If the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A-25g(2), the carrier shall also submit the following:

(1) The assumptions for claim adjudication and payment expense, other administrative expenses, commissions, premium taxes, federal income taxes, risk margin, profit margin and any other margins applicable to the filing;

(2) The assumptions for anticipated investment income; and

(3) The assumptions and the carrier's practices for distributing anticipated divisible surplus including a statement explaining how divisible surplus will be determined and paid; and

4. A certification signed by a member of the American Academy of Actuaries attesting to the accuracy and completeness of the information provided pursuant to (a)1, 2 and 3 above and of the following information which shall also be included:

i. A statement that the filing is complete;

ii. The issue period for which the filed rates are effective, which shall not exceed 12 months;

iii. The coverage period, if any, for which the rates for a group are guaranteed;

iv. A statement of the anticipated incurred loss ratio for each plan and deductible option which shall not be less than 75 percent of the premium therefor;

v. For rates to be charged for policies, contracts or certificates issued or renewed on and after January 1, 1994 through December 31, 1995, a statement that the rating classification will not produce rates (for an individual and for each family status) for the highest rated group which are greater than 300 percent of rates (for an individual and for each family status) produced for the lowest rated group for each policy form (plan and deductible);

vi. For rates to be charged for policies, contracts or certificates issued or renewed on or after January 1, 1996 through December 31, 1996, a statement that the rating classification will not produce rates (for an individual and for each family status) for the highest rated group which are greater than 200 percent of rates (for an individual and for each family status) produced for the lowest rated group for each policy form (plan and deductible option);

vii. For rates to be charged for policies, contracts or certificates issued or renewed on and after January 1, 1997, a statement that each policy form (plan and deductible option) is community rated for each rating tier (individual, husband/wife, parent/child(ren) and family).

viii. Whether the policies provide that the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A-25g(2); and

ix. A statement that the factors which will be used to establish claim reserves are appropriate.

(b) All carriers issuing or renewing policies, contracts or certificates under a standard health benefits plan, including any standard or nonstandard rider option, after September 11, 1994, prior to issuing or renewing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the data set forth in (a) above, except that the classification factors utilized in the calculation of a group's premium rate or rates pursuant to (a)4v and vi above shall be limited to age, gender and geography in accordance with N.J.A.C. 11:21-7.15.

(c) All carriers renewing policies, contracts or certificates under a nonstandard health benefits plan (or issuing policies, contracts or certificates under a nonstandard health benefits plan through an association, multiple employer arrangement or out-of-State trust) after September 11, 1994, prior to renewing (or issuing) any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the data set forth in (a) above, except that the classification factors utilized in the calculation of a group's premium rate or rates pursuant to (a)4v and vi above shall be limited to age, gender and geography in accordance with N.J.A.C. 11:21-7.15.

(d) Any carrier which seeks to change its rates for its health benefits plans shall, prior to the effective date of the revised rates, submit to the Commissioner an informational filing which shall include all of the data set forth in (a) above, except that any change in rates intended to occur after September 11, 1994 shall be filed in compliance with (b) or (c) above, as appropriate.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21-9.4 Informational filing procedures

(a) Informational filings submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Informational Filings
 Division of Life/Health Actuarial Services
 New Jersey Department of Insurance
 20 West State Street
 PO Box 325
 Trenton, NJ 08625-0325

(b) If the Commissioner determines that an informational filing submitted pursuant to this subchapter is incomplete, the Commissioner shall provide written notice within 30 days to the carrier specifying those portions of the filing which are deficient and the information required to be submitted by the carrier. The notice shall specify whether or not the informational filing is deemed to be in substantial compliance with the requirements of N.J.A.C. 11:21-9.3. If the Commissioner takes no action with respect to the informational filing within 30 days of the date of submission thereof, the informational filing shall be deemed complete.

(c) If the informational filing is incomplete but in substantial compliance with the requirements of N.J.A.C. 11:21-9.3, the carrier shall, within 30 days of receipt of written notice in (b) above, provide the Commissioner with the information required to complete the filing. Failure on the part of the carrier to comply with the provisions of this subsection may result in the imposition of a penalty pursuant to N.J.A.C. 11:21-9.6.

(d) If the informational filing is incomplete and not in substantial compliance with the requirements of N.J.A.C. 11:21-9.3, the Commissioner shall provide written notice to the carrier specifying the portions of the filing which are deficient and the information required to be submitted by the carrier. Upon receipt of notice from the Commissioner that the filing for any health benefits plan is not in substantial compliance, no contract, policy or certificate shall be entered into or renewed using the submitted rates until the Commissioner has determined that the informational filing is in substantial compliance or complete, and has provided written notice of that fact to the carrier. If the Commissioner takes no action within 30 days of the carrier's submission of information in an effort to render the filing in substantial compliance, the filing shall be deemed to be in substantial compliance.

(e) Any carrier aggrieved by a determination of the Commissioner pursuant to (b), (c) or (d) above may request a hearing on the Commissioner's determination, within 20 days of the receipt of notice 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 notice involved;
 - iii. A statement requesting the hearing; and

iv. A concise statement specifying the reason(s) the carrier is aggrieved by the Commissioner's determination.

2. The hearing shall be conducted pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

Amended by R.1994 d.580, effective November 21, 1994.
 See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21-9.5 Public disclosure of filed information

(a) All data or information filed with the Department pursuant to N.J.A.C. 11:21-9.3(a) are public records and may be disclosed in accordance with N.J.S.A. 47:1A-1 et seq., except that actuarial memoranda which contain confidential and proprietary information pursuant to N.J.A.C. 11:21-9.3(a)3 shall not be disclosed by the Department to any person other than employees and representatives of the Department.

(b) A carrier shall separately identify in all informational rate filings the confidential actuarial information from all other information required by this regulation. If not so identified, all information shall be considered public information and subject to disclosure.

Amended by R.1994 d.580, effective November 21, 1994.
 See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

11:21-9.6 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of fines or other penalties provided by law, including suspension or revocation of a carrier's authority to do business in the State of New Jersey.

SUBCHAPTER 10. THE MARKET SHARE REPORT

11:21-10.1 Scope and applicability

(a) This subchapter sets forth annual reporting requirements of market share data for the assessment of operational and administrative expenses of the SEH Program.

(b) This subchapter shall apply to all carriers that are, or become, members of the SEH Program for any portion of a calendar year for which reports under this subchapter are required to be filed, whether or not the carrier is a member on the report filing due date.

11:21-10.2 Definitions

Words and terms used in this subchapter shall have the meanings as set forth in the Act or the chapter, unless the context clearly indicates otherwise.