

CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17:1-8.1 and 15e, and 17B:27A-2 et seq.

Source and Effective Date

R.1998 d.443, effective August 7, 1998 and R.1998 d.454, effective August 13, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a);
30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

Executive Order No. 66(1978) Expiration Date

Chapter 20, Individual Health Coverage Program, expires on August 7, 2003.

Chapter Historical Note

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993 (to expire August 13, 1993). See: 25 N.J.R. 2945(a). The concurrent proposal of Chapter 20 was adopted as R.1993 d.439, effective August 13, 1993, with changes effective September 7, 1993. See: 25 N.J.R. 2945(a), 25 N.J.R. 4180(a).

Subchapter 2, Individual Health Coverage Program Temporary Plan of Operation, was adopted as R.1993 d.550, effective October 14, 1993. See: 25 N.J.R. 4707(a), 25 N.J.R. 5244(a).

Subchapter 10, Performance Standards and Reporting Requirements, was adopted as R.1994 d.142, effective February 23, 1994. See: 26 N.J.R. 1202(a), 26 N.J.R. 1351(a).

Subchapter 11, Relief from Obligations Imposed by the Individual Health Insurance Reform Act, was adopted as R.1993 d. 654, effective December 30, 1993. See: 25 N.J.R. 4459(a), 25 N.J.R. 5930(b).

Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans, was adopted as R.1994 d.54, effective December 30, 1993. See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Subchapter 13, Certification of Non-Member Status, was adopted as R.1994 d.177, effective March 10, 1994. See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Subchapter 17, Enrollment Status Report, was adopted as R.1994 d.53, effective December 30, 1993. See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, was adopted as R.1998 d. 339, effective July 6, 1998. See: 29 N.J.R. 2615(a), 30 N.J.R. 2502(a).

Pursuant to Executive Order No. 66(1978), Chapter 20, Individual Health Coverage Program, Subchapters 1 through 10, 12, 13, 17, 18 and Appendix Exhibits A through T, were readopted as R.1998 d.443, effective August 7, 1998, and Subchapter 11 was readopted as R.1998 d.454, effective August 13, 1998. Subchapter 19, Petitions for Rule-making, and Subchapter 20, Appeals from Actions of the Board, were adopted as new rules by R.1998 d.443, effective August 7, 1998. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.), the Individual Health Insurance Reform Act, as amended. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A-2 et seq.

(b) Provisions of the New Jersey Individual Health Insurance Reform Act and of this chapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term member is defined in this subchapter, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after August 1, 1993, except as the specific provisions of the statute and of this chapter state otherwise.

Petition for Rulemaking: Exhibit F.
See: 26 N.J.R. 862(a), 26 N.J.R. 1401(a), 26 N.J.R. 2488(a).
Petition for Rulemaking: Exhibit F.

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(b).
 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 who 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;

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (f) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (h) below pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (g)1 above, and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (f)1 above, accruing from the date of the invoice for the assessment.

(h) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed by the Board until such time as the dispute has been settled or concluded with the disputing member, or until final disposition of the request for deferral by the Commissioner, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed immediately, along with any applicable interest penalty amounts paid or interest earned while held in escrow by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, shall be returned to the appropriate members within 15 days of the date that the Executive Director receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board.

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.

11:20-2.13 Notice of request for deferral

A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h) in order to preserve its right to any monies paid pursuant to the invoice of assessment.

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

Substituted "Executive Director at the address listed in N.J.A.C. 11:20-2.1(h)" for "Interim Administrator (or Administrator)".

11:20-2.14 Failure to pay assessments

If a member is determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the IHC Program Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

11:20-2.15 Penalties/adjustments and dispute resolutions

(a) A member seeking to challenge the amount of an assessment must do so within 20 days of receiving the notice of the assessment pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

(b) If the Board determines that the nature or extent of errors or conduct by a member evidence activity for which penalties or sanctions are appropriate, the Board shall refer the matter to the Commissioner, Attorney General, and/or other appropriate enforcement agency, for appropriate action including the assessment of penalties and sanctions as provided by the Act, as well as any other penalties permitted by law. Nothing herein shall be construed to limit the authority of the Commissioner, the Attorney General or any law enforcement agency to take appropriate regulatory or enforcement action with respect to violations of law and regulations.

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); deleted former (b) through (d); and recodified former (e) as (b).

11:20-2.16 Indemnification

(a) The participation in the IHC Program as a member, the establishment of rates, forms or procedures, or any other joint or collective action required by the Act shall not be the basis of any legal action, criminal or civil liability, or penalty against the IHC Program, member of the Board of Directors, employee of the Board, or any member carrier either jointly or separately except as otherwise provided in the Act.

(b) The Board shall not be liable for any obligation of the IHC Program. No Director, officer or employee of the Board or the Department shall be individually liable and no cause of action of any nature may arise against them, for any action taken or omission made by them unless their conduct was outside the scope of their employment or constituted a crime, actual fraud, actual malice or willful misconduct.

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 "employee of the Board" following "Directors".

11:20-2.17 Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998

(a) The IHC Program Board may assess members for reimbursable net paid losses as may be necessary, pursuant to its authority under N.J.S.A. 17B:27A-11a and according to the procedures set forth in this Temporary Plan.

(b) The IHC Program Board shall determine the preliminary total reimbursable net paid losses, if any, for the preceding two-year calculation period based upon the information submitted by members no later than March 1 of the year immediately following each two-year calculation period to the IHC Program Board in the Carrier Market Share and Net Paid Gain (Loss) Report, set forth as Exhibit K in the Appendix to this chapter, completed in accordance with N.J.A.C. 11:20-8. Such a determination shall be made by the IHC Program Board on or about May 1 of the year immediately following each two-year calculation period.

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

2. Prior to receiving reimbursement for net paid losses, a member must meet the performance standards set forth at N.J.A.C. 11:20-10.

(c) The Board shall determine each member's assessment amount by multiplying the member's market share, or adjusted market share as applicable, by the total reimbursable net paid losses for the preceding two-year calculation period. The portion of assessment amounts forgiven to those members granted a final (full or pro rata) exemption shall be redistributed to carriers not receiving a final (full or pro rata) exemption as described in (c)3 below. Assessment amounts for those members granted a deferral by the Commissioner shall be redistributed as described in (c)2 below.

1. The IHC Program Board shall determine each member's market share by comparing the member's net earned premium for all health benefits plans for the preceding two-year calculation period to the net earned premium of all members for the preceding two-year calculation period as reported by each member in the Carrier Market Share and Net Paid Gain (Loss) Report, set forth as Exhibit K of the Appendix to this chapter, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit a Carrier Market Share and Net Paid Gain (Loss) Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement filed with the Department. Members' market shares shall be adjusted in consideration of the following factors, if necessary:

i. A member that has been granted a full exemption under N.J.A.C. 11:20-9.5 shall not be assessed for any portion of the total reimbursable net paid losses.

ii. A member that has been granted a pro rata exemption under N.J.A.C. 11:20-9.5 shall be liable for an assessment determined by multiplying the total amount of reimbursable losses (program losses) for the preceding two-year calculation period by the ratio of the member's net earned premium to the net earned premium of all members for the preceding two-year calculation period multiplied by a fraction, the numerator of which is the difference between the minimum number of non-group persons allocated to the member by the Board and the number of non-group persons actually enrolled or insured by the member, taking into account the limitations on counting Medicaid recipients and Medicare cost and risk lives, and the denominator of which is the minimum number of non-group persons allocated to the member by the Board. A carrier that has been granted a pro rata exemption under N.J.A.C. 11:20-9.5 shall not be liable for that portion of the loss assessment that is reapportioned as a result of the granting of final (full or pro rata) exemptions.

2. Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by a member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members based on their respective market shares as adjusted pursuant to (c)1ii above.

i. Members that have been granted a deferral shall remain liable to the IHC Program for the amount deferred and any additional amounts required by N.J.A.C. 11:20-11.6.

ii. Upon eventual payment of the deferred amount to the IHC Program, the members to whom the deferred amounts were reapportioned will be credited for those amounts previously apportioned to them.

3. Assessment amounts for members granted a final (full or pro rata) exemption by the Board shall be redistributed to the other members not receiving a final (full or pro rata) exemption. The distribution shall be based on an adjusted market share of the members not receiving a final (full or pro rata) exemption. This adjusted market share shall be the ratio of the member's net earned premium to the net earned premium of all members not receiving a final (full or pro rata) exemption for the preceding two-year calculation period. This additional redistributed portion of the assessment shall be determined by multiplying the total amount of redistributed reimbursable losses from those carriers receiving a final (full or pro rata) exemption for the preceding two-year calculation period by the carrier's market share as adjusted by this paragraph.

(d) Every member shall be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period unless the member has been granted a full exemption from assessments for the preceding two-year calculation period by the Board in accordance with N.J.A.C. 11:20-9.

1. The IHC Program Board shall provide a preliminary notice to its members in writing, on or about May 1 of the year following every two-year calculation period, of the total reimbursable net paid losses for the preceding two-year calculation period and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period.

2. On or about September 1 of the year following every two-year calculation period, the IHC Program Board shall notify each member by invoice of the dollar amount being assessed against the member for its portion of the total reimbursable net paid losses for the preceding two-year calculation period.

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

4. Upon the resolution of all outstanding matters including audits of reimbursable losses and appeals filed pursuant thereto, the IHC Program Board shall notify each member of the final reconciliation of the assessment for reimbursable net paid losses for the appropriate two-year calculation period by invoice stating the dollar amount then due or credit, if any, against future assessments. As a result of the final reconciliation, any monies determined to be owed to or by the Board shall be calculated without provision for interest.

(e) Assessments amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, IHC Program, at the address set forth in N.J.A.C. 11:20-2.1(h).

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent of the assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment, for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that are reported to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (e)1i above. If a carrier makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount of the assessment invoice, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

(f) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:20-11.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (e) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (g) below, pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (f)1 above and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (e)1 above, accruing from the date of the invoice for the assessment.

(g) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for the two-year calculation period. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period, until such time as the dispute has been settled against the disputing member, or the deferral denied, except that any portion of an assessment

not in dispute or subject to a deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period year in accordance with (g) above, along with any applicable interest penalty amounts paid or interest accrued while held in escrow by the Board.

2. Upon receipt of notice that amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate the proportionate amount of interest, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board and provide notice to the carrier of the principal amount and interest amount. The calculated amount shall be returned to the member with interest within 30 days from the date the interest has been calculated.

New Rule, R.1994 d.165, effective March 1, 1994.

See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).

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.

SUBCHAPTER 3. STANDARD BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 Benefits provided

(a) The standard individual health benefits plan established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, Exhibit A;
2. Plan B, "Individual Health Benefits Plan," Exhibit B;
3. Plan C, "Individual Health Benefits Plan C," Exhibit C;
4. Plan D, "Individual Health Benefits Plan D," Exhibit D;
5. Plan E, "Individual Health Benefits Plan E," Exhibit E;
6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F; and
7. Plan A/50, "Basic Health Benefits Plan A/50," Exhibit U.

(b) In accordance with N.J.A.C. 11:20-1.3, members that offer individual health benefits plans in this State shall offer standard health benefits Plans A/50, B, C, and D as set forth in Exhibits U, and B through D, respectively, with variable text as specified on the Explanation of Brackets, Exhibit T, in the Appendix.

1. Members offering Plan D shall offer the following annual deductible options to the policyholder for each plan:

- i. \$500.00 per individual and \$1,000 per family unit;
- ii. \$1,000 per individual and \$2,000 per family unit;

2. Members offering Plans A/50, B and C shall offer the following annual deductible options to the policyholder for each plan:

- i. \$1,000 per individual and \$2,000 per family unit; and
- ii. \$2,500 per individual and \$5,000 per family unit.

3. Members offering Plans C and D may offer those plans, on a guaranteed issue basis, with either or both of the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:

i. \$1,500, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, \$3,000, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit;

ii. \$2,250, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, \$4,500, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit.

4. Members offering Plan/A50 may offer the following annual deductible options to the policyholder for each plan:

- i. \$5,000 per individual and \$10,000 per family unit; and
- ii. \$10,000 per individual and \$20,000 per family unit.

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

In (a), inserted "gain" preceding "(loss)" in the introductory sentence.

11:20-8.8 Audits

(a) A member shall, upon written request of the IHC Program Board, provide additional information that the IHC Program Board may require to substantiate that the member has met the requirements in N.J.A.C. 11:20-8.6(b).

(b) The IHC Program Board shall review, and may audit, a member's reimbursable losses reported in the member's market share and net paid gain (loss) report. The IHC Program Board shall choose and direct the independent auditor. The IHC Program Board and the member being audited shall share equally the cost of an independent audit.

(c) The IHC Program Board shall adjust a member's reported net paid losses, for purposes of determining reimbursement for losses for the preceding two-year calculation period, for the member's failure to meet the certification requirements of this subchapter or as a result of the findings of an independent audit conducted pursuant to (b) above.

New Rule, R.1994 d.177, effective March 10, 1994.

See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(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 (b), inserted "gain" preceding "(loss)" in the first sentence; and in (c), substituted "two-year calculation period" for "calendar year".

11:20-8.9 Hearings

Any member that is denied reimbursement of losses, in whole or in part, on the grounds that the member has failed to meet the certification and reporting requirements of this subchapter, or as a result of the IHC Program Board's review of an independent audit of the member's reported net paid losses, may file an appeal of the Board's determination and request a hearing within 20 days of the date that the IHC Program Board notifies the member of its final determination, pursuant to the procedures set forth in N.J.A.C. 11:20-20.2.

New Rule, R.1994 d.177, effective March 10, 1994.

See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(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 the section.

SUBCHAPTER 9. EXEMPTIONS**11:20-9.1 Purpose**

The purpose of this subchapter is to set forth the procedures for obtaining conditional exemptions, reporting and certifying the number of non-group persons, and the standards for granting final (full or pro rata) exemptions from assessments for reimbursement of losses in accordance with N.J.S.A. 17B:27A-12.

Amended by R.1994 d.177, effective March 10, 1994.

See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

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

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

Inserted "full" preceding "or pro rata".

11:20-9.2 Filing for an exemption from assessments for reimbursements

(a) A member seeking to be exempted from the obligation to pay assessments for reimbursement of losses shall submit a written request for such exemption to the Board. A written request for an exemption shall be submitted on or before June 1 of the first year of each two-year calculation period, except that in 1998, written request for exemptions shall be submitted to the Board within 30 days after the date of receipt of the Board's notice of the member's minimum enrollment share for the 1997 and 1998 two-year calculation period. Written requests shall be submitted to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

(b) Written requests for exemptions shall be certified by the Chief Financial Officer, or other duly authorized officer, of the member, and shall include affirmative statements that the member agrees:

1. To enroll or insure the minimum number of non-group persons in New Jersey necessary for the member to meet its minimum enrollment share of non-group persons, allocated to it by the Board pursuant to N.J.A.C. 11:20-9.3;
2. To enroll or insure the minimum number of non-group persons in New Jersey under:
 - i. Standard health benefits plans;
 - ii. Conversion policies issued pursuant to the IHC Act;
 - iii. Medicaid contracts, if offered; and
 - iv. Medicare cost and risk contracts with the Federal government, with respect to Medicare recipients, if offered; and
3. Not to seek reimbursements for losses the member may incur under the standard health benefits plans in that two-year calculation period for which an exemption is sought by the member.

(c) Within 45 days of receipt of the member's written request for an exemption, the Board shall grant the member a conditional exemption, or deny the member's request for a conditional exemption in writing, specifying the reasons for the denial. If the member's written request for an exemption is neither approved nor disapproved within 45 days of its receipt by the Board, the written request shall be deemed to be conditionally approved.

(d) Approval of a member's written request for a conditional exemption is conditioned upon the following:

1. Compliance by the member with N.J.A.C. 11:20-8 and this subchapter;
2. Compliance by the member with (b) above, as appropriate.

(e) Carriers denied a conditional exemption from assessments for reimbursements for losses may, within 20 days of the date of the Board's ruling, appeal the Board's determination and request a hearing, pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

Amended by R.1994 d.177, effective March 10, 1994.
 See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
 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 the section.

11:20-9.3 Minimum enrollment share

(a) On or about August 14, 1998, and on or about May 1 of the first year of every two-year calculation period thereafter, the IHC Program Board shall issue to each member its minimum enrollment share of non-group persons for that two-year calculation period which the member must agree to cover in that two-year calculation period for purposes of obtaining an exemption from assessments for reimbursements for losses incurred in that two-year calculation period.

(b) The IHC Program Board's determination of minimum enrollment shares shall be based upon information provided by members in accordance with N.J.A.C. 11:20-8 and this subchapter.

(c) The Board shall calculate each member's minimum number of non-group persons as follows:

1. For the first two-year calculation period, the total number of community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives of all Members subject to the Act, except for hospital and medical service corporation carriers, as of the end of the 1995 and 1996 as reported on the Market Share and Net Paid Gain (Loss) Reports, Exhibit K, submitted to the Board, divided by two, and multiplied by the proportion that the member's net earned premium bears to the net earned premium of all members for 1995 and 1996 including those members exempt from assessment.

2. For each two-year calculation period thereafter, the total number of community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives of all members subject to the Act, except for hospital and medical service corporation carriers, covered on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, divided by eight, and multiplied by the proportion that the member's net earned premium bears to the net earned premium of all members for the preceding two-year calculation period.

Amended by R.1994 d.177, effective March 10, 1994.
 See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(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 (c).

11:20-9.4 Satisfaction of minimum number of non-group persons

(a) Persons counted under the following may be counted by a member in meeting its minimum number of non-group persons in New Jersey:

1. Standard health benefits plans;
2. Conversion policies issued pursuant to the Act; and
3. Medicare cost and risk contracts and contracts with the State of New Jersey covering Medicaid recipients, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's minimum number of non-group persons.

(b) If the member is a Federally-qualified HMO that is tax exempt pursuant to paragraph (3) of subsection (c) of Section 501 of the Federal Internal Revenue Code of 1986, 26 U.S.C. § 501, the member may count persons covered under (a)1 through (a)3 above, except that in determining whether the member meets its minimum number of non-group persons, the total may include no more than one-third Medicare recipients and one-third Medicaid recipients.

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 former 3, and recodified former 4 as 3; and in (b), substituted "(a)3" for "(a)4" following "(a)1 through".

11:20-9.5 Procedures for granting or denying final (full or pro rata) exemptions

(a) A member granted a conditional exemption shall be granted a full exemption from assessments for reimbursements for losses for the two-year calculation period in which the conditional exemption was granted if the Board determines that the information filed by the member pursuant to (b) below evidences that the member has enrolled or insured 100 percent of the minimum number of non-group persons allocated to it by the Board for that two-year calculation period.

(b) So that the Board can determine whether the member has satisfied its minimum enrollment share, members seeking final (full or pro rata) exemptions shall report to the Board, on or before March 1 of the year following each two-year calculation period, the number of non-group persons covered by that member on the last day of each calendar quarter of the preceding two-year calculation period, taking into account the limitations on counting the number of Medicaid recipients and Medicare cost and risk lives as described in N.J.A.C. 11:20-9.4(a)3 and (b) except that members seeking final (full or pro rata) exemptions for the first two-year calculation period shall report to the Board the number of non-group persons covered by that member as of December 31 of the two preceding calendar years, taking into account the limitations on counting the number of Medicaid recipients and Medicare cost and risk lives as described in N.J.A.C. 11:20-9.4(a)3 and (b) above. The member shall report separately the number of non-group persons in each category of non-group person enumerated in N.J.A.C. 11:20-9.4. The Chief Financial Officer, or other duly authorized officer of the member, shall certify that the covered non-group persons reported therein: