

CHAPTER 4

ACTUARIAL SERVICES

Authority

N.J.S.A. 17:1C-6e.

Source and Effective Date

R.1996 d.4, effective November 30, 1995.  
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Executive Order No. 66(1978) Expiration Date

Chapter 4, Actuarial Services, expires on November 30, 2000.

Chapter Historical Note

Chapter 4, Actuarial Services, was filed and became effective prior to September 1, 1969.

1972 Revisions: Subchapter 2, Replacement of Life Insurance Policy, was originally filed and became effective April 1, 1972 as R.1972 d.21.

1973 Revisions: Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings, was filed March 23, 1973 as R.1973 d.82, effective April 15, 1973, for automobile insurance; and effective July 1, 1973, for all other lines of insurance. See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).

1974 Revisions: Subchapter 8, Charitable Annuities, was adopted as new rules by R.1974 d.258, effective September 20, 1974. See: 6 N.J.R. 315(a), 6 N.J.R. 399(c).

1976 Revisions: Subchapter 11, Life Insurance Solicitation, was adopted as new rules by R.1976 d.329, effective October 18, 1976. See: 8 N.J.R. 336(a), 8 N.J.R. 517(a).

1977 Revisions: Subchapter 13, Group Student Health Insurance, was adopted as new rules by R.1977 d.309, effective August 22, 1977. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d). Subchapter 14, Home Health Care Insurance Coverage, was adopted as new rules by R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

1978 Revisions: Subchapter 15, Alcoholism Benefits, was adopted as new rules by R.1978 d.165, effective May 22, 1978. See: 10 N.J.R. 162(a), 10 N.J.R. 257(a).

1979 Revisions: Subchapter 20, Blindness; Partial Blindness or other Physical or Mental Impairments; Unfair Discrimination, was adopted as new rules by R.1979 d.434, effective December 6, 1979. See: 11 N.J.R. 384(a), 11 N.J.R. 627(f).

1980 Revisions: Subchapter 16, Minimum Standards for Individual Health Insurance; Subchapter 17, Health Insurance Solicitation; and Subchapter 18, Individual Health Insurance Rate Filings, were adopted as new rules by R.1980 d.176, effective April 21, 1980. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c). On June 12, 1980, the New Jersey Legislature adopted Senate Concurrent Resolution 110 disapproving Subchapters 16, 17 and 18 pursuant to N.J.S.A. 17B:26-45d. On August 5, 1980, the Department of Insurance readopted Subchapters 16, 17 and 18 in their entirety, with amendments to N.J.A.C. 11:4-16.8(b), 11:4-17.6 and 11:4-17.7, as R.1980 d.343. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b). Subchapter 21, Limited Death Benefits Forms, was adopted as new rules by R.1980 d.265, effective June 18, 1980. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c).

1982 Revisions: The existing text of Subchapter 2, Replacement of Life Insurance Policy, was repealed and new rules were adopted as R.1982 d.16, effective February 1, 1982 (operative June 1, 1982). See: 13 N.J.R. 18(e), 14 N.J.R. 158(d).

1983 Revisions: Pursuant to Executive Order No. 66(1978), Subchapter 15, Alcoholism Benefits, expired on May 22, 1983.

1984 Revisions: Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as new rules by R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a). Pursuant to Executive Order No. 66(1978), Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was readopted as R.1984 d.512, effective November 5, 1984. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

1985 Revisions: Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as new rules by R.1985 d.70, effective February 19, 1985 (operative June 19, 1985). See: 16 N.J.R. 2945(a), 17 N.J.R. 460(a). Pursuant to Executive Order No. 66(1978), Subchapter 20 was readopted as R.1985 d.161, effective April 1, 1985. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a). Pursuant to Executive Order No. 66(1978), Subchapters 16, 17 and 18 were readopted as R.1985 d.221, effective April 15, 1985. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a). Subchapter 21 was readopted as R.1985 d.325, effective June 3, 1985. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a). Subchapter 24, Smoker and Non-smoker Mortality Tables, was adopted as new rules by R.1985 d.617, effective December 2, 1985. See: 17 N.J.R. 2348(a), 17 N.J.R. 2907(a). Subchapter 26, Annuity Mortality Tables, was adopted as new rules by R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

1986 Revisions: Subchapter 15, Alcoholism Benefits, was adopted as new rules by R.1986 d.228, effective June 16, 1986. See: 18 N.J.R. 607(a), 18 N.J.R. 1302(a).

1988 Revisions: Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as new rules by R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c). Subchapter 28, Group Coordination of Benefits, was adopted as new rules by R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

1989 Revisions: Subchapter 29, Homeowners Comparison Survey, was adopted as new rules by R.1989 d.50, effective January 17, 1989. See: 20 N.J.R. 2181(a), 21 N.J.R. 164(a). Subchapter 31, Term Life Insurance Comparison Survey, was adopted as new rules by R.1989 d.122, effective February 21, 1989. See: 20 N.J.R. 2990(a), 21 N.J.R. 566(a). Subchapter 32, Health Service Corporation Notice of Increased Rates, was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c). Subchapter 33, Excess Interest Reserve Adjustment, was adopted as new rules by R.1989 d.523, effective October 2, 1989. See: 21 N.J.R. 1308(a), 21 N.J.R. 3175(c). Subchapter 34, Long-Term Care Insurance, was adopted as new rules by R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

1990 Revisions: Subchapter 25 regarding Medicare supplement interim standards, was adopted as new rules by R.1990 d.214, effective April 16, 1990. See: 22 N.J.R. 320(a), 22 N.J.R. 1266(b).

1991 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990. As part of R.1991 d.3, Subchapter 1, Contracts on a Variable Basis, was repealed effective January 7, 1991. See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a). Subchapter 35, Annual Medicare Supplement Policy Survey, was adopted as new rules by R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a). Subchapter 23, Medicare Supplement Policies and Contracts, was changed to Minimum Standards for Medicare Supplement Coverage by R.1991 d.345, effective July 1, 1991. See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a). Notice of Action on Petition for Rulemaking: Regulation of Authority on Group Health Insurance Contracts. See: 23 N.J.R. 2546(c). Denial of Petition for Rulemaking: Declaration of Authority to Regulate Group Health Insurance Contracts. See: 23 N.J.R. 3827(a).

1993 Revisions: Subchapter 25 was repealed by R.1993 d.26, effective January 4, 1993. See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

1994 Revisions: Subchapter 37, Selective Contracting Arrangements of Insurers, was adopted as new rules by R.1994 d.45, effective January 18, 1994. See: 25 N.J.R. 4554(b), 26 N.J.R. 381(a).

1995 Revisions: Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as new rules by R.1995 d.406, effective August 7, 1995. See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a). Subchapter 30, Accelerated Death Benefits, was adopted as new rules by R.1995 d.521, effective September 18, 1995. See: 27 N.J.R. 2046(a), 27 N.J.R. 3613(c). Subchapter 40, Life/Health/Annuity Forms, was adopted as new rules by R.1995 d.569, effective November 6, 1995. See: 27 N.J.R. 2857(a), 27 N.J.R. 2867(a), 27 N.J.R. 4317(a). An administrative correction, published November 20, 1995, restored comments to the notice of adoption of Subchapter 40 which were inadvertently omitted. See: 27 N.J.R. 4728(a).

1996 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1996 d.4, effective November 30, 1995. As part of R.1996 d.4, Subchapter 5, Amendment to Instructions to Life and Accident and Health Annual Statement Blank; Subchapter 10, Expense Experience; Subchapter 32, Health Service Corporation Notice of Increased Rates; Subchapter 35, Annual Medicare Supplement Policy Survey; and Exhibits A and B of the Appendix to Subchapters 16 and 23 were repealed effective January 2, 1996. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. (RESERVED)

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SUBCHAPTER 2. REPLACEMENT OF LIFE  
 INSURANCE POLICY

**11:4-2.1 Purpose**

(a) The purpose of this subchapter is:

1. To regulate the activities of insurers and agents with respect to the replacement of existing life insurance;
2. To protect the interests of life insurance policyowners by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of existing life insurance by:
  - i. Assuring that the policyowner receives information with which a decision can be made in his or her own best interest;
  - ii. Reducing the opportunity for misrepresentation and incomplete disclosures; and
  - iii. Establishing penalties for failure to comply with the requirements of this subchapter.

**11:4-2.2 Definitions**

“Cash dividend” means the current illustrated dividend which can be applied toward payment of the gross premium.

“Conservation” means any attempt by the existing insurer or its agent to continue existing life insurance in force when existing insurer has received a Comparative Information Form as required by N.J.A.C. 11:4-2.5(a)3iv from a replacing insurer. A conservation effort does not include routine administrative procedures like late payment reminders, late payment offers or reinstatement offers.

“Direct-response sales” means any sale of life insurance where the insurer does not utilize an agent in the sale or delivery of the policy.

“Existing insurer” means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of “replacement”.

“Existing life insurance” means any life insurance in force including life insurance under a binding or conditional receipt or a life insurance policy that is within an unconditional refund period, but excluding life insurance obtained through the exercise of a dividend option.

“Generic name” means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

“Replacement” means any transaction in which new life insurance is to be purchased, and it is known or should be known to the proposing agent, or to the proposing insurer if there is no agent, that by reason of such transaction, existing life insurance has been or is to be:

1. Lapsed, forfeited, surrendered, or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or
5. Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25 percent of the loan value set forth in the policy.

“Replacing insurer” means the insurance company that issues a new policy which is a replacement of existing life insurance.

“Sales Proposal” means individualized, written sales aids of all kinds, excluding Comparative Information Forms and Policy Summaries, which are used by an insurer, agent or broker in comparing existing life insurance to proposed life insurance in order to recommend the replacement or conservation of existing life insurance. Sales aids of a generally descriptive nature, which are maintained in the insurer’s advertising compliance file, shall not be considered a Sales Proposal within the meaning of this definition.

**11:4-2.3 Exemptions**

(a) Unless otherwise specifically included, this subchapter shall not apply to:

1. Annuities;
2. Individual credit life insurance;
3. Group life insurance, group credit life insurance, and life insurance policies issued in connection with a pension, profit-sharing or other benefit plan qualifying for tax deductibility of premiums, provided, however, that as to any plan described in this subsection, full and complete disclosure of all material facts shall be given to the administrator of any plan to be replaced;

4. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account;

5. An application to the existing insurer that issued the existing life insurance and a contractual change or conversion privilege is being exercised;

6. Existing life insurance that is a non-convertible term life insurance policy which will expire in five years or less and cannot be renewed; or

7. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company.

**11:4-2.4 Duties of agent**

(a) Each agent shall submit to the replacing insurer with or as part of each application for life insurance:

1. A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and

7. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the loss ratio of any element of any insurance construct will not differ by more than 10 percent from the anticipated loss ratio for the policy.

ii. For the purpose of this paragraph, "construct" means the risk variables which significantly affect the cost of the coverage. For example, age could be a construct wherein its elements would be age 20, age 21 and so forth. The Department of Insurance is particularly concerned with anticipated loss ratios by issue age or issue age groupings;

8. The specific formulas and methodology used in calculating gross premiums; and

9. A certification signed by an actuary who is a member of the American Academy of Actuaries or Casualty Actuarial Society stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio.

Repeal and New Rule, R.1996 d.180, effective April 1, 1996.  
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).  
Section was "Compliance".

**11:4-34.14 Loss ratio standards for individual long-term care insurance**

(a) Long-term care insurance is subject to the loss ratio requirements set forth at N.J.A.C. 11:4-18.5.

(b) When a long-term care policy is funded by a level premium payable over the life of an insured whose issue age is under 65, the anticipated loss ratio cannot be less than:

$$(A-B-C)/A$$

where: A = the present value at policy issue of one dollar of annualized premium;

B = the present value at policy issue of the product of R and one dollar of annualized premium payable for policy years from policy issue to attained age 65;

C = the present value at policy issue of the product of .35 and one dollar of annualized premium payable for policy years after attained age 64;

and where R = the complement of the applicable loss ratio factor for coverage before attained age 65, with complements of .50 for noncancellable insurance and .45 for guaranteed renewable insurance.

New Rule, R.1996 d.180, effective April 1, 1996.  
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

**11:4-34.15 Spousal discount**

(a) A spousal discount is permitted in individual long-term care insurance when the following conditions are met:

1. The objective basis of the rate differential is included in the actuarial memorandum as required by N.J.A.C. 11:4-18.4(a)1iv;

2. All conditions required to be satisfied in order to receive and retain the discount shall be disclosed and shall be related to the objective basis of the rate differential. When improved morbidity is the objective basis for a spousal discount, insurers shall extend the discount to all married individuals regardless of whether the insured's spouse is covered under a long-term care policy; and

3. When a husband and wife both apply for and are issued a long-term care policy offering a spousal discount, both individuals shall receive the discount.

New Rule, R.1996 d.180, effective April 1, 1996.  
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

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SUBCHAPTERS 35 THROUGH 36. (RESERVED)

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SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

**11:4-37.1 Purpose and scope**

(a) The purpose of this subchapter is to set forth standards and procedures whereby a carrier shall obtain approval from the Commissioner of its offering of health benefits plans utilizing selective contracting arrangements that promote health care cost containment while adequately preserving quality of care.

(b) This subchapter applies to all carriers operating pursuant to Title 17B of the New Jersey statutes, and issuing health benefits plans utilizing selective contracting arrangements in this State or which cover New Jersey residents. This subchapter shall not apply to the following: hospital service corporations operating pursuant to N.J.S.A. 17:48-1 et seq.; medical service corporations operating pursuant to N.J.S.A. 17:48A-1 et seq.; hospital and medical service corporations operating pursuant to N.J.S.A. 17:48B-1 et seq.; dental service corporations operating pursuant to N.J.S.A. 17:48C-1 et seq.; dental plan organizations operating pursuant to N.J.S.A. 17:48D-1 et seq.; or health service corporations operating pursuant to N.J.S.A. 17:48E-1 et seq.

**11:4-37.2 Definitions**

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

“Allowable expense” means the usual, customary and reasonable item of expense for a covered service when the item of expense is covered at least in part by the health benefits plan.

“Carrier” means any insurance company operating pursuant to Title 17B of the New Jersey statutes and authorized to issue health benefits plans in this State.

“Coinsurance” means the percentage of the allowable expenses payable by the covered person.

“Coinsurance differential” means the difference in the coinsurance percentage applicable to in-network and out-of-network benefits.

“Commissioner” means the Commissioner of the New Jersey Department of Insurance.

“Copayment” means a specified dollar amount a covered person must pay for specified covered services.

“Covered person” means a person on whose behalf the carrier is obligated to pay benefits pursuant to the health benefits plan.

“Covered service” means a service provided to a covered person under a health benefits plan for which a carrier is obligated to pay benefits.

“Department” means the New Jersey Department of Insurance.

“Emergency care” means covered services that are provided by any health care provider, which are needed immediately because of an injury or sudden illness and the time required to reach a preferred provider would have meant serious deterioration of or risk of permanent damage to the covered person’s health. These services are considered to be emergency care as long as transfer of the covered person to a preferred provider is precluded because of risk to the covered person’s health or because transfer would be unreasonable, given the distance involved in the transfer or the nature of the medical condition.

“Evidence of coverage” means any booklet, certificate, agreement or contract issued to covered persons setting out the services and other benefits to which they are entitled under a health benefits plan.

“Health benefits plan” means a policy or contract delivered or issued for delivery in this State by a carrier paying benefits for covered services.

“Health care provider” means an individual or entity which, acting within the scope of its licensure or certification by the Department of Health, provides a covered service defined by the health benefits plan.

“Preferred provider” means a health care provider or group of health care providers who have entered into selective contracting arrangements with a carrier or a preferred provider organization.

“Preferred provider organization” or “PPO” means an entity other than a carrier that contracts with preferred providers to establish selective contracting arrangements.

“Selective contracting arrangement” means an arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations.

### 11:4-37.3 Standards for selective contracting arrangements

(a) For purposes of paying for covered services under a health benefits plan, a selective contracting arrangement entered into by a carrier shall meet the following criteria:

1. The selective contracting arrangement shall include a mechanism for the review or control of utilization of covered services;
2. The selective contracting arrangement shall provide for an adequate number of preferred providers by specialty to render covered services in the geographic service area(s) where it functions;
3. The selective contracting arrangement shall include a procedure for resolving complaints and grievances of covered persons;
4. The selective contracting arrangement shall provide that information pertaining to the diagnosis, treatment or health of any covered person receiving health care benefits shall be confidential and shall not be disclosed to any person except as follows:
  - i. To the extent that it may be necessary to carry out the purposes of this subchapter;
  - ii. Upon the express consent of the covered person;
  - iii. Pursuant to statute or regulation;
  - iv. Pursuant to court order for the production of evidence or the discovery thereof;
  - v. In the event of a claim or litigation between such covered person and the carrier wherein such data or information is pertinent; or
  - vi. As otherwise required by law.

(b) Health benefits plans utilizing selective contracting arrangements shall meet the following criteria:

1. The health benefits plan utilizing a selective contracting arrangement shall provide that covered persons shall not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered services, if the carrier fails to pay for the covered services for any reason.

2. If a covered person is in need of emergency care as defined herein, the health benefits plan utilizing a selective contracting arrangement shall include a mechanism which reimburses emergency care as if the covered person had been treated by a preferred provider;

3. The carrier shall, within 30 days of delivering a health benefits plan utilizing a selective contracting arrangement, provide covered persons with evidence of coverage which shall contain provisions or statements which are not unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation. The evidence of coverage shall contain either a clear and complete statement or a reasonably complete summary of:

- i. The insurance or other benefits, if any, to which covered persons are entitled;
- ii. Any limitation on the benefits, or kind of benefits, to be provided, including the coinsurance differential for services rendered by a preferred provider as opposed to a non-preferred provider, as well as any copayment, deductible or coinsurance feature;
- iii. Information as to where and in what manner services or benefits may be obtained; and
- iv. A clear, accurate and understandable description of the method for resolving complaints from covered persons;

4. The carrier issuing health benefits plans utilizing a selective contracting arrangement shall provide that subsequent changes in coverage shall be evidenced in a separate document issued to the covered person;

5. The carrier utilizing a selective contracting arrangement may provide in its health benefits plan for direct payment to the preferred provider for covered services rendered, and shall establish either the methodology to determine the amount or the actual amount of payment to the preferred provider whichever is applicable;

6. The carrier utilizing a selective contracting arrangement for a health benefits plan shall include a mechanism which provides that the coinsurance differential, if any, applicable to covered services rendered by a preferred provider, as opposed to covered services rendered by other health care providers, shall be no greater than 30 percent of the allowable expense, provided deductibles and copayments are equivalent for both in-network and out-of-network benefits. If deductibles and copayments for in-network and out-of-network benefits are not equivalent, the 30 percent maximum coinsurance differential shall be adjusted to reflect the differences. The mechanisms for the delivery of a health benefits plan utilizing a selective contracting arrangement established by either the Individual Health Coverage Program Board of Directors or the Small Employer Health Benefits Program Board of Directors on or before January 1, 1994, will be deemed to meet this requirement.

(c) Nothing contained in this subchapter shall be deemed to impair or otherwise affect any selective contracting arrangements, collective bargaining agreements, or health benefits plans which have been filed and approved by the Commissioner and which were in effect before June 1, 1993, except as they may be renewed on or after June 1, 1993.

1. All selective contracting arrangements entered into or renewed on or after June 1, 1993, other than those which provide benefits under a collective bargaining agreement, shall be brought into full compliance with the requirements of this subchapter as they renew but no later than April 18, 1995.

2. Any selective contracting arrangement entered into or renewed on or after June 1, 1993, which provides benefits under a collective bargaining agreement, shall be brought into full compliance with the requirements of this subchapter either on or before January 1, 1995 or within 90 days after the expiration of the term of the collective bargaining agreement, whichever is later.

3. Every carrier with selective contracting arrangements subject to this subsection shall submit to the Department by April 18, 1994, a Plan of Compliance, setting forth the methods and timetable the carrier will follow in bringing its current selective contracting arrangements into full compliance with this subchapter.

4. Carriers shall submit five copies of the Plan of Compliance described in (b)3 above, together with the filing fee set forth at N.J.A.C. 11:4-37.9, to the Department as specified at N.J.A.C. 11:4-37.5(a).

#### 11:4-37.4 Selective contracting arrangement approval procedures

(a) No carrier shall issue health benefits plans utilizing selective contracting arrangements unless the carrier has entered into such arrangements directly with preferred providers or has contracted with preferred provider organizations.

(b) For purposes of obtaining the Commissioner's approval under this subchapter, a carrier issuing health benefits plans utilizing a selective contracting arrangement shall submit five copies of the selective contracting arrangement approval application on a form to be provided by the Department. The items set forth at (b)13 and 14 below shall be set forth separately from the remainder of the items to be included in the approval application.

1. Three copies of the entire application, together with the appropriate filing fee set forth at N.J.A.C. 11:4-37.8, shall be submitted to the Department at the following address:

New Jersey Department of Insurance  
 Managed Health Care Bureau  
 Division of Life/Health Actuarial Services  
 20 West State Street  
 CN 325  
 Trenton, NJ 08625

2. Two copies of the entire application, together with the appropriate filing fee set forth at N.J.A.C. 11:4-37.8, shall be submitted to the Department of Health at the following address:

New Jersey Department of Health  
Alternative Health Systems Program  
300 Whitehead Road  
CN 367  
Trenton, NJ 08625

(c) The selective contracting arrangement approval application shall include the following:

1. A narrative description of the health benefits plan to be offered;
2. A statement that the carrier is entering into a selective contracting arrangement directly with preferred providers, or where the carrier is contracting with a PPO, a description of the PPO that will operate and/or administer the selective contracting arrangement; a description of the relationship between the carrier and the PPO; and a certification signed by a senior officer of the PPO that the PPO does not engage in the business of insurance in this State, and in no way assumes risk in the provision of services for the treatment of injury or illness or preventative care for any person or on behalf of any person other than its own employees;
3. A description of the geographical service areas in which the health benefits plan is to be offered;
4. A description of the manner in which covered services and other benefits may be obtained by covered persons using the selective contracting arrangement;
5. A narrative description of the financial arrangements between the carrier and the preferred providers if the carrier is contracting directly with the preferred providers, or between the carrier and the PPO if the carrier is contracting with a PPO;
6. A copy of every standard form contract, including variables, establishing the selective contracting arrangements that will be utilized in the health benefits plan, including the standard contract(s) or agreement(s) the carrier or PPO has entered into with health care providers or classes of health care providers;
7. A description of the criteria and method used to select preferred providers, including any credentialing plan;
8. The names and addresses of preferred providers, by specialty and geographic service areas, and a copy of the provider directory to be distributed to covered persons;
9. A description of any provisions which allow covered persons to obtain covered services from a health care provider that is not a preferred provider;
10. A description of the utilization review program. At a minimum this shall include:
  - i. A description of the criteria and methods to be used in utilization control, particularly the criteria for determining over- and under-utilization; and
  - ii. A description of the mechanisms for evaluating the success or failure of the utilization review program;
11. A description of the quality assurance program. At a minimum this shall include:
  - i. A clear description of how quality of care will be monitored and controlled;
  - ii. The criteria used to define and measure quality;
  - iii. The criteria used to determine the success or failure of the quality assurance program; and
  - iv. A description of the staff and their qualifications that will be responsible for the quality assurance program;
12. A description of the complaint and grievance system available to covered persons, including procedures for the registration and resolution of grievances;
13. A copy of every standard form policy or contract, including variables, to be issued by the carrier to the contractholders of health benefits plans, which shall include the requirements set forth at N.J.A.C. 11:4-37.3(b)3;
14. A copy of every standard form of evidence of coverage to be issued by the carrier to covered persons, setting forth the carrier's contractual obligations to pay for covered services provided to covered persons, which shall include the requirements set forth at N.J.A.C. 11:4-37.3(b)3;
15. A description of the incentives for covered persons to use the services of preferred providers;
16. A description of the provisions within the health benefits plan for holding covered persons financially harmless for payment denials by, or on behalf of, the carrier for improper utilization of covered services caused by preferred providers;
17. An organizational chart of the carrier's division responsible for managing selective contracting arrangements and of the PPO if appropriate;
18. A listing and biography of the officers and directors, if any, of the carrier's division responsible for managing selective contracting arrangements and of the PPO if appropriate;
19. The address of the place of business of the carrier's division responsible for managing selective contracting arrangements and of the PPO if appropriate;
20. A copy of the PPO's most recent financial statement if the carrier is contracting with a PPO; and

21. The following three-year pro-forma information concerning the benefit plans to be issued utilizing selective contracting arrangements:

- i. Enrollment projections indicating the number of employees by rating status (that is, single, husband/wife, parent/child and family) and number of covered persons. This data is to be provided quarterly for the first year, and annually for the remaining two years; and
- ii. Financial projections, including balance sheet, income and expense statement and a cash-flow statement.

(d) Any significant changes to the nature of the selective contracting arrangement as reflected in the materials in (a) above shall be reported to the Department within 30 days, at the following address:

New Jersey Department of Insurance  
 Managed Health Care Bureau  
 Division of Life/Health Actuarial Services  
 20 West State Street  
 CN 325  
 Trenton, NJ 08625

(e) The Commissioner, in consultation with the Commissioner of Health as necessary, shall review these documents and grant approval, within 30 days of the carrier's filing its application for approval, to those carriers whose selective contracting arrangements are determined to meet the criteria set forth in this subchapter and which promote health care cost containment while adequately preserving quality of care. The Commissioner may extend the 30-day time frame an additional 30 days for good cause shown and shall provide notice to the carrier of such extension. A decision to deny approval shall be accompanied by a written explanation by the Department of the reasons for denial. A carrier whose selective contracting arrangement has been denied approval may request an administrative hearing pursuant to the procedures at N.J.A.C. 11:4-37.6.

(f) The approval of a selective contracting arrangement issued under this subchapter by the Commissioner, in consultation with the Commissioner of Health, shall remain in force for a period of three years excepting suspension or revocation pursuant to this subchapter.

(g) A carrier shall apply for triennial renewal of the Department's approval of its selective contracting arrangement at least 60 days prior to the expiration of the previous three-year approved period. Applications for renewal of the Department's approval shall be subject to the filing fee set forth at N.J.A.C. 11:4-37.9. If the Department has not issued a written notice of disapproval, which clearly sets forth the reasons for disapproval of the renewal application, within 60 days of receipt of the renewal application, the renewal application shall be deemed approved.

#### 11:4-37.5 Confidentiality

(a) The following data or information submitted to the Department under this subchapter shall not be confidential and may be released by the Department and the Department of Health, but only upon written, specified request:

1. The carrier's narrative description of the health benefits plan to be offered;
2. The carrier's description of the geographical service area in which the carrier will offer the health benefits plan;
3. The carrier's description of the manner in which covered services and other benefits may be obtained by covered persons under the selective contracting arrangement;
4. The names and addresses of the selective contracting arrangement's or PPO's preferred providers, by specialty and geographic service areas, and the provider directory;
5. The carrier's description of any provisions included in the selective contracting arrangement which allow covered persons to obtain covered services from a health care provider that is not a preferred provider;
6. The carrier's description of the complaint and grievance system available to covered persons under the selective contracting arrangement;
7. Copies of the standard form policy or contract to be issued by the carrier to the contractholders of health benefits plans;
8. Copies of the standard evidence of coverage form to be issued by the carrier to covered persons;
9. The carrier's description of the incentives for covered persons to use the services of preferred providers;
10. The carrier's description of the provisions within the health benefits plan for holding covered persons financially harmless for payment denials by or on behalf of the insurer for improper utilization of covered services caused by preferred providers;
11. The PPO's most recent financial statement;
12. The PPO's certification that it does not engage in the business of insurance in this State or assume risk in the provision of services for the treatment of injury or illness or preventative care for any person or on behalf of any person, other than its own employees;
13. The carrier's or PPO's organizational chart;
14. The carrier's or PPO's listing and biography of its officers and directors;
15. The address of the carrier's or PPO's place of business; and
16. The address of the carrier's division responsible for managing selective contracting arrangements.

(b) All data or information submitted to the Department under this subchapter, except for those items included in (a) above, is confidential and shall not be disclosed by the Department to any person other than employees and representatives of the Department and the Department of Health.

#### 11:4-37.6 Approval, denial, suspension and revocation

(a) The approval of a selective contracting arrangement issued by the Department under this subchapter may be denied, suspended or revoked if the Commissioner determines that:

1. The selective contracting arrangement criteria set forth in this subchapter are not being met;
2. Payment for covered services provided under the selective contracting arrangement is not in accordance with the terms of the approved arrangement;
3. The arrangement for the payment of covered services fails to meet the requirements of these rules; or
4. Any false or misleading information is submitted by the carrier seeking approval.

(b) If the Commissioner believes that any of the conditions set forth in subsection (a) above exist, the Commissioner shall notify the carrier by directing a notice by certified mail or personal delivery to the last known business or mailing address of the carrier. The notice shall include:

1. A description of the condition(s) in (a) above alleged to exist;
2. A statement that the carrier may within 20 days correct the condition(s) alleged to exist; and
3. A statement advising the carrier of the procedure for requesting a hearing.

(c) A carrier requesting a hearing pursuant to (b)3 above shall submit the hearing request to the Department at the following address:

New Jersey Department of Insurance  
 Managed Health Care Bureau  
 Division of Life/Health Actuarial Services  
 20 West State Street  
 CN 325  
 Trenton, NJ 08625

The hearing request shall include:

1. The name, address and telephone number of a contact person familiar with the matter;
2. A copy of the Commissioner's written allegations;
3. A statement requesting a hearing; and

4. A concise statement describing the factual and legal bases for which the carrier believes that the Commissioner's allegations are erroneous; and

5. All relevant documents in support of the hearing request.

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

(e) 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.

1. If the Commissioner concludes 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.

2. In a matter which has been determined to be a contested case, if the Commissioner concludes that there are no good-faith disputed issues of material fact and the matter may be decided on the documents filed, the Commissioner may notify the carrier in writing of the final disposition of the matter.

(f) In addition, or as an alternative to suspension or revocation, the Commissioner may impose such other penalties as provided by law.

Amended by R.1996 d.4, effective January 2, 1996.  
 See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

#### 11:4-37.7 Monitoring; auditing

(a) The Commissioner, in consultation with the Commissioner of Health as necessary, shall monitor and conduct periodic audits or examinations of the carrier's selective contracting arrangements as necessary to ensure compliance with the approval criteria set forth in this subchapter.

(b) All records of the carrier relating to selective contracting arrangements shall be disclosed upon request of and in a format acceptable to the Commissioner. If such records are maintained in a coded or semi-coded manner, a legend for the codes shall be provided to the Commissioner.

#### 11:4-37.8 Filing and review fees

(a) Every carrier shall pay a \$3,000 filing fee for filing each of the following with the Department:

1. A selective contracting arrangement pursuant to N.J.A.C. 11:4-37.4;
2. A plan of Compliance pursuant to N.J.A.C. 11:4-37.3(b);

3. A triennial renewal application of a selective contracting arrangement pursuant to N.J.A.C. 11:4-37.4(g).

(b) The approval application, renewal application and Plan of Compliance fees of \$3,000 shall be payable as follows:

1. \$1,500 payable to the "Treasurer, State of New Jersey."
2. \$1,500 payable to the "New Jersey Department of Health."

(c) Every carrier, in addition to complying with the filing and review fee requirements set forth in this section, shall be subject to any fees that may be applicable as set forth in N.J.A.C. 11:1-32.

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## SUBCHAPTERS 38 THROUGH 39. (RESERVED)

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## SUBCHAPTER 40. LIFE/HEALTH/ANNUITY FORMS

### 11:4-40.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 1995, c.73 (the Life and Health Insurance and Health Maintenance Organization Form Approval Reform Act) by setting forth standards and procedures whereby all life insurance, health insurance, and annuity forms, and rates where applicable, are to be submitted to the Commissioner for his or her approval prior to use. This subchapter also establishes a file and use system for certain forms deemed eligible by the Commissioner provided that a certification is filed that the particular form complies with the law and rules applicable to it.

(b) This subchapter shall apply to all life insurance, health insurance and annuity forms issued pursuant to N.J.S.A. 17B:17-1 et seq.; all hospital service corporation contracts issued pursuant to N.J.S.A. 17:48-1 et seq.; all medical service corporation contracts issued pursuant to N.J.S.A. 17:48A-1 et seq.; all health service corporation contracts issued pursuant to N.J.S.A. 17:48E-1 et seq.; and all health maintenance organization contracts, evidence of coverage and related forms issued pursuant to N.J.S.A. 26:2J-1 et seq. This subchapter shall not apply to any forms issued pursuant to N.J.S.A. 17B:27A-2 et seq. or 17B:27A-17 et seq., but shall apply to all forms issued pursuant to N.J.S.A. 17B:27A-7 and N.J.S.A. 17B:27A-19.

### 11:4-40.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Annuity" means a contract not included within the definitions of life insurance or health insurance as set forth in this section, under which an insurer obligates itself to make periodic payments for a specified period of time, such as for a number of years, or until the happening of an event, or for life or for a period of time determined by any combination thereof. A contract which includes extra benefits of the kinds set forth in the definitions of life insurance or health insurance set forth in this section shall nevertheless be deemed to be an annuity if such extra benefits constitute a subsidiary or incidental part of the entire contract.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Contract on a variable basis" or "variable contract" means any separate account contract providing for the dollar amount of life insurance or annuity benefits or other contractual payments or values thereunder to vary so as to reflect investment results of one or more separate accounts in which amounts with respect to any such contracts shall have been placed.

"Department" means the New Jersey Department of Insurance.

"Form" or "policy form" or "life/health/annuity form or contract" means any individual or group policy form or contract providing life insurance, health insurance or annuity benefits; any application for such a policy, contract or certificate if a written application is required and is to be made part of that policy or contract; any rider or endorsement for use with such a policy or contract; certificates of such insurance; any evidence of such insurability form; any health maintenance organization contract; and any evidence of such coverage or related form delivered or issued for delivery in this State.

"Funeral insurance policy" means a policy as defined at N.J.S.A. 17B:17-5.1.

"Health insurance" means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance does not include workers' compensation coverage or stop-loss coverage.

"Insurer" means a hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.; a medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.;

a health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.; a life, health or annuity company operating pursuant to N.J.S.A. 17B:17-1 et seq.; and a fraternal benefit society operating pursuant to N.J.S.A. 17:44A-1 et seq. to the extent that it issues certificates or evidence of coverage forms containing accident or health benefits. A fraternal benefit society that issues certificates containing life insurance benefits is not considered an insurer for purposes of this subchapter.

“Life insurance” means a policy or contract whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the cessation of human life. Life insurance also includes the granting of endowment benefits and optional modes of settlement of proceeds of life insurance, as well as provisions for additional benefits in the event of death by accident or accidental means or in the event of dismemberment or loss of sight; or safeguarding such insurance against lapse or giving a special surrender value, or special benefit or annuity in the event that the insured shall become totally and permanently disabled, whether such provisions are incorporated in a policy or contract of life insurance or in a policy or contract supplemental thereto. Life insurance does not include worker’s compensation coverage.

“Limited death benefit policy” means a policy as defined at N.J.A.C. 11:4-21.

“Published guidelines” means guidelines published by the Commissioner on or before April 10, 1995.

“Responsible officer of the insurer” means a corporate officer of the level of vice president or higher, or of an equivalent title within the insurer’s corporate structure, who is either an actuary of the insurer with responsibility for the type of form filed, or the individual with responsibility for managing the form filing process for the insurer with regard to the type of form filed.

“Separate account” means any segregated portfolio of investment or designated account of an insurer established pursuant to N.J.S.A. 17B:28-1 et seq.

“State” means the State of New Jersey.

“Stop loss or excess risk insurance” means insurance designed to reimburse a self-funded arrangement for catastrophic and unexpected expenses exceeding specified per person retention limits of no less than \$25,000 per year and/or aggregate retention limits of no less than 125 percent of expected claims per year, wherein neither the employees nor other individuals are third party beneficiaries under the policy, contract or plan.

“Universal flexible-factor form” means any life insurance policy, rider or endorsement, whether participating or non-participating, which permits the insurer to reserve the right to modify (upward or downward) premiums, premium factors (interests, mortality, expenses), or benefits (death benefits, cash or loan values) on the basis of future anticipated or emerging experience.

### 11:4-40.3 Life/health/annuity form approval standards

(a) All life, health and annuity forms shall comply with the standards set forth in this subchapter and in any other applicable statutes, rules and published guidelines before being delivered or issued for delivery in this State.

(b) No form delivered or issued for delivery in this State shall contain provisions which are unjust, unfair, inequitable, misleading or contrary to law or to the public policy of this State.

### 11:4-40.4 General requirements

(a) All insurers submitting forms or other correspondence to the Department pursuant to this subchapter shall comply with the following general procedures:

1. All individual health, group health, blanket, prepaid legal contracts, group life and service corporation forms and other related correspondence submitted or resubmitted for approval or for file and use pursuant to this subchapter shall be submitted to the Department at the following address:

New Jersey Department of Insurance  
Health Bureau  
20 West State Street  
CN-470  
Trenton, NJ 08625-0470

2. All individual life, credit life and health, mortgage guaranty, separate account, variable contract and annuity forms and other related correspondence pursuant to this subchapter submitted or resubmitted for approval or for file and use shall be submitted to the Department at the following address:

New Jersey Department of Insurance  
Life Bureau  
20 West State Street  
CN-470  
Trenton, NJ 08625-0470

3. All submissions and resubmissions of forms to the Department shall include a self-addressed, stamped envelope.

4. For purposes of computing time limits in this subchapter, “days” shall mean calendar days, except that when the last day of any specified time period is a Saturday, Sunday or State holiday, then the time period shall end on the next following business day. With regard to any specified time period relating to documents or correspondence transmitted between the Department and the insurer, the Department shall rely on one of the following:

i. The date appearing on a clear, legible postmark affixed by the United States Postal Service;