CHAPTER 20

INDIVIDUAL HEALTH COVERAGE PROGRAM

Authority

N.J.S.A. 17:1-8.1 and 15e, and 17B:27A-2 et seq.

Source and Effective Date

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

Chapter Expiration Date

Chapter 20, Individual Health Coverage Program, expires on December 7, 2010.

Chapter Historical Note

Chapter 20, Individual Health Coverage Program, was adopted as emergency new rules by R.1993 d.344, effective June 14, 1993 (to expire August 13, 1993). See: 25 N.J.R. 2945(a). The concurrent proposal of Chapter 20 was adopted as R.1993 d.439, effective August 13, 1993, with changes effective September 7, 1993. See: 25 N.J.R. 2945(a), 25 N.J.R. 4180(a).

Subchapter 2, Individual Health Coverage Program Temporary Plan of Operation, was adopted as R.1993 d.550, effective October 14, 1993. See: 25 N.J.R. 4707(a), 25 N.J.R. 5244(a).

Subchapter 10, Performance Standards and Reporting Requirements, was adopted as R.1994 d.142, effective February 23, 1994. See: 26 N.J.R. 1202(a), 26 N.J.R. 1351(a).

Subchapter 11, Relief from Obligations Imposed by the Individual Health Insurance Reform Act, was adopted as R.1993 d. 654, effective December 30, 1993. See: 25 N.J.R. 4459(a), 25 N.J.R. 5930(b).

Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans, was adopted as R.1994 d.54, effective December 30, 1993. See: 26 N.J.R. 87(a), 26 N.J.R. 804(a).

Subchapter 13, Certification of Non-Member Status, was adopted as R.1994 d.177, effective March 10, 1994. See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Subchapter 17, Enrollment Status Report, was adopted as R.1994 d.53, effective December 30, 1993. See: 26 N.J.R. 90(a), 26 N.J.R. 806(a).

Subchapter 18, Withdrawal of Carriers from the Individual Market and Withdrawal of Plan, Plan Option, or Deductible/Copayment Option, was adopted as R.1998 d. 339, effective July 6, 1998. See: 29 N.J.R. 2615(a), 30 N.J.R. 2502(a).

Pursuant to Executive Order No. 66(1978), Chapter 20, Individual Health Coverage Program, Subchapters 1 through 10, 12, 13, 17, 18 and Appendix Exhibits A through T, were readopted as R.1998 d.443, effective August 7, 1998, and Subchapter 11 was readopted as R.1998 d.454, effective August 13, 1998. Subchapter 19, Petitions for Rulemaking, and Subchapter 20, Appeals from Actions of the Board, were adopted as new rules by R.1998 d.443, effective August 7, 1998. See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a); 30 N.J.R. 2192(a), 30 N.J.R. 3308(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 20, Individual Health Coverage Program, was extended by gubernatorial directive from August 7, 2003 to 270 days following Supreme Court decision in *In re Health Coverage Program's Readoption of N.J.A.C. 11:20-1.1 et seq.* See: 35 N.J.R. 2898(a).

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

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

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

Chapter 20, Individual Health Coverage Program, Subchapters 1 through 3, 6 through 10, 12, 17 through 20, 22 and Appendix Exhibits A through F, J through L, and Q through V, were readopted as R.2006 d.15, effective December 7, 2005, and Subchapter 11 was readopted as R.2006 d.16, effective December 7, 2005. Subchapter 12, Eligibility for and Replacement of Standard Health Benefits Plans and the Basic and Essential Health Care Services Plan, was repealed, and Subchapter 12, Purchase of a Standard Individual Health Benefits Plan or a Basic and Essential Healthcare Services Plan by a Person Covered under an Individual Plan or Eligible for or Covered under a Group Plan, was adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibit R, was repealed, by R.2006 d. 15, effective January 3, 2006. Subchapter 23, Rulemaking; Interested Parties; Public Notices; Interested Parties Mailing List, and Subchapter 24, Program Compliance, were adopted as new rules by R.2006 d.15, effective January 3, 2006. Appendix Exhibits A, C, E and U were repealed by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006). Exhibits A, C and E were adopted as new rules. See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a). See: Source and Effective Date. See, also, section annotations.

Case Note

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

CHAPTER TABLE OF CONTENTS

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

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

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

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

i. The engagement of independent financial consultants, including, but not limited to, examiners, auditors, accountants and actuaries;

ii. The Plan of Operation and amendments thereto;

iii. Standards of acceptability for the selection of auditing firms;

iv. The review of reports prepared by independent auditors and other audit-related matters the Board deems necessary;

v. Contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Plan;

vi. Methods for calculating assessments;

vii. Uniform audit program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier; and

viii. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time.

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

(f) All committee members shall be subject to the Individual Health Coverage Program Code of Ethics adopted by the Board pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D-12 et seq.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (d); and added a new (f).
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (a), deleted "and IHC Program members" in the first sentence; in (b), deleted 4 and recodified former 5 as 4; rewrote (d) and (f).

11:20-2.7 Financial administration

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

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

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

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

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

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

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

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

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

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

(e) All financial records shall be kept in accordance with the State's prescribed policies and procedures. The Board shall maintain the books and records of the IHC Program at a location in New Jersey in a manner so that financial statements may be prepared to satisfy the Act and other requirements of New Jersey law.

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

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

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

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

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

ii. Any adjustments as set forth in this Plan;

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

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

v. Other records required by the Board.

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

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

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

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

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
In (c), rewrote 2; in (d), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator"; and in (f), substituted "Executive Director" for "Interim Administrator or subsequently appointed Administrator" and changed the delivery deadline from September 30 of each year beginning in 1994 to December 31 of each year beginning in 1998 in the introductory paragraph, and substituted "Board" for "Technical Advisory Committee" in 2.
Amended by R.2006 d.15, effective January 3, 2006.
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), inserted "into" following "shall be deposited" in the introductory paragraph; in (c), rewrote 2; in (d), substituted "as necessary for the efficient administration of the program" for "subject to such conditions as the Board may prescribe"; in (e)4, deleted reference to the Temporary Plan.

11:20-2.8 Audits

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

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

2. The annual audit shall include the following items:

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

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

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

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

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

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

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

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

1. With respect to information regarding premium earned:

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

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).
In (b), deleted "or the Department" following "of the Board" in the second sentence.

11:20-2.17 (Reserved)

New Rule, R.1994 d.165, effective March 1, 1994.
See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(b).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.
The Expiration date of N.J.A.C. 11:20-2.17, was extended by gubernatorial directive to December 31, 2005, in accordance with N.J.S.A. 52:14B-5.1d.
See: 37 N.J.R. 2884(a).

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than $20.00, the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12 and 2.17 as appropriate. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12, an invoice for reimbursable net paid losses issued pursuant to N.J.A.C. 11:20-2.17, or a combined invoice for both administrative expenses and net paid losses.

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

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

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

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

2. Plan B, Appendix Exhibit A with pages identified as unique to Plan B;

3. Plan C, Appendix Exhibit A with pages identified as unique to Plan C;

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

5. HMO Plan, Appendix Exhibit B.

(b) 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 chapter Appendix Exhibits A and B, incorporated herein by reference with variable text as specified on the Explanation of Brackets, which is set forth as chapter Appendix Exhibit C, incorporated herein by reference, except as provided in subsection (c) below.

1. Members offering Plans A/50, B, C, and D shall offer the following annual deductible provisions:

i. The per covered person annual deductible shall be $1,000; and

ii. The corresponding per covered family annual deductible shall be $2,000, satisfied on an aggregate basis.

2. Members offering Plans A/50, B, C, and D may offer one or more of the following annual deductible provisions in addition to the deductible provisions specified in (b)1 above:

i. Per covered person annual deductible equal to $2,500, $5,000 or $10,000; and

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

3. Members offering Plans A/50, B, C, and D may offer one or more of the following annual deductible provisions in addition to the deductible provisions required in (b)1 above:

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

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

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

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

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

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

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

5. When issued using deductible provisions set forth in (b)1 and 2 above, Plans A/50, B, C, and D shall contain maximum out of pocket provisions as follows:

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

ii. The per covered person maximum out of pocket for Plan B shall be the sum of the annual deductible and $3,000;

iii. The per covered person maximum out of pocket for Plan C shall be the sum of the annual deductible and $2,500;

iv. The per covered person maximum out of pocket for Plan D shall be the sum of the annual deductible and $2,000;

v. The per covered family maximum out of pocket for Plans A/50, B, C and D shall be two times the per covered person maximum out of pocket, satisfied on an aggregate basis; and

vi. Coinsurance paid for covered prescription drugs under Plans A/50, B, C, and D, issued using deductibles set forth in (b)1 and 2 above shall not count toward the maximum out of pocket. Coinsurance for prescription drugs must continue to be paid even after the maximum out of pocket has been reached.

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

i. In the case of single coverage, the greater of $5,100 or the highest maximum out of pocket amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted, per covered person; and

ii. In the case of other than single coverage, $10,200 or the highest maximum out of pocket amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted.

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

i. In the case of single coverage, $3,000 or the highest maximum out of pocket amount for the calendar year in which coverage is renewed for which deductions under Internal Revenue Code §220(c)(2)(A) are permitted, per covered person; and

ii. In the case of other than single coverage, $5,500 or the highest maximum out of pocket amount for the calendar year in which coverage is renewed for which deductions under Internal Revenue Code Section 220(c)(2)(A) are permitted.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu of Plans A/50, B, C, and D in (a) above. State qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in addition to Plans A/50, B, C, and D in (b) above. HMO carriers offering the HMO Plan shall offer the $15.00 copayment plan design set forth in (c)1i below and may, at the option of the HMO, also offer other copayments or may also offer the HMO plan using deductible and coinsurance provisions. All options offered by the HMO member shall be made available to every eligible individual seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (c)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (c)3 below.

1. Carriers issuing HMO plans with a Copayment Design shall use the copayments set forth below:

i. Members offering the HMO Plan shall offer the plan with a $150.00 per day hospital inpatient copayment, $100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $15.00 copayment for all other services, except that the copayment for pre-natal care may be $25.00 as required by (c)3ii below;