

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.2006 d.15 and d.16, effective December 7, 2005.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 38 N.J.R. 1005(a);
37 N.J.R. 3022(a), 38 N.J.R. 332(a).

Chapter Expiration Date

Subchapter 9, Exemptions, and Subchapter 10, Performance Standards and Reporting Requirements, expire on December 7, 2010.

In accordance with N.J.S.A. 52:14B-5.1c, Subchapters 1 through 3, 8, 12, 17, 19, 20, and 22 through 24, and Appendix Exhibits A through D, F, G, H, K and L, expire on June 5, 2011. See: 43 N.J.R. 131(a).

In accordance with N.J.S.A. 52:14B-5.1c, Subchapters 3A, 6, 7, 11 and 18, and Appendix Exhibits E and J, expire on June 5, 2011. See: 43 N.J.R. 143(a).

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: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a); 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 20, Individual Health Coverage Program, was extended by

gubernatorial directive from August 7, 2003 to 270 days following Supreme Court decision in *In re Health Coverage Program's Re-adoption of N.J.A.C. 11:20-1.1 et seq.* See: 35 N.J.R. 2898(a).

Subchapter 22, Basic and Essential Health Care Services Plan, was adopted as R.2003 d.91, effective January 28, 2003. See: 34 N.J.R. 73(a), 35 N.J.R. 1290(a).

In accordance with N.J.S.A. 52:14B-5.1d, Chapter 20, Individual Health Coverage Program, expiration date was extended by gubernatorial directive from February 4, 2005 to July 4, 2005. See: 37 N.J.R. 778(a).

Subchapter 4, Standard Application Form; Subchapter 5, Standard Claim Form and Appendix Exhibits G, H, and I, expired effective July 4, 2005. See: 37 N.J.R. 2994(a).

Chapter 20, Individual Health Coverage Program, Subchapters 1 through 3, 6 through 10, 12, 17 through 20, 22 and Appendix Exhibits A through F, J through L, and Q through V, were readopted as R.2006 d.15, effective December 7, 2005, and Subchapter 11 was readopted as R.2006 d.16, effective December 7, 2005. Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans and the Basic and Essential Health Care Services Plan, was repealed, and Subchapter 12, Purchase of a Standard Individual Health Benefits Plan or a Basic and Essential Healthcare Services Plan by a Person Covered under an Individual Plan or Eligible for or Covered under a Group Plan, was adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibit R, was repealed, by R.2006 d. 15, effective January 3, 2006. Subchapter 23, Rulemaking; Interested Parties; Public Notices; Interested Parties Mailing List, and Subchapter 24, Program Compliance, were adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibits A, C, E and U were repealed by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006). Exhibits A, C and E were adopted as new rules. See: Source and Effective Date. See, also, section annotations.

Exhibit H of the Appendix was adopted as new rules by R.2009 d.45, effective December 29, 2008. See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Subchapter 6, Individual Health Benefits Carriers Informational Rate Filing Requirement; Subchapter 7, Loss Ratio and Refund Reporting Requirements; and Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, were repealed by R.2009 d.45, effective December 29, 2008 (operative April 20, 2009). See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b), 41 N.J.R. 1875(a).

Subchapter 3A, Policy Forms; Subchapter 6, Individual Health Benefits Carriers Informational Rate Filing Requirements; Subchapter 7, Loss Ratio And Refund Reporting Requirements; and Subchapter 18, Withdrawals of Carriers from the Individual Market and the Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, were adopted as new rules by R.2009 d.128, effective April 20, 2009. See: 41 N.J.R. 73(a), 41 N.J.R. 1866(c).

Case Notes

New Jersey Individual Health Coverage Program Board of Directors did not violate authorized procedures for adopting or amending its regulations when it readopted Individual Health Coverage Program (IHCP) regulations; Board provided notice as required by statute, received written comments regarding proposed regulations, and prepared report that summarized and responded to comments and was published in New Jersey Register. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

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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(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 and essential health care services plan" means the health benefits plan pursuant to P.L. 2001, c.368, N.J.S.A. 17B:27A-4.4 through 4.7.

"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:

1. The applicant’s spouse;
2. The applicant’s same-gender domestic partner as that term is defined in P.L. 2003, c. 246;
3. The applicant’s civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage;
4. A child or step child of the applicant;
5. A child of the applicant’s domestic partner subject to applicable terms of the individual health benefits plan; or
6. A child of the applicant’s civil union partner subject to applicable terms of the individual health benefits plan.

“Director” means a Director of the Individual Health Coverage Program Board 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.” An eligible person shall include a person who is a resident who is eligible for continuation of group coverage under COBRA or a state continuation law, so long as the person elects to be covered under the individual health benefits plan in lieu of continuation coverage.

“Enrollment date” means, with respect to a Federally defined eligible individual, the date the person submits a substantially complete application for coverage. With respect to all other persons, enrollment date means the effective date of coverage under the individual health benefit plan.

“Family unit” means:

1. A legally married man and woman;
2. A person and his or her same-gender civil union partner;
3. A person and his or her same gender domestic partner;
4. A legally married man and woman and their dependent children;
5. A person and his or her same-gender civil union partner and their dependent children, as the term dependent is defined in the individual health benefits plan;
6. A person and his or her same gender domestic partner and their dependent child(ren), as the term dependent is defined in the individual health benefits plan;
7. 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
8. Dependent children only who are members of the same household as the term dependent is defined in the individual health benefits plan.

“Federally defined eligible individual” means an eligible person:

1. For whom, as of the date on which the individual seeks coverage under P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months during which time the eligible person has not had any significant break in coverage (significant break in coverage means a break in coverage of 63 days or more during which time the eligible person has no creditable coverage);

2. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan,

or health insurance coverage offered in connection with any such plan;

3. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §§1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C. §§1396 et seq.) or any successor program, and who does

not have another health benefits plan, or hospital or medical service plan;

4. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

5. Who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and

6. Who has elected continuation coverage described in 5 above and has exhausted that continuation coverage.

“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;
7. The basic and essential health care services plan; and
8. 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.

“Medicare Plus Choice” means policies and contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1853 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.) and amendments thereto.

“Medicare Advantage” means policies and contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1853 of the Federal Social Security Act (42 U.S.C. §§1395 et seq.) and any amendments thereto.

“Member” means a carrier that issues or has in force health benefits plans in New Jersey. A member shall not include a carrier whose combined average Medicare, Medicaid and NJ FamilyCare enrollment represents more than 75 percent of its average total enrollment for all health benefits plans or whose combined Medicare, Medicaid and NJ FamilyCare net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare, Medicaid and NJ FamilyCare enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum of these enrollment figures, as measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight.

“Modified community rated” means, with respect to coverage under standard health benefit plans, a rating system in which the premium for all persons covered under a policy or contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical location or any other factor or characteristic of covered persons, other than age.

The rating system provides that the premium rate charged by a carrier for the highest rated individual or class of individuals shall not be greater than 350 percent of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits plan shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with rules promulgated by the Commissioner, which include age classifications as set forth in N.J.A.C. 11:20-6. There may be a reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or different health benefits plans offered by a carrier.

There is a separate definition in N.J.A.C. 11:20-22.2.

“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, Medicaid or NJ FamilyCare contracts with the State or federal government, but shall not include any premium associated with the benefits enumerated in Section 2 of Part C of the Premium Data Worksheet which is set forth as chapter Exhibit K, incorporated herein by reference.

“NJ FamilyCare” means the FamilyCare Health Coverage Program established pursuant to P.L. 2005, c. 156 (N.J.S.A. 30:4J-8 et al.).

“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.), a basic and essential health care services plan pursuant to P.L. 2001, c. 368, Medicare cost or risk contract, Medicare Plus Choice or Medicare Advantage contract, Medicare Demonstration Project plan 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 enrollment 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 enrollment 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.

“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. For purposes of identifying a Federally defined eligible individual, actual and intended presence in the State for a minimum period may not be considered, but a carrier may require an applicant to demonstrate that New Jersey is his or her primary residence as defined by law.

“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.

Amended by R.2000 d.142, effective March 6, 2000.

See: 32 N.J.R. 643(a), 32 N.J.R. 1253(c).

Rewrote “Member”.

Amended by R.2001 d.55, effective January 17, 2001.

See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).

Inserted “Medicare Plus Choice”; in “Net earned premium”, inserted reference to Medicare Plus Choice enrollees; and in “Non-group persons”, inserted reference to Medicare Plus Choice contract.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Added “Basic and essential health care services plan”: in “Health benefits plan”, added new 7, recodified former 7 as 8; in “Non-group persons”, inserted “a basic and essential health care services plan

pursuant to P.L. 2001, c.368" preceding "Medicare"; deleted "Reimbursement for losses".

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Deleted "Basic health benefits plan" and "Reasonable and customary"; amended "Dependent", "Director", "Eligible person", "Family unit", "Member", "NAIC", "Net earned premium", "Non-group persons", "Pre-existing condition", and "Resident"; added "Enrollment date", "Federally defined eligible individual", "Medicare Advantage", "NJ FamilyCare", and "NJ KidCare".

Amended by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).

See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).

In definition "Federally defined eligible individual", rewrote 1.

Amended by R.2008 d.122, effective April 17, 2008.

See: 40 N.J.R. 1744(a), 40 N.J.R. 2475(a).

Rewrote definitions "Dependent" and "Family unit".

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In definition "Member", substituted "and" for a comma following the first two occurrences of "Medicaid", deleted "and NJ KidCare" following "FamilyCare" three times and inserted "and" following the last occurrence of "Medicaid"; added definition "Modified community rated"; rewrote definition "Net earned premium"; in definition "NJ FamilyCare", substituted "P.L. 2005, c. 156 (N.J.S.A. 30-4J-8 et al.) for "P.L. 2000, c. 71 (N.J.S.A. 30-4J-1 et seq.)"; and deleted definition "NJ KidCare".

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.

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

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

Deleted "including individual standard health benefits plans" following "this subchapter".

11:20-1.5 (Reserved)

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

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

Inserted "plans" following "health benefits".

Repealed by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Section was "Penalties".

11:20-1.6 Mission statement

The mission of the New Jersey Individual Health Coverage Program Board is to administer the New Jersey Individual Health Coverage Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders in the marketplace and other interested persons, and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to individuals and establishing and administering assessment mechanisms. It also includes the regulation of individual health coverage carriers in conjunction with the New Jersey Department of Banking and Insurance and New Jersey Department of Health and Senior Services.

Repeal and New Rule, R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Section was "Severability".

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

11:20-2.1 Purpose and structure

(a) The "IHC Program" created pursuant to the N.J.S.A. 17B:27A-2 to 16, as amended, has as its members all insurance companies, health service corporations, hospital service corporations, medical service corporations, and health maintenance organizations that issue or have in force health benefits plans in this State. The IHC Program's purpose is:

1. To assure the availability of standardized individual health benefits plans in New Jersey on an open enrollment, modified community-rated basis; and

2. To reimburse certain losses of member companies for the calendar year ending December 31, 1992 pursuant to N.J.S.A. 17B:27A-13, for each calendar year ending December 31, 1993 through December 31, 1996, and for each two-year calculation period through the 2007-2008 calculation period pursuant to N.J.S.A. 17B:27A-12, as amended.

(b) The Board of the IHC Program has been charged pursuant to the Act to administer the IHC Program reasonably and equitably under law.

(c) The IHC Program Plan of Operation sets forth as completely as possible the fair, reasonable and equitable manner in which the Board will administer the IHC Program under law.

(d) The Board shall consist of nine directors, including the Commissioner or his or her designee, who shall serve ex officio.

(e) The Board shall appoint an insurance producer licensed to sell health insurance pursuant to N.J.S.A. 17:22A-1 et seq. to advise the Board on issues related to sales of individual health benefits plans issued pursuant to the Act.

(f) Neither the Plan of Operation nor the IHC Program creates any contractual or other rights and obligations between the IHC Program and any entity or other person insured by any carrier.

(g) The IHC Program shall continue in existence subject to termination in accordance with the laws of this State or of the United States. In the event of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the IHC Program, the IHC Program shall terminate and conclude its affairs. Any funds or assets held by the IHC Program following the payment of all claims and expenses of the IHC Program shall be distributed to the member carriers at that time and in accordance with the then existing assessment formula.

(h) All documents or other communications directed to the Board shall be sent to the Executive Director of the IHC Program at the address set forth below. Communications sent by regular mail must be sent to the PO Box:

New Jersey Individual Health Coverage Program
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325
Telephone: (609)633-1882 x50306
Fax: (609) 633-2030

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), rewrote the introductory paragraph 2; and in (h), updated the address.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Changed subchapter heading from "Individual Health Coverage Program Temporary Plan of Operation". In (c) and (f), deleted references to the Temporary Plan of Operation; rewrote (h).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (a)1, inserted "modified"; and in (a)2, substituted "through the 2007-2008 calculation period" for "thereafter".

11:20-2.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 as amended, 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:

"Action" means an action by the Board adopted, in the Board's discretion, in accordance with the procedures set forth either in the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., or in sections 7 and 8 of P.L. 1993, c.164. "Action" includes, but is not limited to: the establishment and modification of health benefits plans; procedures and standards for assessment of members and the apportionment

thereof, policy form filings, rate filings, evaluation of material submitted by carriers with respect to loss ratios, and establishment of refunds to policyholders or contract holders; and the promulgation or modification of policy forms. "Action" shall not include the hearing and resolution of contested cases, personnel matters or applications for exemptions.

"Plan" means the plan of operation of the IHC Program.

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 a P.L. reference; and in (b), deleted "Basic health benefits plan", "Deferral", "Director", "Financially impaired", "HMO", "Reasonable administrative expenses", and "Standard health benefits plan" definitions.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b), deleted "Temporary Plan".

11:20-2.3 Powers of the IHC Program and Board

(a) The IHC Program shall have the general powers and authority granted under the laws of this State to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the IHC Program shall not have the power to issue health benefits plans directly to either groups or individuals.

(b) The Board shall have the authority to do the following:

1. Define the provisions of standard health benefits plans in accordance with the requirements of the Act and the Plan of Operation;

2. Establish benefit levels, including any optional deductibles and copayments, and exclusions and limitations for standard health benefits plans in accordance with law;

3. Establish standard policy forms for standard health benefits plans and rider packages;

4. Establish a procedure for the joint distribution of information on standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended;

5. Establish reasonable guidelines for the purchase of new individual health benefits plans by persons who are already enrolled or insured by another individual health benefits plan;

6. Review filings submitted by carriers in accordance with the Act and rules promulgated pursuant thereto and the Plan of Operation;

7. Establish standards for a means test for standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended by P.L. 1993, c.164, section 3;

8. Establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the IHC Program and provide for performance audits;

9. Make application on behalf of member carriers for benefits, subsidies, discounts or funds that may be provided either by any health care provider or under State or Federal law or regulation;

10. Appoint from among Board members appropriate legal, actuarial and other committees necessary to provide technical and other assistance in the operation of the IHC Program, in policy and other contract design and any other functions within the authority of the Board;

11. Enter into contracts which are necessary or proper to carry out the provisions and purposes of the Act and the Plan of Operation;

12. Employ or retain such persons, firms or corporations to perform such administrative functions as are necessary for the Board's performance of its duties;

13. Provide procedures for receiving oral and written comments from the public, which may include rules relating to the time and place of any public hearing, and for the length and format of testimony from individuals, groups and organizations;

14. Establish rules, conditions and procedures pertaining to the sharing of IHC Program losses and administrative expenses among the members of the IHC Program;

15. Calculate assessments and assess member carriers their proportionate share of IHC Program losses and administrative expenses in accordance with N.J.S.A. 17B:27A-12 and this Plan, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses;

i. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

ii. The Board may provide for other credits against assessments as appropriate;

16. Establish and maintain the appropriate accounts necessary to administer the IHC Program;

17. Impose interest penalties upon members for late payment of assessments as authorized by N.J.S.A. 17B:27A-10(f)(4);

18. Recommend to the Commissioner that actions be instituted in accordance with the Commissioner's authority to impose penalties for violations of the Act;

19. Sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member carrier;

20. Pursuant to P.L. 1993, c. 164, adopt "actions" necessary to execute the Board's powers pursuant to the provisions of N.J.S.A. 17B:27A-2 et seq.;

21. Borrow money to effect the purposes of the IHC Program;

i. Any notes or other evidence of indebtedness of the Program not in default shall be legal investments for carriers and may be carried as admitted assets; and

22. Contract for an independent actuary and any other professional services the Board deems necessary to carry out its duties under N.J.S.A. 17B:27A-2 et seq. as amended.

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), substituted "authority" for "power" in the introductory sentence, deleted a P.L. reference in 4, and rewrote 6.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote (b).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (b)6, deleted "rate filings and other" following "Review".

11:20-2.4 Plan of Operation

(a) The Plan of Operation and amendments thereto shall become effective upon approval by the Commissioner and submission of final action to the Office of Administrative Law for publication. The Commissioner may amend the Plan of Operation by providing written notice to the Board of amendments and their effective dates and upon adoption of amendments in accordance with applicable law.

(b) Upon the submission of a Plan by the Board and approval of the Plan by the Commissioner pursuant to N.J.S.A. 17B:27A-10(d) and (e) as amended by P.L. 1993, c.164, section 6, the Commissioner shall rescind the Temporary Plan.

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 "the Office of Administrative Law" for "OAL"; and in (b), deleted "amend or" preceding "rescind".

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a), substituted references to the permanent "Plan of Operation" for those to the "Temporary Plan" and substituted "approval" for "adoption"; section was "Temporary Plan of Operation".

11:20-2.5 Board of Directors

(a) The Board shall consist of nine Directors, including the Commissioner or his or her designee, who shall sit ex officio.

1. Four Directors shall be appointed by the Governor, with the advice and consent of the Senate.

i. One of the Governor's appointees shall be a representative of an employer, appointed upon the recommendation of a business trade association, who has experience in the management or administration of an employee health benefits plan. One of the Governor's appointees shall be a representative of organized labor, appointed upon the recommendation of the AFL-CIO, who has experience in the management or administration

of an employee health plan. Two of the Governor's appointees shall be consumers of a health benefits plan who are reflective of the population in the State.

ii. The term of the initial appointment shall be for the period as set forth in the appointment.

2. Four Directors shall represent carriers and shall be elected by the members subject to the approval of the Commissioner.

i. To the extent a Carrier elected by the members is willing to serve on the Board, a representative of each of the following types of carrier shall be elected:

(1) A health service corporation or a domestic stock insurer which converted from a health service corporation pursuant to the provisions of P.L. 2001, c. 131 and is primarily engaged in the business of issuing health benefit plans in this State;

(2) A health maintenance organization;

(3) An insurer authorized to write health insurance in this State subject to Subtitle 17B of the New Jersey Statutes; and

(4) A foreign health insurance company authorized to do business in this State.

ii. The Board shall hold a meeting, at least annually, of the members of the IHC Program for the purpose of electing Directors to fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office.

(1) On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the IHC Program members setting forth the time, date and place of the election meeting, stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

(2) Following the close of the nomination period, the Board shall determine from among the carriers nominated those carriers that are eligible and willing to serve in the position for which nominated. A carrier may be placed on the ballot for only one Board position, and may not hold more than one seat on the Board. If a carrier is nominated for two or more positions for which it is eligible, the carrier shall notify the Board before the election as to the single position for which it will accept the nomination, and be designated on the ballot.

(3) At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote via absentee ballot on or before the date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

(4) Affiliated carriers shall have no more than one vote for each position subject to vote and no two affiliated carriers shall serve on the Board at the same time.

(5) Elections shall be by the highest number of those votes properly cast in person and absentee.

(6) The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:20-2.9.

iii. Prior to the Board's annual meeting set forth at (c) below, or no later than 30 calendar days subsequent to the date of the election meeting, whichever date is later, the Board shall send a written notice to IHC Program members of the names of the Directors of the Board, their respective designees, if any.

3. The Commissioner shall file with the Board a letter naming his or her designee, if any.

4. A carrier elected to the Board shall file with the Board a letter naming the person authorized to vote on behalf of the carrier and may name one or more alternates.

5. Appointed Directors shall promptly notify the Board of any change in circumstance that may affect the representative capacity in which they were appointed. Upon receipt of such notice, the Board shall notify the Governor of the appointed Director's change in circumstance.

6. The Directors representing carriers on the Board shall promptly notify the Board of any change in circumstance that may affect the representative capacity of the entity elected by the members. Upon receipt of such notice, the Board shall provide notice of the same to the members of the IHC Program.

7. Directors shall serve their terms of office until their replacements are duly appointed or elected, as appropriate.

(b) The Board shall elect a Chair from among its Directors, and may elect other officers it deems appropriate. As authorized by the Board, such officers may act as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(c) The Board shall hold an annual meeting at which it shall:

1. Elect officers of the Board;
2. Appoint Directors to committees of the Board; and
3. Take action on such other matters that it deems appropriate.

(d) A majority of the Directors shall constitute a quorum for the transaction of business.

1. Each Director shall have one vote. The acts of a majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board, except as provided in (d)2 below.

2. The affirmative votes of five Directors shall be required to act upon the following:

- i. Amendments to the Plan of Operation;
- ii. Amendments to the standard health benefits plans;
- iii. Adoption of any actions, as defined by section 8 of P.L. 1993, c. 164, (N.J.S.A. 17B:27A-16.1) or amendments to the actions of the IHC Program;
- iv. Removal of any Director from membership on any committee;
- v. Recommendations by the Board to the Commissioner regarding amendments to the Act; and
- vi. An assessment or interim assessment.

(e) All meetings of the Board at which a quorum is present, including special meetings, shall be subject to the provisions of the Open Public Meetings Act, N.J.S.A. 10:4-6 to 21.

(f) In addition to the annual meeting and any regularly scheduled meeting, the Board may hold special meetings upon the request of the Chair or of three or more Directors.

(g) Directors shall not receive compensation for attendance at Board and Committee meetings. Directors may be reimbursed for reasonable unreimbursed travel and other reasonable expenses incurred in attending Board and Committee meetings using the State Travel Regulations issued by the Department of the Treasury as a guide.

(h) The Board shall hold meetings either in person or by teleconference.

(i) The Board shall provide for the taking of written minutes of each Board meeting, including teleconferences and closed sessions, and distribute a copy of the minutes to the Directors. The Board shall retain the original of the minutes.

1. The staff of the Board shall take and maintain the written minutes of the proceedings of the Board meetings, including teleconferences and closed sessions. Board meeting minutes shall set forth as a minimum the following:

- i. The time, date and place of the meeting;
- ii. The names of all persons attending the meeting, the organizations they represent, if any, and the identity of the person presiding;
- iii. A narrative describing what occurred at the meeting including subjects considered and actions taken;
- iv. The recorded votes of each member on each matter including abstentions;
- v. The complete text of any resolutions adopted by the Board; and
- vi. Any other information required to be shown in the minutes by law.

(j) All Board members shall be subject to the State of New Jersey Uniform Ethics Code and any supplemental code of ethics the Board adopts.

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.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a), rewrote 2; in (c)2, deleted "and others persons"; rewrote (d)2iii; in (i), removed the requirement that copies of minutes be provided to the Commissioner.

Administrative correction.

See: 38 N.J.R. 1189(a).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Rewrote (j).

11:20-2.6 Committees

(a) The Board shall make appointments to standing and other committees from among Directors. Each of the standing committees shall include no more than four Directors, but the Chair may appoint additional Directors as needed subject to ratification by the Board at the next subsequent meeting.

(b) The Board may, by resolution:

1. Determine the size of a standing committee, appoint Directors, and fill a vacancy;
2. Appoint a Director to serve as an alternate member of any standing committee to act in the absence of a committee member with all the powers of such absent member;
3. Abolish any standing committee; and
4. Appoint or authorize the use of IHC Program staff, consultants, or other advisors to work with any standing committee.

(c) Committees may not take final action; however, within the scope of their purpose and duties, committees may make recommendations and reports to the Board for decision.

(d) Standing committees shall include the following:

1. A Technical Advisory Committee, which shall make recommendations to the Board with respect to:

- i. Methods for calculating assessments;
- ii. A uniform Audit Program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier;
- iii. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time;
- iv. Conditional and final exemptions from assessments; and
- v. Any other reports or recommendations to the Board as may be appropriate regarding the possible impact of suggested plan designs;

2. A Legal Committee, which shall make recommendations to the Board with respect to:

- i. Rules to be promulgated by the Board pursuant to the Act;
- ii. Amendments to the Plan of Operation and the various individual health benefits plans proposed by the Board;
- iii. Any proposed amendments to the Act;
- iv. Contracts and legal documents for the IHC Program;
- v. All litigation and other disputes involving the IHC Program and its operations;
- vi. Coordination with the Office of the Attorney General on matters relating to IHC Program operations; and
- vii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member.

3. A Marketing and Communications Committee, which shall make recommendations to the Board with respect to:

- i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of individual health benefits plans to eligible persons;
- ii. Marketing and communication plans for the IHC Program, as needed;

iii. Submissions by members of good faith marketing reports for the basic and essential health care services plan made pursuant to N.J.A.C. 11:20-22.6;

iv. Submissions of good faith marketing reports as required by N.J.A.C. 11:20-24.6 by those members that are small employer carriers demonstrating marketing of all of the standard health benefits plans the member elects to offer;

v. The insurance producer to be appointed by the Board pursuant to N.J.S.A. 17B:27A-10g, and assist in liaison efforts between the Board and the appointed producer; and

vi. Materials to be distributed to consumers or made available through the Internet which describe the individual health benefits plans available to eligible persons pursuant to the Act.

4. An Operations and Audit Committee, which shall make recommendations to the Board with respect to:

- i. The engagement of independent financial consultants, including, but not limited to, examiners, auditors, accountants and actuaries;
- ii. The Plan of Operation and amendments thereto;
- iii. Standards of acceptability for the selection of auditing firms;
- iv. The review of reports prepared by independent auditors and other audit-related matters the Board deems necessary;
- v. Contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Plan;
- vi. Methods for calculating assessments;
- vii. Uniform audit program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier; and
- viii. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time.

(e) The Board may by resolution establish and appoint other committees.

(f) All committee members shall be subject to the State of New Jersey Uniform Ethics Code and any supplemental code of ethics the Board adopts.

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

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

Rewrote (d); and added a new (f).

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a), deleted "and IHC Program members" in the first sentence; in (b), deleted 4 and recodified former 5 as 4; rewrote (d) and (f).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Rewrote (d)1; added new (d)3iv; recodified former (d)3iv and (d)3v as (d)3v and (d)3vi; and rewrote (f).

11:20-2.7 Financial administration

(a) The fiscal year of the IHC Program shall run from July 1 to June 30 of each year.

(b) All funds of the IHC Program shall be deposited into and disbursements made from the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget.

1. Monies pertaining to the IHC Program shall be deposited into a dedicated account within the State's General Fund.

2. Monies may be credited from the General Fund to IHC bank accounts upon request by the Board through the Department, which request shall include justification for the request with supporting documentation, and shall be pursuant to the approval of the Director of the Division of Budget and Accounting.

(c) Bank checking accounts shall be established separately in the name of the IHC Program and shall be approved by the Board.

1. The Board shall authorize individuals to sign checks on behalf of the Board.

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law.

i. All investment income earned on administrative assessment funds shall be credited to the IHC Program and shall be applied to reduce future administrative assessments of members of IHC Program except as provided in N.J.A.C. 11:20- 2.12(h).

ii. All investment income earned on loss assessment funds shall be credited to the IHC Program and shall be applied to reduce future loss assessments of members of the IHC Program, except as provided in N.J.A.C. 11:20-2.17(h), and except that interest earned on loss assessment funds due to a carrier shall be paid to that carrier to the extent that the investment income is earned during a subsequent loss assessment cycle in which the carrier is no longer seeking reimbursement.

(d) No disbursements shall be made from IHC bank accounts without the approval of the Board, except that the Board may authorize the Executive Director to make disbursements of less than \$1,000 per disbursement for administrative purposes as necessary for the efficient administration of the program.

(e) All financial records shall be kept in accordance with the State's prescribed policies and procedures. The Board shall maintain the books and records of the IHC Program at a

location in New Jersey in a manner so that financial statements may be prepared to satisfy the Act and other requirements of New Jersey law.

1. The receipt and disbursement of cash for the IHC Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when assets or liabilities should be realized by the IHC Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the IHC Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the IHC Program shall be calculated for each carrier either when deemed appropriate by the Board or when requested by the carrier. The Board shall maintain records of each carrier's financial transactions with the IHC Program as necessary to ensure compliance with the Act and Plan of Operation, which records shall include at least the following:

i. Net losses of the IHC Program based upon the assessments calculated in accordance with this Plan;

ii. Any adjustments as set forth in this Plan;

iii. Adjustments to the amount due to or from the IHC Program based upon corrections to carrier submissions;

iv. Interest charges due from a carrier for late payment of amounts due to the IHC Program; and

v. Other records required by the Board.

5. The Board shall maintain a general ledger which shall be used to produce the IHC Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledger journals.

(f) The Executive Director shall prepare an annual financial report to be delivered to the Commissioner and each member of the Board by December 31 of each year beginning in 1998. The annual report shall fairly present the financial condition of the IHC Program for the preceding fiscal year.

1. All accounts shall be reconciled and trial balances shall be determined monthly.

2. Financial statements in a form approved by the Board shall be prepared and delivered to each member of the Board and the Commissioner on a quarterly basis.

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

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

In (c), rewrote 2; in (d), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator"; and in (f), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator" and changed the delivery deadline from September 30 of each year beginning in 1994 to December 31 of

each year beginning in 1998 in the introductory paragraph, and substituted "Board" for "Technical Advisory Committee" in 2.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b), inserted "into" following "shall be deposited" in the introductory paragraph; in (c), rewrote 2; in (d), substituted "as necessary for the efficient administration of the program" for "subject to such conditions as the Board may prescribe"; in (e)4, deleted reference to the Temporary Plan.

Amended by R.2006 d.445, effective December 18, 2006.

See: 38 N.J.R. 1159(a), 38 N.J.R. 5383(a).

In (c)2ii, substituted "(h)" for "(g)".

11:20-2.8 Audits

(a) The Board shall have an annual audit of its operations conducted by a qualified independent certified public accountant.

1. The auditor shall be selected and approved by the Board through a competitive bidding process of certified public accountants qualified in New Jersey to perform audits of entities like the Board.

2. The annual audit shall include the following items:

i. A review of the handling and accounting of assets and monies of the IHC Program;

ii. A determination that administrative expenses have been properly allocated and are reasonable;

iii. A review of the internal financial controls of the IHC Program;

iv. A review of the annual financial report of the IHC Program; and

v. A review of the calculation by the IHC Program of any assessments of carriers for net losses.

3. A copy of the annual audit and related management letters shall be delivered to each Director and to the Commissioner. The annual audit report shall be reviewed by the Technical Advisory Committee or Operations and Audit Committee, or both Committees, which shall present its recommendations to the Board for implementation of findings and recommendations made by the auditor. The actions adopted shall be reported to the Commissioner.

(b) The Board may, from time to time, direct that a member carrier arrange, or the Board may arrange, to have an audit conducted by an independent certified public accountant and a copy of the audit report of the member carrier delivered to the Board. All information regarding an audit of a member carrier conducted pursuant to this subsection shall be confidential and protected from disclosure by the member carrier, by the auditing firm, by the Board and the Commissioner.

(c) The Board shall conduct a full or partial audit of a carrier filing for reimbursement of losses. Carriers filing for reimbursement of losses shall provide, within 90 days of the Board's written request such information as the Board shall request, including, but not limited to:

1. With respect to information regarding premium earned:

i. Detailed electronic data files of premiums which, in total, agree to the premiums earned reported to the IHC Board on the Exhibit K Assessment Report. The data file or files shall include sufficient detail to identify the dollar amounts of premiums, by subscriber or contract number;

ii. All underwriting and premium records relating to the premiums earned on the data files, including, but not limited to, subscriber applications, billing records, cash receipt and disbursement records, advance premium and premium receivable records and rate filings;

iii. A reconciliation, if necessary, between the total premiums earned per the data files requested in (c)1i above and the premium earned amount reported to the IHC Board on the Exhibit K Assessment Report, including an explanation of reconciling items; and

iv. A reconciliation, if necessary, between the premiums earned amount reported to the IHC Board on the Exhibit K Assessment Report and premiums earned amount set forth in the Member's Annual Statement Blank filed with the Department or Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

2. With respect to claims paid:

i. Detailed electronic data files of claims paid which, in total, agree to the claims paid reported to the IHC Board on the Exhibit K Assessment Report. The data files shall include sufficient detail to identify the dollar amounts of claims paid, by claim and subscriber number, and the payment reference such as check or wire transfer number. All claim file and disbursement records relating to the claims paid on the data file, such as claims submission forms, provider invoices, pricing data, eligibility investigations, canceled checks and wire transfer documentation;

ii. A reconciliation, if necessary, between the total claims paid per the data files requested in (c)2i above and the claims paid amount reported to the IHC Board on the Exhibit K Assessment Report, including an explanation of reconciling items; and

iii. A reconciliation, if necessary, between the claims paid amount reported to the IHC Board on the Exhibit K Assessment Report and the claims paid amount set forth in the Member's Annual Statement Blank filed with the Department or the Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

3. With respect to investment income:

i. Detailed schedules of net investment income which, in total, agree to the net investment income re-

ported to the IHC Board on the Exhibit K Assessment Report. The schedules shall set forth the Member's calculation of net investment income allocated to the New Jersey individual line of business and shall include sufficient detail to identify the nature and source of the components used to calculate net investment income; and

ii. All source documentation used in the Member's calculation of net investment income, including, but not limited to, schedules used in the calculation of mean funds by line of business, cash receipt and disbursement records used in the cash flow schedules, and calculations for the Member's investment rate of return.

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 Operations Committee, or both Committees" following "Technical Advisory Committee" in 3; and added a new (c).

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a), substituted "entities like the Board" for "the type of entity" in 1 and inserted "and Audit" following "Operations" in 3; in (c), rewrote the introductory paragraph and updated references to Exhibit K of the chapter Appendix throughout; in (c)lii, added a comma following "including"; in (c)liv, substituted "forth" for "for".

11:20-2.9 Records

(a) The Board shall provide for the maintenance and retention of its official records, and may delegate this function to the Executive Director.

(b) The Board's records shall consist of the following:

1. Minutes of all Board meetings;
2. Written reports and recommendations of committees to the Board;
3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules;
4. The rulemaking file on rules proposed or adopted by the Board, including all comments received;
5. The Plan of Operation and any amendments thereto;
6. Records concerning the election of Directors and appointment of committees and committee members;
7. Determinations on requests for exemption by carriers;
8. Other actions by the Board required by the Act; and
9. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to N.J.S.A. 47:1A-1 et seq., except that information in filings determined by the Board or Department by regulation to be confidential and proprietary shall not be subject to public inspection and copying, and except that written communications of the Board, its staff, or committees, including, but not limited to, reports,

opinions, and recommendations, where such communications contain discussion of litigation strategy, attorney-client advice or other privileged information, shall not be available for public inspection or copying.

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 "Executive Director" for "Interim Administrator and subsequently appointed Administrator"; in (b), deleted ", including rate and form filings, loss ratio filings, reports of net earned premium and reports of net paid losses" at the end of 3, deleted 8, and recodified former 9 and 10 as 8 and 9; and rewrote (c).

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (c), deleted "the Right to Know Law," following "pursuant to"; deleted (d).

11:20-2.10 Standard health benefits plans

(a) The Board shall establish the policy and contract forms and benefit levels (standard health benefits plans) to be made available by members.

1. In designing and amending the standard health benefits plans, the Board shall give consideration to the types of coverage currently in force and/or available in the marketplace, individual's preferences and the evolution of the marketplace towards managed care.

2. The Board shall discuss amendments to the standard policy forms at a meeting open to the public prior to any vote by the Board to adopt, or modify any aspect of, a standard health benefits plan design.

3. The Board shall hold a public hearing on the standard health benefits plans or any amendments thereto prior to adopting or changing a standard health benefits plan.

i. The Board shall provide to all members and interested parties reasonable advance notice of a public hearing in accordance with the procedures set forth in the Act as amended.

ii. The Board may establish procedures for a public hearing and publish them with the notice of the public hearing.

iii. The Board shall maintain a written record of any public hearing and make it available for inspection at the office of the Executive Director.

4. The Board shall adopt or amend a standard health benefits plan in accordance with the procedures set forth in the Act, as amended, or in accordance with the procedures set forth in the Administrative Procedures Act.

i. In accordance with the procedures for taking action set forth in the Act, as amended, the Board may adopt a standard health benefits plan or modifications thereto and thereafter shall address in writing such comments as were received within a reasonable period following the adoption of the proposed action. The Board shall give due consideration to all comments received. Pursuant to the Act as amended, the Board shall, within

a reasonable period of time following submission of the comments, prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the Board's response to the data views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

(1) The Board shall identify whether it made a change in the action proposed at its own initiative or in response to one or more comments.

ii. Except as may be required by law, members shall implement amendments to the standard health benefits plans in the time prescribed by the Board.

5. The Board shall take action as necessary to keep the standard health benefits plans in compliance with State and Federal law.

6. No member shall issue or renew a standard health benefits plan or the basic and essential healthcare services plan until a rate filing has been filed with the Department in accordance with N.J.A.C. 11:20-6.

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.

Amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

Rewrote (a) and (b).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Deleted the former introductory paragraph of (b); recodified former (b)1 as (a)6; and in (a)6, substituted "Department" for "Board".

11:20-2.11 (Reserved)

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

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

Section was "Assessment for 1992 total reimbursable net paid losses".

11:20-2.12 Assessments for administrative expenses and organizational and operating expenses

(a) Except as described in (a)4 below, every member shall be liable for a portion of the administrative expenses of the IHC Program. Within 90 days of approving a final audited statement of the IHC Program financial statements and the conclusion of all appeals of assessments for administrative expenses, the IHC Program Board shall notify each member by separate invoice of the dollar amounts being assessed against the member for its portion of the final administrative expense total for the applicable fiscal year or years. To the extent that an interim assessment has been made for that period, the notice shall provide reconciliation between the original invoice and the final invoice.

1. Such notice shall include a brief summary of the final administrative expenses and shall credit the member for any interim administrative expense assessments paid.

2. If a member has advanced a sum or sums of money to the IHC Program to cover some portion of the IHC Program's administrative expenses, those sums advanced shall be credited against the member's assessment amounts.

3. Each member's final assessment for administrative expenses shall be reduced by any deferral assessment paid by assessed carriers in proportion to the original assessment made to cover the deferred amount.

4. A member shall not be liable for an assessment that is less than the minimum assessment set forth in N.J.A.C. 11:20-2.18.

(b) The Board, at its discretion, may make an interim assessment on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses as well as to cover estimated losses.

(c) Through fiscal year 1997 (that is, July 1, 1996 through June 30, 1997), all members shall be assessed for a proportionate share of final administrative expenses for the fiscal year on the basis of the ratio of the member's health benefits plans net earned premiums for the calendar year which includes the first six months of the fiscal year to the total of all members health benefits plans net earned premiums for that same calendar year. Beginning with fiscal years 1998 and 1999, all members shall be assessed for a proportionate share of final administrative expenses for two-year fiscal periods on the basis of the ratio of the member's health benefits plans net earned premiums for the two-year calculation period which begins six months prior to the beginning of the first fiscal year to the total of all members' health benefits plans net earned premiums for that same two-year calculation period. Thus, for example, for fiscal years 1998 and 1999, all members will be assessed based on 1997 and 1998 net earned premium. Net earned premiums shall be determined as reported by each member to the IHC Program Board in the Exhibit K Assessment Report as set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit an Exhibit K Assessment 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 or Statements, as appropriate, filed with the Department.

(d) Interim assessments beginning with fiscal years 1998 and 1999 shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding two-year calculation period.

(e) Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by the member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members on the same basis as set forth in (c) above.

(f) Assessment amounts are due and payable upon receipt by a member of an invoice for the assessment. Payment shall

be by bank draft made payable to the Treasury-State of New Jersey, IHC Program, at the address set forth in N.J.A.C. 11:20-2.1(h).

1. Pursuant to N.J.S.A. 17B:27A-10(f)(4), 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 per month of the assessment amount or any portion thereof not timely paid 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 a member reports to the Board within 60 days of their occurrence shall not be subject to the interest penalty set forth in (f)1i above. If a member 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 identify the amount of the assessment in dispute and shall be liable for and make payment of the full amount of the assessment invoice when due, 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 Procedure Act, N.J.S.A. 52:14B-1 et seq.

(g) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with procedures established by the Commissioner, which are set forth at 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 (f) above, to be held in an interest bearing 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 by the Board immediately, along with any applicable interest penalty amounts paid or interest earned while held 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 by the Board.

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

Rewrote the section.

Amended by R.2006 d.15, effective January 3, 2006.
Sec: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a), rewrote introductory paragraph and added 4; in (c), updated references to Exhibit K of the chapter Appendix; in (f)1, added N.J.S.A. reference to the introductory paragraph and rewrote iii; in (f)2, added language requiring that members "identify the amount of the assessment in dispute"; in (g), added N.J.A.C. reference in the introductory paragraph; deleted references to an "escrow" account in (g) and (h); in (h)1, inserted "by the Board" following "may be disbursed".

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).

Amended by R.1998 d.443, effective August 7, 1998.
Sec: 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)".

Amended by R.2006 d.15, effective January 3, 2006.
Sec: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Deleted "in order to preserve its right to any monies paid pursuant to the invoice of assessment" at the end of the paragraph.

11:20-2.14 Failure to pay assessments

If a member 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.

Amended by R.2006 d.15, effective January 3, 2006.
Sec: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Deleted "is" following "If a member" in the first sentence.

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

Rewrote (a): deleted former (b) through (d); and recodified former (c) as (b).

Amended by R.2006 d.15, effective January 3, 2006.
Sec: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b), inserted "any" following "the assessment of" in the first sentence.

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

In (a), inserted "employee of the Board" following "Directors".
Amended by R.2006 d.15, effective January 3, 2006.
Sec: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b), deleted "or the Department" following "of the Board" in the second sentence.

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

(a) The Board shall assess members for reimbursable net paid losses, pursuant to N.J.S.A. 17B:27A-11a and 12, according to the procedures set forth in this Plan of Operation.

(b) The IHC Program Board shall determine the preliminary total reimbursable net paid losses, if any, for each preceding two-year calculation period beginning in 1997/1998 based upon the information submitted by members in Part E of the Exhibit K Assessment Report, completed pursuant to N.J.A.C. 11:20-8 (formerly known as the Carrier Net Paid Gain (Loss) Report and set forth in a superseded version of Exhibit K to N.J.A.C. 11:20). The Board shall determine the preliminary total reimbursable net paid losses, if any, approximately 60 days after all IHC members have provided complete Exhibit K Assessment Report filings.

(c) The total reimbursable net paid losses for the preceding two-year calculation period shall be the aggregate of the reimbursable net paid losses for all members issuing individual health benefits plans, reporting net paid losses for that two-year calculation period, subject to any independent audit performed pursuant to N.J.A.C. 11:20-8.8. The loss assessment shall provide for full reimbursement of reimbursable losses, notwithstanding the granting of exemptions pursuant to N.J.A.C. 11:20-9. No member shall be entitled to reimbursement of net paid losses if the member has not issued individual health benefit plans during the two-year calculation period or if the member has applied for a conditional exemption for the two-year calculation period.

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

1. The Board shall provide a preliminary written notice to members of the total of all members' reimbursable net paid losses for the preceding two-year calculation period and the amount of each member's anticipated loss assessment liability. This written notice shall be sent approximately 60 days after every IHC member has provided a complete Exhibit K Assessment Report as required by N.J.A.C. 11:20-8.

2. As necessary, the Board shall make adjustments to the preliminary notice of the loss assessment prior to issuing the loss-assessment invoice. Those adjustments may include, among other things, adjustments in market share, adjustments in net paid losses, and adjustments for defer-

rals granted pursuant to N.J.S.A. 17B:27A-12d(3) and N.J.A.C. 11:20-11.

3. The Board shall notify each member by invoice of its share of the loss assessment for the two-year calculation period. This invoice shall be sent approximately 60 days after the Board has completed its review of the Exhibit K Assessment Report filings for accuracy, including, but not limited to, consistency with other public filings provided to the State by the members.

4. The Board may issue interim assessments and reconciliations after the issuance of the loss-assessment invoice and before the issuance of the final reconciliation set forth in (d)5 below.

5. The Board shall notify each member of the final reconciliation of the loss assessment for the calculation period by issuing an invoice setting forth the dollar amount payable by the member or credit due to the member. The final reconciliation shall be issued approximately 90 days after all outstanding matters have been resolved, including but not limited to the completion of the independent audit of each member seeking reimbursement of losses, and the issuance of a final judicial determination of every appeal, including, but not limited to, those relating to the loss assessment for the two-year calculation period, exemptions from the loss assessment, independent net paid loss audits, and the payment of reimbursable losses. Any monies determined to be owed to or by the Board as a result of the final reconciliation shall be calculated without provision for interest.

(e) The Board shall determine each member's loss assessment share by multiplying the member's market share, as determined pursuant to (e)1 below, by the total reimbursable net paid loss amount for the two-year calculation period.

1. The Board shall determine each member's market share by dividing the member's adjusted net earned premium, as determined pursuant to (e)1i, (e)1ii, or (e)1iii below, for the two-year calculation period by the aggregate adjusted net earned premium of all members for the two-year calculation period.

i. For a member that has been granted a full exemption, the member's adjusted net earned premium shall be \$0.

ii. For a member that has been granted a pro rata exemption, the member's adjusted net earned premium shall be calculated as the reported net earned premium in Part C of its Exhibit K Assessment Report multiplied by (100 percent minus the percentage of the non-group enrollment target the member satisfied).

iii. For a member that has not been granted a full or pro rata exemption, the member's adjusted net earned premium shall be the same as the net earned premium that the member has reported in Part C of its Exhibit K Assessment Report.

2. Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by a member after the dispute is resolved in favor of the disputing member, shall be apportioned to the remaining members based on their respective market shares.

i. A member granted a deferral shall remain liable to the IHC Program for the amount deferred and for 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. A member shall not be liable for a loss assessment that is less than the minimum assessment set forth in N.J.A.C. 11:20-2.18.

(f) Loss assessment amounts are due and payable upon a member's receipt of the invoice for the loss assessment. Payment shall be either by bank draft made payable to the Treasurer—State of New Jersey, IHC Program, and sent to the address set forth in N.J.A.C. 11:20-2.1(h), or by wire transfer consistent with instructions in the invoice. The funds are deposited into the Board's account in Treasury.

1. Pursuant to N.J.S.A. 17B:27A-10f(4), members shall be subject to payment of an interest penalty on any loss assessment, or portion of a loss 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 loss assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of a loss 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, and the interest penalty shall continue to accrue on the unpaid amount.

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

2. A member that disputes whether it is subject to a loss assessment, or that disputes the amount of the loss assessment for which it has been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount shown on the assessment invoice, including any interest penalty accruing thereon. The member shall identify the amount in dispute, subject to verification

by the Board. The Board shall not be liable for any misidentification by the member of the disputed amount that results in an insufficient amount being held by the Board. The disputed amount of the assessment shall be held in a segregated interest-bearing account until there has been a final adjudication of the dispute, or until such time as the Board determines that the member's appeal should be granted.

(g) A member may request that the Commissioner grant a deferral of its obligation to pay a loss 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 a segregated interest-bearing 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 assessments. 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, when the net paid loss audit is complete. 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 loss 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 applicable two-year calculation period, until such time as the dispute has been resolved against the disputing member, or the deferral denied, except that any portion of a loss 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 applicable two-year calculation period year in accordance with (h) above.

2. Upon receipt of notice that amounts of loss assessment disputed or subject to deferral wherein the dispute is resolved 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 by the Board and provide notice to the member of the principal amount and interest amount. The Board shall calculate the amount to be returned to the member, which amount shall be paid within 30 days and shall include the payment of interest up until the date of the expected payment.

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.

The expiration date of N.J.A.C. 11:20-2.17, was extended by gubernatorial directive to December 31, 2005, in accordance with N.J.S.A. 52:14B-5.1d.

See: 37 N.J.R. 2884(a).

N.J.A.C. 11:20-2.17 expired on December 31, 2005.

New Rule, R.2006 d.445, effective December 18, 2006.

See: 38 N.J.R. 1159(a), 38 N.J.R. 5383(a).

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than \$10.00 in the case of either a loss assessment or both a loss assessment and an administrative assessment, or less than \$5.00 in the case of an administrative assessment only, the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12 and 2.17 as appropriate. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12, an invoice for reimbursable net paid losses issued pursuant to N.J.A.C. 11:20-2.17, or a combined invoice for both administrative expenses and net paid losses.

New Rule, R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Substituted "\$10.00 in the case of either a loss assessment or both a loss assessment and an administrative assessment, or less than \$5.00 in the case of an administrative assessment only" for "\$20.00".

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

(a) The standard individual health benefits plans established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter as follows:

1. Plan A/50, Appendix Exhibit A with pages identified as unique to Plan A/50;
2. Plan B, Appendix Exhibit A with pages identified as unique to Plan B;
3. Plan C, Appendix Exhibit A with pages identified as unique to Plan C;

4. Plan D, Appendix Exhibit A with pages identified as unique to Plan D; and

5. HMO Plan, Appendix Exhibit B.

(b) Members that offer individual health benefits plans in this State and members that offer small employer health benefits plans in this State pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21 shall offer at least three of the standard health benefits Plans A/50, B, C, D and HMO as set forth in chapter Appendix Exhibits A and B, incorporated herein by reference with variable text as specified on the Explanation of Brackets, which is set forth as chapter Appendix Exhibit C, incorporated herein by reference, subject to the provisions set forth in (b)1 through 9 below and except as provided in (c) below.

1. Members shall offer Plan A/50 which is designated as the basic plan.

2. Members shall offer at least two of the Plans designated as Plans B, C, D and HMO.

3. Members offering Plan A/50, and at least two of the plans designated as Plans B, C, D and HMO shall offer at least two of the selected plans B, C and/or D if not also offering HMO, and at least one of the selected Plans B, C and/or D is offering the HMO, with the following annual deductible provisions:

i. The per covered person annual deductible shall be \$2,500; and

ii. The corresponding per covered family annual deductible shall be \$5,000, satisfied on an aggregate basis.

4. Members offering Plans A/50, B, C, and/or D may offer the plans with one or more of the following annual deductible provisions in addition to the deductible provisions specified in (b)3 above:

i. Per covered person annual deductible equal to \$1,000, \$5,000 or \$10,000; and

ii. Per covered family annual deductible equal to two times the applicable per covered person annual deductible, satisfied on an aggregate basis.

5. Members offering Plans A/50, B, C, and D may offer the plans with one or more of the following annual deductible provisions in addition to the deductible provisions required in (b)3 above such that the plans may qualify as high deductible health plans:

i. In the case of single coverage, the greater of: \$1,200; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code §223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered person; and in the case of other than single coverage, the greater of: \$2,400; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue

Code §223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered family, with single and other than single deductibles accumulated in accordance with the requirements of Federal law;

ii. In the case of single coverage, \$2,000, and in the case of other than single coverage, \$4,000 with single and other than single deductibles accumulated in accordance with the requirements of Federal law;

iii. In the case of single coverage, \$2,800 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted, per covered person; and in the case of other than single coverage, \$5,600 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted with single and other than single deductibles accumulated in accordance with the requirements of Federal law; and

iv. In the case of single coverage, \$5,000, and in the case of other than single coverage, \$10,000 with single and other than single deductibles accumulated in accordance with the requirements of Federal law.

6. Members offering Plans C and D may renew plans that were issued with the following annual deductible provisions:

i. \$1,500, or the lowest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per individual or in the case of a family unit, \$3,000, or the lowest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per family unit with single and family unit deductibles accumulated in accordance with the requirements of Federal law; and

ii. \$2,250, or the highest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per individual or in the case of a family unit, \$4,500, or the highest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per family unit with single and family unit deductibles accumulated in accordance with the requirements of Federal law.

7. When issued using deductible provisions set forth in (b)3 and 4 above, Plans A/50, B, C, and D shall contain maximum out of pocket provisions as follows:

i. The per covered person maximum out of pocket for Plan A/50 shall be the sum of the annual deductible and \$5,000;

shall not become effective until the Commissioner has confirmed in writing that the basis for disapproval is cured.

(e) Upon the issuance of a notice as set forth in (d) above, the member shall submit any additional information required to make the filing complete in accordance with (c) above. A carrier may appeal the Commissioner's determination that the filing is not in substantial compliance or that the rates are inadequate or unfairly discriminatory and request a hearing within 20 days of receipt of the written notice set forth in (d) above.

11:20-6.5 Permissible rate classification factors

(a) A carrier shall not differentiate premium rates charged to different individuals except on the basis of age (in the case of standard plans and riders) and age, gender, and geography (in the case of basic and essential plans and riders) in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 19 and under; 20-24; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; and 65 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first three digits of the U.S. Postal Service zip codes or the counties listed below. A carrier shall determine which territory applies to a policyholder on the basis of the address of the policyholder's place of residence. The six territories are the following:

i. Territory A consists of zip codes 070-073 or Essex, Hudson and Union counties;

ii. Territory B consists of zip codes 074-076 or Bergen and Passaic counties;

iii. Territory C consists of zip codes 077-079 or Monmouth, Morris, Sussex and Warren counties;

iv. Territory D consists of zip codes 088-089 or Hunterdon, Middlesex and Somerset counties;

v. Territory E consists of zip codes 081, 085-086 or Burlington, Camden and Mercer counties; and

vi. Territory F consists of zip codes 080, 082-084 and 087 or Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

(b) Notwithstanding (a) above, a carrier may differentiate premium rates on the basis of family structure according to only the following four rating tiers:

1. Single;
2. Two adults;
3. Adult and child(ren); and
4. Family.

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20-7.1 Purpose

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

11:20-7.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20-1.2, or as further defined below, unless the context clearly indicates otherwise.

"Claims paid" means a dollar amount determined in accordance with statutory annual statement reporting and consistent with N.J.A.C. 11:20-8.5(c), adjusted as required by this subchapter.

"Preceding calendar year" means the calendar year immediately preceding the reporting year.

"Reporting year" means the year in which the loss ratio report is required to be filed with the Board.

11:20-7.3 Filing of Loss Ratio Report

(a) Each member that had a standard health benefits plan or a basic and essential health care services plan in force during the preceding calendar year shall file with the Commissioner an annual Loss Ratio Report on the form appearing as Exhibit J in the Appendix to this chapter, incorporated herein by reference. Affiliated carriers shall file a separate report for each carrier that had standard health benefits plans or the basic and essential health care services plans in force during the preceding calendar year plus a combined report reflecting the combined data for all affiliated carriers.

(b) The Report shall be filed on the basis of the combined total of the standard health benefits plans and the basic and essential health care services plans written by the member.

(c) The Report shall be completed and filed with the Board on or before August 15 of the reporting year for the preceding calendar year.

11:20-7.4 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form set forth at Appendix Exhibit J shall be completed by August 15 of each year by each member and shall include the following information with respect to standard health benefits plans and basic and essential health care services plans:

1. The reporting member's name and address;
2. The member's net earned premium for the preceding calendar year; and
3. A statement of the member's total losses incurred consisting of:

i. Claims paid during the preceding calendar year, regardless of the year incurred;

ii. Less residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;

iii. Less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year's Loss Ratio Report;

iv. Plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;

v. Plus residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year;

4. The member's loss ratio (determined by dividing the total losses incurred in (a)3 above by the net earned premium as determined in (a)2 above) calculated as a percentage to one decimal place (for example, 81.2 percent); and

5. Certification by a member of the Society of Actuaries, Casualty Actuarial Society, or American Academy of Actuaries that the information provided in the Loss Ratio Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-9 in accordance with this section.

(b) The residual reserve reported in (a)3ii and v above shall be calculated as 3.3 percent of the combination of (a)3i, iii and iv above.

11:20-7.5 Refund plan

(a) If the loss ratio determined in N.J.A.C. 11:20-7.4 is less than 80 percent, the member shall include with the Report a plan to be approved by the Commissioner for a refund to policy and contractholders of an amount equal to the difference between 80 percent of reported premiums and reported claims.

(b) The refund plan shall conform with the following:

1. Refunds shall be made to all contractholders who were covered for any period during the preceding calendar year whose refund is \$5.00 or greater.

2. The refund amount per contractholder may be determined by multiplying the earned premium from each contractholder's standard health benefits plan and rider or basic and essential health care services plan and rider by the percentage resulting from dividing the total refund calculated in accordance with (a) above by the carrier's total net earned premium from the standard health benefits plans and basic and essential health care services plans, or on the basis of a practical and equitable alternative formula

proposed by the carrier and approved by the Commissioner.

3. Refund payments shall be made within 60 days of written approval of the refund plan by the Commissioner.

11:20-7.6 Unclaimed loss ratio refunds

(a) Any loss ratio refund issued by a carrier to a policy or contractholder pursuant to this subchapter which remains unclaimed by that policy or contractholder shall be deemed abandoned two years from the date upon which the Commissioner approves the refund plan as set forth in N.J.A.C. 11:20-7.5(b).

(b) Refunds deemed abandoned pursuant to (a) above shall be subject to all applicable provisions of the Uniform Unclaimed Property Act, N.J.S.A. 46:30B-1 et seq., including, but not limited to, N.J.S.A. 46:30B-30, 46, 47, 49, 50 and 57. All carriers shall follow the procedures set forth in the Uniform Unclaimed Property Act with respect to the disposition of refunds deemed abandoned.

(c) Carriers which comply with the applicable provisions of the Uniform Unclaimed Property Act and this subchapter shall be relieved of liability to the extent of any unclaimed refunds upon payment of any unclaimed refunds to the State administrator designated pursuant to the Uniform Unclaimed Property Act.

11:20-7.7 Certification of loss ratio refunds

Within 30 days of issuing refunds to all policy or contractholders for a specific calendar year, any carrier required to provide a loss ratio refund pursuant this subchapter shall provide a certification to the Commissioner at the address in N.J.A.C. 11:20-6.4(a), stating the following: "The loss ratio refund, as set forth in the Loss Ratio Report, was issued by (name of company) to all policy or contractholders eligible for reimbursement with refund checks mailed, or premiums credited, on (date)."

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

11:20-8.1 Scope and applicability

(a) This subchapter sets forth reporting and certification requirements for premium and non-group enrollment data of Program members and other carriers with reportable accident and health premium in New Jersey. This subchapter also sets forth reporting and certification requirements for premium, claims, and net investment income data of Program members issuing individual health benefits plans.

(b) This subchapter shall apply to all carriers with reportable accident and health premium in New Jersey for

any portion of the two-year calculation period for which reports under this subchapter are required to be filed.

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).

In (a), deleted "annual" preceding "reporting"; and in (b), substituted "two-year calculation period" for "calendar year".

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Scope and applicability".

11:20-8.2 Filing of the assessment report form

(a) Every carrier with reportable accident and health premium in New Jersey shall file the Exhibit K Assessment Report form, a copy of the Exhibit K Part C Premium Data Worksheet, and a copy of the Exhibit K Part D Enrollment Data Worksheet, which are set forth as Exhibit K in the Appendix to this chapter, incorporated herein by reference, on or before April 1 of the year immediately following every two-year calculation period.

(b) If a carrier with reportable accident and health premium in New Jersey is an affiliated carrier, the Exhibit K

Assessment Report, the Part C Premium Data Worksheet and the Part D Enrollment Data Worksheet shall be filed as follows:

1. Each affiliated carrier shall file one copy of the Exhibit K Part C Premium Data Worksheet whether or not that affiliated carrier reported accident and health premium in New Jersey during the two-year calculation period.

2. Each affiliated carrier shall file one copy of the Exhibit K Part D Enrollment Data Worksheet if the carrier issued or renewed any of the coverages specified on the Enrollment Data Worksheet. If an affiliated carrier neither issued nor renewed any of the coverages specified on the Enrollment Data Worksheet, it is not necessary for that affiliated carrier to file the Exhibit K Part D Enrollment Data Worksheet.

3. The combined affiliated carriers, identified using a single carrier name, shall file one copy of the Exhibit K Assessment Report. The information specified on the

Exhibit K Assessment Report shall be the aggregated information supplied on the Premium Data Worksheets for all affiliated carriers and the Enrollment Data Worksheets for those affiliated carriers with non-group person enrollment.

4. The Exhibit K Assessment Report along with the Premium Data Worksheet(s) and the Enrollment Data Worksheet(s) shall be filed together. For example, a carrier with three affiliates with reportable accident and health premium in New Jersey but only two of which issue non-group coverage, shall file one Exhibit K Assessment Report with the aggregated information for all affiliated carriers, three copies of the Exhibit K Part C Premium Data Worksheet, and two copies of the Exhibit K Part D Enrollment Data Worksheet.

(c) Certified Exhibit K Assessment Reports shall be submitted either by facsimile, with paper copy to follow by mail, or by hand delivery to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

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).

In (a), changed the report filing deadlines; and rewrote (b).
Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Filing of the market share and net paid gain or (loss) report form".

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote (a); in (b)3, added "Exhibit K" preceding "Assessment Report" in the second sentence; rewrote (b)4; rewrote (c).

11:20-8.3 Calculation of net earned premium and determination of program membership for the two-year calculation period

(a) In Part C of the Exhibit K Assessment Report, each member shall set forth its total net earned premium from plans issued, continued or renewed for all affiliated carriers during the preceding two-year calculation period. Net earned premium reported in Part C of Exhibit K shall be consistent with the data set forth on the Exhibit K Part C Premium Data Worksheet(s).

(b) In Part C of the Exhibit K Assessment Report, each carrier with no net earned premium in the preceding two-year calculation period shall assert its status as a non-member by checking the box designated for non-members on the Exhibit K Assessment Report. Carriers either with no net earned premium or whose Section 3 Calculation of Net Earned Premium on the Exhibit K Part C Premium Data Worksheet is equal to 0 are non-members.

(c) Every carrier, whether a member or not, shall complete an Exhibit K Part C Premium Data Worksheet for each affiliate and shall attach each Worksheet to its Exhibit K Assessment Report.

1. In Section 1 of the Premium Data Worksheet, the carrier shall report the total accident and health premium reported on its annual statement blank for each calendar year of the two-year calculation period.

2. In Section 2 of the Premium Data Worksheet, the carrier shall report the total net earned premium in each calendar year of the two-year calculation period for each of the excepted types of coverage which are specifically identified in Section 2 of the Worksheet.

3. In Section 3 of the Premium Data Worksheet, the carrier shall calculate the affiliate's net earned premium by subtracting the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1 of the Worksheet.

4. The carrier shall report the aggregated two-year net earned premium on Exhibit K Part C by taking the sum of each affiliate's two-year net earned premium total as calculated on the Exhibit K Part C Premium Data Worksheet.

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).

Amended by R.2001 d.55, effective January 17, 2001.
See: 33 N.J.R. 15(a), 33 N.J.R. 668(a).

In the introductory paragraph of (a), inserted N.J.A.C. reference, and in (a)1, inserted " , but not be limited to,".

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Net earned premium".

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote (b); in (c), added "Assessment Report" at the end.

11:20-8.4 Calculation of average non-group enrollment for the two-year calculation period

(a) In Part D of the Exhibit K Assessment Report, each carrier shall report its aggregated average non-group enrollment for all affiliates for the preceding two-year calculation period.

(b) Each carrier shall complete an Exhibit K Part D Enrollment Data Worksheet for each affiliate that issued or renewed the categories of non-group enrollment listed on the worksheet and shall attach each Worksheet to its Exhibit K.

1. In Section a of the Enrollment Data Worksheet, the carrier shall report all community rated persons covered under individual health benefits plans issued prior to August 1, 1993, all modified community rated persons issued on or after August 1, 1993, and all persons covered under as the basic and essential health care services plan as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters. For contracts issued prior to August 1, 1993, where a carrier's administrative systems cannot provide the number of actual covered persons, the following factors shall be used to convert contracts or subscribers to the total number of covered persons: single = 1; two

adults = 2; adult and child(ren) = 2.8; family = 3.9. If a two adults category is not used, a carrier shall use a composite factor of 3.33 in order to reflect the two adults category in the family factor.

2. In Section b of the Enrollment Data Worksheet, the carrier shall report all modified community rated conversion policy persons as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

3. In Section c of the Enrollment Data Worksheet, the carrier shall report all Medicaid recipients, including NJ FamilyCare Plan A recipients, but no recipients of any other plans through NJ FamilyCare, as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

4. In Section d of the Enrollment Data Worksheet, the carrier shall report all Medicare Plus Choice, Medicare Advantage, Medicare cost and risk lives and Medicare Demonstration Project lives as of the last day of the end of each calendar quarter during the Two-Year Calculation Period, and shall report the total of all eight quarters.

5. In Section e of the Enrollment Data Worksheet, the carrier shall calculate the two-year non-group enrollment total by adding the totals from a through d of the Worksheet.

6. In Section f of the Enrollment Data Worksheet, the carrier shall calculate the average two-year non-group enrollment to be reported on Exhibit K Part D by dividing the total two-year non-group enrollment total by eight.

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 the section.

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Calculation of covered non-group persons".

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b)1, substituted "two adults" for "husband and wife" throughout and substituted "composite" for "compromise"; in (b)4, substituted "Medicare Advantage," for "and".

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (b)1, inserted "issued prior to August 1, 1993, all modified community rated persons issued on or after August 1, 1993"; in (b)2, inserted "modified"; and in (b)3, deleted "NJ KidCare Part A recipients and" following "including" and "NJ KidCare" following "through".

11:20-8.5 Calculating net paid losses or gains

(a) For purposes of completing Part E of the Exhibit K Assessment Report form, each member issuing individual health benefits plans shall provide data for its individual health benefits plans issued or renewed pursuant to sections 2b(1) or 3 of the Act (N.J.S.A. 17B:27A-3b(1) or 4), or the basic and essential health care services plan pursuant to the requirements of P.L. 2001, c. 368 for the preceding two-year calculation period up to and including the 2007–2008 calcu-

lation period which shall be the final period for which loss reimbursement may be sought. For purposes of completing Part E of the Exhibit K Assessment Report, a member that does not have any net earned premium for standard individual health plans or basic and essential healthcare services plans during a two-year calculation period shall not be considered to be issuing coverage, and thus shall not complete Part E and is not eligible for reimbursement.

1. All data shall be for direct business only; reinsurance accepted shall not be included, and reinsurance ceded shall not be deducted.

2. The method used by a member to allocate to sublines of the individual line shall be consistent with the method used by a member to allocate to the individual line.

(b) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report premium earned. Premium earned shall be adjusted:

1. By any changes in non-admitted premium assets consistent with statutory report requirements, except that any change in non-admitted assets associated with premium accrued shall be reported consistent with the bases, as appropriate to the member, from the member's NAIC annual statement, adjusted for the individual health benefits plan for which the report is being made, as necessary; and

2. To reflect the premium that a carrier should have earned based on charging premiums consistent with the rate filings the member filed with the board for the applicable time period.

(c) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report claims paid. Claims paid shall be reported on a basis consistent with statutory reporting, as is appropriate for the member based on the member's NAIC annual statement, adjusted as necessary for the individual health benefits plans for which the report is being made. Claims paid as reported on Exhibit K Assessment Report shall include reimbursement for charges made by providers for services and supplies, surcharges mandated pursuant to the New York Health Care Reform Act of 2000, P.L. 1999, c.1, codified in the New York Public Health law, section 2807-c through 2807-w, and network access fees where such fees may be demonstrated to have reduced specific claim payments and where the carrier has reported such fees as claims on its NAIC annual statement blank. In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. Claims paid shall be adjusted to only include claims that should have been paid according to the terms and conditions of the individual health benefits policy and N.J.S.A. 17B:27A-2 et seq.

(d) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits shall report its net investment income. Net investment income shall be calculated in accordance with statutory reporting requirements. For

purposes of Exhibit K Assessment Report reporting, and notwithstanding how a carrier allocates net investment income to individual lines in other statutory reports or filings, carriers shall allocate net investment income consistent with the following basis, adjusted for the individual health benefits plans for which the report is being made as necessary.

1. The cost of granting and servicing premium notes and policy loans and liens shall be allocated to investment expense. The resulting net income on premium notes and policy loans and liens may be distributed to those lines of business which produced such income. In making such distribution, due consideration shall be given to the variation in the interest rate and incidence of expense on such notes, loans, and liens.

2. Net investment income, after adjustment, if any, as permitted by (d)1 above, shall be distributed to major and secondary lines of business in proportion to the mean funds of each line of business, after suitable adjustment, if any, on account of policy loans, except that any miscellaneous interest income arising from policy or annuity transactions may be allocated directly to the line of business producing such income. "Mean funds" refers to the average net cash flow balance over the two-year calculation period for which the calculation is being made, with the average net cash flow balance determined on a monthly or quarterly basis. The average net cash flow balance is the sum of the beginning of the month or quarter and end of month or quarter cash flow balances divided by two. The "cash flow balance" at the beginning of the month or quarter is equal to the inception to date paid premiums, plus the net investment income at the beginning of the month or quarter, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid, and less paid expenses. The "cash flow balance" at the end of the month or quarter is equal to the inception to date paid premiums, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid and less paid expenses, plus net investment income at the beginning of the month or quarter. "Inception to date" shall mean a measurement of cash flow from the first date the carrier receives premium for standard individual health benefits plans until the end of the most recent two-year calculation period.

(e) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report its net paid gain or net paid loss. The net paid gain or loss for the two-year calculation period shall be determined by taking the claims paid on individual health benefits plans (as set forth on line b in Part E of Exhibit K), less 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans (as set forth in lines a and c, respectively, in Part E of Exhibit K). If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is greater than claims paid on individual health benefits plans, the amount shown of line d represents a net paid gain. If 115 percent of the sum of the net earned premium and the net

investment income earned on individual health benefits plans is less than claims paid on individual health benefits plans, the amount shown on line d represents a net paid loss.

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.

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote the section.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a), rewrote the introductory paragraph; in (c), added "Assessment Report" following "Exhibit K" in the third sentence; in (d), in the third sentence, added "Assessment Report" following "Exhibit K" and deleted the space between "not" and "withstanding"; in (d)2, added quotation marks around "Mean funds".

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In the introductory paragraph of (a), inserted "up to and including the 2007-2008 calculation period which shall be the final period for which loss reimbursement may be sought".

11:20-8.6 Certifications

(a) In Part F of the Exhibit K Assessment Report, the Chief Financial Officer, or other duly authorized officer of the carrier, shall certify that the Exhibit K Assessment Report, all Exhibit K Part C Premium Data Worksheets, and all Exhibit K Part D Enrollment Data Worksheets filed with the IHC Board are accurate and complete and conform with the requirements of this subchapter. Every duly authorized officer who provides a certification for the reporting required under this subchapter shall be responsible for errors contained therein.

(b) The Chief Financial Officer, or other duly authorized officer, of a member which has filed for reimbursement of losses shall certify, on or before April 1 of the year following every two-year calculation period that the net investment income reported on the Exhibit K Assessment Report has been allocated on a basis consistent with N.J.A.C. 11:20-8.5(d) or, if not, the changes have been outlined in detail including the impact and reason for the change.

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).

In (a), inserted "gain" preceding "(loss)" throughout; and rewrote (b).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote (a); in (b)1, substituted "the assessment" for "Exhibit K" following "reported on".

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a), inserted "Exhibit K" before the second occurrence of "Assessment Report"; rewrote (b).

Case Notes

Health insurer became member of Individual Health Coverage Program subject to assessment for share of program losses upon receiving certificate of authority to operate as health maintenance organization (HMO) in state, regardless of status of its application for approval as federally qualified HMO. Matter of Individual Health Coverage Program Final Administrative Orders Nos. 96-01 and 96-22, 302 N.J.Super. 360, 695 A.2d 371 (N.J.Super.A.D. 1997).

11:20-8.7 Failure to file Exhibit K Assessment Report

(a) Failure to file in a timely manner the Exhibit K Assessment Report and certifications required by this subchapter shall result in the Board's using the premium set forth in the member's most recent Annual Statements filed with the Department as the premium base to calculate that member's market share allocation of assessments for reimbursement of losses and minimum number of non-group persons.

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).

In (a), inserted "gain" preceding "(loss)" in the introductory sentence.
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), substituted "the Assessment Report" for "market share and net paid gain (loss) report" in the introductory paragraph.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote the section; section was "Penalties for failure to file market share and net paid loss report".

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 Exhibit K Assessment 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, except that, for loss periods beginning with 2001/2002, if the member fails to provide sufficient information to the auditor within 18 months after the auditor's first written request for records to enable the auditor to complete its audit, then the costs incurred after that time shall be the sole responsibility of carrier if the member should choose to proceed with seeking reimbursement of its losses and an audit. If a carrier fails to complete the audit within two years of the commencement of the audit, the Board may terminate the 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. Such findings shall include the failure of a carrier to pay claims consistent with the terms of the applicable contract and applicable law, or to collect premiums consistent with the terms of its informational rate filing and applicable law. If the audit for any loss period beginning with 2001/2002 is terminated by the Board because the carrier did not cooperate in the completion of the audit within two years of the auditor's first written request for records, then the carrier shall not be entitled to reimbursement.

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".
Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (b), substituted "Assessment Report" for "market share and net paid gain (loss)report"; in (c), added the second sentence.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote (b) and (c).

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 receipt of written notification of the Board's 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.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Substituted "receipt of written notification of the Board's" for "the date that the IHC Program Board notifies the member of its".

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 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 applicable two-year calculation period. Written requests shall be sub-

mitted to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

(b) A member's written request for an exemption 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 and the basic and essential health care services plan;
 - ii. Conversion policies issued pursuant to the IHC Act;
 - iii. Medicaid contracts, if offered, including NJ FamilyCare Plan A contracts; and
 - iv. Medicare cost and risk contracts with the Federal government, Medicare Plus Choice, Medicare Advantage and Medicare Demonstration plans 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.

(e) Carriers denied a conditional exemption from assessments for reimbursements for losses may, within 20 days of receipt of written notification of the Board's final determination, 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.

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (b)2, rewrote i and iv.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote (a); in (b), rewrote the introductory paragraph, rewrote 2iii., and added reference to "Medicare Advantage" in 2iv.; in (d)2, deleted "as appropriate" at the end; rewrote (e).

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (b)2iii, deleted "and NJ KidCare Plan A contracts" preceding the semicolon at the end.

11:20-9.3 Minimum enrollment share

(a) Approximately 60 days after all IHC members have provided complete Exhibit K Assessment Reports, the IHC Program Board shall issue to each member its minimum enrollment share of non-group persons for that two-year calculation period that the member must agree to cover in that two-year calculation period to qualify for 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 by adding together the total number of persons covered under the plans set forth in (c)1 through 3 below on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, dividing by eight, and multiplying 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.

1. Standard health benefits plans and the basic and essential health care services plan, and community rated, individually enrolled or insured plans issued prior to the IHC Act;

2. Conversion policies issued pursuant to the Act; and

3. Medicare cost and risk contracts, Medicare Plus Choice contracts, Medicare Advantage contracts, Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, including NJ FamilyCare Plan A.

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).

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (c), deleted 1 and recodified former 2 as new 1.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote (a) and (c).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (c)3, deleted "and NJ KidCare Plan A contracts" from the end.

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 and the basic and essential health care services plan;
2. Conversion policies issued pursuant to the Act; and
3. Medicare cost and risk contracts, Medicare Plus Choice contracts, Medicare Advantage contracts, Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, including NJ FamilyCare Plan A contracts, 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".

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), rewrote 1 and 3.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a)3, substituted ", Medicare Advantage contracts," for "and".

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (a)3, deleted "and NJ KidCare Plan A" following "Plan A".

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

(a) So that the Board can determine whether the member has satisfied its minimum enrollment share, any member that has been granted a conditional exemption and seeks a final (full or pro rata) exemption shall file with the Board, on or before April 1 of the year following each two-year calculation period, a Certification of Non-Group Lives, in which it reports 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, Medicare Plus Choice lives, Medicare Advantage lives and Medicare Demonstration Project lives as described in N.J.A.C. 11:20-9.4(a)3 and (b).

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:

1. Were counted in accordance with N.J.A.C. 11:20-9.4;
2. If covered by standard health benefits plans and conversion health benefits plans, were enrolled on an open enrolled and modified community rated basis or if covered under a basic and essential health care services plan were enrolled on an open enrolled basis;
3. Were actual covered lives and not estimates of covered lives based on conversion factors applied to contracts or other approximation methods;
4. Were counted consistent with N.J.S.A. 17B:27A-12d(1) and (2);
5. Do not include persons whose premium due is more than 30 days overdue; and
6. Were issued a policy that was issued, or issued for delivery, in New Jersey.

(b) 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 (a) above.

(c) The IHC Program Board shall review, and may audit, a member's non-group persons reported pursuant to (a) above. 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.

(d) The IHC Program Board shall adjust a member's reported non-group persons, for purposes of determining whether the member should receive a final (full or pro rata) exemption from assessment for reimbursable losses, for the member's failure to meet the certification requirements of (a) above or as a result of the findings of an independent audit conducted pursuant to (c) above.

(e) 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 (a) above demonstrates that the member has enrolled or insured at least 100 percent of the minimum number of non-group persons allocated to it by the Board for that two-year calculation period.

(f) Members receiving full exemptions from the Board shall not be liable for any portion of any assessments for reimbursements for losses for the two-year calculation period for which the full exemption is granted. The Board shall

determine, in writing, whether the member is granted a final (full or pro rata) exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for that two-year calculation period.

1. A member granted a conditional exemption that enrolls or insures fewer than the minimum number of non-group persons allocated to it by the Board shall be granted a pro rata exemption from assessments for reimbursements for losses based upon the percentage of the minimum number of non-group persons actually enrolled or insured by the member.

(g) Members denied a pro rata exemption from assessments for reimbursements for losses may, within 20 days of receipt of written notification of the Board's final determination, appeal the Board's determination and request a hearing pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

(h) A member requesting a hearing by the Board shall remain liable for the full amount of any assessments for reimbursements for losses issued to it by the Board, including any interest that may accrue, until and unless there has been a final adjudication finding that the member qualifies for an exemption, or until such time as the Board determines that the member's appeal should be granted.

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 the section.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (b), inserted "Medicare Plus Choice lives and Medicare Demonstration Project lives" preceding the N.J.A.C. reference in the introductory paragraph and rewrote 2.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote the section.

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (a)2, inserted "modified".

Case Notes

Regulation giving pro rata exemption from Individual Health Coverage Program (IHCP) assessments to health insurance carriers that fell short of writing 50% of their target goal of individual policies, so long as they engaged in good-faith marketing efforts, conflicted with assessment scheme of Individual Health Insurance Reform Act; statute's pro rata assessment provision mandated assessment based on difference between target number and actual number of policies written. New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1, 847 A.2d 552.

Good-faith marketing requirements in Individual Health Coverage Program (IHCP) regulations were within authority of New Jersey Individual Health Coverage Program Board of Directors; Board's development of a program that gave incentives and required carriers to prove that they made a good-faith effort to enroll their target amount of individual or non-group policyholders was within the Legislature's intent in establishing Individual Health Insurance Reform Act. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

11:20-9.6 (Reserved)

New Rule, R.1994 d.352, effective June 17, 1994.

See: 26 N.J.R. 2737(a), 26 N.J.R. 2904(a).

Amended by R.1994 d.509, effective September 15, 1994.

See: 26 N.J.R. 3809(a), 26 N.J.R. 4193(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 (a); and in (c), substituted references to New Jersey individual health benefits plans for references to health benefits plans.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted references to basic and essential health care services plans following references to health plans throughout.

Repealed by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Section was "Good faith marketing report".

SUBCHAPTER 10. PERFORMANCE STANDARDS AND REPORTING REQUIREMENTS

11:20-10.1 Purpose and scope

(a) The purpose of this subchapter is to establish performance standards and reporting requirements which a member shall meet in order to receive reimbursement for losses reported pursuant to N.J.A.C. 11:20-8 in the year following the two-year calculation period.

(b) This subchapter applies to all members that seek reimbursement for losses.

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 "in the year following the two-year calculation period" for "for calendar year 1993 and thereafter".

11:20-10.2 Definitions

Words and terms used in this subchapter shall have the meanings defined in N.J.S.A. 17B:27A-2 and N.J.A.C. 11:20-1.

11:20-10.3 Filing requirements and Board review

(a) Every member seeking reimbursement for losses, in accordance with N.J.A.C. 11:20-2.17, shall provide a Performance Report to the IHC Program Board, no later than May 1, in the year following the two-year calculation period which contains a statement certified by member's Chief Executive Officer that:

1. The member's performance for the preceding two-year calculation period reflected good faith efforts to apply sound risk management principles in an efficient manner; and

2. If applicable, the member applied the same individual case management and claims handling techniques and other methods of operation to its group and non-group

business, for the same delivery system, as provided in its health benefits plan policies and contracts.

(b) The IHC Program Board shall adjust a member's reported net paid losses to account for the member's failure to meet performance standards and filing requirements.

(c) A carrier shall not be eligible for any reimbursement of losses until a performance report is provided pursuant to (a) above and has been found consistent with the requirements of (a) above by the IHC 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 (a); and in (b), deleted "1" following "(a)"; and added a new (e).

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote (a); deleted (b)-(c) and recodified existing (d)-(e) as (b)-(c).

11:20-10.4 Hearings

Any member that is denied reimbursement for losses, in whole or in part, on the grounds that the member has failed to meet the performance standards and filing requirements of this subchapter, may appeal the Board's determination and request a hearing within 20 days of receipt of written notification of the Board's final determination, pursuant to the procedures set forth at N.J.A.C. 11:20-20.2.

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.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Substituted "receipt of written notification of the Board's" for "the date that the IHC Program Board notifies the member of its".

11:20-10.5 (Reserved)

Repealed by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Section was "Penalties".

SUBCHAPTER 11. RELIEF FROM OBLIGATIONS IMPOSED BY THE INDIVIDUAL HEALTH INSURANCE REFORM ACT

11:20-11.1 Purpose and scope

(a) This subchapter establishes the informational and procedural requirements for members requesting relief from obligations to pay assessments pursuant to N.J.S.A. 17B:27A-12 (including assessments for IHC Program losses and administrative expenses), or to offer coverage or accept applications to provide a standard health benefits plan to eligible persons, pursuant to N.J.S.A. 17B:27A-8.

(b) This subchapter applies to all members of the IHC Program.

Amended by R.1998 d.454, effective September 8, 1998.

See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (a), deleted an N.J.S.A. reference.

11:20-11.2 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.

"Applicant" means the member seeking a deferral of its obligation to pay assessments or a waiver of its obligation to offer coverage and accept applications pursuant to N.J.S.A. 17B:27A-2 et seq.

"Financially impaired" means a member that is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or a member which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Relief" means a deferral of obligations imposed pursuant to N.J.S.A. 17B:27A-12, or a waiver of obligations pursuant to N.J.S.A. 17B:27A-8, as applicable.

Amended by R.1998 d.454, effective September 8, 1998.

See: 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In (b), deleted "which, after December 20, 1993" following "member" in "Financially impaired" definition; and deleted an N.J.S.A. reference in "Relief" definition.

11:20-11.3 Application procedures and filing format

(a) Any member seeking relief may submit such request to the Department at any time, except that requests for relief from payment of assessments pursuant to N.J.S.A. 17B:27A-12a(3) shall be submitted to the Department no later than 15 days following the due date of payment of the assessment.

(b) All requests outlined in this subchapter shall be accompanied by a statement averring a need for relief from the obligation(s), as the case may be, including supporting documentation as set forth in N.J.A.C. 11:20-11.4, and shall specify the statutory and regulatory basis for such relief. A single filing may request relief from more than one obligation, but shall specify each obligation from which relief is sought.

(c) Each request shall be in loose leaf form inserted into standard two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in N.J.A.C. 11:20-11.4. The loose leaf sheets used in the request shall be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(d) All members requesting relief pursuant to this subchapter shall submit five copies of each request in the format set forth in (c) above.

“Eligible to participate in a group health benefits plan” means, with respect to a group health benefits plan offered by an employer to an employee and to the employee’s dependents, if any, that the employee is a member of a class of persons eligible for coverage, works at least the minimum number of hours required for coverage and that the employee has been employed for at least the minimum period required by the employer to be eligible for coverage, and the employee’s dependents have satisfied all lawful standards for participation in the group health benefits plan. With respect to group coverage issued by an HMO carrier, a person who resides outside the HMO’s service area shall not be considered eligible to participate in a group health benefits plan.

“Group health benefits plan” means a health benefits plan as defined in N.J.A.C. 11:20-1.2 as well as a self-funded health benefits plan for groups of two or more persons.

“Open enrollment period” means the calendar month of November 1 through November 30 of each calendar year, beginning in 2006, and annually thereafter.

“Same as or similar to the individual plan” means the group plan under which a person is covered or eligible to participate features cost sharing provisions consistent with those in the standard individual health benefits plan or basic and essential healthcare services plan for which the person has made application.

1. For a plan that uses coinsurance and deductible cost provisions, this means the coinsurance percentage in the group plan is identical to the coinsurance requirement in the individual plan and the deductible under the group plan differs from the deductible in the individual plan by no more than \$100. When comparing coinsurance provisions in a plan that features network and non-network benefits, the coinsurance and deductible applicable to network services and supplies must be considered. Plans that feature different cost sharing provisions, such as coinsurance and deductible in one plan and copayment in the other plan, are not the same or similar.

2. For a plan that uses copayment provisions, this means the copayment for primary care services under the group plan is either: the same as the copayment for primary care services under the individual plan; or less than \$10 more or less than the copayment for primary care services under the individual plan. When reviewing copayment provisions in a plan that features network and non-network benefits, the copayment applicable to network services and supplies must be considered. Plans that feature different cost sharing provisions, such as coinsurance and deductible in one plan and copayment in the other plan, are not the same or similar.

3. In addition to 1 and 2 above, for contributory group plans, the group plan is only the same or similar to the individual plan if the employee’s share of the cost for the

group plan differs from the cost of the individual plan by \$100.00 or less per month.

4. Notwithstanding 1 and 2 above, for group plans that are closed panel HMO plans, the group plan is not the same or similar to the individual plan if the provider network for the group plan is not the same as the provider network for the individual plan.

“Special open enrollment period” means January 5, 2009 through March 31, 2009.

Amended by R.2009 d.45, effective December 29, 2008.
Sec: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Added definition “Special open enrollment period”.

11:20-12.3 Covered under an individual plan: replacement at any time

(a) Except as stated in N.J.A.C. 11:20-12.4(c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with the same type of plan using the same or greater deductible, same or greater coinsurance or same or greater copayments from another carrier, where there is no lesser deductible, coinsurance or copayment.

(b) Except as stated in N.J.A.C. 11:20-12.4(b) or (c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with any standard individual health benefits plan or basic and essential healthcare services plan for which the filed monthly premium is less than the filed monthly premium for the existing standard individual health benefits plan.

(c) A person who is covered under a basic and essential health care services plan without rider may elect at any time to replace the plan with a basic and essential healthcare services plan without rider.

(d) A person who is covered under an individual plan issued prior to August 1, 1993 may elect at any time to replace the plan with a standard individual health benefits plan or a basic and essential healthcare services plan.

(e) The existing standard health benefits plan, basic and essential healthcare services plan or plan issued prior to August 1, 1993 must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan as of the midnight on the day before the effective date of the new plan if the person covered under the new plan notified the existing carrier of the replacement within 30 days after the effective date of the new plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the new plan, the new plan shall be of no force and effect and premium paid shall be refunded.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).
In (b), inserted "filed" twice.

**11:20-12.4 Covered under an individual plan:
replacement only during Open Enrollment
Period or Special Open Enrollment Period**

(a) A person who is covered under a standard individual health benefits plan may only elect during the Open Enrollment Period or Special Open Enrollment Period to replace the plan with a standard individual health benefits plan or basic and essential healthcare services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan.

(b) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period or Special Open Enrollment Period to replace the HMO plan with an HMO plan featuring a lower copayment.

(c) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period or Special Open Enrollment Period to replace the HMO plan with an indemnity, preferred provider (PPO) or point of service (POS) plan. However, a person whose initial purchase in the individual market is an HMO plan may elect, at any time during the 90 days following the effective date of the individual plan, to replace the HMO plan with an indemnity, preferred provider (PPO) or point of service (POS) plan.

(d) A person who is covered under a basic and essential healthcare services plan without a rider may only elect during the Open Enrollment Period or Special Open Enrollment Period to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a rider.

(e) A person who is covered under a standard individual health benefits plan without a rider may only elect during the Open Enrollment Period or Special Open Enrollment Period to replace the plan with a standard individual health benefits plan with a rider or with a basic and essential healthcare services plan with a rider.

(f) A person who is covered under a basic and essential healthcare services plan with a rider may only elect during the Open Enrollment Period or Special Open Enrollment Period to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a different rider.

(g) The effective date of the replacement plan issued as a result of (a) through (e) above will be January 1 of the year following the Open Enrollment Period and no later than April 1, 2009 in the case of the Special Open Enrollment Period.

(h) The existing standard health benefits plan, basic and essential healthcare services plan must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan as of the midnight on the day before the effective date of the new plan if the person covered under the new plan notified the existing carrier of the replacement within 30 days after the effective date of the new plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the new plan, the new plan shall be of no force and effect and premium paid shall be refunded.

(i) Notwithstanding (a), (b), (d), (e) and (f) above, a person covered under a standard individual health benefits plan or a basic and essential health care services plan may elect to replace the standard individual health benefits plan or a basic and essential health care services plan with a standard individual health benefits plan that is a high deductible health plan sold in conjunction with a Health Savings Account, at any time during the 60 days following the date a high deductible health plan is first made available by the carrier to whom the person makes application for the high deductible health plan.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Section was "Covered under an individual plan: replacement only during Open Enrollment Period". In (a), (b), (c) and (d), inserted "or Special Open Enrollment Period"; in (c), substituted "an indemnity, preferred provider (PPO) or point of service (POS)" for "non-HMO" and "a non-HMO"; added new (e); recodified former (e) through (h) as (f) through (i); in (f), inserted "or Special Open Enrollment Period"; in (g), deleted "items" preceding "(a)" and inserted "and no later than April 1, 2009 in the case of the Special Open Enrollment Period"; and in (i), substituted "(b), (d), (e) and (f)" for "(b) (d) and (e)".

**11:20-12.5 Covered under or eligible to participate in a
group health benefits plan**

(a) A person who is covered under or eligible to participate in a group health benefits plan that is not the same as or similar to the individual plan for which application has been made may elect only during the Open Enrollment Period or Special Open Enrollment Period to be covered under a standard health benefits plan or a basic and essential healthcare services plan. The effective date of the individual plan will be January 1 of the year following the Open Enrollment Period or no later than April 1, 2009 in the case of the Special Open Enrollment Period.

(b) A person who is covered under or eligible to participate in a group health benefits plan that is the same as or similar to the individual plan for which the person has applied is not eligible to be covered under a standard individual health benefits plan or basic and essential healthcare services plan.

(c) A person who is covered under a group plan pursuant to State or Federal continuation laws may elect at any time to be covered under a standard individual health benefits plan or basic and essential healthcare services plan.

(d) When an application for individual coverage is made during the Open Enrollment Period, coverage under the group plan must be terminated no later than midnight on December 31 immediately prior to the effective date of the standard individual health benefits plan or basic and essential health-care services plan except as may be required under an extension of benefits under the group plan. When an application for individual coverage is made during the Special Open Enrollment Period, coverage under the group plan must be terminated no later than midnight on the day immediately prior to the effective date of the standard individual health benefits plan or basic and essential healthcare services plan except as may be required under an extension of benefits under the group plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of coverage under the group plan is not before the effective date of the standard individual health benefits plan or basic and essential healthcare services plan, the standard individual health benefits plan or basic and essential healthcare services plan shall be of no force and effect and premium paid shall be refunded.

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (a), substituted "Period or Special Open Enrollment Period" for "period", and inserted "or no later than April 1, 2009 in the case of the Special Open Enrollment Period"; and in (d), inserted the second sentence.

SUBCHAPTERS 13 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 or renew standard health benefits plans or the basic and essential health care services plans to individuals.

Amended by R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (b), inserted "or renew" following "issue" and "or the basic and essential health care services plans" following "benefits plans".

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.

"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 any individual covered under an individual health benefits plan.

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.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b), deleted "Conversion" and "Replacement contract" and rewrote "Insured".

11:20-17.3 Filing requirements

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

(b) Members shall file 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 gender category in the format of Part 2 of Exhibit L which shall reflect data as of December 31 of the prior 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).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), inserted "and the basic and essential health care services plans" following "standard health benefits plan".

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b), deleted "hard copy" following "Members shall file"; in (c), substituted "gender" for "sex" and "the prior" for "each".

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 or PPO or POS for Plans A/50, B, C and D, the HMO plans reported by copay or coinsurance, as well as indemnity, PPO, EPO or HMO coverage under the basic and essential health care services plan, 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 issued during the period, and subtracting the number of contracts lapsed during the period.

i. Contracts issued shall be reported according to previous insured status. Previous insured status shall be separated into three categories: previously insured, previously uninsured, and unknown. Previous insured status shall be obtained from the section of the application that requires the applicant to indicate if the applicant had previous 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 uninsured. If the question has not been answered, the contract shall be reported as unknown.

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; two adults = 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 Tier shall be reported separately by rating tier, that is: single; two adults; adult and child(ren); and family; and

4. In section D of Part 1 of Exhibit L, Report of Contracts By Deductible/Copayment Option, shall be reported separately by the required and permitted deductible options for Plans A/50, B, C, and D or the required and permitted copayment options for the HMO Plan. Members issuing

PPO or POS plans shall report according to the copayment or deductible applicable to network physician visits. Members issuing HMO plans that include deductible and coinsurance provisions shall report according to the deductible applicable to services and supplies for which coinsurance applies. Members issuing basic and essential health care plans shall report contracts for plans issued with and without riders.

(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, separately for each of the standard health benefits plans, broken down by indemnity or PPO or POS for Plans A/50, B, C and D, the HMO plans, as well as the indemnity, PPO, POS or EPO or HMO basic and essential health care services plan, both with and without any rider:

1. In section A of Part 2 of Exhibit L, Report of Inforce Contracts by Zip Code, categorized by Territory A – F or the first three digits of the zip code;

2. In section B of Part 2 of Exhibit L, Report of insured males, separated by age distribution as of December 31 of the previous year;

3. In section C of Part 2 of Exhibit L, Report of insured females, separated by age distribution as of December 31 of the previous year; and

4. In section D of Part 2 of Exhibit L, Report of Contracts as amended by one or more optional benefit riders.

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 (b).

Amended by R.1998 d.503, effective September 16, 1998 (operative November 1, 1998).

See: 30 N.J.R. 3235(b), 30 N.J.R. 3838(a).

In (a) and (b), inserted references to indemnity for Plan A/50 in the introductory paragraphs.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a) and (b), inserted references to indemnity or HMO coverage under the basic and essential health services plan following "HMO plans" in the introductory paragraph.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote the section.

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In the introductory paragraph of (a), (a)4 and the introductory paragraph of (b), inserted "or POS"; in the introductory paragraph of (b), inserted " , POS"; in (b)2, deleted "and" from the end; in (b)3, substituted " , and" for a period at the end; and added (b)4.

11:20-17.5 (Reserved)

Repealed by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Section was "Penalties".

11:20-22.5 Riders to amend the basic and essential health care services plan

(a) Members may develop optional benefit riders to amend the basic and essential health care services plan provided the riders increase the benefits provided under the basic and essential health care services plan and do not contain any feature that would represent a decrease in the coverage or the actuarial value of the plan. The enhanced or additional rider benefits must be included in a manner which will avoid adverse selection to the extent possible.

(b) Before a member may offer or issue a rider to amend the basic and essential health care service plan, the member shall file the rider with the Board for approval. The member shall submit:

1. A copy of the rider to amend the basic and essential health care services plan to the Board at the address specified at N.J.A.C. 11:20-2.1(h);

2. A copy of the provision from the basic and essential health care services plan that the rider is amending, notated to highlight the area of the change;

3. A certification signed by a duly authorized officer of the member that states clearly that:

i. The member shall make the basic and essential health care services plan available to residents of New Jersey and will make a good faith effort to market the plan both with and without the rider;

ii. Rates for the rider amending the basic and essential health care services plan have been submitted pursuant to the requirements of N.J.A.C. 11:20-6;

iii. The rider increases a benefit or benefits and does not decrease any benefits or the actuarial value of the basic and essential health care services plan;

iv. The member shall offer the rider in a manner which will avoid adverse selection to the extent possible;

v. None of the ridered benefits exceed the benefits in the standard Plan A/50 through Plan D plans, or HMO plan, as applicable (benefits would include any benefits set forth in the standard Plan A/50 through Plan D "Covered Charges" or "Charges Covered with Special Limitations" sections of the policy or set forth in the standard HMO "Covered Services and Supplies" section of the contract); and

vi. If an HMO, none of the ridered benefits are provided with a copayment that is lower than the lowest HMO copayment option allowed by the Board's rules; and

4. A comprehensive list of benefits in the proposed rider compared with the carrier's standard A/50 through D plan or standard HMO plan, as applicable.

(c) The Board shall notify a member in writing of its determination whether the rider filing is approved within 30 days of the date the filing is received. If the Board does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

(d) A member seeking to challenge the Board's disapproval of a rider filing must do so within 20 days of receiving the notice of the disapproval pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

(e) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later than 60 days following the close of each calendar quarter:

1. For standard indemnity plans, standard PPO plans, standard POS plans, standard HMO plans, basic and essential health care services plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar quarter;

ii. Paid claims for the calendar quarter;

iii. New business enrollment reporting both the number of contracts and number of lives for the calendar quarter, which shall include the enrollment of persons who applied for and were issued coverage, whether or not the persons were new customers to the carrier or had coverage under other plans issued by the carrier and terminated the prior plans in favor of the plan for which application was made; and

iv. Total enrollment (total in force) reporting both number of contracts and number of lives as of the last day of the calendar quarter; and

2. For basic and essential health care services plans issued during the calendar quarter with a rider, the carrier shall submit:

i. The number of persons enrolled who were previously uninsured; and

ii. For all persons previously insured, the numbers of persons whose prior source of coverage was group; COBRA/state continuation; standard IHC plan; unridered basic and essential health care services plans plan, or other basic and essential health care services plans with rider.

(f) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later than 90 days following the close of the calendar year:

1. For standard indemnity plans, standard PPO plans, standard POS plans, standard HMO plans, basic and essential health care services plans, plans issued without a

rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

- i. Earned premium for the calendar year; and
- ii. Incurred claims for the calendar year.

(g) The Board shall evaluate the filings to determine whether the carrier has avoided adverse selection to the extent possible.

(h) If the Board finds that a carrier's rider has resulted in adverse selection, then the carrier shall cease issuing the rider within 60 days of receipt of the Board's written determination letter, but shall continue to renew the plan and rider for contractholders that had already purchased the plan with the rider.

(i) A member seeking to challenge the Board's finding that the rider has resulted in adverse selection must do so within 20 days of receiving the Board's written determination pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (b)1, substituted "A" for "One"; in (b)3, added iv-vi; added (b)4; added (d)-(i).

Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

In (e)1 and (f)1, inserted ", standard POS plans".

11:20-22.6 Good faith effort to market the basic and essential health care services plan

(a) In order for the Board to determine whether a member has made a good faith effort to market the basic and essential health care services plan, as required by section 2g of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.5g), every member shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year a report detailing the activities the member undertook during the prior calendar year to market the basic and essential health care services plan. Members may satisfy the requirement by marketing the plan as an HMO plan, a PPO plan, an EPO plan, or as an indemnity plan.

(b) The report shall include only those marketing activities which were in direct support of the sale of the basic and essential health care services plan during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the report submitted by each member to determine whether the member has demonstrated that it made a good faith effort to market the basic and essential health care plan and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a carrier has marketed in good faith if:

i. The carrier provides evidence that that it has included the basic and essential health care services plan on the carrier's standard application in the prior calendar year;

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the basic and essential health care services plan during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes or other communications advising the producers of the availability of the plan; or information specific to the basic and essential health care services plan on the carrier's website. Members may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the basic and essential health care services plan; and

iii. The carrier provides a certification in which it certifies that it either did or did not use any New Jersey individual market marketing materials during the prior year that identified a list of plan choices. If the carrier did use any marketing materials that included a list of plan choices, the carrier shall provide evidence that the basic and essential health care services plan was listed as one of the plan choices.

2. A member will be found to have not to have made a good faith effort if the report does not meet the standards set forth in (c)1 above or if the member fails to submit a report by May 1 of each year.

Amended by R.2006 d.15, effective January 3, 2006.

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote (a); in (c)1ii, deleted "may" in the second sentence; in (c)1iii, substituted "provides a certification in which it certifies that it either did or did not use any" for "certifies whether it used any".

11:20-22.7 Penalties

Members found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plan will be subject to the provisions of N.J.S.A. 17B:30-1.

SUBCHAPTER 23. RULEMAKING; INTERESTED PARTIES; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

11:20-23.1 Purpose and scope

(a) The purpose of N.J.A.C. 11:20-23.2 through 23.5 is to establish the procedures that the Board uses in rulemaking made pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The purpose of N.J.A.C.

EXHIBIT K

New Jersey Individual Health Coverage Program Assessment Report
For the Two-Year Calculation Period 20XX-20XX

All carriers reporting accident and health premium to the New Jersey Department of Banking and Insurance shall submit this report and attachments in accordance with the provisions of N.J.A.C. 11:20-8. Reports must be completed and returned on or before April 1, 20XX.

Part A. Carrier Information

Carrier's Name:	
NAIC Number:	
Affiliated Carriers: (Name and NAIC Number)	

Part B. Information of Person completing this Report

Name:			
Title:			
Phone:		Fax:	
Email:			
Mailing Address:			

Part C. Program Membership for the Two-Year Calculation Period (Attach worksheet(s))

Members and Non-members with reportable accident and health premium in New Jersey MUST complete and return one copy of the attached "Exhibit K-Part C Premium Data Worksheet" for each of the affiliates listed above. If any of the affiliates has any net earned premium for the two-year period, the carrier is a Member and shall record the amount below. If no affiliates have net earned premium, then the carrier is a Non-member and the carrier shall check the Non-member box below.

Member's net earned premium, including all affiliates, for the two-year period:	\$
OR Non-member of the IHC Program with no net earned premium.	

Part D. Number of Non-group Persons Enrolled by Member Carrier (Attach worksheet(s))

Members MUST complete and return one copy of the attached "Exhibit K Part D Enrollment Data Worksheet" for each of the affiliates listed above that issued or renewed non-group enrollment.

Average non-group enrollment for the two-year period:	
---	--

Part E. Member's Net Paid Gain (Loss) for Individual Health Benefits Plans

a. Premium Earned	\$
b. Claims Paid	\$
c. Net Investment Income	\$
d. Net Paid Gain (Loss) [115% (a+c)]-b	\$

Part F. Certification

I certify that I am an officer of the company, that the information provided in this report and all attachments is accurate and complete, and that it has been prepared in accordance with the provisions of N.J.A.C. 11:20-8.

Printed Name:		
Title:		
Signature:		Date:

Exhibit K Part C Premium Data Worksheet

The purpose of this Part C Premium Data Worksheet is to demonstrate whether a carrier is a member of the IHC Program by virtue of having any "net earned premium" during the two-year calculation period. "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. Health benefits plans include, but may not be limited to the following coverages: health insurance for individuals or groups of any size; Medicaid; and New Jersey FamilyCare Part A. Net earned premium shall not include premium earned from plans excluded from the definition of "health benefits plan" as set forth at N.J.A.C. 11:20-1.2.

Directions:

Copy the attached worksheet, if necessary, and provide the following information for each affiliate:

- The name of the affiliate.
- Section 1: The total accident and health premium reported on the annual NAIC statement blank for both calendar years of the two-year calculation period for that affiliate.
- Section 2: The total premium amounts earned in each calendar year of the two-year calculation period for each of the excepted types of coverage listed on the worksheet for each affiliate.
- Section 3: To arrive at the net earned premium in section 3, subtract the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1. All premium that is not from some type of excepted coverage is net earned premium from health benefits plans.
- Each affiliate’s worksheet shall be attached to the carrier’s one-page Exhibit K.

Members shall report the combined two-year net earned premium calculated from each affiliate’s Exhibit K Part C Premium Data Worksheet on Part C of the Exhibit K Assessment Report.

If the combined two-year net earned premium total from each affiliate’s Exhibit K Part C Premium Data Worksheet is zero either because all of the premium is from excepted coverages or because the carrier had no accident and health premium, then the carrier shall assert Non-member status by checking the Non-member box on Exhibit K Part C, and completing the certification in Part F.

Exhibit K Part C Premium Data Worksheet for the Two-Year Calculation Period 20XX-20XX

Name of Affiliate: _____ Name of Carrier on Exhibit K: _____

Carriers shall complete and return this page for each affiliate along with Exhibit K.

Section 1: Total A&H Premium	Premium for 20XX	Premium for 20XX	Two-Year Total
Amount of Accident & Health Premium on New Jersey NAIC Statement Blank:	\$	\$	\$

Section 2: List of Excepted Benefits and Premium	Premium for 20XX	Premium for 20XX	Two-Year Total
a. Medicare Advantage and Medicare + Choice coverage and Medicare Demonstration and Medicare Part D Coverage	\$	\$	\$
b. contracts funded pursuant to the “Federal Employee Health Benefits Act of 1959,” 5 U.S.C. §§ 8901-8914	\$	\$	\$
c. excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan	\$	\$	\$
d. Medicare supplement policies or contracts	\$	\$	\$
e. non-expense incurred specified disease coverage	\$	\$	\$
f. coverage only for accident, disability income insurance, or any combination	\$	\$	\$
g. coverage issued as a supplement to liability insurance	\$	\$	\$
h. liability insurance, including general liability insurance and automobile liability insurance	\$	\$	\$
i. workers’ compensation or similar insurance	\$	\$	\$
j. automobile medical payment insurance	\$	\$	\$
k. credit-only insurance	\$	\$	\$
l. coverage for on-site medical clinics	\$	\$	\$
m. other similar insurance coverage, as specified in federal regs., under which benefits for medical care are secondary or incidental to other insurance benefits	\$	\$	\$
n. limited scope dental or vision benefits*	\$	\$	\$
o. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof *	\$	\$	\$
p. such other similar, limited benefits as are specified in federal regulations*	\$	\$	\$
q. 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	\$	\$	\$
r. coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.)	\$	\$	\$

Section 2: List of Excepted Benefits and Premium	Premium for 20XX	Premium for 20XX	Two-Year Total
s. similar supplemental coverage provided to coverage under a group health plan	\$	\$	\$
Total excepted premium:	\$	\$	\$

* Include as an excepted benefit if the coverage is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of the plan.

Section 3: Calculation of "Net Earned Premium"	Premium for 20XX	Premium for 20XX	Two-Year Total
Net Earned Premium = (Section 1 premium – Section 2 premium)	\$	\$	\$

**Exhibit K Part D Enrollment Data Worksheet
for the Two-Year Calculation Period 20XX-20XX**

Name of Affiliate: _____ Name of Carrier on Exhibit K: _____

Carriers shall complete and return this page with Exhibit K.

For a through e below, provide the number of covered lives as of the end of each calendar quarter during the Two-Year Calculation Period for each of the categories of coverage described below, and the two-year total for each category. Non-members should be reporting no covered lives in any of the categories below because premium from all of the coverage listed below result in net earned premium.

a. Persons covered under standard individual health benefits plans or basic and essential health care services plans

Q1	Q2	Q3	Q4	Total Q1-Q8
Q5	Q6	Q7	Q8	

b. Community rated conversion policy persons

Q1	Q2	Q3	Q4	Total Q1-Q8
Q5	Q6	Q7	Q8	

c. Medicaid recipients (Include NJ FamilyCare Part A, but no other NJ FamilyCare lives)

Q1	Q2	Q3	Q4	Total Q1-Q8
Q5	Q6	Q7	Q8	

d. Medicare Advantage and Medicare Plus Choice lives, Medicare Risk and Cost lives, Medicare Demonstration Project lives (Do not include Medicare Supplement)

Q1	Q2	Q3	Q4	Total Q1-Q8
Q5	Q6	Q7	Q8	

e. Two-Year non-group enrollment total

(Total Q1- Q8 for a through d): _____

f. Average two-year non-group enrollment to be reported on Exhibit K Part D

(Line e divided by 8): _____

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).
Section was "Exhibit K: New Jersey Individual Health Coverage Program; Carrier Market Share and Net Paid Gain (Loss) Report".

Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
Amended by R.2009 d.45, effective December 29, 2008.
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

New Jersey Individual Health Coverage Program
Quarterly Enrollment Report - Part 1 of Exhibit L

Carrier:
Respondent:
Phone: Fax:
Email:

Quarter Reported:

A. Report by Contracts	Issued Prior to 8/1/93	Standard Plans													Basic & Essential Plans		Totals
		Plan A/50		Plan B		Plan C		Plan D		HMO Plans					Indemnity, PPO/EPO	HMO Plans	
		Indemnity	PPO	Indemnity	PPO	Indemnity	PPO	Indemnity	PPO	Copay	50% Coins	40% Coins	30% Coins	20% Coins			
I. Contracts Inforce Beginning of Period	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. Contracts Issued During Period	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1. Contracts Issued to Previously Uninsured Individuals	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2. Contracts Issued to Previously Uninsured Individuals	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Contracts Issued with Unknown Prior Insured Status	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Contracts Lapsed During Period	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Contracts Inforce End of Period (I+II-III)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
B. Report by Persons Insured																	
I. Insureds Beginning of Period	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. New Insureds During Period	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Insureds Lapsed During Period	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Insureds End of Period (I+II-III)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
C. Report of Contracts by Rating Tier																	
I. Single Contracts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. Two Adult Contracts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Adult and Child(ren) Contracts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Family Contracts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
V. Contracts Inforce End of Period (I+II+III+IV)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
D. Report of Contracts by Deductible/Copayment Option																	
I. Contracts with \$1,000 Deductible	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
II. Contracts with \$2,500 Deductible	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
III. Contracts with \$5,000 Deductible	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IV. Contracts with \$10,000 Deductible	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
V. Contracts with \$15 Copay	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
VI. Contracts with \$30 Copay	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
VII. Contracts with \$40 Copay	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
VIII. Contracts with \$50 Copay	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IX. Contracts with HDHP Deductibles (MSA provisions) - <i>renewal business only</i>	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
X. Contracts with HDHP Deductibles (HSA Provisions)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
XI. Contracts Issued as Basic & Essential Plans - <i>without any rider</i>	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
XII. Contracts Issued as Basic & Essential Plans - <i>with a rider</i>	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
XIII. Contracts with \$500 Deductible, \$10 or \$20 Copay - <i>runoff business only</i>	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
XIV. Contracts Inforce End of Period (I+II+III+IV+V+VI+VII+VIII+IX)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
% of Contracts Issued to Persons Previously Uninsured	-	Revised 5/31/05															

(*NOTE: A.IV = C.V = D.IV)

EXHIBIT L