

(b) A carrier may submit a single filing to request withdrawal of more than one closed and open nonstandard health benefits plans, but shall clearly specify each nonstandard health benefits plan for which a withdrawal is sought, with separate proofs of unreasonable financial burden submitted for each nonstandard health benefits plan.

(c) A carrier shall submit five copies of each request to withdraw in loose leaf form, inserted into two-ring or three-ring binders, tabbed or otherwise indexed to correspond to the exhibits set forth below.

1. A cover letter stating:

i. The name of the carrier, and 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;

ii. A clear specification of the nonstandard health benefits plan(s) which the carrier is seeking to withdraw, including the market name(s), form number(s), and the date(s) the form filing(s) was (were) approved by the Department; and

iii. A statement of facts relied upon as the basis under which the request is sought, including the specific factor(s) upon which the Commissioner may find that maintaining the nonstandard health benefits plan(s) represents an unreasonable financial burden to the carrier;

2. If the carrier intends to establish that renewal of an open nonstandard health benefits plan is an unreasonable financial burden for the carrier, then the carrier shall provide the following:

i. A statement certified to by an officer of the carrier that the total number of lives eligible for small employer health benefits plans covered under the open nonstandard health benefits plan during the 12 month period immediately preceding the date of submission of the request to withdraw was 1,000 or fewer, including only employees and not dependents; or a demonstration that the actual loss ratio of the open nonstandard health benefits plan is 100 percent, or greater, for the 12 month period preceding the date of submission of the request to withdraw;

ii. A detailed explanation, with supporting documentation, of the projected effect that continuation of the nonstandard health benefits plan(s) would have on the immediate and long term financial condition of the carrier;

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

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

v. Three-year financial projections beginning with the calendar year of the date of the filing assuming both

that the request to withdraw is granted and that it is denied;

vi. A description of any relief from obligations imposed by this State or any other state granted or in effect within the preceding 12 months, and the basis upon which such relief was granted; and

vii. Any other information the Commissioner may specifically deem relevant to the consideration of the particular carrier's request.

(d) The request to withdraw shall be accompanied by the form of the notice of nonrenewal to be provided to policyholders, contractholders, and certificateholders, which notice shall be in compliance with N.J.A.C. 11:21-13.6(a).

(e) Carriers requesting to withdraw a nonstandard health benefits plan shall concurrently provide notice of the request to the SEH Program at the address specified at N.J.A.C. 11:21-1.3.

(f) At the time of the filing of the request to withdraw, the carrier shall specify the number of policies, contracts and certificates issued under each nonstandard health benefits plan that is the subject of the request to withdraw, the approximate number of lives covered under each such nonstandard health benefits plan, and the approximate number of small employers covered under each such nonstandard health benefits plan.

(g) Carriers submitting a request to withdraw shall submit that request to:

SEH Program
Request to Withdraw Nonstandard Plans
Division of Financial Solvency
New Jersey Department of Banking and Insurance
CN 325
Trenton, NJ 08625-0325

11:21-13.5 Review and approval of a request to withdraw

(a) The Department shall deny a request to withdraw if the request fails to substantially comply with the filing format and information requirements set forth in N.J.A.C. 11:21-13.4. The Department shall notify the carrier in writing that its request to withdraw is deficient on such grounds. If the carrier intends to pursue its request to withdraw, the carrier shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in N.J.A.C. 11:21-13.4 within 30 days of receipt of the Department's notice of deficiency. Failure to submit within 30 days the required information shall result in the carrier's request being denied without prejudice.

(b) When the Commissioner determines that the requirement to continue servicing the nonstandard health benefits plan(s) specified in the request to withdraw is an unreasonable financial burden for the carrier, the Commissioner shall notify the carrier in writing that it may withdraw the specified nonstandard health benefits plan(s) subject to the standards of N.J.A.C. 11:21-13.6.

(c) If the Commissioner denies a carrier's request to withdraw made pursuant to the provisions of N.J.A.C. 11:21-13.4, the carrier may request a hearing on the Commissioner's determination within seven days from the date of receipt 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 Commissioner's determination;
- iii. A statement requesting a hearing; and
- iv. A statement describing in detail the basis for which the carrier believes that the Commissioner's denial is erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the carrier and such personnel of the Department as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

3. The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

i. In a matter which has been determined to be a contested case, if the Commissioner finds that there are no good-faith disputed issues of material fact and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition on the matter.

ii. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:21-13.6 Standards for the process of withdrawal of a nonstandard health benefits plan

(a) Carriers shall effect the withdrawal of the specified nonstandard health benefits plan(s), if the request is granted by the Commissioner, through nonrenewal of the policies, contracts or certificates issued under the nonstandard health benefits plan(s) at the time of the 12-month anniversary date of each such policy, contract or certificate, provided that each policyholder, contractholder or certificateholder is given 60 days written notice prior to the date of the nonrenewal.

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.

11:21-13.7 Other policyholder rights unaffected

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

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. 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

Authority

N.J.S.A. 17:1-8, 17:1-8.1, 17:1C-6(e), 17B:27A-17 et seq. and P.L. 1993, c.162.