

See: 26 N.J.R. 4228(b), 26 N.J.R. 4452(d), 27 N.J.R. 1321(a).

Petition for Rulemaking: Exhibit F.

See: 26 N.J.R. 5119(a), 27 N.J.R. 946(d).

Petition for Rulemaking: Exhibits A through F.

See: 26 N.J.R. 5120(b), 27 N.J.R. 946(b).

Petition for Rulemaking: Exhibit D.

See: 28 N.J.R. 1315(a), 28 N.J.R. 2413(b).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), inserted "as amended" at the end of the first sentence; in (b), inserted "as the term member is defined in this subchapter" following "Coverage Program"; and in (c), substituted "August 1, 1993" for "November 30, 1992".

11:20-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

"Act" means the Individual Health Insurance Reform Act, P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 through 16.5).

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another.

"Basic health benefits plan" means the health benefits plan designed by the Board in accordance with N.J.S.A. 17B:27A-4c as amended by P.L. 1993, c.164, § 3.

"Board" means the Board of Directors of the New Jersey Individual Health Coverage Program established by the Act.

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this chapter, carriers that are affiliated carriers shall be treated as one carrier.

"Church plan" has the same meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(33)).

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

"Community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, without regard to age, sex, health status, occupation and geographical location.

"Conversion health benefits plan" means a group conversion contract or policy issued on or after August 1, 1993 that is not subsidized by either:

1. A single charge or ongoing increase in premium rates chargeable to the group policy or contract, identifiable as an excess morbidity charge in the group rating formula to cover group conversion excess morbidity costs; or
2. A reduction in dividends or returns paid to a group policy or contract holder, identifiable as a charge to or reduction in the group dividend or return formula to cover group conversion excess morbidity costs.

"Deferral" means a deferment, in whole or in part, of payment by a member of any assessment issued by the IHC Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-12a(3) and N.J.A.C. 11:20-11.

"Department" means the New Jersey Department of Banking and Insurance.

"Dependent" means the spouse, or child of an eligible person, or the child of a policyholder or contractholder, subject to applicable terms of the individual health benefits plan.

"Director" means a Director of the Individual Health Coverage Program who, in accordance with N.J.S.A. 17B:27A-10 as amended by P.L. 1993, c.164, § 5:

1. Has been elected by the members of the Individual Health Coverage Program and approved by the Commissioner;
2. Has been appointed by the Governor and confirmed by the Senate; or
3. Sits ex officio on the Board of Directors.

"Eligible person" means a person is a resident who is not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan, or Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.), "Medicare."

"Family unit" means a legally married man and woman; a legally married man and woman and their dependent child(ren), as the term dependent is defined in the individual health benefits plan; an adult and his or her dependent child(ren), as the term dependent is defined in the individual health benefits plan, who are members of the same household; and dependent children only who are members of the same household as the term dependent is defined in the individual health benefits plan.

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub. L. 93-222 (42 U.S.C. § 300e et seq.).

“Fiscal year” means the time period beginning on July 1st of each year and ending on June 30th of the following calendar year.

“Governmental plan” has the meaning given that term under Title I, section 3 of Pub.L. 93-406, the “Employee Retirement Income Security Act of 1974” (29 U.S.C. §§ 1002(32)) and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.

“Group health benefits plan” means a health benefits plan for groups of two or more persons.

“Group health plan” means an employee welfare benefit plan, as defined in Title I, section 3 of Pub.L. 93-406, the “Employee Retirement Income Security Act of 1974” (29 U.S.C. § 1002(1)), to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

“Health benefits plan” means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers’ compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan. The term “health benefits plan” specifically includes:

1. Standard health benefits plans as defined in this section;
2. Closed blocks of business otherwise meeting the definition of health benefits plan;
3. Executive medical plans;
4. Student coverage which provides more than accident-only coverages;
5. All prescription drug plans whether or not written on a stand alone basis;

6. Plans that cover both active employees and retirees eligible for Medicare for which separate statutory reporting is not made by the carrier; and

7. All other health policies, plans or contracts not specifically excluded.

“HMO” means a health maintenance organization authorized in accordance with N.J.S.A. 26:2J-1 et seq.

“Hospital confinement indemnity coverage” means coverage that is provided on a stand alone basis, contains no elimination period greater than three days, provides coverage for no less than 31 days during one period of confinement for each person covered under the policy, and provides no less than \$40.00 but no more than \$250.00 in daily benefits except that the benefit for the first day of hospital confinement may exceed \$250.00 as long as the following formula is satisfied:

$$\frac{\text{1st day benefit} - \text{2nd day benefit}}{5} + \text{2nd day benefit} < \$250.00$$

“IHC Program” means the New Jersey Individual Health Coverage Program.

“Individual health benefits plan” means: (a) a health benefits plan for eligible persons and their dependents; and (b) a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy of contract pursuant to continuation of benefits provisions applicable under Federal or State law. The term “individual health benefits plan” shall include a policy, contract, or certificate evidencing coverage by a policy or contract issued to a trust or association, issued to an eligible person described in, but not limited to, the following examples: a student, except coverage issued to an institution of higher education for coverage of students and their dependents in New Jersey if such policy has been filed by the Commissioner as a discretionary group pursuant to N.J.S.A. 17B:27-49, an unemployed individual or part-time employee, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.3; a self-employed person; an employer, when he or she (and dependents) is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.6; any person who is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.6; and an employee who is one of several employees of the same employer who are covered by certificates, contracts or policies issued by the same carrier, trust or association, if the employer does not contribute to, and remit payment for, the coverage of such employees.

The term “individual health benefits plan” shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan, to the extent the “Employee Retirement Income Security Act of 1974” (29 U.S.C. §§ 1001 et seq.) preempts the application of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.) to that plan.

“Medicaid” means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

“Medical care” means amounts paid:

1. For the diagnosis, care, mitigation, treatment, or prevention of a disease, illness, or medical condition or for the purpose of affecting any structure or function of the body; and
2. Transportation primarily for and essential to medical care referred to in paragraph 1 above.

“Medicare” means coverage provided pursuant to Part A or Part B of Title XVIII of the Federal Social Security Act, Pub.L. 89-97 (42 U.S.C. §§ 1395 et seq.) and amendments thereto.

“Medicare cost and risk contracts” means policies or contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.) and amendments thereto.

“Member” means a carrier that issues or has in force health benefits plans in New Jersey.

“NAIC” means the National Association of Insurance Commissioners.

“Net earned premium” means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier’s insured group and individual business and health maintenance organization business, including premiums from any Medicare, or Medicaid contracts with the State or Federal government, but shall not include premiums earned from contracts funded pursuant to the “Federal Employee Health Benefits Act of 1959,” 5 U.S.C. §§ 8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts.

“Non-group persons” or “non-group persons covered” means coverage by an individual health benefits plan or

conversion policy or contract subject to P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.), Medicare cost or risk contract or Medicaid contract.

“Open enrollment” means the continuous offering of a health benefits plan to any eligible person on a guaranteed issue basis, except as stated in N.J.A.C. 11:20-12.

“Plan” means the plan of operation of the IHC Program.

“Plan sponsor” shall have the meaning given that term under Title I, section 3 of Pub.L. 93-406, the “Employee Retirement Income Security Act of 1974” (29 U.S.C. § 1002(16)(B)).

“Pre-existing condition” means a condition that, during a specified period of not more than six months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the effective date of coverage.

“Premium earned” means premium received, adjusted for the changes in premium due and unpaid, and paid in advance, and unearned premium, net of refunds or dividends paid or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.

“Program” means the New Jersey Individual Health Coverage Program established pursuant to the Act.

“Reasonable and customary” means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey, or other state where services or supplies are provided, for various medical services, published and available to carriers from the Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004-1109.

“Reimbursement for losses” means reimbursements distributed through the IHC Program to cover losses, in whole or in part, incurred by members applying for reimbursements with respect to individual standard health benefits plans beginning in calendar year 1993 and thereafter.

“Resident” means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of each calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of each calendar year.

“Standard health benefits plan” means a health benefits plan, including riders, if any, adopted by the IHC Program Board.

“Stop loss” or “excess risk insurance” means an insurance policy designed to reimburse a self-funded arrangement for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Individual Health Insurance Reform Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than \$20,000 per covered person per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

“Two-year calculation period” means a two calendar year period, the first of which shall begin January 1, 1997 and end December 31, 1998.

Amended by R.1994 d.54, effective December 30, 1993.

See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Amended by R.1995 d.37, effective December 20, 1994.

See: 27 N.J.R. 41(b), 27 N.J.R. 371(b).

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).

Amended “Eligible person” and “Family unit”.

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Rewrote the section.

11:20-1.3 Closing of noncomplying individual health benefits plan

(a) All coverage under individual health benefits plans delivered or issued for delivery with an effective date of August 1, 1993 or thereafter shall comply with this chapter.

(b) Health benefits plans not subject to the Act shall remain subject to the full review and approval of the Commissioner in accordance with N.J.S.A. 17B:26-1 et seq., N.J.S.A. 17:49-1 et seq., N.J.S.A. 17:48A-1 et seq., N.J.S.A. 17:48E-1 et seq., N.J.S.A. 26:2J-1 et seq. and rules promulgated pursuant thereto.

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), deleted the first sentence; and in (b), inserted N.J.S.A. references.

11:20-1.4 Other laws of this State

All health benefits plans delivered or issued for delivery in New Jersey, as defined by this subchapter, shall be subject to the Individual Health Insurance Reform Act, as well as all relevant statutes and rules of New Jersey not inconsistent with, amended or repealed by this Act.

11:20-13.2 Non-member status

(a) An entity is a non-member of the IHC Program if:

1. It is not a carrier as that term is defined in N.J.A.C. 11:20-1.2;

2. It is a carrier that neither has issued nor has enforced health benefits plans during the two-year calculation period of certification; or

3. It is a carrier that is permitted by law to be certified as a non-member.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), substituted "two-year calculation period" for "calendar year" in 2.

11:20-13.3 Filing of non-member certification requests

(a) A carrier or other entity that desires to be considered a non-member of the IHC Program for a preceding two-year calculation period shall file with the Board a request for non-member certification by March 1 following the end of the two-year calculation period for which non-member status is sought. Such request shall be sent to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

(b) A carrier or other entity that submits a request for non-member certification shall include an affirmative statement, certified by a duly authorized officer, of the reasons for which non-member status is requested.

Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a) and deleted (c).

11:20-13.4 Decisions on filings by the Board

Within 45 days of receipt of a written request for non-member status, the Board shall grant or deny the request for non-member status in writing, specifying the reasons for the decision. If the Board does not grant or deny the written request for non-member status within 45 days of its receipt by the Board, the written request shall be deemed to be approved, except that the Board may extend the decision period for an additional 30 days by notifying a carrier or other entity, in writing, of the Board's need for additional information in order to make a determination.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Substituted "45 days" for "30 days" throughout.

11:20-13.5 Review and hearing by the Board

(a) A carrier or other entity that has been denied non-member status may appeal the Board's determination and request a hearing by the Board pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

(b) A carrier or other entity that requests a hearing shall be considered a member of the IHC Program until and unless the Board determines that the carrier is not a member.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

Rewrote (a).

SUBCHAPTERS 14 THROUGH 16. (RESERVED)

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

11:20-17.1 Purpose and scope

(a) This subchapter provides for the quarterly and annual submission of enrollment status reports by all members of the IHC Program, and sets forth the procedures and format for those reports.

(b) This subchapter applies to all members of the IHC Program that issue standard health benefits plans to individuals.

11:20-17.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 and N.J.A.C. 11:20-1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Conversion" means the first-time transfer of insurance coverage from a pre-reform plan, issued prior to August 1, 1993, to a standard plan.

"Enrollment status report" means a complete and accurate document that is prepared and filed in accordance with the requirements of this subchapter and sets forth the information in the format of Part 1 of Exhibit L for the quarterly submission and Part 2 of Exhibit L for the annual submission in the Appendix to this chapter, which is incorporated herein by reference.

"Insured" or "insured individual" means the number of individuals covered under an individual health benefits plan.

"Replacement contract" means the transfer of insurance coverage from one plan type to another with a different coinsurance, deductible or delivery system. A change in rating tier does not constitute a replacement contract.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (b), added new "Conversion", "Insured" or "insured individual" and "Replacement contract" definitions.

11:20-17.3 Filing requirements

(a) Every member of the IHC Program issuing or renewing standard health benefits plans shall complete and file with the Board the enrollment status reports required by this subchapter.

(b) Members shall file hard copy enrollment status reports on a quarterly basis reflecting the information set forth in N.J.A.C. 11:20-17.4 and in the format of Part 1 of Exhibit L which shall reflect data as of March 31, June 30, September 30 and December 31 of each year.

(c) Members shall file enrollment status reports on an annual basis reflecting the number of contracts by zip code category, and insured persons by age and sex category in the format of Part 2 of Exhibit L which shall reflect data as of December 31 of each year.

(d) Members shall submit completed enrollment status reports to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h) no later than 45 days following the end of the quarter or end of the year (for annual reporting purposes).

(e) Affiliated carriers shall submit the enrollment status reports only on a combined basis. Each affiliated carrier shall be identified on the report.

Administrative Change.

See: 27 N.J.R. 1423(a).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), inserted "or renewing" following "issuing"; rewrote (b) and (c); and deleted (f).

11:20-17.4 Contents of the enrollment status report

(a) Members shall report the following information on a quarterly basis on the enrollment status report form set forth as Part 1 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken out into indemnity for Plan A, and indemnity for Plan A/50, indemnity or PPO for Plan B, or indemnity, PPO and POS delivery systems for Plans C through E, the HMO plans, and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. In section A of Part 1 of Exhibit L, Report By Contracts shall be calculated by adding the number of contracts in force at the beginning of the period to the number of contracts representing new sales and conversions during the period, and subtracting the number of contracts lapsed during the period.

i. New sales and conversion contracts shall be reported separately by employment status and replacement status.

(1) Employment status shall be separated into three categories: employed, unemployed, unknown. Employment status shall be obtained from the section of the application entitled, Other Health Care Coverage, and the question "Are you employed?" If the response is yes, then the contract should be reported as employed. If the response is no, then the contract should be reported as unemployed. If the question has not been answered, the contract should be reported as unknown.

(2) Replacement status shall be separated into three categories: previously insured, previously uninsured, and unknown. Replacement status shall be obtained from the section of the application entitled, Other Health Care Coverage, and the question "Are you replacing existing coverage?" If the response is yes, then the contract shall be reported as previously insured. If the response is no, then the contract shall be reported as previously insured. If the question has not been answered, the contract shall be reported as unknown.

ii. A reinstatement shall be reported by reducing the number of contracts lapsed;

2. In section B of Part 1 of Exhibit L, Report By Persons Insured shall be calculated by adding the number of persons insured at the beginning of the period and the number of new insureds during the period, and subtracting the number of insureds lapsed during the period.

i. The number of lives insured should be reported in this section. For those members who do not maintain actual dependent data, the following factors shall be used to convert contracts to persons insured: single = 1; husband and wife = 2; adult and child(ren) = 2.8; family = 3.9;

3. In section C of Part 1 of Exhibit L, Report of Contracts By Rating Category shall be reported separately by rating category, that is: single; husband and wife (or two person); adult and child(ren); family; and child(ren) only, if applicable; and

4. In section D of Exhibit L, Report of Contracts By Deductible/Copayment Option, shall be reported separately by the required and permitted deductible options for Plans A-E or the required and permitted copayment options for the HMO Plan.

(b) Members shall report the following information on an annual basis on the enrollment status report form set forth at Part 2 of Exhibit L in the Appendix, cumulatively for all years to date and separately for each of the standard health benefits plans, broken down by indemnity for Plan A, and indemnity for Plan A/50, indemnity or PPO for Plan B, or indemnity PPO and POS delivery systems for Plans C-E, the HMO plans: