

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

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

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

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

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

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

#### 11:20-2.13 Notice of request for deferral

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

Amended by R.1998 d.443, effective August 7, 1998.  
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).  
Substituted "Executive Director at the address listed in N.J.A.C. 11:20-2.1(h)" for "Interim Administrator (or Administrator)".

#### 11:20-2.14 Failure to pay assessments

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

#### 11:20-2.15 Penalties/adjustments and dispute resolutions

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

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

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

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

#### 11:20-2.16 Indemnification

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

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

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

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

In (a), inserted "employee of the Board" following "Directors".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

New Rule, R.1994 d.165, effective March 1, 1994.  
See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).  
Amended by R.1998 d.443, effective August 7, 1998.  
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).  
Rewrote the section.

#### CASE NOTES

Individual Health Insurance Reform Act did not authorize Individual Health Coverage Program (IHCP) regulation that completely excused carriers from second-tier assessment if they received pro rata first-tier exemptions from assessment for failing to meet Act's enrollment requirements; Act did not allow Ne Jersey Individual Health Coverage Program Board of Directors to further penalize carriers who were not entitled to any exemption. In re N.J. IHCP, 353 N.J.Super. 494, 803 A.2d 639.

### SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

#### 11:20-3.1 The standard health benefits plans

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

1. Plan A, Exhibit A;
2. Plan B, "Individual Health Benefits Plan," Exhibit B;
3. Plan C, "Individual Health Benefits Plan C," Exhibit C;
4. Plan D, "Individual Health Benefits Plan D," Exhibit D;
5. Plan E, "Individual Health Benefits Plan E," Exhibit E;

6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F; and

7. Plan A/50, "Basic Health Benefits Plan A/50," Exhibit U.

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

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

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

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

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

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

- i. \$1,500, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, \$3,000, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit;
- ii. \$2,250, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, \$4,500, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit.

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

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

## SUBCHAPTER 9. EXEMPTIONS

**11:20-9.1 Purpose**

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

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

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

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

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

Inserted "full" preceding "or pro rata".

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

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

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

1. To enroll or insure the minimum number of non-group persons in New Jersey necessary for the member to meet its minimum enrollment share of non-group persons, allocated to it by the Board pursuant to N.J.A.C. 11:20-9.3;
2. To enroll or insure the minimum number of non-group persons in New Jersey under:
  - i. Standard health benefits plans and the basic and essential health care services plan;
  - ii. Conversion policies issued pursuant to the IHC Act;
  - iii. Medicaid contracts, if offered; and
  - iv. Medicare cost and risk contracts with the Federal government, Medicare Plus Choice 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, as appropriate.

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

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

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

Administrative Change.

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

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

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

Rewrote the section.

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.

**11:20-9.3 Minimum enrollment share**

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

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

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

1. For each two-year calculation period beginning with 1997/1998, the total number of community rated, individually enrolled or insured persons, including Medicare cost and risk lives, Medicare Plus Choice lives and Medicare Demonstration Project lives and enrolled Medicaid lives, NJ KidCare Part A lives and NJ FamilyCare Part A lives

of all members subject to the Act, and all individually enrolled or insured persons covered under a basic and essential health care services plan, except for hospital and medical service corporation carriers, covered on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, divided by eight, and multiplied by the proportion that the member's net earned premium bears to the net earned premium of all members for the preceding two-year calculation period.

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

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

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

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

Rewrote (a) and (c).

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.

#### 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 and Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's minimum number of non-group persons.

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

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

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

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

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.

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

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

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

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 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 estimations 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.

(c) 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 (b) above.

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

(e) 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 (b) above or as a result of the findings of an independent audit conducted pursuant to (d) above.

(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, but has enrolled or insured at least 50 percent of 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.

2. A member granted a conditional exemption that enrolls or insures fewer than 50 percent of the minimum number of non-group persons allocated to it by the Board must demonstrate in writing, pursuant to N.J.A.C. 11:20-9.6, that the member has made a good faith effort to enroll or insure the minimum number of non-group persons allocated to it by the Board. The member 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 only if the Board finds that the member has made a good faith effort to enroll or insure its minimum number of non-group persons. The Board shall not grant a pro rata exemption to the member if it finds that the member has not made a good faith effort to enroll its minimum share, and the Board shall notify the member in writing as to its reasons for not granting the member a 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.

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

(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, until and unless the Board makes a finding that the member is

liable for a pro rata assessment only, including any interest that may accrue.

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.

#### CASE NOTES

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 Good faith marketing report

(a) In order for the Board to determine whether a carrier has made a good faith marketing effort as required by N.J.A.C. 11:20-9.5(f)2, members that have received conditional exemptions from assessments for reimbursable losses and have enrolled less than 50 percent of the minimum number of non-group persons determined by the Board shall submit to the Board a marketing report on or before July 1 of the year immediately following the two-year calculation period to which the conditional exemption applies containing the following information pertaining to advertising, marketing and promotion efforts in direct support of sales of standard individual health benefits plans and basic and essential health care services plans in New Jersey during the two-year calculation period and the calendar quarter immediately preceding the two-year calculation period to which the conditional exemption applies provided such efforts were directed toward sales during the two-year calculation period to which the exemption applies.

1. With respect to print media, the names of newspapers, magazines or other print media, including billboards, in which advertising was placed; the number of times an advertisement appeared in each; the dates those advertisements appeared; the size of the advertisements in each; copies of such advertisements; the total cost of print media advertising;

2. With respect to broadcast media, the names of television stations, radio stations, or cable television franchises over which commercial advertising appeared; the number of times a commercial advertisement was broadcast or played, the time of day and the duration of each; audio or video tapes of such commercial advertisements; the total cost of such broadcast media advertising;

3. With respect to direct marketing by mail or telephone, the number of mailings distributed or calls placed; the approximate dates of the mailings or telephone calls;

the geographic areas to which the mailings or calls were addressed; copies of the mailing or scripts of the telephone calls; the total cost of direct marketing through mail or telephone solicitation;

4. With respect to sales through producers licensed by the State of New Jersey, details of efforts to recruit and educate producers to sell standard health benefits plans and the basic and essential health care services plan; the number of producers through whom such sales were made; the total cost of commissions and other incentives paid to producers for sales of standard health benefits plans and the basic and essential health care services plan;

5. With respect to other forms of marketing or promotion of standard health benefits plans and the basic and essential health care services plan, describe the methods of media used; the frequency of use; the total cost of such efforts.

(b) Carriers required to submit the marketing report described in (a) above shall send it to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

(c) The Board will review the marketing reports submitted and determined that a carrier has made a good faith marketing effort as required by N.J.A.C. 11:20-9.5(f)2 if the carrier has demonstrated that it has either:

1. Undertaken a significant media advertising or other marketing campaign, in proportion to its minimum enrollment share, in direct support of sales of standard individual health benefits plans and the basic and essential health care services plan in New Jersey; or

2. Undertaken significant efforts, in proportion to its minimum enrollment share, to educate licensed insurance producers about its standard individual health benefits plans and the basic and essential health care services plan in New Jersey and offered to pay competitive commission schedules for sales of such plans and competitive rates.

(d) A member's failure to file the marketing report described in (a) may result in the Board's denial of a final exemption from assessment for reimbursable losses.

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.

#### CASE NOTES

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.

### 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 April 1, in the year following the two-year calculation period which contains the following:

1. A statement certified by the Chief Executive Officer of the member that:

i. 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

ii. 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; and

2. Audit statements for the preceding two-year calculation period of the member's accounts receivable, premium billing operations, and claims eligibility systems, performed by an auditor at the member's expense.