

CHAPTER 21

SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Authority

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

Source and Effective Date

R.1998 d.512, effective September 25, 1998 and
R.1998 d.533, effective October 15, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a);
30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

Executive Order No. 66(1978) Expiration Date

Chapter 21, Small Employer Health Benefits Program, expires on September 25, 2003.

Chapter Historical Note

Chapter 21, Small Employer Health Benefits Program, was adopted as R.1993 d.553, effective October 15, 1993. See: 25 N.J.R. 3599(a), 25 N.J.R. 5253(a).

Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was adopted as 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 Subchapter 14 was repealed by R.1997 d.126, effective March 17, 1997.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, was adopted as R.1993 d.629, effective November 5, 1993. See: 25 N.J.R. 4577(a), 25 N.J.R. 5692(a).

Subchapter 6, Standard Employer and Employee Application and Small Employer Certification Forms, Subchapter 7, Program Compliance, Subchapter 17, Fair Meeting Standards, and Subchapter 18, Petitions for Rules, were adopted as R.1993 d.644, effective November 12, 1993. See: 25 N.J.R. 4437(a), 30 N.J.R. 5668(a).

Subchapter 3A, Non-Standard Health Benefits Plan, was adopted as R.1994 d.499, effective September 2, 1994. See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b). Subchapter 3A as was repealed and Subchapter 3A, Non-Standard Health Benefits Plans, was adopted as new rules by R.1997 d.62, effective February 3, 1997. See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Subchapter 9, Informational Rate Filing Requirements Pursuant to the Small Employer Health Benefits Program, was adopted as R.1994 d.25, effective December 9, 1993. See: 25 N.J.R. 5757(a), 26 N.J.R. 245(a).

Subchapter 16, Withdrawals of Small Employer Carriers From the Small Employer Health Benefits Plans Market, was adopted as R.1994 d.26, effective December 9, 1993. See: 25 N.J.R. 4859(a), 26 N.J.R. 247(a).

Subchapter 2, New Jersey Small Employer Health Benefits Program Plan of Operation, was adopted as R.1994 d.48, effective December 22, 1993. See: 25 N.J.R. 4563, 26 N.J.R. 391(a).

Subchapter 8, Carrier Certification of Non-Member Status, and Subchapter 10, The Market Share Report, were adopted as R.1994 d.228, effective April 11, 1994. See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

Subchapter 11, Nonstandard Health Benefits Plan Filings With the Commissioner: Form Filings and Request to Withdraw Plan Forms, was adopted as R.1994 d.580, effective November 21, 1994. See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a). Subchapter 11 was renamed Non-standard Health Benefits Plans (Filings With the Commissioner): Re-

quirements for Maintaining Nonstandard Plans by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Subchapter 19, SEH Program Premium Comparison Survey, was adopted as R.1995 d.289, effective June 5, 1995. See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).

Subchapter 7A, Loss Ratio Reports; Dividends and Credits, was adopted as R.1996 d.213, effective May 6, 1996. See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).

Subchapter 13, Nonstandard Plans: Withdrawal of Plans, was adopted as R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Pursuant to Executive Order No. 66(1978), Subchapters 1 through 7, 8, 10, 17, 18, and Appendix Exhibits A through KK of Chapter 21, Small Employer Health Benefits Program, were readopted by the Small Employer Health Benefits Program Board as R.1998 d.512, effective September 25, 1998 and Subchapters 7A, 9, 11, 13, 15, 16, 19 and Appendix were readopted by the Department of Banking and Insurance as R.1998 d.533, effective October 15, 1998. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 11:21-1.1 Purpose and scope
- 11:21-1.2 Definitions
- 11:21-1.3 Communications with the Board
- 11:21-1.4 Penalties
- 11:21-1.5 Severability

SUBCHAPTER 2. NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM PLAN OF OPERATION

- 11:21-2.1 Purpose and structure
- 11:21-2.2 Definitions
- 11:21-2.3 Powers of the Board
- 11:21-2.4 Plan of Operation
- 11:21-2.5 Board structure and meetings
- 11:21-2.6 Committees
- 11:21-2.7 Administrator or Executive Director selection and duties
- 11:21-2.8 Assessments for administrative and operating expenses
- 11:21-2.9 Reporting requirements
- 11:21-2.10 Financial administration
- 11:21-2.11 Records
- 11:21-2.12 Audit functions
- 11:21-2.13 Penalties/adjustments and dispute resolution
- 11:21-2.14 Indemnification
- 11:21-2.15 Amendment and termination
- 11:21-2.16 (Reserved)

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

- 11:21-3.1 Benefits provided
- 11:21-3.2 Optional benefit riders to standard plans and administrative functions

SUBCHAPTER 3A. NON-STANDARD HEALTH BENEFITS PLANS

- 11:21-3A.1 Purpose and scope
- 11:21-3A.2 Definitions
- 11:21-3A.3 Renewal of non-standard health benefits plans
- 11:21-3A.4 New issuance of non-standard health benefits plans
- 11:21-3A.5 Mandatory offerings by carriers issuing non-standard plans
- 11:21-3A.6 Amendment of a non-standard health benefits plan
- 11:21-3A.7 Penalties

SUBCHAPTER 4. POLICY FORMS

- 11:21-4.1 Policy forms
- 11:21-4.2 Certification or filing of forms
- 11:21-4.3 Standards for review
- 11:21-4.4 Compliance and variability rider

SUBCHAPTER 5. STANDARD CLAIM FORM

- 11:21-5.1 Standard Claim Form

SUBCHAPTER 6. STANDARD EMPLOYER AND EMPLOYEE APPLICATION AND SMALL EMPLOYER CERTIFICATION FORMS

- 11:21-6.1 Standard application form
- 11:21-6.2 Annual Small Employer Certification Form
- 11:21-6.3 Enrollment
- 11:21-6.4 Waiver

SUBCHAPTER 7. PROGRAM COMPLIANCE

- 11:21-7.1 Purpose and scope
- 11:21-7.2 Definitions
- 11:21-7.3 Eligibility and issuance
- 11:21-7.4 Restrictions on replacement of health benefits plans
- 11:21-7.5 Participation requirements
- 11:21-7.6 Contribution requirements
- 11:21-7.7 Preexisting condition standards
- 11:21-7.8 Effective date of coverage
- 11:21-7.9 Price quotes; disclosures
- 11:21-7.10 Tie-ins
- 11:21-7.11 Guaranteed renewal
- 11:21-7.12 Reporting requirements
- 11:21-7.13 Paying benefits
- 11:21-7.14 Permissible rate classification factors
- 11:21-7.15 (Reserved)

SUBCHAPTER 7A. LOSS RATIO REPORTS; DIVIDENDS AND CREDITS

- 11:21-7A.1 Purpose
- 11:21-7A.2 Definitions
- 11:21-7A.3 Filing of loss ratio reports
- 11:21-7A.4 Contents of loss ratio report
- 11:21-7A.5 Dividend or credit plan

SUBCHAPTER 8. CARRIER CERTIFICATION OF NON-MEMBER STATUS

- 11:21-8.1 Purpose and scope
- 11:21-8.2 Definitions
- 11:21-8.3 Non-member status
- 11:21-8.4 Non-member certification requests
- 11:21-8.5 Decisions on filings by the Board
- 11:21-8.6 Review

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

- 11:21-9.1 Purpose and scope
- 11:21-9.2 Definitions
- 11:21-9.3 Informational rate filing requirements for small employer health benefits plans issued or renewed after December 31, 1993
- 11:21-9.4 Purchasing alliances
- 11:21-9.5 Informational filing procedures
- 11:21-9.6 Public disclosure of filed information
- 11:21-9.7 Penalties

SUBCHAPTER 10. THE MARKET SHARE REPORT

- 11:21-10.1 Scope and applicability
- 11:21-10.2 Definitions
- 11:21-10.3 Filing of the Market Share Report

- 11:21-10.4 Net earned premium
- 11:21-10.5 Certification
- 11:21-10.6 Failure to comply

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

- 11:21-11.1 Purpose and scope
- 11:21-11.2 Definitions
- 11:21-11.3 General standards for continuing and renewing a non-standard health benefits plan
- 11:21-11.4 Certification of benefits coverage and actuarial value of nonstandard health benefits plans
- 11:21-11.5 Closed books of business
- 11:21-11.6 Obligation to market
- 11:21-11.7 Amendments
- 11:21-11.8 Agreement by a carrier to add a nonstandard health benefits plan to its portfolio
- 11:21-11.9 Additional standards for certifications and standards for review of certifications by the Department
- 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)
- 11:21-11.11 Penalty and fines

SUBCHAPTER 12. (RESERVED)**SUBCHAPTER 13. NONSTANDARD PLANS: WITHDRAWAL OF PLANS**

- 11:21-13.1 Purpose and scope
- 11:21-13.2 Definitions
- 11:21-13.3 Restricted withdrawal and marketing
- 11:21-13.4 Request to withdraw nonstandard health benefits plans
- 11:21-13.5 Review and approval of a request to withdraw
- 11:21-13.6 Standards for the process of withdrawal of a nonstandard health benefits plan
- 11:21-13.7 Other policyholder rights unaffected

SUBCHAPTER 14. (RESERVED)**SUBCHAPTER 15. RELIEF FROM OBLIGATIONS IMPOSED UNDER THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM**

- 11:21-15.1 Purpose and scope
- 11:21-15.2 Definitions
- 11:21-15.3 Application procedures and filing format
- 11:21-15.4 Informational filing requirements
- 11:21-15.5 Confidentiality of request for relief
- 11:21-15.6 Disposition of request for relief
- 11:21-15.7 Hearings
- 11:21-15.8 Notice of the SEH program
- 11:21-15.9 Exceptions for health maintenance organizations due to lack of capacity
- 11:21-15.10 Other actions by the Commissioner
- 11:21-15.11 Penalties

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

- 11:21-16.1 Purpose and scope
- 11:21-16.2 Definitions
- 11:21-16.3 General provisions
- 11:21-16.4 Restrictions on writings
- 11:21-16.5 Penalties
- 11:21-16.6 Other policyholder rights unaffected
- 11:21-16.7 Revocation of a notice of intent to withdraw

SUBCHAPTER 17. FAIR MARKETING STANDARDS

- 11:21-17.1 Plan identification and marketing materials
- 11:21-17.2 Retention of marketing and promotional materials

- 11:21-17.3 Certification
- 11:21-17.4 "Get the Facts" brochure
- 11:21-17.5 Producer contracts

SUBCHAPTER 18. PETITIONS FOR RULES

- 11:21-18.1 Scope
- 11:21-18.2 Procedure for petitioner
- 11:21-18.3 Procedure of the Board

SUBCHAPTER 19. SEH PROGRAM PREMIUM COMPARISON SURVEY

- 11:21-19.1 Purpose and scope
- 11:21-19.2 Definitions
- 11:21-19.3 SEH Program premium comparison survey
- 11:21-19.4 Penalties

SUBCHAPTER 20. WITHDRAWALS OF STANDARD SEH PLAN OPTIONAL BENEFIT RIDERS

- 11:21-20.1 Purpose and scope
- 11:21-20.2 Definitions
- 11:21-20.3 Withdrawal of optional benefit riders

SUBCHAPTER 21. SMALL EMPLOYER PURCHASING ALLIANCES

- 11:21-21.1 Purpose and scope
- 11:21-21.2 Definitions
- 11:21-21.3 Filing requirements
- 11:21-21.4 Eligibility requirements
- 11:21-21.5 Termination of membership in a purchasing alliance
- 11:21-21.6 Violations and penalties

APPENDIX. EXHIBITS A THROUGH KK

SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended by P.L. 1993, c.162, P.L. 1994, c.11, P.L. 1994, c.97, P.L. 1995, c.50, P.L. 1995, c.298, and P.L. 1995, c.340 (N.J.S.A. 17B:27A-17 et seq.), herein referred to as the Small Employer Health Benefits Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-17 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Small Employer Health Benefits Program pursuant to N.J.S.A. 17B:27A-17 et seq.

(b) Provisions of the New Jersey Small Employer Health Benefits Act and of this chapter shall be applicable to all carriers that are members of the Small Employer Health Benefits Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Small Employer Health Benefits Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

Petition for Rulemaking: Exhibit G.
See: 26 N.J.R. 2488(b), 26 N.J.R. 3089(a), 26 N.J.R. 3758(a).
Petition for Rulemaking: Exhibit G.
See: 26 N.J.R. 5120(a), 27 N.J.R. 1321(b).
Petition for Rulemaking: Exhibits A through G.
See: 26 N.J.R. 5120(c), 27 N.J.R. 946(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted additional P.L. references.

11:21-1.2 Definitions

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

"Act" means P.L. 1992, c.162, as adopted and subsequently amended (N.J.S.A. 17B:27A-17 et seq.), also referred to herein as the Small Employer Health Benefits Act.

"Affiliated carrier" means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another carrier.

"Board" means the Board of Directors of the New Jersey Small Employer Health Benefits Program established by the Act.

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this chapter, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Cash deductible" or "deductible" means the amount of covered charges that a covered person must pay before the health benefits plan pays any benefits for such charges.

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

"Coinsurance" means the percentage of a covered charge that must be paid by a covered person. Coinsurance does not include cash deductibles, copayment or non-covered charges.

“Coinsurance cap” means the maximum amount a covered person is required to pay as a result of the application of the coinsurance under the standard plans, as set forth in the Appendix Exhibits to this chapter. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsurance cap.

“Coinsured charge limit” means, with respect to a preferred provider organization (PPO) plan, or a point of service (POS) plan, developed based on the standard health benefit plans set forth in the Appendix Exhibits to this chapter, the amount of covered charges a covered person must incur before no coinsurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsured charge limit.

“Commissioner” means the Commissioner of New Jersey Department of Banking and Insurance.

“Copayment” or “copay” means a specified dollar amount a covered person must pay for specified covered charges.

“Creditable coverage” means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.); Title XIX of the Federal Social Security Act (42 U.S.C. §§ 1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the Federal Social Security Act (42 U.S.C. § 1396s); chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §§ 8901 et seq.); a public health plan as defined by Federal regulation; a health benefits plan under section 5(e) of the “Peace Corps Act” (22 U.S.C. § 2504(e)); or coverage under any other type of plan as set forth by the Commissioner by regulation. Creditable coverage shall not include coverage consisting solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers’ compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage, as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

“Department” means the New Jersey Department of Banking and Insurance.

“Dependent” means the spouse or child of an eligible employee subject to applicable terms of the employee’s health benefits plan.

“Eligible employee” means a full-time, bona fide employee who works a normal work week of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 25 hours a week, work on a temporary or substitute basis or are participating in an employee welfare arrangement pursuant to a collective bargaining agreement.

“Enrollment date” means, with respect to a person covered under a health benefits plan, the date of enrollment of the person in the health benefits plan or, if earlier, the first day of the waiting period for such enrollment.

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

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

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

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).

(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.

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.

(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.

"Health benefits plan" means any standard health benefits plan or nonstandard health benefits plan including any rider or endorsement thereto.

"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 a small employer or to one or more employees of a small employer.

“Nonstandard rider” means a rider or endorsement developed by a carrier to be offered with one or more of the standard health benefits plans.

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

“Plan” means a policy or contract form under which policies, contracts or certificates are issued evidencing benefits for expenses incurred or coverage of services rendered when referring to a type of health benefits plan.

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

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

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).

Inserted “Closed nonstandard health benefits plan” and “Open nonstandard health benefits plan”; and rewrote “Nonstandard health benefits plans”.

11:21-9.3 Informational rate filing requirements for small employer health benefits plans issued or renewed after December 31, 1993

(a) All carriers issuing policies, contracts or certificates under health benefits plans to small employers, including any standard or nonstandard rider option, prior to issuing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the following data:

1. A plan schedule for each of the standard health benefits plans and nonstandard health benefits plans offered, outlining:

- i. The benefit options available;
- ii. The delivery system(s) for each plan;
- iii. The in-network and out-of-network coinsurance percentages and/or copays for selective contracting arrangements or HMO point-of-service arrangements;
- iv. The benefit differential for each nonstandard rider offered, separately specifying benefit increases and benefit decreases;
- v. The basic premium rates or rating factors applicable for each option including the difference when Medicare is primary or secondary, which must be based on actual employee or spouse Medicare coverage status; and
- vi. The coverage period, if any, for which the rates for a group are guaranteed;

2. A rate manual containing:

i. The numerical value of the classification factors utilized in the calculation of a group’s premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of the covered persons in accordance with N.J.A.C. 11:21-7.14;

ii. A written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates set forth pursuant to (a)1v above into the rates charged to a small employer group;

iii. A detailed example calculation, in the proposal format used by the carrier, for any one plan including a rider or POS option, showing all of the steps to develop premiums for a small group and demonstrating the adjustment, if any, to achieve the required 200 percent maximum ratio between the premiums for the highest rated group and the lowest rated group in the State; and

iv. A specification of the rule, which must be invariable, stating if the issue rate is based on the issue enrollment or the proposal rate.

3. A detailed actuarial memorandum setting forth the assumptions and methods used in the development of the rates, which shall include:

i. Recent claim cost experience, a description of the source of the claim costs and the time period for which the claim costs were calculated;

ii. The assumptions used in developing the anticipated loss experience and the basic premium rates specified in (a)1v above, and the anticipated distribution of business by rating classification described in (a)2 above;

iii. A statement whether or not the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A-25g(2). If such dividends are payable, the carrier shall also submit the following:

(1) The detailed assumptions and practices for determining and distributing such dividends; and

(2) A demonstration that such dividends are not in violation of 3iv(4), 3iv(5) or 3iv(6) below, as appropriate;

iv. A certification signed by a member of the American Academy of Actuaries attesting as follows:

(1) The filing is accurate and complete and complies with the provisions of this subchapter;

(2) The issue period for which the filed rates are applicable, which period shall not exceed 12 months;

(3) The anticipated incurred loss ratio for each plan, which shall not be less than 75 percent of the premium therefor;

(4) For rates to be charged for policies, contracts or certificates issued or renewed on or after January 1, 1996, that the rating methodology will not provide rates (for an individual and for each family status) for the highest rated group in this State which are greater than 200 percent of rates (for an individual and for each family status) produced for the lowest rated group in this State for each plan and option;

(5) That rates to be charged to any group do not vary based on any classification factor other than those permitted in (a)2i above; and

(6) Whether the rates for the Open Nonstandard and Closed Nonstandard plans are on the same or a different basis as the rates for the Standard plans and, if different, the average percentage relationship to the Standard plan basis; and

v. A certification that the actuarial memorandum contains confidential and proprietary information, if it is the actuary's belief that it does.

(b) All carriers issuing or renewing policies, contracts or certificates under a standard health benefits plan (including any standard or nonstandard rider option after September 11, 1994), an open nonstandard health benefits plan or a closed nonstandard health benefits plan, prior to issuing or renewing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the data set forth in (a) above.

1. Carriers that issued or renewed open nonstandard health benefits plans or closed nonstandard health benefits plans prior to the effective date of this amendment shall have until 90 days following the effective date of this amendment within which to come into compliance with this subchapter.

(c) Any carrier which seeks to change its rates for its health benefits plans shall, prior to the effective date of the revised rates, submit to the Commissioner an informational filing which shall include all of the data set forth in (a) above.

(d) In addition to meeting the requirements of (a) through (c) above, an informational rate filing shall not be considered complete unless the plan schedule and rate manual meet the following format requirements:

1. Each page shall contain the name of the carrier for which the filing is made;
2. Each page shall be distinctively numbered;
3. If future filings may be made by way of replacement pages only, then each page shall be dated clearly and distinctively; and

4. In all instances, there shall be a table of contents which shall include the date of the most recent filing, and shall include the date(s) of the respective pages when filings are made by way of replacement page.

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).

Rewrote the section.

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)3iv(5), substituted "(a)2i" for "(a)2ii".

11:21-9.4 Purchasing alliances

(a) All carriers providing discounts to small employer purchasing alliances shall file an informational rate filing with the Commissioner prior to the date of providing such discounts, which shall include the following data:

1. A statement that the discount is based on reductions in anticipated expenses and profit margins and not on favorable claims experience;

2. Information regarding the discounts, including:

i. The small employer rate filings ("reference filing") pursuant to N.J.A.C. 11:21-9.3 to which the discounts apply;

ii. Eligibility requirements that a small employer group must satisfy, including participation requirements or cost-sharing requirements;

iii. The amount of the discounts expressed as a percentage of the non-alliance premium for the same coverage and small employer group. If the same discount is not offered to all purchasing alliances, the criteria for the variation in the discount, which shall not include any of the factors set forth at N.J.A.C. 11:21-21.4(a);

iv. The contract issue or renewal period to which the discounts apply, the time period for which the discount is guaranteed, and any conditions for maintaining the discount; and

v. A statement that the same discount is available to all members of the purchasing alliance;

3. Information regarding the application of the discount to a particular group, including:

i. A written description in plain language of the method by which the discounted rate is obtained from the reference rate; and

ii. A detailed example calculation, in the proposal format used by the carrier, of the application of the discount to the example calculation found in the reference filing, showing all the steps necessary to develop the discounted premium from the undiscounted premium, and demonstrating the adjustment, if any, to achieve the required 200 percent maximum ratio between the premiums for the highest rated group and the lowest rated group in the State;

4. An actuarial memorandum setting forth the assumptions used in the development of the discount, which shall include:

i. The anticipated claim cost for the purchasing alliances;

ii. A demonstration that the discount is based on the anticipated expenses (including marketing and claims administration expenses) and profit margins, identifying those differences from the anticipated expenses and profit margins in the reference filing that are the only bases for the purchasing alliance discount;

iii. A statement whether or not the policyholder shall or may receive policyholder dividends, other than the dividends required by N.J.S.A. 17B:27A-25(g)(2). If such dividends are payable, the carrier shall also submit the following:

(1) The detailed assumptions and practices for determining and distributing such dividends; and

(2) A demonstration that such dividends are not in violation of 4iv(4), 4iv(5) or 4iv(6) below, as appropriate; and

iv. A certification signed by a member of the American Academy of Actuaries attesting to the following:

(1) That the filing is accurate and complete, and complies with the provisions of this subchapter;

(2) The issue period for which the discount is applicable;

(3) The anticipated incurred loss ratio for each plan offered to purchasing alliances, which shall not be less than 75 percent of the premium;

(4) That the rating methodology, taking into account both discounted and undiscounted rates, shall not provide rates for the highest group in the State that are greater than 200 percent of the rates (for an individual and each family status) produced for the lowest rated group in this State for each plan and option;

(5) That the rates to be charged to any group do not vary based on a classification factor other than those permitted in N.J.A.C. 11:21-9.3(a)2i;

(6) That discounted rates do not result in rates that vary between groups based upon a health status-related factor; and

(7) That the anticipated incurred loss ratio in (a)4iv(3) above exceeds the anticipated incurred loss ratio for the reference filing by an amount that reflects the expense and profit savings attributed to the purchasing alliance.

(b) A single filing shall be made, even if multiple purchasing alliances are covered. The addition of purchasing alliances or other changes shall require submission of an

amendment or modification to the rate filing within 30 days of such change.

New Rule, 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. 11:21-9.4, Informational filing procedures, recodified to N.J.A.C. 11:21-9.5.

11:21-9.5 Informational filing procedures

(a) Informational filings submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Informational Rate Filings
Life and Health Division
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

(b) If the Commissioner determines that an informational filing submitted pursuant to this subchapter is incomplete, the Commissioner shall provide written notice within 60 days to the carrier specifying those portions of the filing which are deficient and the information required to be submitted by the carrier. The notice shall specify whether or not the informational filing is deemed to be in substantial compliance with the requirements of N.J.A.C. 11:21-9.3. If the Commissioner takes no action with respect to the informational filing within 60 days of the date of submission thereof, the information filing shall be deemed complete.

(c) If the informational filing is incomplete but in substantial compliance with the requirements of N.J.A.C. 11:21-9.3, the carrier shall, within 30 days of receipt of written notice in (b) above, provide the Commissioner with the information required to complete the filing. Failure on the part of the carrier to comply with the provisions of this subsection may result in the imposition of a penalty pursuant to N.J.A.C. 11:21-9.6.

(d) If the informational filing is incomplete and not in substantial compliance with the requirements of N.J.A.C. 11:21-9.3, the Commissioner shall provide written notice to the carrier specifying the portions of the filing which are deficient and the information required to be submitted by the carrier. Upon receipt of notice from the Commissioner that the filing for any health benefits plan is not in substantial compliance, no contract, policy or certificate shall be entered into or renewed using the submitted rates until the Commissioner has determined that the informational filing is in substantial compliance or complete, and has provided written notice of that fact to the carrier. If the Commissioner takes no action within 30 days of the carrier's submission of information in an effort to render the filing in substantial compliance, the filing shall be deemed to be in substantial compliance.

(e) Any carrier aggrieved by a determination of the Commissioner pursuant to (b), (c) or (d) above may request a hearing on the Commissioner's determination, within 20 days of the receipt of notice of such determination, as follows:

1. A request for a hearing shall be in writing and shall include:

- i. The name, address, and daytime telephone number of a contact person familiar with the matter;
- ii. A copy of the notice involved;
- iii. A statement requesting the hearing; and
- iv. A concise statement specifying the reason(s) the carrier is aggrieved by the Commissioner's determination.

2. The hearing shall be conducted pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

(f) The Commissioner may disapprove a purchasing alliance rate reduction if it results in rates that are excessive, inadequate or unfairly discriminatory.

1. Rates will be considered excessive if they are projected to give rise to a loss ratio that is less than the loss ratio for the reference rate filing, increased by an amount that reflects the savings giving rise to the discount.

2. Rates will be considered inadequate if they result in a subsidization of the alliance business by the non-alliance business.

3. Rates will be considered unfairly discriminatory if they are based on a health status-related factor of the group or any individual eligible for coverage in the group.

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).

In (b), increased periods for providing written notice and taking action from 30 to 60 days.

Recodified from N.J.A.C. 11:21-9.4 and amended by R.2002 d. 342, effective November 4, 2002.

See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).

Added (f). Former N.J.A.C. 11:21-9.5, Public disclosure of filed information, recodified to N.J.A.C. 11:21-9.6.

11:21-9.6 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.

11:21-9.7 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of fines or other penalties provided by law, including suspension or revocation of a carrier's authority to do business in the State of New Jersey.

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).

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.