NEW JERSEY ADMINISTRATIVE CODE

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TITLE 11. DEPARTMENT OF BANKING AND INSURANCE - DIVISION OF INSURANCE
CHAPTER 21. SMALL EMPLOYER HEALTH BENEFITS PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended (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.

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); Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. § § 1397aa through 1397jj); 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. At the option of the small employer, "spouse" includes a domestic partner pursuant to P.L. 2003, c.246.

"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. If an employee changes plans or if the employer transfers coverage to another carrier, the covered person's enrollment date does not change.

"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.

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital or medical services corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19), or any other similar contract, policy or plan issued to a small employer not explicitly excluded from the definition of health benefits plan. For purposes of this Act, "Health benefits plan" shall not include one or more, or any combination 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; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

"Health status-related factor" means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, death of a spouse, or divorce or legal separation or termination of a domestic partnership; and requests enrollment within 90 days after termination of coverage provided under another employer's

health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; the individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order; or initially waived coverage under the policy for himself or herself and any then existing dependents provided the employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the policy within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.

"Maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all covered services and supplies in a calendar year. All amounts paid as copayment, deductible and coinsurance shall count toward the maximum out of pocket. Once the maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for covered services and supplies for the remainder of the calendar year.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

"Medical care" means amounts paid:

1. For the diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and

2. Transportation primarily for and essential to medical care referred to in paragraph 1 above.

"Medicare" means coverage provided pursuant to Title XVIII of the Federal Social Security Act, Pub. L. 89-97 (42 U.S.C. § 1395 et seq.) and amendments thereto.

"Member" means a carrier that issues health benefits plans in New Jersey on or after November 30, 1992.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, as determined by the commissioner and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"Network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all services and supplies provided by network providers in a calendar year. All amounts paid as copayment, deductible and coinsurance shall count toward the network maximum out of pocket. Once the network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by network providers for the remainder of the calendar year. If a carrier wishes to use a common maximum out of pocket provision in a plan that has both network and non-network benefits, the network maximum out of pocket shall mean the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all services and supplies provided by network providers and non-network providers in a

calendar year. All amounts paid as copayment, deductible and coinsurance for both network and non-network services and supplies shall count toward the network maximum out of pocket. Once the network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by network or non-network providers for the remainder of the calendar year.

"Non-network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as deductible and coinsurance for all services and supplies provided by non-network providers in a calendar year. All amounts paid as deductible and coinsurance shall count toward the non-network maximum out of pocket. Once the non-network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by non-network providers for the remainder of the calendar year.

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.

"Plan sponsor" has the meaning given that term under Title I of section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(16)(B)).

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be considered as a preexisting condition.

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to the Act.

"Public health plan" means any plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two eligible employees on the first day of the plan year, and the majority of the eligible employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer. Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of P.L. 1992, c.162 (N.J.S.A. 17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L. 1992, c.162 (N.J.S.A. 17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such employer.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan issued to small employers pursuant to N.J.S.A. 17B:27A-19.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board, described at N.J.A.C. 11:21-3.1, and set forth in the Appendix to this chapter.

"State" means the State of New Jersey.

"State approved HMO" is a health maintenance organization which is approved pursuant to P.L. 1973, c.337 (N.J.S.A. 26:21-1 et seq.).

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Small Employer Health Benefits Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $ 20,000 per covered person per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

11:21-1.3 Communications with the Board

All written communications with the SEH Board shall be submitted to the SEH Board at the following address:

New Jersey Small Employer Health Benefits Program Board

20 West State Street, 10th Floor

PO Box 325

Trenton, New Jersey 08625-0325

Fax: (609) 633-2030

11:21-1.4 Penalties

Failure of a carrier to comply with any provision of this chapter shall result in the imposition of penalties as authorized by law, including, but not limited to, penalties set forth at N.J.S.A. 17B:27A-41 and 17B:27A-43.

11:21-1.5 Severability

If any provision of this chapter or the application thereof to any person or circumstance is found to be invalid for any reason, the remainder of the chapter and the application thereof to other persons or circumstances shall not be affected thereby.

11:21-1.6 Mission statement

The mission of the New Jersey Small Employer Health Benefits Program Board is to administer the New Jersey Small Employer Health Benefits Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders in the marketplace and other interested parties, and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to small employers and establishing and administering assessment mechanisms. It also includes the regulation of small employer health coverage carriers in conjunction with the New Jersey Department of Banking and Insurance and New Jersey Department of Health and Senior Services.

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

11:21-2.1 Purpose and structure

(a) The Program has been created pursuant to section 12 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-28) as amended to assure the availability of the five standardized health benefits plans to New Jersey small employers, their eligible employees and the dependents of those eligible employees, on a guaranteed issue basis.

(b) The Board has been created pursuant to Section 13 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-29) to administer the Program reasonably and equitably under law.

(c) The Program Plan of Operation ("Plan") has been created in accordance with Section 14 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-30) to set forth as completely as possible the reasonable and equitable manner by which the Board will administer the Program under applicable law.

(d) The Program shall be administered by the Board. The Board shall administer the Program in accordance with the Plan developed and adopted by the Board pursuant to law, subject to the review and approval of the Commissioner of Insurance.

(e) The Board shall consist of 18 persons, including the Commissioners of Health and Senior Services and Banking and Insurance or their designees, both of whom shall serve ex officio, and 10 public members who shall be elected by the members of the Program, subject to approval by the Commissioner, and six public members who shall be appointed by the Governor with the advice and consent of the Senate. Initially, three of the elected public members of the Board shall be elected for a three year term, three shall be elected for a two year term, and three shall be elected for a one year term. The tenth elected public member, added by P.L. 1994, c.97, shall be elected for a three year term. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a

term of two years. Thereafter, all public members of the Board shall be elected or appointed for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. No carrier shall have more than one representative on the Board, nor shall an HMO carrier and its affiliated insurance company, health service corporation, hospital service corporation, or medical service corporation have more than one representative on the Board.

(f) The following categories shall be represented among the elected public members:

1. Three carriers whose principal health insurance business is in the small employer market;

2. One carrier whose principal health insurance business is in the larger employer market;

3. A health, hospital or medical service corporation;

4. Two health maintenance organizations; and

5. Three persons representing small employers, at least one of whom represents minority small employers.

(g) The following categories shall be represented among the appointed public members:

1. Two insurance producers licensed to sell health insurance pursuant to N.J.S.A. 17:22A-1 et seq.;

2. One representative of organized labor;

3. One physician licensed to practice medicine and surgery in this State; and

4. Two persons who represent the general public and are not employees of a health benefits plan provider.

11:21-2.2 Definitions

The words and terms used in this Plan shall have the meanings set forth at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.2 or as further defined below:

"Administrator" or "Executive Director" means that person, persons, or entity selected by the Board to effectuate the administrative functions of the Program.

"Deferral" means a deferment, in whole or in part, of payments by a member of any assessment issued by the SEH Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-38 and N.J.A.C. 11:21-15.

"Earned premiums" means the premium earned in New Jersey on health benefits plans less returned premiums thereon.

"Plan of Operation" means the plan of operation of the Program, including articles, by-laws and operating rules approved by the Board pursuant to the Act.

11:21-2.3 Powers of the Board

(a) The Board has the specific authority pursuant to the Act to:

1. Adopt rules and regulations to establish a voluntary risk pooling arrangement.

2. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Act;

3. Sue or be sued, including taking any legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims;

4. Establish benefit levels, deductibles and copayments, exclusions, and limitations for the standard health benefits plans in accordance with applicable law;

5. Establish additional policy forms by which a small employer carrier, other than a health maintenance organization, may provide indemnity benefits for health maintenance organization enrollees by direct contract with the enrollees' small employer through the issuance of dual contracts to the small employer;

6. Assess members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organization and reasonable operating expenses. Such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

7. Establish rules, conditions and procedures pertaining to the assessment of the members of the Program;

8. Establish a standard policy form for five standard health benefits plans and five rider packages, as provided in the Act;

9. Appoint from among the members appropriate legal, actuarial, and other committees as necessary to provide technical and other assistance in the operation of the Program, policy and other contract design, and any other functions within the authority of the Program;

10. Employ or retain such persons, firms or corporations to perform such functions as are necessary for the Board's performance of its duties. The Board may use the mailing address of such person, firm or corporation as the official address of the Program. Such persons may include an Administrator or Executive Director with such authority as may be delegated by the Board to implement and carry out broad directives of the Board made pursuant to statutory powers. Such persons may include actuaries, accountants, auditors, insurance producers and such other specialists or persons whose advise or assistance is deemed by the Board to be necessary to the discharge of its duties under the Act. The Board may agree to compensate such persons so as best to serve the interests of the Program and the public. Such persons, firms or corporations shall keep and maintain such records of their activities as may be required by the Board.

11. Develop a method of handling and accounting for assets and moneys of the Program and an annual fiscal reporting to the Commissioner;

12. Develop a means of providing for the filling of vacancies on the Board, subject to the approval of the Commissioner;

13. Address any additional matters which are appropriate to effectuate the provisions of this Act; and

14. Develop a buyers' guide or other informational material for the Program, and provide for a reasonable charge for the use and distribution of such informational material.

11:21-2.4 Plan of Operation

(a) The Board shall perform its function under this Plan, and in accordance with the Act. The Plan is intended to assure the fair, reasonable and equitable administration of the Program and shall constitute a public record and accordance with the Act.

(b) The Plan does not, nor is it intended to, create any contractual or other rights or obligations between the Program and any entity or any person insured by any carrier. It does

not provide any benefits or create any obligation, contractual or otherwise, to any person or entity.

11:21-2.5 Board structure and meetings

(a) The Program shall exercise its powers through a Board.

1. The Board shall be made up of the Commissioner, the Commissioner of Health and Senior Services, or their designees (who shall serve ex officio) and 16 public members. The composition of the Board shall be as described in N.J.S.A. 17B:27A-29 as amended. No person representing one of the public members shall serve, or continue to serve, on the Board unless such person represents one of the categories specified in N.J.S.A. 17B:27A-29 as amended.

2. Initially, three of the elected public members shall serve for a term of three years; three shall serve for a term of two years; and three shall serve for a term of one year. The tenth elected public member, added by P.L. 1994, c.94 shall be elected for a three year term. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Thereafter, all public members shall serve for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. The public directors shall serve their terms of office until their replacements are duly elected or pursuant to the terms of their appointments as applicable.

i. On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the Program members setting forth the time, date and place of the election meeting, stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

ii. Following the close of the nomination period, the Board shall determine from among the carriers and/or small employers representatives nominated those persons that are eligible and willing to serve in the position for which nominated. Carriers may be placed on the ballot for only one position, and may not hold more than one seat on the Board. If a carrier is nominated for two or more positions for which it is eligible, the carrier shall notify the Board as to the single position for which it will accept the nomination, and be designated on the ballot.

iii. At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote absentee on or before a date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

iv. Affiliated carriers shall have no more than one vote for each position subject to vote and no two affiliated carriers shall serve on the Board at the same time.

v. Elections shall be by the highest number of votes properly cast in person and absentee.

vi. The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:21-2.11.

3. The Board may elect a Chair and Vice Chair from among its Directors, as well as other officers, as it deems appropriate. The election of officers shall be held annually or more frequently if needed to fill vacancies. Subject to the provisions of the Act and as authorized by the Board, such officers are authorized to serve as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(b) The votes of the Board shall be on a one person, one vote basis. An elected public member, other than the three small employer representatives provided for in Section 13 of the Act (N.J.S.A. 17B:27A-29) as amended by P.L. 1994, c.97, and the Commissioners of Health and Senior Services and Banking and Insurance or their designees, may designate a voting alternate employed by the same carrier or same State agency, as appropriate. Appointed public members and the three small employer representatives, all of whom are appointed or elected as individuals, may not designate a voting alternate.

(c) A majority of the Directors shall constitute a quorum for the transaction of business. The acts of the majority of the Directors at a meeting at which a quorum is present shall be the acts of the Board, except as otherwise provided herein.

(d) A meeting of the Board shall be held no later than the first Tuesday in April each year in accordance with the State's Open Public Meetings Act.

(e) At least once each year, the Board shall meet to:

1. Review the Plan and submit proposed amendments, if any, to the Commissioner for review;

2. Review reports of the committees established by the Board;

3. Review and approve the rate of interest to be charged for late payments;

4. Review and approve changes in the communications program, as recommended by the Marketing and Communications Committee;

5. Determine whether any technical corrections or amendments to the Act should be recommended to the Commissioner;

6. Fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office; and

7. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the program.

(f) The Board shall hold other meetings upon the request of the Chair or three or more Directors, as deemed appropriate. A meeting may be held in person or by telephone. Notice of such a meeting and its purpose shall be provided to the general public and to the Directors in accordance with the State's Open Public Meetings Act.

(g) The Board shall keep reasonably comprehensive minutes of all its meetings showing the time and place, the Directors present, the subjects considered, the actions taken, the vote of each Director, and any other information required to be shown in the minutes by law. The original of the public record shall be retained by the Board or its agent and shall be promptly available to the public to the extent that making such matters public shall not be inconsistent with Section 7 of the Open Public Meetings Act (N.J.S.A. 10:4-12). At least two copies of the minutes of each meeting of the Board shall be delivered forthwith to the Commissioner; delivery to the Commissioner's designee on the Board shall satisfy this requirement.

(h) The Board may establish rules of the Program consistent with the Act and this Plan.

(i) Amendments to the Plan or suggestions for technical corrections to the Act shall require the concurrence of a majority of the entire Board.

(j) Directors shall not be compensated by the Program for their services but may be reimbursed for reasonable unreimbursed travel expenses incurred in attending Board and committee meetings pursuant to the State Travel Guidelines issued by the Department of the Treasury.

(k) The Board may adopt rules for the taking of testimony from the public, which may include rules relating to the time and place of any such public hearing, and reasonable rules for the length and format of testimony from individuals, groups and organizations.

(l) The Board may take up any additional matters which are appropriate to effectuate the provisions of this Act.

(m) The affirmative vote of at least two-thirds of the Directors present at a meeting shall be required to authorize assessments and the expenditure of Program funds.

11:21-2.6 Committees

(a) Appointments to Standing and other committees shall be approved by a majority of the Board present. Each of the Standing Committees shall include no more than seven directors, but the Board Chair may appoint additional persons, who need not be directors, as needed, with the approval of a majority of the Board. A written record of the proceedings of each committee shall be maintained by the Administrator or Executive Director. Committee members are responsible for providing staff support, but may recommend that the Board provide funding for outside contractors. Committees may not take final action; however, within the scope of their mission and duties, Committees may make recommendations and reports to the Board for its decision and action.

(b) Standing Committees shall include the following:

1. A Finance and Operations Committee which shall make recommendations to the Board with respect to:

i. The methods and rules for calculating assessments;

ii. Assessment of members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organizational and reasonable interim operating expenses;

iii. Independent consulting actuaries who may be approved by the Board;

iv. Establishment of rules, conditions, and procedures pertaining to the registry of multiple employer arrangements in accordance with the provisions of the Act; and

v. Oversight of studies necessary for development of reinsurance mechanisms;

vi. The Plan amendments thereto;

vii. The selection of an independent auditor for the annual audit of the Program operations;

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

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

x. Developing the means to select a Program Administrator or Executive Director, a statement of the powers and duties of the Administrator or Executive Director, the compensation of the Administrator or Executive Director, and a statement of the efficiency standards an Administrator or Executive Director must meet; and

xi. Recommendations for employing or retaining persons, firms or corporations to perform the functions necessary for the Board's performance of its duties, including retention of an Administrator or Executive Director for the Program;

2. A Legal Committee which shall make recommendations to the Board with respect to:

i. Appropriate interpretations of the Act, and such other matters as the Board may desire, including rules and regulations promulgated by the Board pursuant to the Act;

ii. Amendments to the Plan, and the various health benefits plans proposed by the Board for compliance with the Act, and by implication under Federal or other State legislation;

iii. Proposed amendments to the Act for Board approval;

iv. Contracts and legal documents for the Program;

v. All litigation and other disputes involving the Program and its operations;

vi. Maintenance of a written record of all written requests for a formal opinion of the Board received and responses provided by the Board.

vii. Coordination with legal counsel for the Board, as needed, on matters relating to the Program operations, including proposed contracts, operational practices, and statutory construction;

viii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the Program or a member;

ix. The Board's entering into contracts necessary or proper to carry out the provisions and purposes of the Act; and

x. Legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims and other matters related to lawsuits by or against the Board;

xi. Whether and how to respond to interpretations of the Board's rules made by carriers and inquiries and complaints received from consumers, policyholders, carriers or others.

(1) Recommendations by the Legal Committee may include a recommendation that the Board issue a statement interpreting its regulations, seek declaratory or injunctive relief as may be appropriate, or other administrative or legal remedies as may be available.

(2) In an effort to answer any inquiry or resolve any dispute or complaint, the Legal Committee, Administrator, or Executive Director may seek the input of other appropriate Committees in order to assist the Legal Committee in reaching a recommendation.

(3) The Legal Committee may refer matters as necessary to any other Committee which may also make recommendations to the Board.

3. A Marketing and Communications Committee which shall make recommendations to the Board with respect to:

i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of health benefits plans to eligible employees;

ii. Marketing and communication plans for the Program, as needed;

iii. Issues or concerns arising out of the marketing of Program coverage;

iv. The development of information concerning the Program to be released to the general public; and

v. Reviewing marketing material submitted by carriers in accordance with the Act; and

4. A Policy Forms Committee which shall make recommendations to the Board with respect to:

i. Optional benefit rider filings received pursuant to N.J.A.C. 11:21-3.2(d);

ii. Modifications to the standard health benefits plan policy forms and related forms;

iii. Interpretations of the standard health benefits plans and policy forms;

iv. Development of new standard health benefits plan policy forms as permitted by statute; and

v. Substantive and structural plan design issues.

(c) The Board may appoint other committees. The Board may by resolution adopted by a majority of the entire Board:

1. Determine the size of and appoint members to and/or fill any vacancy in any committee;

2. Appoint one or more persons to serve as alternate members of any committee, to act in the absence or disability of members of any committee with all the powers of such absent or disabled members;

3. Abolish any committees, in its discretion;

4. Remove any person from membership on any committee at any time, with or without cause; and

5. Authorize or appoint the use of consultants or other advisors to work with any committee.

(d) All committee members, including those committee members who are not also members of the Board, shall be subject to the Small Employer Health Benefits 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. Committee members who are not also members of the Board shall be required to file a Certification, in a form to be provided by the Board, stating that they, and the respective entities and/or carrier by whom they are employed, agree to be subject to all applicable terms set forth in the Code of Ethics.

11:21-2.7 Administrator or Executive Director selection and duties

(a) The Administrator or Executive Director shall be selected by the Board.

(b) The Administrator or Executive Director shall perform the administrative functions required under the Act and the Plan. The Administrator or Executive Director is responsible, along with the Board, for the fair, equitable and reasonable administration of the Program.

(c) The Administrator or Executive Director shall perform all administrative functions developed by the Board including the following:

1. Preparing and submitting an annual report to the Board and the Commissioner no later than September 1; preparing and submitting monthly reports to the Board;

2. Establishing the procedures and installing the systems needed to properly administer the operations of the Program;

3. Establishing with Board approval, one or more depository accounts for the transaction of Program business;

4. Collecting assessments due to the Program on a timely basis;

5. Depositing all moneys collected on behalf of the Program on a timely basis in the State Treasury in an account established for that purpose;

6. Issuing checks or drafts, on and or approving charges against bank accounts of the Program;

7. Keeping all accounting, administrative and financial records of the Program;

8. Acting as a resource for carriers in complying with the Program;

9. Calculating all assessments in accordance with the methodology approved by the Board; notifying members of amounts due; tracking the amount of assessments in dispute or subject to deferral request; coordinating with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters;

10. Preparing an annual estimate of the operating and administrative expenses of the Program; and

11. Performing other functions as agreed between the Board and the Administrator or Executive Director.

(d) The Administrator or Executive Director shall maintain calendar year records of premiums, reimbursements, and fiscal year operating and administrative expenses of the Program and shall retain these records for a period of seven years following the end of such calendar year or as otherwise required pursuant to N.J.S.A. 47:3-15 et seq.

(e) The Board may select, and establish compensation for, such other staff as may be necessary for the administration of the Program.

11:21-2.8 Assessments for administrative and operating expenses

(a) Within 45 days after approving a final audited Program statement, the Board shall determine the final administrative expense total for the fiscal year, if any.

1. Each member's final assessment shall be reduced by any interim assessment paid by the member or credited to the member by the Board.

2. Each member's final assessment shall be reduced by any deferred assessments paid by assessed carriers in proportion to the original additional assessment made to cover the deferred amount.

3. Members shall be assessed for a proportionate share of the final administrative expenses for the fiscal year on the basis of health benefits plan earned premiums for the calendar year that includes the first six months of the fiscal year. The administrative expense assessment for each member shall be equal to the total of all administrative expenses for the fiscal year multiplied by the ratio of that member's earned premium for health benefits plans to the earned premium for health benefits plans of all members of the calendar year that includes the first six months of the fiscal year.

i. Beginning in Fiscal Year 2005, if a member's proportionate share of the interim assessment or final administrative assessment is less than $ 5.00, the carrier shall not be assessed and the amounts uncollected will be reapportioned proportionally, based on market share, among the member carriers.

(b) The Board may make an interim assessment of members for reasonable and necessary organizational expenses and to cover anticipated interim operating expenses. At the discretion of the Board, interim assessments may be made on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses.

(c) Assessment 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, SEH Program, and mailed to the Executive Director at the address in N.J.A.C. 11:21-1.3.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 45 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 as permitted by N.J.S.A. 17B:27A-32c.

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 amount has accrued, shall include the interest penalty amount accrued as of the invoice date; otherwise, payment shall not be considered to be in full.

2. Carriers that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the Board, shall be assessed 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 carrier, or, if a contested case, the Board has rendered a final determination in favor of that carrier in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

3. A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:21-15.

i. 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 to be held in an interest bearing account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

ii. If the member withholds payment, as permitted herein and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth herein, accruing from the date of the invoice for the assessment.

4. Amounts deferred by the Commissioner or subject to dispute, which dispute is resolved in favor of the carrier, shall be redistributed among all other members proportionately.

(d) The Administrator or Executive Director shall coordinate with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters, and develop appropriate procedures for such matters, and disburse funds for administrative expenses upon the directive of the Board.

1. Amounts of assessment in dispute or subject to deferral request, including any interest penalty paid by a carrier pursuant thereto, shall not be disbursed by the Administrator or Executive Director until such time as the dispute has been settled against the disputing carrier, or the deferral denied, 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 according to Board directive.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing carrier, or a deferral is granted, shall be returned to the appropriate

carrier within 15 days of the date that the Administrator or Executive Director receives notice of the determination by the Board or the Commissioner, as applicable along with the proportionate amount of interest penalty, if any, paid by the carrier for late payment of the amount.

(e) A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Administrator or Executive Director in order to preserve its right to the moneys owed and paid pursuant to the invoice for assessment.

(f) If a member 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 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 or to take such other action against the carrier as may be authorized by law. 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.

11:21-2.9 Reporting requirements

Carriers shall submit statements, assessments and other reports as may be required by the Board pursuant to the Act.

11:21-2.10 Financial administration

(a) The Board shall maintain the books and records of the Program so that financial statements can be prepared to satisfy the Act. Further, these books shall satisfy any additional requirements of the Board and outside auditors.

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

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

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

4. The net balance due to or from the Program shall be calculated for each carrier and confirmed as deemed appropriate by the Board or when requested by the respective carrier. These balances should be supported by a record of each individual carrier's financial transactions with the Program. These records include:

i. Any adjustments to assessments as explained in this Plan;

ii. Adjustments to the amount due to/from the Program based upon corrections to carrier submissions;

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

iv. Other records required by the Board.

5. The Board shall maintain a general ledger which balances are used to produce the 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 ledgers or journals.

6. The Board's fiscal year shall begin on July 1 and end on June 30.

7. Assessments shall be paid when billed. If the assessment is not received by the Board within 45 days of the invoice date, the carrier shall pay interest on the assessment from the invoice date at the rate of 1.5 percent per month except if the carrier is granted a deferral.

(b) All funds of the Program shall be deposited in, and all disbursements made from, the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget, and all financial records shall be kept in a form acceptable to the Office of Management and Budget.

1. Funds of the Program shall be deposited into a dedicated account within the General Fund.

2. Moneys shall be credited from the General Fund, with the approval of Director of the Division of Budget and Accounting to the Program's bank accounts upon request by the Board through the Department.

3. The Administrator or Executive Director shall make such requests for funds as directed by the Board and shall deposit all moneys received from the Treasury in a Board bank account.

(c) A bank checking account and interest-bearing investment accounts shall be established separately in the name of the 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. All investment income earned shall be credited to the Program and shall be applied to reduce future assessments of members for the Program administrative expenses.

11:21-2.11 Records

(a) The Board shall provide for the maintenance and retention of its official records in accordance with the Destruction of Public Records law (N.J.S.A. 47:3-15-32) and all other applicable laws.

(b) The Board's records shall include the following:

1. Minutes of all Board meetings;

2. Written reports and recommendations of committees to the Board;

3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules;

4. Riders proposed or adopted by the Board, including all comments received;

5. The Plan of Operation and any amendments thereto;

6. Records concerning the election of Directors and appointment of committees and committee members;

7. Regulations or actions proposed or adopted by the Board, including all comments received; and

8. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to the "Right-to-Know" Law (N.J.S.A. 47:1A-1 et seq.) except that information in filings determined by the Board or the Department by regulation to be confidential and proprietary shall not be subject to public inspection and copying, and except that written communications of the Board, its staff, or committees, including, but not limited to, reports, opinions, and recommendations, where such communications contain discussion of litigation strategy, attorney-client advice or other privileged information, shall not be available for public inspection and copying.

11:21-2.12 Audit functions

(a) The Program shall have an annual audit of its operations conducted by an independent certified public accountant approved by the Board. This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for the Program; and

2. The annual fiscal report of the Program.

11:21-2.13 Penalties/adjustments and dispute resolution

(a) Numerous factual determinations and tasks shall be performed by carriers relative to their participation in the Program. It is expected that all carriers will exercise good faith and due diligence in all aspects of their relationship with the Program. Errors may occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

1. Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, except as provided herein.

2. All other additional sums due to the Program as a result of errors made by carriers shall be paid immediately, with interest.

3. If the Board determines that the nature or extent of errors made by a particular carrier evidences gross negligence or intentional misconduct, the Board may, after notice, recommend to the Commissioner, Attorney General, and other appropriate officials, penalties and sanctions as may be appropriate in accordance with the Act.

4. All interest payments required under this Plan shall be calculated at 1.5 percent per month, from the date the incorrect payment occurred or a payment should have been made, through the date the correct payment is made. Errors reported by carriers within 60 days of their occurrence shall not be subject to interest.

(b) A carrier seeking to challenge the amount of an assessment shall do so within 20 days of receiving the notice of assessment following the procedures in (d) below.

(c) A carrier which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the Board consistent with the appeals procedures set forth at N.J.A.C. 11:21-2.17.

11:21-2.14 Indemnification

(a) A member or employee of the Board, including the Administrator or Executive Director and staff, shall not be liable in an action for damages to any person for any action taken or recommendation made by him or her within the scope of his or her functions as a member or employee, if the action or recommendation was taken or made without malice.

(b) The members of the Board shall be indemnified and their defense of any action provided for in the same manner and to the same extent as employees of the State under the "New Jersey Tort Claims Act," P.L. 1972, c.45, on account of acts or omissions in the scope of their employment.

11:21-2.15 Amendment and termination

(a) This Plan may be amended by a majority vote of the entire Board, subject to approval of the Commissioner as provided hereinafter. A vote on an amendment may be taken at any meeting called, in whole or in part, for the purpose of considering a proposed amendment. Written notice of any meeting at which an amendment to the Plan is to be considered shall be sent to each Director by mail or facsimile transmission at least 10 days (exclusive of the meeting day) prior to the date of the meeting. Such notice shall state that an amendment to the Plan is to be considered at the meeting and shall set forth the substance of any amendments which have been proposed or a description of the section or sections which are proposed to be amended. Notice to a Director shall be deemed sufficient if mailed, postage prepaid, to the most recent address provided by the Director to the Board or sent by facsimile transmission to the most recent facsimile reception number provided by the Director. At any meeting for the consideration of an amendment to the Plan, for which proper notice has been given pursuant to this section, the Board may vote on any amendment proposed by a Director prior to, or during the meeting. Any amendment adopted by the Board shall be submitted to the Commissioner for approval. Any such amendment submitted to the Commissioner shall be deemed approved no later than 90 days after receipt by the Commissioner unless expressly disapproved in writing by the Commissioner before expiration of the approval period. Amendments to the Plan must be adopted pursuant to P.L. 1993, c.162.

(b) The Program shall continue in existence subject to termination in accordance with the laws of this State or the United States of America. In case of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the Program, the Program shall terminate and conclude its affairs. Any funds or assets held by the Program following the payment of all claims and expenses of the Program shall be distributed to the members at that time in accordance with the then-existing assessment formula.

11:21-2.16 (Reserved)

11:21-2.17 Appeals

(a) If the Board denies a member's request for relief made pursuant to this chapter, or if the member objects to the terms of the relief granted, the member may request a hearing on the Board's determination within 20 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, daytime telephone number, and fax number of a contact person familiar with the matter;

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the material facts in dispute and describing the basis for which the member believes that the Board's findings of fact are erroneous.

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are material issues of fact in dispute.

3. The Board shall, within 45 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., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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

ii. If the Board finds that the matter does not constitute a contested case, it may, with the approval of the Director of the Office of Administrative Law, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21. If the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

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SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

11:21-3.1 Benefits provided

(a) The standard health benefits plans 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, "The Small Group Health Benefits Basic Policy," Exhibit A and V;

2. Plan B, "The Small Group Health Benefits Policy B," Exhibit F and W;

3. Plan C, "The Small Group Health Benefits Policy C," Exhibit F and W;

4. Plan D, "The Small Group Health Benefits Policy D," Exhibit F and W;

5. Plan E, "The Small Group Health Benefits Policy E," Exhibit F and W;

6. Exhibit F contains those items of Plans B, C, D and E which are common among the plans as well as text which is unique to Plans B, C, D and E, where such Plan unique text is clearly identified;

7. HMO Plan, "The Small Group Health Maintenance Organization Contract," Exhibit G and Y; and

8. HMO/POS Plan, "The Small Group Health Maintenance Organization Point of Service ("POS") Contract," Exhibit HH and II.

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall offer all of the health benefits Plans A, B, C, D and E as set forth in Exhibits A and F, V and W, in the Appendix, except as set forth in (c) below.

1. Plan A shall contain a deductible of $ 250.00 per covered person and:

i. $ 500.00 per covered family, to be satisfied by two separate covered persons and a per person maximum out of pocket of $ 7,750; or

ii. $ 750.00 per covered family, to be satisfied on an aggregate basis and a per person maximum out of pocket of $ 7,750.

2. Plans B, C, and D shall contain annual deductible provisions consistent with the following specifications:

i. The per covered person annual deductible shall be an amount not less than $ 250.00 and not greater than $ 5,000.

ii. The per covered family annual deductible shall be, at the option of the carrier, either:

(1) Two times the per covered person annual deductible, and may either be satisfied by two separate covered persons or on an aggregate basis; or

(2) Three times the per covered person annual deductible and must be satisfied on an aggregate basis.

3. Plans B, C, and D shall contain maximum out of pocket provisions consistent with the following specifications:

i. The per covered person maximum out of pocket for Plan B shall be the sum of the annual deductible and an amount not less than $ 2,000 and not greater than $ 10,000.

ii. The per covered person maximum out of pocket for Plan C shall be the sum of the annual deductible and an amount not less than $ 2,000 and not greater than $ 10,000.

iii. The per covered person maximum out of pocket for Plan D shall be the sum of the annual deductible and an amount not less than $ 2,000 and not greater than $ 10,000.

iv. The per covered family maximum out of pocket shall be at the option of the carrier, either:

(1) Two times the per covered person maximum out of pocket, and may either be satisfied by two separate covered persons or on an aggregate basis; or

(2) Three times the per covered person maximum out of pocket and must be satisfied on an aggregate basis.

4. Plan E shall contain a deductible of $ 150.00 per covered person and:

i. $ 300.00 per covered family, to be satisfied by two separate covered persons, with a per person maximum out of pocket of $ 1,650, and a family maximum out of pocket of $ 3,300 to be satisfied by two separate covered persons; or

ii. $ 450.00 per covered family, to be satisfied on an aggregate basis, with a per person maximum out of pocket of $ 1,650, and a family maximum out of pocket of $ 4,950 to be satisfied on an aggregate basis.

(c) State approved and Federally qualified HMO members may offer the HMO Plan, as set forth in Exhibit G of the Appendix, in lieu of Plans A through E in (a) above. HMO members offering the HMO Plan shall offer one or more of the following plan designs using copayments and may, at the option of the HMO members, also offer HMO plans using deductible and coinsurance provisions. All options offered by the HMO member shall be made available to every small employer 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. Copayment Design:

i. The hospital inpatient copayment shall be: $ 75.00; $ 100.00; $ 150.00; $ 200.00; $ 300.00; $ 400.00; or $ 500.00.

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, pre-natal care and prescription drugs shall be: $ 5.00; $ 10.00; $ 15.00; $ 20.00; $ 30.00; $ 40.00; or $ 50.00, respectively.

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be: $ 5.00; $ 10.00; $ 15.00; $ 20.00; $ 30.00; $ 40.00; or $ 50.00.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $ 250.00 and not greater than $ 2,500 per person. The covered family deductible shall be two times the per person deductible and may, at the option of the HMO, either be satisfied by two separate covered persons or may be satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies or prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in five percent increments.

iv. The maximum out of pocket shall be a dollar amount not to exceed $ 5,000, and for a covered family shall not exceed two times the per person maximum out of pocket.

3. Common Features:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall be, at the option of the carrier, $ 50.00, $ 75.00 or $ 100.00.

ii. The pre-natal care/maternity copayment, which shall only be required at the initial visit, shall be, at the option of the carrier, either $ 25.00, or equal to the copayment applicable to a primary care physician visit.

iii. Prescription drugs covered under the HMO plan, as opposed to under a separate prescription drug rider, shall be subject to 50 percent coinsurance, or a $ 15.00 copayment, at the option of the HMO.

(d) The standard health benefits Plans B, C, D and E and optional riders may be offered through or in conjunction with a selective contracting arrangement approved pursuant to P.L. 1993, c.162, section 22. The standard health benefits Plans B, C, D and E and optional riders may be offered with the same selective contracting arrangement by a carrier that is exempt from the requirements of P.L. 1993, c.162, section 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through an approved selective contracting arrangement and plans with selective contracting arrangement features issued by an entity exempt from the requirements shall be subject to the following:

1. All of the requirements of N.J.A.C. 11:4-37.3(b)6;

2. The network annual deductible shall be an amount not less than $ 250.00 and not greater than $ 2,500 per covered person, and for a covered family shall not exceed two times the per covered person annual deductible, satisfied on either an individual basis or on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies;

3. The network maximum out of pocket shall not exceed $ 5,000 per covered person, and for a covered family shall not exceed two times the per covered person maximum out of pocket. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies;

4. The non-network annual deductible shall be no more than three times the network annual deductible per covered person, and for a covered family shall equal two times the per covered person annual deductible;

5. The non-network maximum out of pocket shall be no more than three times the network maximum out of pocket per covered person, and for a covered family shall equal two times the per covered person maximum out of pocket; and

6. The HMO Plan standard copayment levels for practitioner visits, emergency room and hospital confinements may be substituted for deductibles applicable to network benefits.

(e) The standard health benefits Plan A may be offered through or in conjunction with a managed care arrangement, and shall be subject to the following:

1. For those services which are subject to 20 percent coinsurance, the network benefit shall not be subject to coinsurance;

2. For those services which are subject to 50 percent coinsurance, the network coinsurance shall be 30 percent;

3. The network maximum out of pocket shall not exceed $ 5,000 per covered person. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies; and

4. The non-network maximum out of pocket shall be no more than three times the network maximum out of pocket per covered person.

(f) An insurer with an approved selective contracting agreement, like all other carriers, shall offer the standard health benefits plans, whether as indemnity plans or through or in conjunction with a selective contracting arrangement, in all geographic areas in the State.

1. If an insurer's approved service area for its selective contracting arrangement includes all geographic areas in the State, the insurer shall offer the standard health benefits plans as either indemnity plans or through or in conjunction with a selective contracting arrangement, or both, in all geographic areas in the State.

2. If an insurer's approved service area for its selective contracting arrangement does not include all geographic areas in the State, the insurer shall offer:

i. The standard health benefits plans as indemnity plans in all areas in the State not included in its approved service area; and

ii. The standard health benefit plans as either indemnity plans or in conjunction with a selective contracting arrangement, or both, in all geographic areas within its approved service area.

3. If an insurer with a limited approved service area chooses to offer the standard health benefit plans only through or in conjunction with a selective contracting arrangement in its limited approved service area, and later receives approval for its selective contracting arrangement in additional geographic areas in the State, the insurer shall not be required to offer the standard health benefits plans as indemnity plans in the newly approved areas, but

shall be required to renew the in force standard health benefits plans in the newly approved service areas.

(g) A carrier that is exempt from the requirements of P.L. 1993, c.162, section 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute shall offer the standard health benefits plans whether as indemnity plans or as PPO or POS plans in all geographic areas of the State.

1. If such a carrier has agreements with participating providers in all geographic areas of the State, the carrier shall offer the standard health benefits plans either as indemnity plans or as PPO or POS plans or any such combination in all geographic areas of the State.

2. If such a carrier has agreements with participating providers only in certain geographic areas of the State, the carrier shall offer:

i. The standard health benefits plans as indemnity plans in all geographic areas of the State where it does not have agreements with participating providers; and

ii. The standard health benefits plans whether as indemnity plans or as PPO or POS plans or any such combination in all geographic areas of the State where it has agreements with participating providers.

3. If such a carrier which has agreements with participating providers only in certain geographic areas of the State chooses to offer the standard health benefits plans only as PPO or POS plans in such areas and later expands the area in which it has agreements with providers, the carrier shall not be required to offer the standard health benefits plans as indemnity plans in the expanded area, but shall be required to renew the in force standard health benefits plans in the newly expanded area.

(h) State approved and Federally qualified HMO members may offer the HMO POS plan, as set forth in Exhibit HH of the Appendix, so long as the member is in compliance with N.J.A.C. 8:38-14, which regulations set forth requirements for HMOs offering indemnity benefits. HMO members offering the HMO POS plan may offer the following arrangements set forth in (h)1, 2 and 3 below with respect to their network services and supplies. The non-network deductible, coinsurance and maximum out of pocket must comply with N.J.A.C. 11:21-3.1(d).

1. Copayment Design:

i. The hospital inpatient copayment shall be: $ 75.00; $ 100.00; $ 150.00; $ 200.00; $ 300.00; $ 400.00; or $ 500.00.

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, pre-natal care and prescription drugs shall be: $ 5.00; $ 10.00; $ 15.00; $ 20.00; $ 30.00; $ 40.00; or $ 50.00, respectively.

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be: $ 5.00; $ 10.00; $ 15.00; $ 20.00; $ 30.00; $ 40.00; or $ 50.00.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $ 250.00 and not greater than $ 2,500 per person. The covered family deductible shall be two times the per person deductible and may, at the option of the HMO, either be satisfied by two separate covered persons or may be satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies or prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in five percent increments.

iv. The maximum out of pocket shall be a dollar amount not to exceed $ 5,000 and for a covered family shall not exceed two times the per person maximum out of pocket.

3. Common Features:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall be, at the option of the carrier, $ 50.00, $ 75.00 or $ 100.00.

ii. The pre-natal care/maternity copayment, which shall only be required at the initial visit, shall be, at the option of the carrier, either $ 25.00, or equal to the copayment applicable to a primary care physician visit.

iii. Prescription drugs covered under the HMO-POS plan, as opposed to under a separate prescription drug rider, shall be subject to the non-network deductible and coinsurance.

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

(a) Members that offer health benefits Plans B, C, D and E may offer one or more of the standard optional benefit riders set forth in (c)1 and 2 below. Members that offer the HMO health benefits plan may offer the prescription drug riders set forth in (c)3 below. All riders shall contain the benefits, limitations and exclusions set forth in the Appendix which is incorporated herein by reference and shall be issued in the standard form set forth in the Appendix which is incorporated herein by reference. A member electing to offer an optional benefits rider with a standard health benefits plan (Plan B, C, D, E, HMO plan, or HMO POS plan as applicable) must offer the rider to any employer seeking to purchase that health benefits plan.

(b) Any member electing to offer one or more standard optional benefits riders shall file a statement identifying the rider(s) to be offered and identifying the health benefits plan(s) with which the rider will be offered. The statement shall be filed with the Board no later than 30 days prior to the date the rider is to be offered to employers, and shall set forth the date on which the carrier proposes to offer such rider(s).

(c) The standard optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select the following rider, set forth at Exhibit H, to be offered with each health benefits Plan (Plan B, C, D or E):

i. Mail order and card;

ii. Card only; or

iii. Mail order only; and

2. Replacement prescription drug benefits for the HMO Plan or the HMO POS Plan. The carrier may select the following rider, set forth at Exhibit H, to be offered with the HMO or HMO POS health benefits plan:

i. Mail order and card;

ii. Card only; or

iii. Mail order only.

(d) In addition to the standard optional benefit riders listed in (c) above, members may offer riders that revise in any way the coverage offered by Plans A, B, C, D, E, HMO, and HMO POS plan subject to the provisions set forth in (d)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that decreases any one benefit or decreases the actuarial value of Plans A, B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof for informational purposes with the Board, and for approval by the Commissioner. No rider filed with the Commissioner may be sold until approved by the Commissioner.

2. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans A, B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof with the Board for informational purposes.

3. "Coverage" offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above includes, but is not limited to:

i. The types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations" and "Exclusions" sections of Plans A, B, C, D, and E the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan, and the "Covered Services and Supplies," "Covered Charges," "Covered Charges with Special Limitations," "Non-Covered Services and Supplies and Non-Covered Charges" sections of the HMO POS plan;

ii. Deductibles, Coinsurance, Copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans A, B, C, D, E, HMO, and HMO POS as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident; and

iii. Eligibility as set forth in the "Employee coverage," "Dependent coverage" and "Continuation rights" sections of Plans A, B, C, D, and E, the "Eligibility" and "Continuation Provisions" of sections of the HMO plan, and the "Eligibility" and "Continuation Rights" sections of the HMO POS plan.

4. "Coverage" offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:21-1.2, except for dental coverage where the additional dental coverage is subject to the standard plan's deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:21-1.2.

5. In addition to (d)1, 2, 3 and 4 above, any benefit rider or amendments thereof shall be subject to the provisions of Sections 2, 3(b), 6, 7, 8, 9 and 11 of P.L. 1992, c.162.

6. A member making an informational filing to the Board pursuant to (d)2 above shall:

i. Submit one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:21-1.3;

ii. Submit one copy of the rider or riders which amend the standard group policy and certificate forms, which rider or riders shall include cross-references to the standard group policy and certificate provisions or sections and/or pages which are being modified;

iii. Specify whether the rider or amendment thereof is to be used in connection with standard health benefit Plans A, B, C, D, E, HMO, or HMO POS plan and provide clear and conspicuous notice of such on the forms submitted for each rider;

iv. The standard group policy and employee certificate language shall not be altered, and the benefit modifications shall appear only on the rider or riders;

v. Submit copies of the standard group policy and certificate page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

vi. For riders of increasing value only, submit copies of a certification signed by a duly authorized officer of the member that states clearly:

(1) That the rider or amendment thereof increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan A, B, C, D, E, HMO, or HMO POS;

(2) That the filing is complete and in accordance with all the requirements of this subsection and applicable New Jersey statutes and regulations;

(3) That the member will offer the rider or amendment thereof to any small employer seeking to purchase the health benefits plan it modifies;

(4) That a rate filing for the rider has been made with the Commissioner pursuant to N.J.A.C. 11:21-9; and

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement or the HMO POS contract, that the plan as ridered continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and N.J.A.C. 8:38-14.4(c), as applicable.

7. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in compliance with this subsection, within 45 days of the Board's receipt of the member's submission of a rider or amendment thereof. If the Board does not notify a member of its determination with respect to an informational filing within 45 days of the Board's receipt of the submission, the informational filing shall be deemed complete.

i. If an informational filing is incomplete and not in compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing. Upon receipt of notice from the Board that a filing is incomplete and not in substantial compliance with the requirements of this subchapter, the member shall not sell the rider or amendment thereof until the member has received written notice from the Board that the informational filing is complete.

ii. If the Board takes no action within 45 days of receipt by the Board of a member's submission of information requested by the Board to complete an informational filing, the filing shall be deemed to be complete.

(e) A carrier may provide for alternative means of administering aspects of the standard forms which administration does not affect the benefits provided in the standard policy forms and riders. Administration includes, but is not limited to, administration of claims, COBRA, premium collection, and issue functions. The delegation of administrative functions shall be achieved by a separate contract between the carrier and/or the small employer, and a third party. Such arrangements shall not alter the standard group policy and certificate language.

(f) All carriers shall file, by March 1 of each year, Exhibit BB Part 6, on which all optional benefit riders are identified, regardless of whether or not the carrier has filed optional benefit

riders. Carriers shall include in such filing information that is current through December 31 of the prior year.

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SUBCHAPTER 3A. NON-STANDARD HEALTH BENEFITS PLANS

11:21-3A.1 Purpose and scope

This subchapter establishes the conditions under which non-standard health benefits plans may be issued, renewed or continued pursuant to P.L. 1995, c.340, and specifies the rules which shall apply to the issuance, renewal or continuation of a non-standard health benefits plan.

11:21-3A.2 Definitions

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

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board described at N.J.A.C. 11:21-3.1, and set forth in the Appendix to this chapter.

11:21-3A.3 Renewal of non-standard health benefits plans

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall renew or continue a non-standard health benefits plan at the option of the small employer policy or contract holder, unless that plan is withdrawn by the carrier pursuant to N.J.A.C. 11:21-16, subject to the following:

1. The non-standard health benefits plan shall comply with the provisions of N.J.S.A. 17B:27A-18, 17B:27A-19b, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27.

2. The non-standard health benefits plan shall comply with all applicable rating and loss ratio requirements, and shall comply with all regulations adopted by the Commissioner pursuant to P.L. 1995, c.340, § 7; and

3. The non-standard health benefits plan, if issued by a carrier through an out-of-State trust:

i. Shall offer benefits that are at least equal to the actuarial value and benefits coverage of the least comprehensive standard health benefits plan established by the Board; and

ii. Shall be filed for approval with the Commissioner and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(b) A carrier, association, multiple employer arrangement or out-of-State trust shall not renew or continue a health benefits plan that is neither a standard health benefits plan nor a non-standard health benefits plan.

11:21-3A.4 New issuance of non-standard health benefits plans

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall not issue a non-standard health benefits plan unless the non-standard health benefit plan:

1. Complies with the provisions of N.J.S.A. 17B:27A-18, 17B:27A-19b, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27;

2. Complies with all applicable rating and loss ratio requirements, and complies with all regulations adopted by the Commissioner pursuant to P.L. 1995, c.340, § 7; and

3. If issued by a carrier through an out-of-State trust:

i. Offers benefits that are at least equal to the actuarial value and benefits coverage of the least comprehensive standard health benefits plan established by the Board; and

ii. Is filed for approval with the Commissioner and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(b) An association, multiple employer arrangement or out-of-State trust may offer and issue a non-standard health benefits plan provided that the association, multiple employer arrangement, or out-of-State trust:

1. Shall offer and issue a non-standard health benefits plan to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust;

2. Shall offer or issue coverage only to a small employer that is or becomes a member of that association, multiple employer arrangement or out-of-State trust;

3. Shall not use actual or expected health status in determining its membership; and

4. Shall make available to its small employer members at least one of the standard health benefits plans, as determined by the Commissioner, in addition to any health benefits plans permitted to be renewed or continued pursuant to this subsection.

(c) A carrier may, but is not required to, issue to a small employer a non-standard health benefits plan that had been issued to the small employer by another carrier, so long as the replacing carrier has filed the health benefits plan with the Commissioner for approval and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(d) A carrier may, but is not required, to issue a non-standard health benefits plan to a small employer through an association, multiple employer arrangement or out-of-State trust if the non-standard health benefits plan had previously been issued to a small employer by another carrier through the same association, multiple employer arrangement or out-of-State trust, so long as the replacing carrier files the non-standard health benefits plan with the Commissioner for approval and the carrier has received approval from the Commissioner or the filing is deemed approved.

(e) A carrier, association, multiple employer arrangement or out-of-State trust shall not offer or issue a health benefits plan that is neither a standard health benefits plan nor a non-standard health benefits plan.

11:21-3A.5 Mandatory offerings by carriers issuing non-standard plans

(a) A carrier offering a non-standard health benefits plan through any arrangement, including by or through an association, multiple employer arrangement or out-of-State trust, shall also offer the standard health benefits plans to any small employer.

(b) An association, multiple employer arrangement or out-of-State trust that offers a non-standard health benefits plan to its member's employees and dependents shall make available to its small employer members at least one of the standard health benefits plans, as determined by the Commissioner, in addition to the non-standard health benefits plan.

11:21-3A.6 Amendment of a non-standard health benefits plan

(a) Except as set forth in (b) below, a carrier may amend the benefits structure of a non-standard health benefits plan so long as:

1. The amendment does not reduce the actuarial value and the benefits coverage of the health benefits plan below that of the least comprehensive standard health benefits plan established by the Board; and

2. The amendment has been filed with the Commissioner for approval and the amendment has been approved or deemed approved.

(b) A carrier shall not modify the benefit structure of a non-standard health benefits plan in any way within six months of issuing the non-standard health benefits plan previously issued by another carrier directly to the small employer.

11:21-3A.7 Penalties

A carrier, association, multiple employer arrangement or out-of-State trust that violates any provision of this subchapter shall be subject to penalty and fines available under law.

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SUBCHAPTER 4. POLICY FORMS

11:21-4.1. Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D, and E which are set forth in the Appendix to this chapter as Exhibits A, F, V, and W subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference. Members shall not make any changes to the text of the standard policy forms, except as permitted consistent with the explanation of brackets set forth as Exhibit K.

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G and Y, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(c) Members shall use the standard policy form for HMO-POS plan which is set forth in the Appendix to this chapter as Exhibit HH and II, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(d) In issuing standard optional benefit riders pursuant to N.J.A.C. 11:21-3.2(c), members shall use the standard rider form which is set forth in the Appendix to this chapter as Exhibit H.

(e) All health benefits plans and optional benefits riders issued to small employers on and after January 1, 1994 shall be issued in accordance with these rules.

(f) Members shall use the standard small group health benefits certificate for Plan A which is set forth in the Appendix to this chapter as Exhibit V, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(g) Members shall use the standard small group health benefits certificate for Plans B, C, D and E which is set forth in the Appendix to this chapter as Exhibit W, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(h) Members shall use the standard employee evidence of coverage for HMO Plan which is set forth in the Appendix to this chapter as Exhibit Y, subject to "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(i) Members shall use the standard employee evidence of coverage for the HMO POS plan which is set forth in the Appendix to this chapter as Exhibit II, subject to "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(j) Members that wish to use the standard Prescription Drug Rider shall use the form set forth in the Appendix to this chapter as Exhibit H.

(k) All small group health benefits certificates and employee evidences of coverage issued to employees covered under small employer health benefits plans on and after January 1, 1994, shall be issued in accordance with these rules.

11:21-4.2 Certification or filing of forms

(a) No carrier shall issue any health benefits plan certificate or evidence of coverage to a small employer or the employees of a small employer or use any application form, employer or employee certification, waiver or enrollment form or make any amendments thereto until the carrier has certified that its health benefits plans and forms are in compliance with the small employer health benefits plans and all provisions of N.J.A.C. 11:21-4 and 6.

1. A carrier shall submit completed Certification of Compliance forms, set forth in Parts 1, 2 and 6 of Exhibit BB of the Appendix to this chapter and incorporated herein by reference upon entering the small employer market, on or before 45 days of the date amendments to the standard policy forms are effective, and on or before March 1 of each year thereafter. The market entry filing and the filing upon amendments being made to the standard policy forms shall address the plans the carrier will be marketing and issuing. The March 1 filing shall address the plans the carrier issued or renewed at anytime during the prior calendar year.

2. A carrier shall submit completed Certification of Compliance forms to the Board, at the address set forth at N.J.A.C. 11:21-1.3.

3. Certification of Compliance forms shall be certified by a duly authorized officer of the carrier.

(b) Carriers that submit Certification of Compliance forms may issue and make effective small employer health benefits plans upon filing such forms with the Board and the Commissioner, and may continue to do so until such time as the filing is disapproved in writing by the Board (in consultation with the Commissioner), following an opportunity for a hearing held in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and any rules promulgated thereunder.

(c) All forms to be used by a hospital service corporation and another carrier in conjunction in order to offer the small employer health benefits plans pursuant to N.J.S.A. 17B:27A-19e shall be submitted simultaneously to the Board and the Commissioner, and shall not be used until approved by the Board in consultation with the Commissioner.

1. Forms shall be submitted as set forth in (a)2 above.

2. Carriers shall submit a certification of substantial compliance and a description of the differences between the combined forms and the forms promulgated by the Board. The certification of substantial compliance shall be certified by a duly authorized officer of each of the carriers.

3. The Board shall notify the small employer carriers in writing within 60 days of receipt by the Board and the Commissioner of a completed submission, whether the combined forms are approved.

4. The small employer carriers shall have a right of appeal if the Board, in consultation with the Commissioner, disapproves the combined forms, in accordance with procedures established by the Board in its Plan of Operation.

(d) If the SEH Board adopts changes to the standard policy forms, a hospital service corporation and the carrier or carriers writing in conjunction with the hospital service corporation that has received approval by the SEH Board to issue plans pursuant to N.J.S.A. 17B:27A-19e shall submit revised forms to the SEH Board for review and approval within 60 days of the Board's adoption of changes to the standard policy forms. The revised forms shall not be used until approved by the Board in consultation with the Commissioner. Approval of previously approved forms will be withdrawn as of 60 days following the date the Board adopts changes to the standard policy forms.

11:21-4.3 Standards for review

(a) In determining whether to approve combined forms (of a hospital service corporation and another small employer carrier), a carrier shall consider in submitting in its certification of substantial compliance (with respect to combined forms), and the Board and Commissioner shall consider in their review whether:

1. The inclusion of words, terms and descriptions that are not contained in the Board's forms changes the meaning or effect of any material aspect of the small employer health benefits plans and other attendant Board forms;

2. The combined forms contain all provisions required by New Jersey law and the small employer health benefits plans forms which, if not the same as that required by law or in the small employer health benefits plans forms, is at least as favorable to the covered person;

3. The combined forms contain all coverages, coverage limits and exclusions set forth in the small employer health benefits plans forms; and

4. Easy comparison with the appropriate small employer health benefits plans forms by the consumer, the Board or the Commissioner is impeded.

(b) In addition to (a) above, the Board, in consultation with the Commissioner, may disapprove combined forms on the grounds that its provisions are unjust, unfair, inequitable, misleading, contrary to law or to the public policy of this State.

11:21-4.4 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board, through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix, incorporated herein by reference, subject to the following:

1. If expressly permitted by the Board, the Compliance and Variability Rider may be issued by Members to incorporate changes to the standard policy forms Plans A-E, HMO and HMO POS contracts, certificates, evidences of coverage, or standard riders promulgated by the Board. Nothing contained herein shall prevent a Member from issuing a standard policy form Plans A-E, HMO or HMO POS contract, certificate, evidence of coverage or standard rider which has incorporated Board promulgated changes.

(b) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, members may make any changes to the standard policy forms, standard HMO and HMO POS contracts, certificates, and

evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board consistent with the variability as explained in Exhibit K to this Appendix through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix.

(c) Members may use the Compliance and Variability Rider only as permitted by (a) and (b) above. In no event shall the Compliance and Variability Rider be used in lieu of optional benefit riders which riders are subject to filing requirements set forth in N.J.A.C. 11:21-3.2(d).

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SUBCHAPTER 5. (RESERVED)

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

11:21-6.1 Standard application form

(a) All small employer carriers offering small employer health benefits plans with an effective date on or after January 1, 1994, shall use the standard application form approved by the Board and specified in Exhibit N of the Appendix to this chapter incorporated herein by reference.

(b) Small employer carriers shall require any small employer applying for a small employer health benefits plan to be issued by that small employer carrier to complete, as part of the application, the New Jersey Small Employer Certification form approved by the Board and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference.

11:21-6.2 Annual Small Employer Certification Form

Small employer carriers shall require each small employer covered by a small employer health benefits plan issued by the small employer carrier to that small employer to complete each year the New Jersey Small Employer Certification form approved by the Board and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference. This form shall be sent to the small employer for completion no earlier than 150 days prior to the renewal of the small employer's health benefits plan.

11:21-6.3 (Reserved)

11:21-6.4 Waiver

Any eligible employee who declines coverage under the small employer health benefits plan shall complete the employee waiver form approved by the Board and specified in Exhibit T of the Appendix to this chapter incorporated herein by reference.

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SUBCHAPTER 7. PROGRAM COMPLIANCE

11:21-7.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering, issuing and renewing all health benefits plans to any small employer, the small employer's eligible employees, and the dependents of those eligible employees.

11:21-7.2 Definitions

All words and terms used in this subchapter shall have the meanings as set forth in the Act, N.J.A.C. 11:21-1.2 or as further defined below, unless the context clearly indicates otherwise.

"Affiliated company" means a person that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another person. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

"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); Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. § § 1397aa through 1397jj), 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; and 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.

"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. If an employee changes plans or if the employer transfers coverage to another carrier, the covered person's enrollment date does not change.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such a statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, termination of the employer's contribution toward coverage, death of a spouse, or divorce or legal separation; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent

also shall not be considered a late enrollee if the small employer is employed by an employer which offers multiple health benefits plans and the small employer elects a different plan during an open enrollment period; the small employer had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order. An eligible employee and his or her dependent spouse, if any, will not be considered late enrollees because the eligible employee initially waived coverage under the health benefits plan for himself or herself and any then existing dependents provided the eligible employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the plan within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.

"Non-standard health benefits plan" means only a health benefits plan that was issued to cover one or more small employers by or through a carrier, association, multiple employer arrangement or out-of-State trust prior to January 1, 1994, and which was in effect on February 28, 1994.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy is not a preexisting condition.

"Public health plan" means any plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

11:21-7.3 Eligibility and issuance

(a) Except as may otherwise be provided in N.J.A.C. 11:21-3A with respect to nonstandard health benefits plans, a small employer carrier shall issue a health benefits plan to any small employer which requests it, pays the premiums therefor and meets the contribution and participation requirements, if any, of the small employer carrier. All health benefits plans shall provide coverage for all eligible employees and their dependents who elect to participate regardless of health status-related factors and without exclusionary riders.

1. A small employer carrier shall not refuse to issue coverage, or discriminate in the issuance of coverage, to a small employer based upon the geographical location of the employees of the small employer, except that:

i. The small employer carrier shall refuse to issue coverage to an employer if the majority of its eligible employees are not employed within the State of New Jersey; or

ii. An HMO carrier may refuse to issue coverage to an employer to cover an employee that does not live, work, or reside in the small employer carrier's service area.

2. Every small employer carrier except small employer carriers that are HMOs, shall, as a condition of transacting business in this State, actively offer to small employers the five standard health benefits plans, including all riders it has elected to write, except as such riders may be restricted to specific standard health benefits plans. Small employer carriers that are HMOs shall, as a condition of transacting business in this State, actively offer to small employers every standard health benefits plan it writes, including all riders it has elected to write, except as such riders may be restricted to specific standard health benefits plans.

3. A small employer carrier shall consider the number of all eligible employees of all affiliated companies of a small employer in determining whether an employer is a small employer and in determining participation levels.

4. At the time of application, the determination of whether an employer is a small employer shall be based upon the small employer's completed New Jersey Small Employer Certification form.

i. If an employer qualifies as a small employer in the immediately preceding calendar year, the employer shall be considered a small employer regardless of the status of the employer on the date of application or the effective date of coverage so long as it employs at least two employees on the first day of the plan year.

ii. If an employer did not qualify as a small employer in the immediately preceding calendar year, the employer shall not be considered a small employer, regardless of the status of the employer on the date of application or the proposed effective date of coverage, if any.

iii. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. An employer that was not in existence during the preceding calendar year must have at least two eligible employees when completing the employer certification and on the first day of the plan year to be considered a small employer.

(b) Except as otherwise provided in N.J.A.C. 11:21-3A with respect to the issuance of non-standard health benefits plans, a small employer carrier shall issue only standard health benefits plans to an association, trust or multiple employer arrangement to provide coverage to member small employers or to two or more eligible employees of a member small employer.

1. No carrier shall issue a health benefits plan to any association, trust or multiple employer arrangement which bases membership criteria of any small employer or employee of the small employer, in whole or in part, upon the health status or claims experience of the employer or employee.

2. Every small employer member of an association, trust or multiple employer arrangement shall be offered coverage under every health benefits plan issued to the association.

(c) In determining an employer's number of eligible employees, a small employer carrier shall consider in the calculation the number of independent contractors that the employer may include on its application for coverage to the extent that each independent contractor:

1. Is performing a service for the employer pursuant to a written contract for monetary or other legal consideration;

2. Is working exclusively for the employer;

3. Works 25 or more hours per week for the employer;

4. Works on other than a temporary or substitute basis; and

5. The independent contractor relationship has been established to serve a substantial business need of the employer and is not intended primarily to obtain insurance coverage.

(d) Employees who enroll within 30 days of first becoming eligible for coverage shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to their risk characteristics or that of their dependents, except that a small employer carrier may exclude coverage for preexisting conditions consistent with the provisions of N.J.A.C. 11:21-7.7. Employees who are late enrollees shall be accepted for

coverage by the small employer carrier, but a small employer carrier may exclude coverage for preexisting conditions consistent with the provisions of N.J.A.C. 11:21-7.8. Small employer carriers shall not delay the effective date or eligibility date of a late enrollee until an "open enrollment" period.

(e) A small employer carrier may elect to provide coverage to a small employer's part-time employees (that is, working fewer than 25 hours per week), if the small employer covered part-time employees under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all part-time employees of all such small employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts.

2. Such covered employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(f) A small employer carrier may elect to provide coverage to a small employer's retired employees, if the small employer's retired employees were covered under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all retired employees of all such employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts; and

2. Such covered retired employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(g) A small employer carrier may elect to provide coverage to retired employees and/or part-time employees of an employer that becomes a small employer subsequent to January 1, 1994, if the employer covered retired and/or part-time employees under a group health plan issued prior to January 1, 1994, under a health benefits plan renewed or reinstated by the carrier in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or a standard health benefits plan issued to the small employer by the carrier, subject to the requirements of (e)1 and 2 and (f)1 and 2 above.

(h) In the event that the previous health benefits plan of a small employer group was cancelled for nonpayment of premiums or fraud, a small employer carrier may require the small employer group to pay up to six months of premiums in advance of the issuance of a health benefits plan.

11:21-7.4 Limitations on purchase by small employers of health benefits plans or riders with different actuarial value than existing plan

(a) A small employer who purchases a health benefits plan or rider pursuant to the Act shall not be permitted to purchase a health benefits plan or rider with a greater actuarial value until the first anniversary date of the small employer's existing health benefits plan.

(b) When a small employer replaces a health benefits plan or rider with a health benefits plan or rider of greater actuarial value, the small employer shall not be permitted to change the health benefits plan or rider to one of less actuarial value until the anniversary date of the small employer's health benefits plan.

(c) A small employer who has purchased a health benefits plan or rider pursuant to the Act may purchase a health benefits plan or rider of lesser actuarial value prior to the anniversary date of the existing health benefits plan or rider, provided that the existing health benefits plan or rider was purchased at least 12 months prior to the latest anniversary date of the health benefits plan or rider.

11:21-7.5 Participation requirements

(a) A small employer carrier shall require a minimum participation under the small employer's health benefits plan of 75 percent of eligible employees who are not serving under a waiting period as permitted under N.J.A.C. 11:21-7.8(c), except as set forth in (b) below. This participation requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers. A carrier shall count as covered under the small employer's health benefits plan, for the purpose of satisfying employee participation requirements, an eligible employee who:

1. Is covered as an employee or dependent under any fully insured health benefits plan offered by the small employer;

2. Is covered under Medicare;

3. Is covered under Medicaid or NJ FamilyCare;

4. Is covered under another group health benefits plan; or

5. Is covered under a spouse's health benefits plan.

(b) A small employer carrier may, upon approval by the Board, require a minimum participation of less than 75 percent provided that the small employer carrier:

1. Notifies the Board in writing of its minimum requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser participation requirements, in accordance with procedures established by the Board in its Plan of Operation.

11:21-7.6 Contribution requirements

(a) A small employer carrier shall not require a minimum small employer contribution of more than 10 percent of the annual cost of the small employer's health benefits plan. This contribution requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers.

(b) A small employer carrier may, upon approval of the Board, require a minimum contribution of less than 10 percent provided that the small employer carrier:

1. Notifies the Board in writing of its contribution requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser contribution requirements, in accordance with procedures established by the Board in its Plan of Operation.

11:21-7.7 Preexisting condition standards

(a) A health benefits plan shall not include a preexisting condition exclusion, except as provided in (b) or (c) below.

(b) A health benefits plan issued to a small employer with five or fewer eligible employees, as determined on the effective date of the plan and on each subsequent policy anniversary, may contain a preexisting condition exclusion. However, a preexisting condition exclusion shall not exclude coverage for a period of more than 180 days following the enrollment date, and shall relate to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of the enrollee and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date.

(c) A health benefits plan issued to a small employer may contain a preexisting condition exclusion that may apply to a late enrollee. However, a preexisting condition exclusion shall not exclude coverage for a period of more than 180 days following the enrollment date of coverage, and shall relate to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of the enrollee and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date of coverage. If 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition exclusion shall apply to any such enrollee.

(d) In determining whether a preexisting condition provision applies to an eligible employee or dependent, carriers shall credit the time that person was covered under previous creditable coverage if the creditable coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any waiting period under such plan. A carrier shall provide credit pursuant to this provision pursuant to one of the following methods:

1. A carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period; or

2. A carrier shall count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits specified in Federal regulation rather than the method provided in (d)1 above. This election shall be made on a uniform basis for all covered persons. Under this election, a carrier shall count a period of creditable coverage with respect to any class or category, of benefits if any level of benefits is covered within that class or category. A carrier which elects to provide credit pursuant to this provision shall comply with all Federal notice requirements.

(e) A health benefits plan shall not impose a preexisting condition exclusion for the following:

1. A newborn child who, as of the last date of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of the adoption or placement for adoption; or

3. Pregnancy.

11:21-7.8 Effective date of coverage

(a) A small employer carrier, prior to issuing a health benefits plan, may require the following:

1. A completed small employer standard application form including the small employer certification form in accordance with N.J.A.C. 11:21-6.1(a) and (b);

2. Complete employee enrollment forms and waiver forms; and

3. An advance premium payment not to exceed one month's premium, except as provided in N.J.A.C. 11:21-7.5(d)2, which shall be refunded to the employer if the health benefits plan is not issued by the small employer carrier.

(b) A small employer carrier shall provide notice to the employer within 15 working days of receipt by the small employer carrier of the information set forth in (a) above whether the small employer carrier approves or disapproves the employer's application for the health benefits plan. If approved, the effective date of coverage under the health benefits plan shall be no later than the first day of the month following the date of notice of such approval by the small employer carrier unless the small employer has requested a later effective date which is agreed to by the small employer carrier.

(c) At the option and upon the request of the small employer, a waiting period may be applied by the small employer carrier with respect to employees when they first become eligible for coverage, not to exceed six months. Waiting periods may be applied to these employees by class of employee based upon conditions pertaining to employment.

(d) A small employer carrier may offer an automatic checking withdrawal option to small employer groups for the monthly or quarterly payment of premiums. In the event that a small employer carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all small employer groups, regardless of the size of the group or the type of health benefits plan.

(e) A small employer carrier may require that its small employer groups make monthly or quarterly premium payments through an automatic checking withdrawal option. In the event that a small employer carrier elects to require that its small employer groups pay premiums through an automatic checking withdrawal option, the small employer carrier shall apply this requirement to every small employer group, regardless of the size of the group or the type of health benefits plan.

11:21-7.9 Price quotes; disclosures

(a) A small employer carrier shall provide a price quote to a small employer, directly or through an authorized third party, within 10 working days of receiving a request for a quote and such information as is reasonable and necessary to provide the quote. A small employer carrier shall notify a small employer, directly or through an authorized producer, within five

working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

(b) Each small employer carrier shall make reasonable disclosure in price quotes provided to small employers of the provisions concerning the small employer carrier's right to change premiums and the criteria in the small employer carrier's rate filing which affect changes in premium rates.

11:21-7.10 Tie-ins

A small employer carrier shall not require, as a condition to the offer or sale of a health benefits plan to a small employer, that the small employer purchase or qualify for any other insurance products or services.

11:21-7.11 Guaranteed renewal

(a) All health benefits plans that are issued or renewed on or after January 1, 1994, must be guaranteed renewable at the option of the policy or contract holder or small employer, except that a carrier may discontinue a health benefits plan pursuant to (b) below or nonrenew a health benefits pursuant to (c) below.

(b) A carrier may discontinue a health benefits plan only if:

1. The policyholder, contract holder, or employer has failed to pay premiums or contributions in accordance with the terms of the health benefits plan or the carrier has not received timely premium payments; or

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

(c) A carrier may nonrenew a health benefits plan only if:

1. The number of employees covered under the health benefits plan is less than the number or percentage of employees required by participation requirements under the health benefits policy or contract;

2. The small employer fails to comply with a small employer carrier's employer contribution requirements;

3. The carrier files with the Commissioner to withdraw from the small employer market and meets the requirements of N.J.A.C. 11:21-16;

4. The small employer ceases its membership in an association or trust of employers where the health benefits plan was issued in connection with such membership;

5. The carrier receives approval to cease offering and renewing a particular type of a plan and meets the requirements of N.J.A.C. 11:21-13;

6. The SEH Board discontinues a particular standard health benefits plan or plan option; or

7. In the case of a health maintenance organization plan issued to a small employer:

i. An eligible person who no longer resides, lives, or works in the carrier's approved service area, but only if coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

ii. A small employer that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the carrier and the carrier would deny enrollment with respect to such plan pursuant to N.J.S.A. 17B:27A-26.

11:21-7.12 Reporting requirements

(a) A small employer carrier shall file with the Board, quarterly no later than 45 days after the end of the fiscal quarter, the following information reported separately with respect to standard and non-standard health benefits plans:

1. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter, reported separately as to newly issued plans and renewals, and separately for standard health benefits plans A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

2. The total number of health benefits plans in force at the end of the quarter, and the total number of employees and dependents covered, reported separately for each standard health benefits plan A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

3. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter and were uninsured for at least the three months prior to issue.

(b) Quarterly reports shall be filed at the address listed in N.J.A.C. 11:21-1.3.

(c) An insurance company, health service corporation, hospital service corporation, or medical service corporation and affiliated health maintenance organization shall file separate reports.

11:21-7.13 Paying benefits

(a) In paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services, on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, incorporated herein by reference published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

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

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

11:21-7.14 Permissible rate classification factors

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

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

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

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

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

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

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

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

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

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

1. Employee only;

2. Employee and spouse;

3. Employee and child(ren); and

4. Family.

11:21-7.15 Employer waiting period

A small employer carrier shall not be required to modify the waiting period provision of a health benefits plan except as of an anniversary date of the plan, and upon the request of a small employer.

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SUBCHAPTER 7A. LOSS RATIO REPORTS; DIVIDENDS AND CREDITS

11:21-7A.1 Purpose

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

11:21-7A.2 Definitions

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

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

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

"Preceding calendar year" means the calendar year immediately preceding the reporting year.

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

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

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

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

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

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

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

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

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

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

Attention: SEH Loss Ratio Report Filings

Life and Health Division

New Jersey Department of Banking and Insurance

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

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

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

1. The reporting carrier's name and address;

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

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

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

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

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

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

8. Such other information as the Department may request.

11:21-7A.5 Dividend or credit plan

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

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

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

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

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

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

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

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

(g) The dividend or credit amount per policyholder shall be determined by multiplying the premium for each policyholder by the percentage calculated by dividing the total dividend or

credit by the total premium or on the basis of a practical and equitable alternate methodology filed by the carrier in accordance with (a) above.

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

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SUBCHAPTER 8. CARRIER CERTIFICATION OF NON-MEMBER STATUS

11:21-8.1 Purpose and scope

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

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

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.

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.

11:21-8.4 Non-member certification requests

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

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

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

Attn: SEH Annual Certification of Non-Member Status

Life/Health Actuarial Services

New Jersey Department of Banking and Insurance

PO Box 325

Trenton, NJ 08625-0325

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.

11:21-8.6 Review

A carrier which has been denied non-member certification may contest that determination by filing an appeal with the Board pursuant to procedures set forth in N.J.A.C. 11:21-2.17.

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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.

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.

"Effective date" means the date on which coverage begins for the policyholder.

"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.

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 benefit 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 rate or rating factors applicable for each option including the difference when Medicare is primary or secondary, based on actual employee or spouse Medicare coverage status. Reduced premium rates or rating factors must be provided when Medicare is primary for an employee eligible for Medicare by reason of age; 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 rate, 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. The assumptions underlying the reduced premium rates or rating factors where Medicare is primary for the employee or spouse based on the actual Medicare coverage status of the employee or spouse;

iv. 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;

v. A summary of the overall change in rate levels, including:

(1) The average percentage change, for each standard and nonstandard plan, between the rates contained in the rate filing and the rates that were in effect one year prior to the effective date of the rate filing; and

(2) The average percentage change, for each standard and nonstandard plan, between the rates contained in the rate filing and the rates contained in the immediately prior rate filing;

vi. 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

vii. 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.

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.

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.

11:21-9.6 Errors in rate quotations and rate calculation

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

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

2. Be prohibited from charging, collecting, offsetting or otherwise recouping the amount of the undercharges; and

3. Continue to charge the erroneous rate for a period of at least 60 days from the date the written notice of the error is received by the small employer.

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

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

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

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

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

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

11:21-9.7 Public disclosure of filed information

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

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

11:21-9.8 Penalties

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

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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.

11:21-10.3 Filing of the Market Share Report

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

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

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

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

11:21-10.4 Net earned premium

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

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers, less any refunds paid by the carrier during that calendar year as a result of the application of the minimum loss ratio requirement.

2. Net earned premium reported in Part C of the Market Share Report shall be based upon, if not the same as, the data set forth in the member's annual NAIC statement blank, adjusted to meet the definition of group health benefits plan and exclude refunds as described in (a)1 above, as necessary.

11:21-10.5 Certification

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

11:21-10.6 Failure to comply

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

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

11:21-11.1 Purpose and scope

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

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

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

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

11:21-11.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The small employer fails to meet either the participation or contribution requirements;

4. In the case of nonstandard health benefits plans issued to or through an association, trust or other multiple employer arrangement, for a small employer if the small employer ceases to be a member of the association, trust or other multiple employer arrangement but only if such coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual;

5. The small employer has decided to cease offering and to nonrenew a particular type of nonstandard health benefits plan in the small employer market, or as permitted or required pursuant to N.J.S.A. 17B:27A-19; or

6. In the case of a health maintenance organization plan issued to a small employer, an eligible person no longer resides, lives or works in the carrier's approved service area, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; or a small employer no longer has any enrollee in connection with such plan who lives, resides or works in the service area of the carrier and the carrier would deny enrollment with respect to such plan pursuant to N.J.S.A. 17B:27A-26.

(d) In the event that a small employer is being nonrenewed pursuant to (c)4 above, the carrier shall provide notice to the small employer that the same standard health benefits plan(s) available to the small employer through the association, trust or other multiple employer arrangement are available from the carrier directly along with the other standard health benefits plans and rider options that the carrier offers to other small employers.

11:21-11.4 Certification of benefits coverage and actuarial value of nonstandard health benefits plans

(a) For nonstandard health benefits plans for which the carrier made an informational filing of a Certification of Prior Filing and Compliance with P.L. 1994, c.11, set forth as Part 3 of Exhibit BB in the Appendix to this chapter, on or before January 20, 1995 in accordance with N.J.A.C. 11:21-11.9, or made an informational filing of a Certification of Informational Filing and Compliance with P.L. 1994, c.11, as set forth as Part 4 of Exhibit BB in the Appendix to

this chapter, on or before January 31, 1995 in accordance with N.J.A.C. 11:21-11.9, carriers shall file the nonstandard health benefits plan accompanied by a completed Checklist and Certification as set forth in Part 5 of Exhibit BB in the Appendix to this chapter, incorporated herein as part of this subchapter.

(b) Each such filing shall comply with N.J.A.C. 11:4-40, except that only one copy of the forms need be submitted. The forms submission shall include the nonstandard health benefits plan form, the form of all riders offered therewith, and the application for the nonstandard health benefits plan.

(c) Separate checklists and certifications and certified statements as set forth in Part 5 of Exhibit BB of the Appendix to this chapter shall be submitted for each nonstandard health benefits plan.

(d) A checklist and certification and statement certified to by an officer of the carrier submitted pursuant to this section shall not be accepted by the Commissioner until it is complete.

11:21-11.5 Closed books of business

(a) A carrier seeking approval to treat a nonstandard health benefits plan as a closed nonstandard health benefits plan shall specify that on the Checklist and Certification required to be filed for that nonstandard health benefits plan pursuant to N.J.A.C. 11:21-11.4.

(b) Notwithstanding that a nonstandard health benefits plan may meet the definition of a closed nonstandard health benefits plan, if the carrier does not specify that the nonstandard health benefits plan is closed as set forth in (a) above, the carrier shall not treat the nonstandard health benefits plan as a closed nonstandard health benefits plan at any time in the future.

11:21-11.6 Obligation to market

(a) Except with respect to nonstandard health benefits plans for which the carrier has filed a statement in accordance with N.J.A.C. 11:21-11.5, the carrier shall market the nonstandard health benefits plan to all small employers, their eligible employees and their eligible employees' dependents, as appropriate, within an association, out-of-State trust or other multiple employer arrangement, with all options and riders until such time as the carrier withdraws the nonstandard health benefits plan pursuant to N.J.A.C. 11:21-13, the carrier withdraws from the small employer market pursuant to N.J.A.C. 11:21-16, or, in the case of an association, the association terminates its sponsorship or endorsement of the nonstandard health benefits plan.

1. The obligation to market a nonstandard health benefits plan exists only with respect to an association's, trust's or other multiple employer arrangement's small employers, the small employers' eligible employees and the eligible employees' dependents, as appropriate; a carrier shall not newly issue a nonstandard health benefits plan to any other association, out-of-State trust or multiple employer arrangement (that will be offered to small employer members or participants of the association, multiple employer arrangement or out-of-State trust) except as N.J.A.C. 11:21-11.8 may apply.

2. The carrier shall similarly market every nonstandard health benefits plan that the carrier agrees to add to its portfolio in accordance with N.J.A.C. 11:21-11.8 at the request of a small employer or association, out-of-State trust or multiple employer arrangement.

(b) With respect to nonstandard health benefits plans offered by or through an association, multiple employer arrangement or out-of-State trust, the small employers of the association,

multiple employer arrangement or out-of-State trust shall be offered one or more standard health benefits plans through the association, multiple employer arrangement or out-of-State trust, among which shall be Plan C.

(c) No carrier shall be relieved of its obligation to market all of the standard health benefits plans by virtue of marketing at least one standard health benefits plan through an association, multiple employer arrangement or out-of-State trust.

11:21-11.7 Amendments

(a) A carrier may amend a nonstandard health benefits plan that has been approved or deemed approved by the Commissioner by submitting for approval the amendment together with a new, completed Checklist and Certification set forth in Part 5 of Exhibit BB of the Appendix to this chapter.

1. Each such filing shall comply with N.J.A.C. 11:4-40, except that only one copy of the form(s) need be submitted.

2. The carrier shall submit a separate Checklist and Certification for each nonstandard health benefits plan form being amended, clearly identifying the nonstandard health benefits plan form, and the date(s) previous certification(s) made in compliance with this subchapter were filed.

3. The carrier shall certify on the Checklist and Certification, for each plan being amended that the amendment to the nonstandard health benefits plan does not reduce the actuarial value or the benefits coverage of the nonstandard health benefits plan below the benefits coverage of Plan A and the actuarial value of the standard health benefits plan with the lowest actuarial value of the standard health benefits plans created by the Board.

4. The carrier simultaneously shall submit an explanation of the manner in which the amendment to the nonstandard health benefits plan affects the premiums for the health benefits plan, in accordance with N.J.A.C. 11:21-8.

(b) Notwithstanding (a) above, a carrier shall not amend a nonstandard health benefits plan for six months following the date that the first contract or policy under the nonstandard health benefits plan becomes effective with that carrier if the carrier agreed to add the nonstandard health benefits plan to its portfolio at the request of a small employer pursuant to N.J.S.A. 17B:27A-19j(12) and N.J.A.C. 11:21-11.8.

11:21-11.8 Agreement by a carrier to add a nonstandard health benefits plan to its portfolio

(a) A carrier may agree to add a nonstandard health benefits plan not currently being offered by the carrier to its portfolio of small employer health benefits plans at the request of either an association, multiple employer arrangement, trust or a single small employer if that nonstandard health benefits plan has been renewed by the current carrier in accordance with this subchapter and upon the new carrier filing the nonstandard health benefits plan with the Commissioner in accordance with N.J.A.C. 11:4-40 and submission of a completed Checklist and Certification as set forth in Part 5 of Exhibit BB of the Appendix to this chapter.

(b) The filing carrier simultaneously shall comply with N.J.A.C. 11:21-11.6, with initial date of marketing of the nonstandard health benefits plan specified in writing by the filing carrier, which date shall be no later than the effective date of the filing carrier's obligations pursuant to any contract transferred to the filing carrier under the nonstandard health benefits plan.

(c) Upon written request by the Department, the carrier currently marketing the nonstandard health benefits plan shall submit to the Department in writing for each

nonstandard health benefits plan form being accepted by a filing carrier the current carrier's identification of the nonstandard health benefits plan form, and the date(s) the current carrier's checklists and certification(s) with appropriate statements made in compliance with this subchapter for the nonstandard health benefits plan form(s) were filed by the Department (including amendments thereto, if any).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11:21-11.11 Penalty and fines

Pursuant to N.J.S.A. 17B:27A-43, a carrier failing to comply with the requirements of this subchapter shall be subject to payment of a fine of not less than $ 2,000 nor more than $ 5,000 per violation.

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SUBCHAPTER 12. (RESERVED)

SUBCHAPTER 13. NONSTANDARD PLANS: WITHDRAWAL OF PLANS

11:21-13.1 Purpose and scope

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

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

11:21-13.2 Definitions

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

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

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

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

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

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

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

11:21-13.3 Restricted withdrawal and marketing

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

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

(c) A carrier shall market all open nonstandard health benefits plans made available through an association, trust or other multiple employer arrangement to all small employers members within that association, trust or other multiple employer arrangement, and the employees of such small employers.

(d) A carrier shall not market a closed nonstandard health benefits plan either directly or through an association, out-of-State trust or multiple employer arrangement.

(e) An association, multiple employer arrangement or out-of-State trust may market an open nonstandard health benefits plan, but if it does market an open nonstandard health

benefits plan to its members' employees and dependents it shall offer coverage to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust, and in no instance shall actual or expected health status be used in determining membership.

1. An association, multiple employer arrangement or out-of-State trust that markets an open nonstandard health benefits plan shall also market at least one standard health benefits plan in accordance with N.J.A.C. 11:21-11.6.

2. In no instance shall a closed nonstandard health benefits plan be marketed.

3. No carrier shall be relieved of its obligation to market all of the standard health benefits plans by virtue of marketing at least one standard health benefits plan through an association, multiple employer arrangement or out-of-State trust.

11:21-13.4 Request to withdraw nonstandard health benefits plans

(a) A carrier may submit to the Commissioner a completed request to withdraw one or more closed and open nonstandard health benefits plan(s) at any time except that a carrier shall not:

1. Submit more than one request to withdraw at any one time, but may amend its request to withdraw, if necessary;

2. Submit a request to withdraw a nonstandard health benefits plan that the carrier added to its portfolio of health benefits plans in accordance with N.J.A.C. 11:21-11.8 within the first 12 month period following the effective date of the carrier's obligation pursuant to contracts issued under that nonstandard health benefits plan; or

3. Submit a request to withdraw while a request for relief pursuant to N.J.A.C. 11:20-11 or 11:21-15 is pending.

(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

Life and Health Division

New Jersey Department of Banking and Insurance

PO Box 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, and all covered persons and their dependents under the contract or certificate is given 90 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, nothing in this subchapter shall be construed to contravene any rights of policyholders, contractholders or certificateholders concerning nonrenewal requirements or obligations set forth in a policy or contract of a health benefits plan that is the subject of a request to withdraw.

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SUBCHAPTER 14. (RESERVED)

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

11:21-15.1 Purpose and scope

(a) This subchapter establishes the informational and procedural requirements for members requesting relief from obligations to pay assessments pursuant to N.J.S.A. 17B:27A-38 or to offer coverage or accept applications to a small employer, pursuant to N.J.S.A. 17B:27A-26.

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

11:21-15.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Applicant" means the member seeking a deferral of its obligation to pay assessments or a waiver of its obligation to offer coverage and accept applications pursuant to N.J.S.A. 17B:27A-17 et seq.

"Financially impaired" means a member which, after November 5, 1993, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or a member which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Relief" means a deferral of obligations pursuant to N.J.S.A. 17B:27A-38 or a waiver of obligations pursuant to N.J.S.A. 17B:27A-26, as applicable.

11:21-15.3 Application procedures and filing format

(a) Any member seeking relief may submit such request to the Department at any time, except that requests for relief from payment of assessments pursuant to N.J.S.A. 17B:27A-38 shall be submitted to the Department no later than 15 days following the due date of payment of the assessment.

(b) All requests outlined in this subchapter shall be accompanied by a statement averring a need for relief from the obligation(s), as the case may be, including supporting documentation as set forth in N.J.A.C. 11:21-15.4, and shall specify the statutory and regulatory basis for such relief. A single filing may request relief from more than one obligation, but shall specify each obligation from which relief is sought.

(c) Each request shall be in loose leaf form inserted into standard two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in N.J.A.C. 11:21-15.4. The loose leaf sheets used in the request shall be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(d) All members requesting relief pursuant to this subchapter shall submit five copies of each request in the format set forth in (c) above.

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

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

SEH Program

Request for Relief

New Jersey Department of Banking and Insurance

Division of Financial Solvency

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

11:21-15.4 Informational filing requirements

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

1. A cover letter stating:

i. The name of the applicant;

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

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

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

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

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

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

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

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

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

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

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

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

7. A report signed by the attesting actuary referred in (a)6 above, which includes, in summary form if necessary, all data utilized, a complete explanation of methods and assumptions and sufficient additional narrative to account for any features of the data or circumstances necessary for proper interpretation;

8. A copy of the annual statement of the applicant, including all accompanying exhibits, filed with this State immediately preceding the date of the relief filing;

9. Copies of all quarterly statements for the period beginning January 1 in the year of the filing to the quarterly statement immediately preceding the date of the filing;

10. Three year financial projections beginning with the calendar year of the date of the filing assuming relief is granted and assuming relief is denied. The projections shall include, in summary form if necessary, all data utilized, and a complete explanation of methods and assumptions utilized and relied upon by the applicant in making the projections. The projections shall include results for the applicant's operations worldwide by line of business and for the applicant's operations in New Jersey only for health benefits plans issued pursuant to N.J.S.A. 17B:27A-17 et seq. The projections shall assume the same rate of assessment as in the first year for the subsequent years, and shall include projections of the applicant's operating results containing the information and in the format set forth in the following:

i. For life and health insurers, the balance sheet and summary of operations exhibits of the statutory annual statement filed by the insurer;

ii. For property and casualty insurers, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the insurer;

iii. For health service corporations, hospital service corporations and medical service corporations, the balance sheet and Underwriting and Investment Exhibit of the statutory annual statement filed by the service corporation; and

iv. For health maintenance organizations, the balance sheet and statement of revenue, expenses and net worth of the annual statement filed by the health maintenance organization;

11. 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;

12. A non-refundable filing fee of $ 1,000, unless the applicant is in rehabilitation or conservation at the time of filing pursuant to N.J.S.A. 17B:32-31 et seq. or such similar law of the applicant's state of domicile; and

13. Any other information the Commissioner may deem relevant to the consideration of the request.

(b) An applicant asserting that the Department's review of its request be evaluated on a particular basis (that is, pre-pooled, post-pooled, consolidated or unconsolidated), shall submit a written statement which sets forth the specific reasons, with supporting documentation, if any, for which it believes evaluation on a particular basis is appropriate to that applicant, and the specific reasons, with supporting documentation, if any, for which evaluation on other bases would be inappropriate.

(c) All filings shall be accompanied by the following certification signed by the chief financial officer of the applicant: "I ..... certify that the attached filing complies with all requirements set forth in N.J.A.C. 11:21-15 and that all of the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of the applicant."

11:21-15.5 Confidentiality of request for relief

(a) All data or information contained in the request for relief filed pursuant to this subchapter shall be confidential and shall not be subject to public disclosure or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A-1 et seq., except for the following items, but only upon written, specified request and following 10 days written notice by the Department to the member/applicant:

1. N.J.A.C. 11:21-15.4(a)1i and ii--cover letter with name of applicant and describing relief sought;

2. N.J.A.C. 11:21-15.4(a)1iv--name, title, telephone number and telefax number of person familiar with the filing;

3. N.J.A.C. 11:21-15.4(a)3--most recent financial examination report;

4. N.J.A.C. 11:21-15.4(a)5i and ii--list of members of holding company system and intercompany transactions for period preceding date of filing;

5. N.J.A.C. 11:21-15.4(a)8--annual statement filed immediately preceding date of filing;

6. N.J.A.C. 11:21-15.4(a)12--non-refundable filing fee; and

7. N.J.A.C. 11:21-15.4(a)13--additional information required by the Commissioner to evaluate a particular filing.

11:21-15.6 Disposition of request for relief

(a) When the Commissioner determines pursuant to N.J.S.A. 17B:27A-26b or 17B:27A-38 as applicable, that the member is or would be placed in a financially impaired condition through fulfillment of a coverage or assessment obligation or obligations, the Commissioner shall notify the member that its duty to fulfill the applicable obligation shall be waived, or deferred in whole or in part, as appropriate. If the Commissioner defers in whole or in part a member's obligation to pay assessments pursuant to N.J.S.A. 17B:27A-38, the member shall remain liable to the SEH Program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the SEH Program if it fails to pay assessments.

(b) The Commissioner shall find that a member is or would be financially impaired if:

1. The member has been placed in rehabilitation or conservation pursuant to N.J.S.A. 17B:32-31 et seq. or such similar law of the member's state of domicile;

2. The Commissioner finds that the member is in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2-27; or

3. The Commissioner finds that fulfillment of the obligation(s) from which relief is sought would place the member in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2-27.

(c) Any waiver or deferral from a particular obligation granted by the Commissioner pursuant to this subchapter shall be for a specified period as set forth in the notice granting the request, but shall not exceed 12 months from the date of the notice. Any member seeking to continue a waiver or deferral shall file a separate request for relief in accordance with this subchapter no later than 45 days prior to the expiration of the waiver or deferral period set forth in the original notification granting the request. Such a request shall also include a detailed explanation of all actions the applicant has taken and intends to take to cure the financial impairment. Failure to file a properly completed request for relief within the time prescribed shall result in the expiration of the waiver or deferral at the expiration of the period set forth in the original notification granting the request. Nothing herein shall be construed as limiting or prohibiting any member from applying for relief at any time in accordance with this subchapter.

(d) If the Commissioner grants a request for a deferral of payment of an assessment, the terms of the deferral shall include the requirement that the member shall pay to the Board an additional amount representing the loss to the Board of the time value of the assessment for the period of the deferral.

1. In calculating the additional amount to be paid, the member shall use the annual interest rate on one-year U.S. Treasury bills as of the date the assessment was due and payable.

2. In calculating the additional amount to be paid, the period of deferral shall begin on the date that payment of the assessment was due and payable and end on the date of the amount deferred is paid to the Board.

3. The payment of the additional amount set forth in (d) above shall be in lieu of payment by the member of any interest or penalty on the amount deferred, which otherwise may be required under any other rule.

4. The requirement to pay an additional amount as provided in (d) above shall not apply when the reason for granting the deferral is that the member is in rehabilitation or conservation.

11:21-15.7 Hearings

(a) If the Commissioner denies a member's request for relief made pursuant to this subchapter, or if the member objects to the terms of the relief granted, the member 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 concise statement describing the basis for which the member believes that the Commissioner's findings of fact are erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the member 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. 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.

ii. 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 facts and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition of the matter.

11:21-15.8 Notice of the SEH Program

Members requesting relief pursuant to this subchapter shall concurrently provide notice of all such requests to the SEH Program through the Interim Administrator or Administrator, as appropriate. Members shall also provide notice to the SEH Program of all dispositions of such requests by the Commissioner, within 15 days of such disposition.

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

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

1. A cover letter stating:

i. The name of the member HMO;

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

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

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

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

11:21-15.10 Other actions by the Commissioner

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

11:21-15.11 Penalties

Failure to comply with this subchapter, including all notice requirements set forth herein, may result in the denial of relief requested and imposition of penalties pursuant to N.J.S.A. 17B:27A-43 and the SEH Program Plan of Operation as codified at N.J.A.C. 11:21-2, including, but not limited to, imposition of an interest penalty for assessments due from the member and a recommendation by the Board to remove the member's authority to issue any health benefits plans in this State.

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SUBCHAPTER 16. WITHDRAWALS FROM THE SMALL EMPLOYER HEALTH BENEFITS PLANS MARKET AND WITHDRAWALS OF PLAN(S), PLAN OPTION(S) AND COPAYMENT/ DEDUCTIBLE OPTION(S)

11:21-16.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers may cease doing business in the small employer market in this State. Additionally, this

subchapter establishes the requirements and procedures by which carriers may cease issuing and nonrenew: a specific standard plan issued using a particular delivery option; a plan option; a specific standard benefit rider; or a specific copayment/deductible option available under the standard plans. The subchapter applies to all small employer carriers issuing or renewing policies or contracts after November 30, 1992. Pursuant to the provisions of N.J.S.A. 17B:27A-17 et seq., every policy or contract issued to a small employer in this State shall be renewable with respect to all eligible employees or dependents at the option of the policy or contractholder or small employer, except under the circumstances prescribed by N.J.S.A. 17B:27A-23a, c, d, e, f, h, and i. One of the circumstances delineated therein is where a carrier ceases to do business in the small employer health benefits plans market in New Jersey pursuant to N.J.S.A. 17B:27A-23e.

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

11:21-16.2 Definitions

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

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

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

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

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

"Plan option withdrawal" means a carrier's cessation of the issuance of a standard health benefits plan option and the nonrenewal on the anniversary date of all inforce standard small employer health benefits plans issued with that option.

"Plan withdrawal" means a carrier's cessation of the issuance of a standard health benefits plan and the nonrenewal on the anniversary date of all inforce small employer health benefits plans of that plan type.

"State" means the State of New Jersey.

11:21-16.3 General provisions for market withdrawal

(a) No small employer carrier shall nonrenew except in accordance with N.J.S.A. 17B:27A-23a, c, d, f, h and i or refuse to issue any small employer health benefits plan unless the small

employer carrier withdraws from the small employer market in New Jersey in accordance with the provisions of this subchapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

contract will be nonrenewed on the anniversary date. This initial notice to each small employer shall be sent by certified mail and shall include the following information:

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

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

3. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the withdrawal;

4. A statement that the small employer may contact its broker for additional information regarding the withdrawal;

5. A notice that a list of active small employer carriers and information about small employer health benefits coverage may be obtained by writing to the New Jersey Small Employer Health Benefits Coverage Program Board, PO Box 325, Trenton, NJ 08625-0325 or by calling 1-800-263-5912, and requesting a copy of the "Get the Facts" brochure; and

6. A statement that pursuant to N.J.S.A. 17B:27A-19, all carriers offering small employer health benefits plans must issue coverage to any small employer group which requests coverage under a small employer health benefits plan, meets the participation requirements of the carrier, and pays the required premium for the coverage.

(f) A withdrawing small employer carrier shall provide at least one copy of its notice of intent to cancel on a date certain or termination on the anniversary of each policy or contract, to the producer of record for each policy or contract. The notice shall be sent by certified mail, no less than six months prior to the effective date of withdrawal.

(g) Simultaneous with its notice to the Commissioner, a withdrawing small employer carrier shall submit a notice to the Board at the address specified at N.J.A.C. 11:21-1.2, which:

1. Indicates that the carrier shall withdraw from the State of New Jersey;

2. States that the carrier will nonrenew its in force policies or contracts on their anniversary date; and

3. Sets forth the date when the nonrenewals shall begin.

(h) Following the initial notice to the small employer, a small employer carrier shall submit subsequent notices to the small employer of the nonrenewal on the anniversary date of the contract and the date upon which the nonrenewal shall occur. Such notice shall be included with each monthly premium bill or premium notice issued prior to the date of nonrenewal. Where no monthly premium statement is transmitted, a small employer carrier shall provide a small employer with no fewer than three notices, which notices shall be sent at a minimum on the sixth, third and last month prior to the date of nonrenewal.

11:21-16.4 Restrictions on writings following a market withdrawal

Any small employer carrier that ceases to do business pursuant to this subchapter shall be prohibited from writing new business in the New Jersey small employer market for a period of five years from the date of termination of the last health benefits plan nonrenewed under this subchapter.

11:21-16.5 General provisions for withdrawal of plan, plan option and copayment/deductible option

(a) No carrier shall cease to issue or nonrenew a standard small employer health benefits plan, plan option or copayment/deductible option required or permitted to be offered pursuant to N.J.A.C. 11:21-3 until the carrier submits a notice of intent to withdraw a plan, plan option or copayment/deductible option with the Commissioner in accordance with the provisions of this subchapter.

(b) A carrier may cease to issue and nonrenew a standard small employer health benefits plan pursuant to this section only if:

1. The copayment/deductible option is not required to be offered pursuant to N.J.A.C. 11:21-3.1(b) or (c); or

2. In the case of a copayment/deductible option required to be offered pursuant to N.J.A.C. 11:21-3.1, the carrier meets its obligation to offer the standard small employer plans and required copayment/deductible options either by offering the plans as indemnity plans or by making the plan or plans available through or in conjunction with a selective contracting arrangement to all New Jersey small employer groups.

(c) A carrier may cease to issue and nonrenew a standard plan option pursuant to this section by offering another approved plan option. Examples of plan options include, but are not limited to, a carrier's option to calculate the family deductible based on a two times individual or three times aggregate basis, and an HMO's option to offer prescription drug coverage with either a $ 15.00 copayment or with 50 percent coinsurance.

(d) A carrier that seeks to withdraw a plan, plan option or copayment/deductible option pursuant to this section shall provide the Commissioner with written notification of its intent to withdraw a plan, plan option or copayment/deductible option. An original and two copies of the notice of intent to withdraw a plan, plan option or copayment/deductible option shall be sent to the attention of: SEH Withdrawal Notice, Life and Health Division, New Jersey Department of Banking and Insurance, PO Box 325, Trenton, New Jersey 08625-0325, and shall include the following information:

1. The name of the carrier;

2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for plan, plan option or copayment/deductible option withdrawal;

3. A specific description of the reasons the carrier is withdrawing the plan, plan option or copayment/deductible option;

4. Copies of a nonrenewal notice the applicant intends to send to its policy or contractholders. Nonrenewal notices for policy or contract holders shall include the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option or copayment/deductible option;

ii. The date upon which the plan, plan option or copayment/ deductible option shall be nonrenewed;

iii. A statement that the plan, plan option or copayment/ deductible option is being nonrenewed under the authority of this subchapter;

iv. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option or copayment/deductible option withdrawal; and

v. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan, plan option or copayment/deductible option withdrawal; and

5. Copies of the proposed nonrenewal notices the applicant intends to send to its producers. Nonrenewal notices for producers shall contain the same information as the notices to policy and contract holders.

(e) The Commissioner shall review the notice of intent to withdraw a plan, plan option or copayment/deductible option to determine whether it complies with the filing requirements of (d) above. The Commissioner shall notify the carrier, in writing, of any deficiencies and the requirements that are necessary to bring it into compliance with this section.

(f) A carrier which has submitted a notice of intent to withdraw a plan, plan option or copayment/deductible option shall:

1. Not more than 60 days after the date of the notice of intent to withdraw the plan, plan option or copayment/deductible option, cease issuing the standard small employer health benefits plan, plan option or copayment/deductible option;

2. Not more than 60 days following the date of notice of intent to withdraw the plan, plan option or copayment/deductible option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option or copayment/deductible option, mail a notice, in the same format submitted to the Commissioner pursuant to (d)4 above, to every policy or contract holder, informing the policy or contract holder that the plan, plan option or copayment/deductible option will be nonrenewed on the plan's anniversary date;

3. Following the initial notice to each policy or contractholder, send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium is transmitted, send a notice at least 30 days prior to nonrenewal; and

4. Not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option or copayment/deductible option, mail a notice in the same format submitted to the Commissioner pursuant to (d)5 above, to the producer of record, if any, for each policy or contract.

11:21-16.6 Penalties

Failure to comply with the requirements of this subchapter shall result in the imposition of penalties pursuant to N.J.S.A. 17B:27A-43 and any and all other penalties provided by law.

11:21-16.7 Other policyholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policyholders concerning cancellation requirements or obligations set forth in a policy or contract issued by a small employer carrier.

11:21-16.8 Revocation of a notice of intent to withdraw

(a) A carrier may revoke its notice of intent to withdraw, filed with the Commissioner pursuant to N.J.A.C. 11:21-16.3, prior to the date that its withdrawal is complete, by submitting a statement to the Department at the address specified at N.J.A.C. 11:21-16.3(c) and to the Board at the address specified at N.J.A.C. 11:21-1.2 revoking its notice of intent to

withdraw. The revocation shall be signed by a duly authorized officer, and shall include the following:

1. A statement agreeing to reinstate any small employer that was nonrenewed by the carrier pursuant to the provisions of N.J.S.A. 17B:27A-23e and this subchapter.

HISTORY:

New Rule, R.1994 d.580, effective November 21, 1994.

See: 26 New Jersey Register 3118(a), 26 New Jersey Register 4620(a).

Amended by R.1998 d.533, effective November 16, 1998.

See: 30 New Jersey Register 2978(a), 30 New Jersey Register 4045(a).

In (a), changed N.J.A.C. reference in the introductory paragraph, substituted "nonrenewed" for "cancelled, or terminated" in 1, and deleted former 2 through 4.

Recodified from N.J.A.C. 11:21-16.7 by R.2004 d. 108, effective March 15, 2004.

See: 35 New Jersey Register 4438(a), 36 New Jersey Register 1605(a).

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SUBCHAPTER 17. FAIR MARKETING STANDARDS

11:21-17.1 Plan identification and marketing materials

(a) Each small employer carrier which issues marketing and/or promotional materials in conjunction with the standard health benefits plans may attach its own name or identification to each of the plans, but shall also identify each of those standard health benefits plans by the alphabetical designation (A, B, C, D, E, HMO, HMO POS) assigned to it in N.J.A.C. 11:21-3.1. The alphabetical designation shall be clearly identified in the designation of each of the small employer carrier's standard health benefits plans.

(b) All eligibility, coverage and exclusions described in the small employer carrier's marketing and/or promotional material shall be consistent with the Act and this chapter.

11:21-17.2 Retention of marketing and promotional materials

Small employer carriers shall maintain a complete file of all marketing and promotional material specific to the health benefits plans, which it disseminates to consumers, producers, or otherwise publicly disseminates. Small employer carriers shall retain each piece of promotional and marketing materials for a period of three calendar years from the last date the material is publicly disseminated, which shall be deemed its complete file for the purposes of this subchapter. Upon written request of the Board, a small employer carrier shall, within three business days, make available for inspection its complete file of marketing and promotional material to the Board.

11:21-17.3 Certification

(a) Each small employer carrier disseminating marketing and promotional material shall certify that its marketing and promotional material conforms with the requirements of this subchapter. The certification, set forth in Part 2 of Exhibit BB of the Appendix, incorporated herein by reference, shall be signed by a duly authorized officer of the small employer carrier.

Each small employer carrier shall file its initial certification with the Board no later than the first day upon which the small employer carrier disseminates promotional or marketing materials for the health benefits plans to consumers, producers or the public in general.

(b) Small employer carriers shall continue to file a certification as required in (a) above on an annual basis, on or before March 1 of each year following the filing of its initial certification.

11:21-17.4 (Reserved)

11:21-17.5 Producer contracts

(a) A small employer carrier may select those insurance producers, as defined by N.J.S.A. 17:22A-2j, with whom it chooses to contract. No small employer carrier shall terminate or refuse to renew the contract of its insurance producers because of health status-related factors of eligible employees or dependents, the average number of eligible employees or the average number of employees enrolled in small employer plans placed by the producer with the carrier, or the occupation or geographic location of the small employer groups placed by the insurance producer with the small employer carrier.

(b) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an insurance producer that provides for or results in any consideration provided to an insurance producer for the issuance or renewal of a small employer health benefits plan that varies on account of health status-related factors of eligible employees or dependents, the number of eligible employees or the number of employees enrolled, or the industry, occupation or geographic location of a small employer covered by a small employer health benefits plan.

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SUBCHAPTER 18. PETITIONS FOR RULES

11:21-18.1 Scope

This subchapter shall apply to all petitions made by interested persons for the promulgation, amendment or repeal of any rule by the Board, pursuant to N.J.S.A. 52:14B-4(f).

11:21-18.2 Procedure for petitioner

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

1. Name and address of the petitioner;

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

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

4. References to the statutory authority of the Board to take the requested action; and

5. A caption at the top of the document identifying it as a petition for rulemaking pursuant to N.J.S.A. 52:14B-4(f) and this subchapter.

(b) The petition shall be sent to the Executive Director at the address in N.J.A.C. 11:21-1.3.

(c) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the

event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

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

11:21-18.3 Procedure of the Board

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

1. The name of the petitioner;

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

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

4. The date the petition was received.

(b) Within 60 days of receiving a petition in compliance with N.J.A.C. 11:21-18.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;

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

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

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

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

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

1. Denying the petition;

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

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

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SUBCHAPTER 19. SEH PROGRAM PREMIUM COMPARISON SURVEY

11:21-19.1 Purpose and scope

(a) This subchapter requires the annual submission of data by small employer carriers to the Department, and establishes the format for the submission of such data, regarding premiums charged for the five standard health benefits plans, the HMO plan, the HMO/POS plan, and any

standard rider packages established by the Board, so that the Department may develop and publish an annual SEH Program Premium Comparison Survey, pursuant to N.J.S.A. 17B:27A-33g.

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

11:21-19.2 Definitions

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

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

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

11:21-19.3 SEH Program premium comparison survey

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

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

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

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

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

SEH Program Premium Comparison Survey

Public Affairs Office

New Jersey Department of Banking and Insurance

20 West State Street

PO Box 325

Trenton, New Jersey 08625-0325

11:21-19.4 Penalties

Failure to comply with the requirements of this subchapter may result in the imposition of penalties as authorized by N.J.S.A. 17B:27A-43.

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SUBCHAPTER 20. WITHDRAWALS OF STANDARD SEH PLAN OPTIONAL BENEFIT RIDERS

11:21-20.1 Purpose and scope

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

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

11:21-20.2 Definitions

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

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

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

11:21-20.3 Withdrawal of optional benefit riders

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

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

1. The written application shall include the following:

i. The name of the carrier;

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

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

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

v. A copy of the nonrenewal notice the carrier shall provide to policyholders or contractholders as described in (c) below;

vi. A copy of the nonrenewal notice the carrier shall provide to producers as described in (d) below; and

vii. A copy of the optional benefit rider the carrier is withdrawing, along with evidence of approval of the rider by the Department or acknowledgment of the rider by the SEH Board.

2. The completed application shall be sent to the following address:

New Jersey Department of Banking and Insurance

Life and Health Division

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

3. The Department shall review the completed application for compliance with the requirements of this section, and shall provide the carrier within 30 days of receipt with written notice of any deficiencies in the application or with an acknowledgment that the application is complete and in compliance with the requirements of this section.

4. The carrier shall return to the Department an amended application correcting any deficiencies within 30 days of receipt of the Department's deficiency notice.

5. The carrier shall cease issuing the optional benefit rider no later than 60 days after the date that acknowledgment of a complete application to withdraw the optional benefit rider is received.

(c) In addition to meeting all of the other requirements of this subchapter, a carrier seeking to withdraw an optional benefit rider shall provide written notice of nonrenewal of the optional benefit rider to the policyholder or contractholder as follows:

1. An initial notice of nonrenewal shall be provided at least 90 days prior to the anniversary date of the optional benefit rider, and shall include the following:

i. A statement that the carrier has elected to nonrenew the optional benefit rider pursuant to the authority of this subchapter;

ii. A statement that the optional benefit rider shall be nonrenewed on the anniversary date of the rider;

iii. A statement that the carrier shall offer the policyholder the option to purchase any other optional benefit riders that the carrier offers in the small employer market;

iv. A statement that the policyholder or contractholder may contact his or her producer, if any, for additional information regarding the optional benefit rider withdrawal;

v. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the optional benefit rider withdrawal; and

vi. A statement that in choosing to nonrenew the optional benefit rider and offering all other health insurance the carrier offers in the small employer market, the carrier is acting uniformly without regard to the claims experience of the policyholder or contractholder or to any health status-related factors relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for coverage.

2. In addition to the nonrenewal notice described in (c)1 above, a subsequent notice of nonrenewal shall be included with each monthly premium bill or premium notice issued prior to the date of nonrenewal. If no monthly premium statement is issued, a subsequent notice of nonrenewal shall be provided at least 30 days prior to nonrenewal. The notice shall contain at least the information set forth at (c)1ii and v above.

(d) In addition to meeting all of the other requirements of this subchapter, a carrier seeking to withdraw an optional benefit rider shall provide at least 90 days prior to the anniversary date of the optional benefit rider, a written notice of nonrenewal to the producer of record, if any, for each policy or contract, as follows:

1. The nonrenewal notice to the producer shall include the following:

i. A statement that the carrier has elected to nonrenew the optional benefit rider pursuant to the authority of this subchapter;

ii. The date the optional benefit rider shall be nonrenewed;

iii. A statement that the carrier will offer the policyholder or contractholder the option to purchase all other optional benefit riders that the carrier offers in the small employer market; and

iv. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the optional benefit rider withdrawal.

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SUBCHAPTER 21. SMALL EMPLOYER PURCHASING ALLIANCES

11:21-21.1 Purpose and scope

(a) This subchapter implements P.L. 2001, c.225 by establishing rules for the formation and operation of small employer purchasing alliances.

(b) This subchapter shall apply to eligible groups of small employers as defined in P.L. 1992, c.162 (N.J.S.A. 17B:27A-17).

11:21-21.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Department of Banking and Insurance" means the New Jersey Department of Banking and Insurance.

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

11:21-21.3 Filing requirements

(a) Within 30 days of formation, a small employer purchasing alliance shall file the following with the Commissioner:

1. A certification of an officer or director of the purchasing alliance, which shall include:

i. The name of the purchasing alliance;

ii. The members of the purchasing alliance;

iii. The names of the board of directors, chairman, treasurer and secretary of the purchasing alliance;

iv. The New Jersey mailing address at which communications for the purchasing alliance are to be received;

v. The toll free telephone number for prospective members to use to contact the purchasing alliance;

vi. The eligibility requirements for membership in the purchasing alliance;

vii. The fees charged to members of the purchasing alliance; and

viii. A description of the SEH standard plans, and any optional benefit riders, for which the purchasing alliance negotiates or intends to negotiate premiums for its members;

2. A copy of the certificate of incorporation, if any, of the purchasing alliance;

3. A copy of the joint contract executed by all members of the purchasing alliance;

4. A description of the eligible small employers that constitute the purchasing alliance, including their common or similar type of trade or business; the common trade association, professional association or other associations; or common geographic area;

5. A copy of the bylaws of the purchasing alliance, which shall include:

i. The procedures for the organization and administration of the purchasing alliance; and

ii. The procedures for the qualification and admission of additional members of the purchasing alliance; and

6. Information about the procedures a small employer should follow to join the purchasing alliance, including a contact person, address, telephone number, and eligibility requirements for membership.

(b) Filings shall be submitted to:

NJ Department of Banking and Insurance

Att: SEH Rate Filings

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

(c) A current listing of the membership of the purchasing alliance as required by (a)1ii above shall be filed with the Commissioner quarterly. Any other change in the information specified in (a) above shall be filed with the Commissioner within 30 days of the change.

11:21-21.4 Eligibility requirements

(a) No purchasing alliance shall use as a basis for exclusion from membership in the alliance any of the following characteristics of any small employer group as a whole, or any person eligible for coverage in that group:

1. Health status;

2. Medical condition, including both physical and mental illness;

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability, including conditions arising out of acts of domestic violence;

8. Partial or total disability;

9. Group size;

10. Age;

11. Gender; or

12. Any other health status-related factor.

(b) A purchasing alliance shall not inquire as to the insured or uninsured health care claims experience or cost of any employer or employee.

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

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

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

11:21-21.6 Violations and penalties

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

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SUBCHAPTER 22. (RESERVED)

SUBCHAPTER 23. RULEMAKING; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

11:21-23.1 Purpose and scope

(a) The purpose of this subchapter is to establish the procedures that the Board uses in providing notice of proposed rulemaking, receiving public comments regarding existing rules and proposed rulemaking, extending the public comment period, conducting a public hearing, and providing notice of public meetings.

(b) This subchapter shall apply to all rulemaking of the Board.

11:21-23.2 Public notice regarding proposed rulemaking

(a) Unless the Board proposes a rule pursuant to the special procedures set forth at N.J.S.A. 17B:27A-51, the Board shall provide for the following four types of public notice for rule proposals in accord with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30:

1. The rule proposal shall be filed with the Office of Administrative Law for publication in the New Jersey Register;

2. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be posted and made available electronically on the Department of Banking and Insurance website at: http://www. njdobi.org;

3. The news media maintaining a press office in the State House Complex shall be provided notice of the rule proposal, as posted and made available electronically on the New Jersey Department of Banking and Insurance website; and

4. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be made available to the Board's list of "interested persons" by e-mail or hard copy. Interested persons are those who have informed the Board in writing that they wish to receive notice of the Board's proposed regulations, as well as those people or entities that the Board determines are the subject of or significantly related to the rulemaking so that the persons most likely to be affected by or interested in the intended action receive notice.

11:21-23.3 Extension of the public comment period

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may extend the time for submission of public comments on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall extend the time for submission of public comments for an additional 30-day period, if, within 30 days of the publication of a notice of proposal, sufficient public interest is demonstrated in an extension of time to submit comments.

(c) The Board shall determine that a sufficient public interest for the purpose of extending the public comment period has been demonstrated if any of the following has occurred:

1. Comments received indicated a previously unrecognized impact on a regulated entity or persons; or

2. Comments received raise unanticipated issues related to the notice of proposal.

11:21-23.4 Conducting a public hearing

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may conduct a public hearing on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall conduct a public hearing if sufficient public interest has been demonstrated.

(c) A person interested in having a public hearing held on a notice of proposal shall submit an application within 30 days following the publication of the notice of proposal in the New Jersey Register in a form prescribed by the Board, to the Executive Director at the address listed in N.J.A.C. 11:21-1.3. The application shall contain the following information:

1. The person's name, address, telephone number, agency or association (if applicable);

2. The citation and title of the proposed rule and the date the notice of proposal was published in the New Jersey Register; and

3. The reasons a public hearing regarding the notice of proposal is considered necessary pursuant to (d) below.

(d) The Board shall determine that a sufficient public interest has been demonstrated for the purpose of holding a public hearing if the application demonstrates that additional data, findings and/or analysis regarding the notice of proposal are necessary for the Board to review prior to adoption of the proposal in order to ensure that the notice of proposal does not violate the intent of the statutory law.

11:21-23.5 Public notice regarding board meetings

(a) The Board shall adopt an annual schedule of regular meetings to be held by it the following calendar year.

(b) The Board may schedule meetings in addition to those set forth in the annual schedule.

(c) The Board shall provide public notice for all meetings by:

1. Posting of a notice at the office of the Secretary of State;

2. Posting of a notice at the office of the Board at the address set forth at N.J.A.C. 11:21-1.3;

3. Posting of a notice on the Department of Banking and Insurance website at: http://www.njdobi.org;

4. Posting of the notice in two newspapers of general circulation designated by the Board; and

5. Mailing, either by hard copy or electronically, of the notice to a distribution list of those persons who have requested in writing to be informed of the Board's meeting schedule.

11:21-23.6 Board mailing list of interested parties

(a) For the purpose of disseminating information about the SEH Program, including information about rulemaking and meeting dates, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of members shall be based upon the member carriers' addresses filed with its most recently filed Exhibit CC Market Share Report.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and mailing address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications, other than copies of proposals, from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

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