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

11:21–7.13 Paying benefits

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

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

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

Recodified from 11:21–7.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.12.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), rewrote the introductory paragraph.

11:21–7.14 Permissible rate classification factors

(a) For health benefits plans issued or renewed on or after September 11, 1994, a carrier shall not differentiate premium rates charged to different small employers for the same health benefits plan except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25–29; 30–34; 35–39; 40–44; 45–49; 50–54; 55–59; 60–64; 65–69; 70 and over.

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

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

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

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

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

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

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

(b) Notwithstanding (a) above, a carrier may differentiate premium rates charged to different small employers for the same standard health benefits plan, whether it be A, B, C, D, E or HMO, on the basis of family structure according to only the following four rating tiers:

1. Employee only;

2. Employee and spouse;

3. Employee and child(ren); and

4. Family.

New Rule, R.1994 d.418, effective July 15, 1994 (operative September 11, 1994).
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Recodified from 11:21–7.15 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.13.

11:21–7.15 (Reserved)

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

SUBCHAPTER 7A. LOSS RATIO REPORTS; DIVIDENDS AND CREDITS

11:21–7A.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of N.J.S.A. 17B:27A–19.3 and 25.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Substituted a reference to N.J.S.A. 17B:27A–19.3 and 25 for a reference to the Act.

11:21–7A.2 Definitions

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

"Closed nonstandard health benefits plan" means a closed nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

"Open nonstandard health benefits plan" means an open nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

"Preceding calendar year" means the calendar year-wrmmediately preceding the reporting year.

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

"Small employer purchasing alliance," "purchasing alliance" or "alliance" means a small employer purchasing alliance as established pursuant to N.J.S.A. 17B:27A–25.3.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Inserted "Closed nonstandard benefits plan" and "Open nonstandard health benefits plan"; and deleted "Total employee months exposed".
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Added "Small employer purchasing alliance". d.342

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

(a) Each carrier having the five standard health benefits plan policy forms, open or closed nonstandard health benefits plan policy forms or HMO plans in force at any time during the preceding calendar year shall file with the Department an annual loss ratio report on the form appearing as Exhibit GG in the Appendix to this chapter, incorporated herein by reference. The annual loss ratio report, beginning with 1997 data reported in 1998, shall:

1. Aggregate standard health benefit plans, other than alliance plans, including all standard and nonstandard riders and endorsements thereto;

2. Aggregate open nonstandard health benefits plans, including all riders and endorsements thereto;

3. Aggregate closed nonstandard health benefits plans including all riders and endorsements thereto; and

4. Aggregate alliance health benefits plans, including all riders and endorsements thereto.

(b) The loss ratio report shall be completed and filed with the Department on or before August 1 of the reporting year for the preceding calendar year.

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

Attention: SEH Loss Ratio Report Filings
Life and Health Division
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote (a); and in (b), deleted exception at the end of the sentence.
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
In (a), inserted "other than alliance plans" preceding "including", "and endorsements" preceding "thereto" in 1 and added 4.

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

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

1. The reporting carrier's name and address;

2. The carrier's earned premiums, before dividends or credits applicable to prior years, and claims for the preceding calendar year, calculated pursuant to the instructions of Exhibit GG;

3. The carrier's loss ratio determined by dividing the claims by the premiums;

4. The carrier's calculation of the dividends and credits to be issued pursuant to N.J.S.A. 17B:27A–25g(2). (A credit is a dividend paid in the form of a reduction in a current premium due, as distinguished from dividends paid in cash.);

5. An explanation of the carrier's plan to issue dividends and credits;

6. An explanation of the carrier's plan to distribute a dividend in the event of cancellation or termination by a policyholder;

7. Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A–25g(2), N.J.A.C. 11:21–7A and instructions; and

8. Such other information as the Department may request.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
In (a)2, substituted a reference to dividends for a reference to refunds, and added ", calculated pursuant to the instructions of Exhibit GG" at the end.

11:21–7A.5 Dividend or credit plan

(a) If the preceding calendar year loss ratio for any of the classifications listed in N.J.A.C. 11:21–7A.3(a) is less than 75 percent, the carrier shall include within the loss ratio report a plan to be approved by the Department for the distribution of all dividends and credits against future premiums for all policyholders with that classification in the preceding calendar year in an amount sufficient to assure that the claims in the preceding calendar year plus the amount of the dividends and credits shall equal 75 percent of the premiums for that classification in the preceding calendar year.

1. Carriers that issue health benefits plans through out-of-State trusts, associations or other multiple employer arrangements shall specify in the plan for distribution of dividends and credits that dividends and credits for such health benefits plans shall be paid or credited, as applicable, to the small employers covered under the health benefits plans, not the trust, association or other multiple employer arrangement.

2. Carriers that issue health benefits plans to small employers that are members of purchasing alliances shall specify in the plan for distribution of dividends and credits that dividends and credits for such health benefits plans shall be paid or credited, as applicable, to the small employers covered under the health benefits plans, not the trust, association or other multiple employer arrangement.

(b) The experience for all non-alliance standard health benefits plans shall be combined for dividend purposes.

(c) The experience for all alliance health benefits plans shall be combined for dividend purposes. The experience for alliance health benefits plans shall not be combined with the experience for non-alliance standard health benefits plans, or the experience of open or closed non-standard health benefits plans, for dividend purposes.

(d) The experience for all open nonstandard health benefits plans shall be combined for dividend purposes. Open nonstandard health benefits plans shall not be combined with any standard health benefits plans or closed nonstandard health benefits plans.

(e) The experience for all closed nonstandard health benefits plans shall be combined for dividend purposes. Closed nonstandard health benefits plans shall not be combined with any standard health benefits plans or open nonstandard health benefits plan.

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

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

(h) All dividends and credits shall be distributed by December 31 of the reporting year.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote (a) through (c); inserted a new (d); recodified former (d) through (f) as (e) through (g); in (e), substituted a reference to small employers for a reference to policyholders; in (f), substituted a reference to dividends and credits for a reference to refunds; and rewrote (g).
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
In (a), added 2; inserted a new (c) and recodified former (c) through (g) as (d) through (h).

SUBCHAPTER 8. CARRIER CERTIFICATION OF NON–MEMBER STATUS

11:21–8.1 Purpose and scope

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

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

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to "other entities"; and in (b), deleted reference to accident insurance.

11:21–8.2 Definitions

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

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Group health benefits plan" and "Small employer".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21–8.3 Non-member status

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

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

1. The carrier neither issued nor had in force a group health benefits plan covering New Jersey small employers during the calendar year for which certification is submitted;

2. Other reasons which under law permit a carrier or entity to be certified a non-member.

Amended by R.1994 d.583, effective October 27, 1994.
See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), substituted "shall" for "may" following "carrier" in the second sentence.

11:21–8.4 Non-member certification requests

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

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

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

Attn: SEH Annual Certification of Non-Member Status
Life/Health Actuarial Services
New Jersey Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625–0325

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to non-members for calendar year 1993; and in (b), inserted reference to statements required by N.J.A.C. 11:21–8.3.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted a reference to the Executive Director in the second sentence.

11:21–8.5 Decisions on filings by the Board

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

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.

11:21–8.6 Review

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

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

(c) Within 45 days of its receipt of a request for a hearing, the Board shall determine whether bona fide issues of material fact exist such that a hearing shall be conducted. If bona fide factual issues do not exist, the Board shall review the challenge itself and may delegate this review to an appropriate Board committee to make a recommendation to the Board. If a hearing is appropriate, the Board shall determine whether to hear the matter itself or refer it to the Office of Administrative Law for a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (c), substituted a reference to 45 days for a reference to 30 days in the first sentence.

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

11:21–9.1 Purpose and scope

(a) The purpose of this subchapter is to establish informational rate filing requirements and procedures applicable to health benefits plans, including riders or endorsements, issued, renewed, reinstated or continued pursuant to N.J.S.A. 17B:27A–17 et seq.

(b) This subchapter applies to all carriers issuing, renewing, reinstating or continuing health benefits plans to small employers pursuant to N.J.S.A. 17B:27A–17 et seq.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Substituted references to N.J.S.A. 17B:27A–17 et seq. for references to the Act throughout.

11:21–9.2 Definitions

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

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

"Closed nonstandard health benefits plan" means a closed nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

(b) Any carrier that quotes, bills or collects a premium to or from a small employer that is more than the rate shown in the carrier's informational SEH rate filing in effect at the time the premium is billed or collected shall:

1. Immediately cease charging the incorrect rate and charge the correct rate;

2. Provide written notice to the small employer of the error as soon as possible but no later than 30 days after discovery of the error; and

3. Send the small employer a refund or post a premium credit within 30 days after discovery of the error for the full amount of all overcharges.

(c) If more than 50 small employer groups were undercharged or overcharged as a result of the error, a carrier shall provide the Department at the address listed at N.J.A.C. 11:21–9.4(a) with a certification describing the nature and scope of the error, including a list of all small employers affected and a sample copy of the notice to all small employers.

(d) The requirements of this section shall not apply to any deviation in rates from the filed rates that is less than one-quarter of one percent (.25 percent) or that arises from a rounding error of less than $1.00.

New Rule, R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Former N.J.A.C. 11:21–9.6, Public disclosure of filed information, recodified to N.J.A.C. 11:21–9.7.

11:21–9.7 Public disclosure of filed information

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

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

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Recodified from N.J.A.C. 11:21–9.5 by R.2002 d. 342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Former N.J.A.C. 11:21–9.6, Penalties, recodified to N.J.A.C. 11:21–9.7.
Recodified from N.J.A.C. 11:21–9.6 by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Former N.J.A.C. 11:21–9.7, Penalties, recodified to N.J.A.C. 11:21–9.8.

11:21–9.8 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of fines or other penalties provided by N.J.S.A. 17B:27A–43.

Recodified from N.J.A.C. 11:21–9.6 by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Recodified from N.J.A.C. 11:21–9.7 and amended by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Substituted "N.J.S.A. 17B:27A–43" for "law, including suspension or revocation of a carrier's authority to do business in the State of New Jersey".

SUBCHAPTER 10. THE MARKET SHARE REPORT

11:21–10.1 Scope and applicability

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

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

11:21–10.2 Definitions

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

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Small employer".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21–10.3 Filing of the Market Share Report

(a) Every member of the SEH Program shall file the Market Share Report set forth as Exhibit CC in the Appendix to this chapter, incorporated herein by reference, on or before March 1. Every member shall complete Parts A, B, C and D of the Market Share Report.

1. Affiliated carriers shall submit a combined Market Share Report, except as (a)2 below implies. The combined Market Share Report shall be submitted under the name of one of the affiliated carriers' members.

2. Any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in the State, and any health maintenance organization located in the State that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall submit separate Market Share Reports.

(b) Certified Market Share Reports shall be submitted by mail or facsimile to the SEH Program Administrator or Executive Director, as set forth at N.J.A.C. 11:21–2.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted "April 15, 1994 and annually thereafter no later than" following "before" in the first sentence of the introductory paragraph; and in (b), inserted a reference to the Executive Director.

11:21–10.4 Net earned premium

(a) Every member's net earned premium for the preceding calendar year ending December 31 shall be set forth in Part C of the Market Share Report.

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers.

2. Net earned premium reported in Part C of the Market Share Report shall be based upon, if not the same as, the data set forth in the member's annual reports adjusted to meet the definition of group health benefits plan, as necessary.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote (a)2.

11:21–10.5 Certification

All reports shall be certified as accurate, complete and conforming with the requirements of this subchapter by the Chief Financial Officer or other duly authorized officer of the member.

11:21–10.6 Failure to comply

Failure to comply with the reporting provisions of this subchapter shall result in the Board determining that the premium set forth in the member's most recent Annual Statement filed with the Department is the premium based upon which that member's market share allocation of assessments shall be calculated by the Board.

SUBCHAPTER 11. NONSTANDARD HEALTH BENEFITS PLANS (FILINGS WITH THE COMMISSIONER): REQUIREMENTS FOR MAINTAINING NONSTANDARD PLANS

11:21–11.1 Purpose and scope

(a) This subchapter applies to nonstandard health benefits plans which were in effect on December 31, 1993 and have been renewed, continued or reinstated and filed with the Commissioner for informational purposes in accordance with N.J.S.A. 17B:27A–19j(6)(a) on or before January 31, 1994 which may continue to be renewed, amended and moved to another carrier by a small employer or an association, out-of-State trust and multiple employer arrangement subject to the approval of the Commissioner, but which are not subject to N.J.S.A. 17B:27A–19b, and the rating of which shall be segregated from the rating of all other health benefits plans.

(b) This subchapter defines the procedures for filing and standards for approval of nonstandard health benefits plans which were in effect on December 31, 1993 and have been renewed, continued or reinstated and filed with the Commissioner for informational purposes in accordance with N.J.S.A. 17B:27A–19j(6)(a) on or before January 31, 1994 which the carrier, association, out-of-State trust or other multiple employer arrangement shall continue to issue, and renew, and may amend and which may be moved from one carrier to another by a small employer or an association, out-of-State trust and multiple employer arrangement subject to the approval of the Commissioner.

(c) This subchapter establishes the procedures for making a complete filing of nonstandard health benefits plans with the Commissioner for renewal, amendment or movement to another carrier, and the standards for review of the filings submitted.

(d) This subchapter sets forth standards for renewal of a nonstandard health benefits plan, and standards for determining what constitutes a request for renewal by a small employer.

Amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Substantially amended section.

11:21–11.2 Definitions

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

"Benefits coverage" means the services and supplies covered by a health benefits plan and certain general provisions, definitions and covered charges with special limitations (as specified in the Checklist and Certification set forth in Part 5 of Exhibit BB of the Appendix to N.J.A.C. 11:21, incorporated herein as part of this subchapter) governing the health benefits plan.

"Closed nonstandard health benefits plan" means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and was reinstated, renewed or continued at the option of the small employer(s) pursuant to N.J.S.A. 17B:27A–19j, but under which contracts or certificates have not been issued or offered on or after January 1, 1994 to a small employer group that was not covered under the health benefits plan prior to January 1, 1994, and which the carrier has certified shall not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

The term "closed nonstandard health benefits plan" also means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and reinstated, renewed or continued at the option of a small employer pursuant to N.J.S.A. 17B:27A–19j under which contracts or certificates have been issued subsequent to January 1, 1994 to small employers who were not covered under the health benefits plan prior to January 1, 1994, but under which no such small employers remain covered as of the effective date of this subchapter and which the carrier has certified shall not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

"Market," when used as a verb, means to offer or advertise as available a nonstandard health benefits plan for initial purchase by small employers or to a small employer who formerly purchased the nonstandard health benefits plan but who is not currently covered under the nonstandard health benefits plan. The term does not include continuation or renewal of a contract, policy or certificate under a nonstandard health benefits plan by a carrier for a small employer currently covered under the nonstandard health benefits plan.

"Nonstandard health benefits plan" means a health benefits plan policy or contract form under which policies or contracts were issued on or before December 31, 1993 to small employers or to one or more employees of a small employer by virtue of the employment arrangement, or a policy or contract form under which policies or contracts were issued on or before December 31, 1993 to an association, out-of-State trust or multiple employer arrangement and offered to small employers or to one or more employees of a small employer.

"Open nonstandard health benefits plan" means a nonstandard health benefits plan which has been issued or offered to a small employer group that was not covered under the health benefits plan on or before December 31, 1993, or which would otherwise meet the requirements for a closed nonstandard health benefits plan except that the carrier has not certified that the nonstandard health benefits plan shall not be offered for issue to any small employer that was not covered under the health benefits plan on December 31, 1993.

Amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
In introductory paragraph, substituted reference to N.J.A.C. 17B:27A–17 for reference to the Act; added "Benefits coverage", "Closed nonstandard health benefits plan", and "Open nonstandard health benefits plan"; deleted "Substantial threat to a carrier's financial condition" and "Withdraw"; and amended "Market" and "Nonstandard health benefits plan".

11:21–11.3 General standards for continuing and renewing a nonstandard health benefits plan

(a) A carrier shall continue and renew a nonstandard health benefits plan in accordance with this subchapter unless the carrier has:

1. Filed a request to withdraw the nonstandard health benefits plan in accordance with the requirements of N.J.A.C. 11:21–13, and the request has been approved by the Commissioner; or

2. The carrier has filed a notice of withdrawal from the small employer market in accordance with the requirements of N.J.A.C. 11:21–16 and N.J.S.A. 17B:27A–23e.

(b) Renewal of a nonstandard health benefits plan shall be provided at the request of a small employer that is covered by the nonstandard health benefits plan issued by the carrier at the time that the request is made.

1. A request made by a small employer that was covered by the nonstandard health benefits plan issued by the carrier, but who is not so covered at the time that the request is made, shall not be deemed a request for renewal.

2. A request made of a carrier by a small employer to renew a nonstandard health benefits plan issued by and inforce under another carrier at the time the request is made shall not be deemed a request for renewal.

(c) Notwithstanding (b) above, a carrier shall not be required to renew a nonstandard health benefits plan under the following circumstances:

1. Nonpayment or payment beyond expiration of the grace period, if any, of the required premium by the policyholder, contractholder or employer;

2. The policyholder, contractholder or employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(d) If the filing carrier is accepting the nonstandard health benefits plan upon the request of an association, trust or multiple employer arrangement, the filing carrier may amend the nonstandard health benefits plan form to be effective simultaneously with the effective date of the filing carrier's obligations pursuant to any contract transferred to the filing carrier under the nonstandard health benefits plan, subject to the filing carrier filing an amendment made in accordance with N.J.A.C. 11:21–11.7.

(e) If the filing carrier agrees to add a nonstandard health benefits plan to its portfolio at the request of a small employer, the filing carrier shall not amend the nonstandard health benefits plan for six months following the date that the filing carrier's obligations pursuant to the contract issued to the small employer under the nonstandard health benefits plan becomes effective.

1. Any amendment made subsequently shall be made by the filing carrier in accordance with N.J.A.C. 11:21–11.7.

(f) A filing carrier shall not make a request to withdraw a nonstandard health benefits plan that it adds to its portfolio of small employer health benefits plans for at least one 12 month period following the date that the filing carrier's obligations pursuant to contracts issued under the nonstandard health benefits plan first become effective.

New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Former section recodified as N.J.A.C. 11:21–11.10.

11:21–11.9 Additional standards for certifications and standards for review of certifications by the Department

(a) In addition to complying with the other requirements of this subchapter, certifications submitted by carriers in accordance with this subchapter shall comply with the requirements of N.J.A.C. 11:4–40.4, 40.5 and 40.11.

(b) All rate filings shall be submitted as specified in N.J.A.C. 11:21–9.

New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Former section recodified as N.J.A.C. 11:21–11.11.

11:21–11.10 Informational filing of nonstandard health benefits plans (made in accordance with N.J.S.A. 17B:27A–19j(6)(a) on or before January 31, 1995)

(a) A carrier shall submit a Certification of Prior Filing and Compliance with P.L. 1994, c.11, as set forth in Part 3 of Exhibit BB of the Appendix to this chapter, incorporated herein as part of this subchapter, for all nonstandard health benefits plans continued, renewed or reinstated pursuant to P.L. 1994, c.11, if the carrier has previously submitted the nonstandard health benefits plans to the Commissioner for filing and the nonstandard health benefits plans were so filed.

(b) A carrier shall submit a Certification of Informational Filing and Compliance with P.L. 1994, c.11, as set forth in Part 4 of Exhibit BB of the Appendix to this chapter, incorporated herein as part of this subchapter, for all nonstandard health benefits plans continued, renewed or reinstated pursuant to P.L. 1994, c.11, if those nonstandard health benefits plans were not previously submitted to the Commissioner for filing.

(c) A certification submitted pursuant to this section shall not be filed by the Commissioner until it is complete.

1. The Commissioner shall notify a carrier when a certification is determined by the Commissioner to be deficient, specifying the reasons therefor in writing.

2. The Commissioner shall determine a certification to be deficient if the certification in any way deviates from the forms as set forth in the Appendix, fails to provide answers to any of the questions contained therein, or the form fails to be certified by a duly authorized officer of the carrier. A certification shall continue to be considered deficient until the carrier submits information satisfactory to the Department to render the certification complete.

3. A carrier shall submit the information necessary to cure any deficiency(ies) or incompleteness specified within 30 days of the date of the notice, or shall become subject to fine.

(d) The completed certification shall include all amendments necessary to bring the nonstandard health benefits plan into compliance with N.J.S.A. 17B:27A–17 et seq. as required by P.L. 1994, c.11. The amendments shall include all necessary language changes, and shall clearly indicate (for ease of reference) all additions and deletions in language necessary for both the nonstandard health benefits plan and any riders and endorsements which may have been issued with or for the nonstandard health benefits plan.

Recodified from 11:21–11.8 and amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Section name changed by adding parenthetical text.
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Deleted a former (c); recodified former (d) and (e) as (c) and (d).

11:21–11.11 Penalty and fines

A carrier failing to comply with the requirements of this subchapter shall be subject to payment of a fine not less than $2,000 nor more than $5,000 per violation. Except for plans issued through an out-of-State trust, no fine or other penalty shall be assessed against a carrier with nonstandard health benefits plans specified at N.J.A.C. 11:21–11.4 for failure to comply specifically with this subchapter until May 16, 1997, and, with the exception of plans issued through an

out-of-State trust, all carriers with nonstandard health benefits plans as specified at N.J.A.C. 11:21–11.4 shall have the opportunity to come into compliance with this subchapter without penalty by May 16, 1997. This provision shall not effect any penalty or fine made against a carrier prior to the effective date of this subchapter.

Recodified from 11:21–11.9 and amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Substantially amended section.

SUBCHAPTER 12. (RESERVED)

SUBCHAPTER 13. NONSTANDARD PLANS: WITHDRAWAL OF PLANS

11:21–13.1 Purpose and scope

(a) This subchapter sets forth the procedures by which a carrier may make a request to withdraw a nonstandard health benefits plan.

(b) This subchapter sets forth standards for review of a request to withdraw a nonstandard health benefits plan.

11:21–13.2 Definitions

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

"Closed nonstandard health benefits plan" means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and was reinstated, renewed or continued at the option of the small employer(s) pursuant to N.J.S.A. 17B:27A–19j, but under which contracts or certificates have not been issued or offered on or after January 1, 1994 to a small employer group that was not covered under the health benefits plan prior to January 1, 1994, and which the carrier has certified will not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

The term "closed nonstandard health benefits plan" also means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and reinstated, renewed or continued at the option of a small employer pursuant to N.J.S.A. 17B:27A–19j under which contracts or certificates have been issued subsequent to January 1, 1994 to small employers who were not covered under the health benefits plan prior to January 1, 1994, but under which no such small employers remain covered as of the effective date of this subchapter and which the carrier has certified will not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

"Market," when used as a verb, means to offer or advertise as available a nonstandard health benefits plan to a small employer for initial purchase or to a small employer who formerly purchased the nonstandard health benefits plan but who is not currently covered under the nonstandard health benefits plan. The term does not include continuation or renewal of a contract, policy or certificate under a nonstandard health benefits plan by a carrier for a small employer currently covered under the nonstandard health benefits plan.

"Nonstandard health benefits plan" means a health benefits plan policy or contract form under which policies or contracts were issued on or before December 31, 1993 to small employers or to one or more employees of a small employer by virtue of the employment arrangement, or a policy or contract form under which policies or contracts were issued on or before December 31, 1993 to an association, out-of-State trust or multiple employer arrangement and offered to small employers or to one or more employees of a small employer.

"Open nonstandard health benefits plan" means a nonstandard health benefits plan which has been issued or offered to a small employer group that was not covered under the health benefits plan on or before December 31, 1993, or which would otherwise meet the requirements for a closed nonstandard health benefits plan except that the carrier has not certified that the nonstandard health benefits plan will not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

"Withdraw" or "withdrawal" means a nonrenewal initiated by a carrier, association, multiple employer arrangement or out-of-State trust of all inforce policies, contracts or certificates issued under a nonstandard health benefits plan.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In "Withdraw" or "withdrawal", deleted a reference to cancellation.

11:21–13.3 Restricted withdrawal and marketing

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall not withdraw a nonstandard health benefits plan without prior approval of the Commissioner if there was one or more policies or contracts inforce under that nonstandard health benefits plan on December 31, 1993, and one or more small employers continued to be covered under that nonstandard health benefits plan as of January 1, 1994, except as (b) below applies.

(b) A carrier may withdraw a nonstandard health benefits plan without obtaining prior approval pursuant to this subchapter if the carrier is effecting withdrawal from the small employer market in accordance with N.J.A.C. 11:21–16.

1. The carrier shall include in the notice the reasons for the nonrenewal (that is, that withdrawal of the health benefits plan has been approved by the Commissioner pursuant to this subchapter).

2. The carrier shall include in the notice an offer to obtain coverage under the standard health benefits plans issued by the carrier if the policyholder, contractholder, or certificateholder is a small employer (unless the carrier has been granted relief by the Commissioner pursuant to N.J.S.A. 17B:27A–26) or a statement that coverage may be available under an individual health benefits plan if the policyholder, contractholder or certificateholder is not a small employer.

3. The carrier shall include in the notice the name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information concerning the withdrawal.

4. The carrier shall provide notice of the withdrawal to the producer of record for each policy, contract or certificate within 60 days of the date that the request to withdraw is granted.

(b) The withdrawal of the nonstandard health benefits plan shall be completed within 16 months of the date that the request to withdraw is granted.

(c) The nonstandard health benefits plan that is the subject of the request to withdraw shall not be marketed by or through an association, multiple employer arrangement or out-of-State trust to any new small employer from the date that the request to withdraw is granted.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (a), substituted ", and all covered persons and their dependents under the contract or certificate is given 90 days" for "is given 60 days" following "certificateholder" in the introductory paragraph.

11:21–13.7 Other policyholder rights unaffected

Except with respect to a right of guaranteed renewability, nothing in this subchapter shall be construed to contravene any rights of policyholders, contractholders or certificateholders concerning nonrenewal requirements or obligations set forth in a policy or contract of a health benefits plan that is the subject of a request to withdraw.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Deleted a reference to noncancellation, and substituted a reference to nonrenewal requirements for a reference to cancellation requirements.

SUBCHAPTER 14. (RESERVED)

Subchapter Historical Note

Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was adopted as new rules by R.1993 d.551, effective October 15, 1993. See: 25 N.J.R. 4572(a), 25 N.J.R. 5347(a). Subchapter 14 was repealed by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

SUBCHAPTER 15. RELIEF FROM OBLIGATIONS IMPOSED UNDER THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM

11:21–15.1 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–38 or to offer coverage or accept applications to a small employer, pursuant to N.J.S.A. 17B:27A–26.

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

11:21–15.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1, 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–17 et seq.

"Financially impaired" means a member which, after November 5, 1993, 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 pursuant to N.J.S.A. 17B:27A–38 or a waiver of obligations pursuant to N.J.S.A. 17B:27A–26, as applicable.

11:21–15.3 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–38 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. 11:21–15.4, 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. 11:21–15.4. 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.

(e) If a request fails to materially comply with the filing format and information requirements set forth in N.J.A.C. 11:21–15.4 and this section, the Department shall notify the member that its request for relief is deficient and is denied on such grounds. The notice shall also set forth any information or other action required to cure the deficiency(s). If the member intends to pursue its request, the member shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in this section within 15 days of receipt of the Department's notice of deficiency. Failure to submit within 15 days the information necessary in the proper format to cure the deficiency shall result in the member's request being denied.

(f) All requests for relief or other information required pursuant to this subchapter shall be filed with the Department at the following address:

SEH Program
Request for Relief
New Jersey Department of Banking and Insurance
Division of Financial Solvency
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (f), updated address.

11:21–15.4 Informational filing requirements

(a) When requesting relief from obligations pursuant to N.J.S.A. 17B:27A–26b or 17B:27A–38, the applicant shall provide with its request the following information in a clear, concise and complete manner:

1. A cover letter stating:

i. The name of the applicant;

ii. The form of relief and, if a deferral of less than the full amount, specific amount/percentage of relief which the applicant is requesting;

iii. A statement of facts relied upon as the basis under which relief is sought, including the specific factor(s) upon which the Commissioner may find that the member is or would be placed in a financially impaired position as set forth in N.J.A.C. 11:2–27.3(a)1 to 29; and

iv. The name, title, telephone number and telefax number of a contact person familiar with the filing to whom the Department may direct any additional questions;

2. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation would have on the immediate and long term financial condition of the applicant unless relief is granted as requested;

3. The most recent financial examination report, whether conducted by the applicant's state of domicile or other state;

4. A statement addressing whether the applicant is planning to modify its method of doing business in any way including, but not limited to, new acquisitions or new restructuring;

5. If the applicant is a member of a holding company system, the following shall be provided:

i. A list of all members of the holding company system;

ii. A list of all intercompany transactions for the period beginning January 1 in the year of the filing to the date of the quarterly statement immediately preceding the date of the filing, in the format set forth in the statutory annual statement filed by the applicant; and

iii. A copy of the registration statement filed pursuant to N.J.S.A. 17:27A–3 and the applicant's organizational chart;

6. An actuarial opinion attesting to the adequacy of reserves specifically for all accident and health lines of business, and for all lines of business which the applicant transacts, in the format of and satisfying all requirements for the actuarial opinion and memorandum required to be submitted as a part of the annual statement filed by the applicant.

i. If the applicant is a health maintenance organization, the applicant shall obtain and file an actuarial opinion which complies with the requirements set forth in (a)6 above;

11:21–15.9 Exceptions for health maintenance organizations due to lack of capacity

(a) Any member HMO asserting that it is not required to offer coverage or accept applications pursuant to the requirements of the Act because it reasonably anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, pursuant to N.J.S.A. 17B:27A–26a, shall file the following information with the Commissioner:

1. A cover letter stating:

i. The name of the member HMO;

ii. A statement that the member is not required to offer coverage or accept applications pursuant to the Act because it anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, and the basis for that assertion, with supporting documentation, certified by the president or duly authorized officer of the member; and

iii. The number of the member's current individual and group members, listed by provider and classified by the provider's specialty, which shall be updated annually each year the member asserts a waiver pursuant to N.J.S.A. 17B:27A–26a.

(b) The member shall concurrently file the information required pursuant to (a) above with the SEH Program.

(c) Any member HMO denying coverage pursuant to (a) above shall not offer coverage in the small employer market within such service area for a period of at least 180 days after the date that the carrier first denies coverage.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Added (c).

11:21–15.10 Other actions by the Commissioner

Nothing in this subchapter shall be construed as limiting the Commissioner's authority to take such action with respect to insurers, health service corporations, medical service corporations, hospital service corporations or health maintenance organizations as may be authorized by law, including, but not limited to, placing an insurer, health service corporation, medical service corporation, hospital service corporation or health maintenance organization in rehabilitation, liquidation or conservation pursuant to N.J.S.A. 17B:32–31 et seq.

11:21–15.11 Penalties

Failure to comply with this subchapter, including all notice requirements set forth herein, may result in the denial of relief requested and imposition of penalties as authorized by law, including any actions that may be taken by the Board pursuant to N.J.S.A. 17B:27A–17 et seq. and the SEH Program Plan of Operation, including, but not limited to, imposition of an interest penalty for assessments due from the member and a recommendation by the Board to remove the member's authority to issue any health benefits plans in this State.

SUBCHAPTER 16. WITHDRAWALS OF SMALL EMPLOYER CARRIERS FROM THE SMALL EMPLOYER HEALTH BENEFITS PLANS MARKET

11:21–16.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers may cease doing business in the small employer market in this State. The subchapter applies to all small employer carriers issuing or renewing policies of contracts after November 30, 1992. Pursuant to the provisions of N.J.S.A. 17B:27A–17 et seq., every policy or contract issued to a small employer in this State shall be renewable with respect to all eligible employees or dependents at the option of the policy or contractholder or small employer, except under the circumstances prescribed by N.J.S.A. 17B:27A–23 a, c, d, e, f, h, and i. One of the circumstances delineated therein is where a carrier ceases to do business in the small employer health benefits plans market in New Jersey pursuant to N.J.S.A. 17B:27A–23e.

(b) This subchapter applies to all small employer carriers as defined in this subchapter that seek to cease doing business in the small employer market.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (a), changed N.J.S.A. reference.

11:21–16.2 Definitions

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

"Affiliate" or "affiliated company" means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the carrier that initiates a withdrawal.

"Cease doing business" for purposes of these rules means withdraw or withdrawal.

"Nonstandard health benefits plan" means a health benefits plan policy or contract form under which policies, contracts or certificates were issued on or before December 31, 1993 to small employers or to one or more employees of a small employer by virtue of the employment arrangement.

"State" means the State of New Jersey.

"Withdraw" or "withdrawal" means the nonrenewal on the anniversary date of all in force nonstandard health benefits plans or small employer health benefits plans, or both as appropriate, issued to small employers without offering replacement with a small employer health benefits plan (or a nonstandard health benefits plan, if offered through an association, multiple employer arrangement or out-of-State trust that continues to market its nonstandard health benefits plans pursuant to P.L. 1994, c.11), except where such action is taken pursuant to N.J.S.A. 17B:27A–23a, c, d, f, h and i or is approved by the Commissioner in accordance with N.J.A.C. 11:21–11.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In the introductory paragraph, changed N.J.A.C. reference; and in "Withdraw" or "withdrawal", substituted "nonrenewal" for "cancellation on a date certain or the termination" following "means the", and changed N.J.S.A. reference.

11:21–16.3 General provisions

(a) No small employer carrier shall nonrenew except in accordance with N.J.S.A. 17B:27A–23a, c, d, f, h and i or refuse to issue any small employer health benefits plan unless the small employer carrier withdraws from the small employer market in New Jersey in accordance with the provisions of this subchapter.

(b) Any small employer carrier which seeks to withdraw from the small employer market in the State shall provide the Commissioner with written notification of its intent to withdraw not later than eight months prior to the nonrenewal on the anniversary date of each in force policy or contract.

1. Until such time as the withdrawal shall be completed, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A–17 et seq. and all rules promulgated thereunder.

2. A withdrawing carrier shall cease issuing new policies no more than two months after filing a notice of intent to withdraw with the Commissioner.

(c) The notice of withdrawal to the Commissioner shall be sent to the attention of: SEH Withdrawal Notice, Life and Health Division, New Jersey Department of Banking and Insurance, PO Box 325, Trenton, NJ 08625–0325, and shall include an original and two copies of the following information:

1. The carrier's percentage market share in the small employer market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;

2. A statement, describing with specificity, the reasons for which the carrier is withdrawing from the small employer market in this State;

3. A statement indicating whether the carrier has any affiliates writing any health lines in this State, the names of such affiliates and the lines of insurance written and a statement indicating whether any such affiliates will continue to write small employer health benefits plans;

4. A statement indicating whether the carrier is withdrawing from other lines of business in this State, and if so, the lines from which it is withdrawing;

5. A statement specifying the date or dates upon which the small employer health benefits plans and nonstandard health benefits plans, as applicable, shall be nonrenewed specifying the date upon which all in force policies or contracts shall begin to be nonrenewed, which shall be the anniversary dates of the policies or contracts of each policyholder;

6. The date upon which the carrier shall cease writing any new nonstandard health benefits plans (if through an association, multiple employer arrangement or out-of-State trust) or small employer health benefits plans, as applicable, which shall be no later than two months after the date the carrier has filed its notice with the Commissioner; and

7. A copy of the form of notice required pursuant to (f) below, which is to be mailed to each affected small employer.

(d) The Commissioner shall review the notice of withdrawal to determine whether it complies with (c) above and whether sufficient notice will be provided to policyholders. The Commissioner shall notify, in writing, the small employer carrier of any deficiencies and the requirements which are necessary to bring it into compliance with N.J.S.A. 17B:27A–23 and this subchapter.

(e) Any small employer carrier which seeks to withdraw from the small employer market shall, not later than two months following the date of notification to the Commissioner, nor less than six months in advance of the nonrenewal on the anniversary date of the policy or contract, mail notices to every small employer insured by the carrier, with copies for each covered person, informing the small employer and all covered persons that the policy or contract will be nonrenewed on the anniversary date. This initial notice to each small employer shall be sent by certified mail and shall include the following information:

1. The date upon which the policy or contract shall be nonrenewed;

2. That the policy or contract is being nonrenewed under the authority of N.J.S.A. 17B:27A–23e and this subchapter;

11:21–18.2 Procedure for petitioner

(a) Any person who wishes to petition the Board to promulgate, amend or repeal a rule shall submit to the Board, in writing, the following information:

1. Name and address of the petitioner;

2. The substance or nature of the rulemaking which is requested;

3. The reasons for the request and the petitioner's interest in the request; and

4. References to the authority of the Board to take the requested action.

(b) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

(c) Any document submitted to the Board which is not in substantial compliance with (a) above shall not be deemed to be a petition for a rule requiring further Board action pursuant to N.J.S.A. 52:14B–4(f).

11:21–18.3 Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:21–18.2 the Board shall, within 15 days, file a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;

2. The substance or nature of the rulemaking action which is requested;

3. The problem or purpose which is the subject of the request; and

4. The date the petition was received.

(b) Within 30 days of receiving a petition in compliance with N.J.A.C. 11:21–18.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;

2. The New Jersey Register citation for the notice of petition, if that notice appeared in a previous New Jersey Register;

3. Certification by the Board that the petition was duly considered pursuant to law;

4. The nature or substance of the Board's action upon the petition; and

5. A brief statement of reasons for the Board's action.

(c) Board's action on a petition may include:

1. Denying the petition;

2. Filing a notice of proposed rule or a notice of preproposal for a rule with the Office of Administrative Law; or

3. Referring the matter for further deliberations, the nature of which shall be specified and which shall conclude upon a specified date. The results of these further deliberations shall be mailed to petitioner and submitted to the Office of Administrative Law for publication in the New Jersey Register.

Amended by R.1998 d.512, effective September, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted ", within 15 days," following "shall" in the introductory paragraph.

SUBCHAPTER 19. SEH PROGRAM PREMIUM COMPARISON SURVEY

11:21–19.1 Purpose and scope

(a) This subchapter requires the annual submission of data by small employer carriers to the Department, and establishes the format for the submission of such data, regarding premiums charged for the five standard health benefits plans, the HMO plan, the HMO/POS plan, and any standard rider packages established by the Board, so that the Department may develop and publish an annual SEH Program Premium Comparison Survey, pursuant to N.J.S.A. 17B:27A–33g.

(b) This subchapter shall apply to all small employer carriers.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (a), inserted a reference to HMO/POS plans.

11:21–19.2 Definitions

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

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

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

11:21–19.3 SEH Program premium comparison survey

(a) Every small employer carrier shall prepare and file with the Department a premium survey reflecting premiums charged for each of the five standard small employer health benefits plans, the HMO plan, the HMO/POS plan, and for any standard rider packages, as set forth in Exhibit FF of the Appendix to this chapter, incorporated herein by reference.

(b) Every small employer carrier shall complete the survey in the format set forth in Exhibit FF in accordance with the instructions set forth therein, and shall not vary the information solicited in Exhibit FF.

(c) Completed survey forms shall be filed no later than November 1 of each year, and shall reflect the monthly premiums to be charged for each of the five standard health benefits plans, the HMO plans, the HMO/ POS plans, and any standard rider packages as of January 1 of the year immediately following.

(d) All filings shall be accompanied by the following certification signed by the person who completed the survey: "I _____ certify that the information set forth in the attached SEH Program Premium Comparison Survey is true and accurate, and hereby further certify that I am authorized to execute this certification on behalf of the carrier named in the survey."

(e) Completed survey forms and signed certification shall be filed with the Department pursuant to this subchapter at the following address:

SEH Program Premium Comparison Survey
Public Affairs Office
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, New Jersey 08625–0325

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (a) and (c), inserted references to HMO/POS plans; in (c), deleted a former second sentence; deleted a former (d); recodified former (e) and (f) as (d) and (e); and in the new (e), updated the address.

11:21–19.4 Penalties

Failure to comply with the requirements of this subchapter may result in the imposition of penalties as authorized by law, including, but not limited to, penalties set forth in N.J.S.A. 17B:27A–17 et seq.

SUBCHAPTER 20. WITHDRAWALS OF STANDARD SEH PLAN OPTIONAL BENEFIT RIDERS

Authority

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

Source and Effective Date

R.1999 d.156, effective May 17, 1999.
See: 31 N.J.R. 109(a), 31 N.J.R. 1357(a).

11:21–20.1 Purpose and scope

(a) The purpose of this subchapter is to establish standards and procedures for carriers to withdraw standard SEH plan optional benefit riders.

(b) This subchapter applies to all riders to a standard SEH plan filed with the Commissioner or the SEH Board pursuant to N.J.S.A. 17B:27A–19i(1).

11:21–20.2 Definitions

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

"Optional benefit rider" means a rider to a standard SEH plan or plans filed with the Commissioner and/or the SEH Board pursuant to N.J.S.A. 17B:27A–19i(1).

"Small employer health benefits program" or "SEH" means the New Jersey Small Employer Health Benefits Program established pursuant to section 12 of P.L. 1992, c.162 (N.J.S.A. 17B:27A–28).

11:21–20.3 Withdrawal of optional benefit riders

(a) A carrier seeking to withdraw an optional benefit rider to a standard SEH plan that has been filed with the Commissioner and/or the Board pursuant to N.J.S.A. 17B:27A–19i(1) shall first obtain the Commissioner's approval by complying with all of the requirements of this subchapter.

(b) A carrier seeking to withdraw an optional benefit rider shall prior to withdrawal of the optional benefit rider submit a written application to the Commissioner as follows:

1. The written application shall include the following:

i. The name of the carrier;

ii. The name, address, telephone number and fax number of the carrier's representative responsible for the application to withdraw the optional benefit rider;

iii. The reason(s) the carrier is withdrawing the optional benefit rider;

iv. The number of inforce plans affected by the withdrawal;

11:21–21.5 Termination of membership in a purchasing alliance

(a) An employer may discontinue purchasing coverage as a member of a purchasing alliance at any time.

(b) A purchasing alliance may include a requirement in its bylaws or joint contract that employers provide no more than 30 days notice of discontinuance to the alliance.

11:21–21.6 Violations and penalties

(a) Failure to comply with any of the requirements of this subchapter shall be a violation of P.L. 2001, c.225 (N.J.S.A. 17B:27A–25.1 et seq.). If the Commissioner, after notice and a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., finds that such a violation exists, the premium reduction permitted by N.J.S.A. 17B:27A–25 shall not be applied, and the undiscounted applicable SEH rate shall be applied retroactive to the effective date of the discount.

EXHIBIT A

[Carrier] **PLAN A**

SMALL GROUP HEALTH BENEFITS BASIC POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER: [G-12345]

GOVERNING JURISDICTION: New Jersey

EFFECTIVE DATE OF POLICY: [January 1, 1998]

POLICY ANNIVERSARIES: [January 1st of each year beginning in 1999.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1998.]

AFFILIATED COMPANIES: [DEF Company]

[Carrier] in consideration of the application for this Policy and of the payment of premiums as stated herein, agrees to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Policy.

The Effective Date is specified above.

This Policy takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

[Secretary President]

[Dividends are apportioned each year.]

POLICY INDEX

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN A

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below: