INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Individual Health Benefits Plans

Proposed Amendments: N.J.A.C. 11:20:1, 3, 8, 12, 17, 19, 23, 24 and Appendix Exhibits A and B

Proposed Repeal: N.J.A.C. 11:20-22 and Appendix Exhibit L Parts 1 and 2

Authorized By: New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director.

Authority: N.J.S.A. 17B:27A-2 et seq.

Calendar Reference: See Summary below for an explanation of inapplicability of the calendar requirement.

Proposal Number: PRN 2016-.

As required by N.J.S.A. 17B:27A-16.1, interested parties may testify with respect to the standard health benefits plans set forth in N.J.A.C. 11:20 Appendix Exhibits A and B at a **public hearing** to be held at 10:00 a.m. on Thursday, August 18, 2016, at the New Jersey Department of Banking and Insurance, 11th floor Conference Room, 20 West State Street, Trenton, New Jersey.

Submit comments by August 22, 2016 to:

Ellen DeRosa

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The agency proposal follows:

Summary

The Individual Health Coverage (IHC) Program was established in accordance with P.L. 1992, c. 161. The IHC Program is administered through a Board of Directors (Board). The primary functions of the IHC Program and its Board are the creation of standard health benefits plans (standard plans) to be offered in the individual market in New Jersey and the regulation of the individual health coverage market. There are five standard plans, which have been established through regulation, and are set forth in Exhibits A and B of the Appendix to N.J.A.C. 11:20, the rules for the IHC Program, along with Exhibit C, which provides explanations of how certain variables in the standard plans may be used by carriers.

Discussion of Proposed Amendments and Repeals to the Rules

The IHC Board proposes to delete all references to the Basic and Essential Plan and provisions governing the operation of such plan since the plan has not been available for sale since December 31, 2013. In some places the Basic and Essential Plan was referred to as the Basic and Essential Healthcare Services Plan. The Basic and Essential Plan was discontinued because it featured annual limits that are prohibited by 45 CFR 147.126(a)(2) and failed to include coverage for all of the essential health benefits as required by 42 U.S.C. § 18022(a) and 45 CFR 156.110.

The IHC Board proposes an amendment to the definition of "Dependent" to clarify that only coverage which is not issued through the Marketplace may define dependent to include a

child with a legal or blood relationship. Such children do not satisfy the eligibility requirements with respect to coverage issued through the Marketplace.

The IHC Board proposes to delete the definition of and all references to the "Initial enrollment period" since such period ended March 31, 2014 and is no longer relevant to the rules.

The IHC Board is proposing to amend the definition of eligible person to state that a person is not an eligible person if the person is covered by Medicare. The existing definition states that a person is not an eligible person if the person is eligible for Medicare. Thus the amendment changes the Medicare status from "eligible" for Medicare to "covered" for Medicare. Eligible for Medicare means a person has satisfied the requirements to be able to be covered for Medicare but has not yet signed up for Medicare whereas covered for Medicare means the person is not only eligible but has completed the enrollment for Medicare and is in fact covered under Medicare. This amendment is necessitated by text in the February 20, 2015, Issuer letter from CMS that references the CMS FAQ Regarding Medicare and the marketplace dated August 28, 2014.

The IHC Board proposes to delete the definition of the term "NAIC" as the term is not used in the rules.

The IHC Board proposes an amendment to the definition of "Net earned premium" to delete the phrase "incorporated herein by reference" since Exhibit K is in fact included in the Appendix Exhibits to N.J.A.C. 11:20. Similarly, throughout the regulations, all references to "incorporated herein by reference" are proposed to be deleted since all exhibits referenced in the rules are included in the appendix to N.J.A.C. 11:20.

The IHC Board proposes to delete the definition of "Pre-existing condition" because the use of a pre-existing condition exclusion is prohibited by 42 U.S.C. § 300gg-3 and 45 CFR 147.108.

The IHC Board proposes an amendment to the definition of "Special enrollment period" to explain that such period also includes a 60-day period preceding loss of coverage as required by 45 CFR 147.104(b)(1)(ii). The same amendment is made throughout the rules when discussing the special enrollment period.

The IHC Board proposes an amendment to the definition of "triggering event" to include a court order as required by 45 CFR 155.420(b)(2)(v).

The IHC Board proposes an amendment to the address for communications in N.J.A.C. 11:20-2.1(h) to include an email address.

The IHC Board proposes an amendment to N.J.A.C. 11:20-2.5(d) to delete item (d)2 which requires the affirmative vote of five Board members for stated actions. The IHC Board proposes to rely on the standard specified in (d)1 which requires the majority of directors present at any meeting at which a quorum is present for all actions. Although N.J.S.A. 17B:27A-10a provides for a nine-member Board of Directors, fewer than that number have served on the IHC Board for some time. The reduced membership on the IHC Board makes it difficult for the IHC Board to take necessary action if five votes are necessary and fewer than five members attend a meeting or if one or more of the members is recused from considering and voting on a matter.

The IHC Board proposes to delete N.J.A.C. 11:20-2.9(b)7 because the opportunity to submit exemption requests ceased.

The IHC Board proposes to clarify N.J.A.C. 11:20-2.9(c) with respect to the records that are not subject to public inspection and copying pursuant to N.J.S.A. 17:1A-1 et seq.

The IHC Board proposes to amend N.J.A.C. 11:20-2.12(b) to delete the reference to interim assessments to fund losses since there is no longer the opportunity for carriers to seek reimbursement for losses.

The IHC Board proposes an amendment to N.J.A.C. 11:20-3.1(e)1 to correct an incorrect citation to N.J.A.C. 11:4-37.3.

The IHC Board proposes to delete N.J.A.C. 11:20-3.5 which addressed the Basic and Essential Health Care Services Plan because such plan no longer exists as explained above.

The IHC Board proposes amendments to N.J.A.C. 11:20-3.6(a)4 – 6 and N.J.A.C. 11:20-3.6(a)7 vi(3) and (4) to explain that the use of a rider creates a unique plan and such unique plan must be available to all individuals seeking to purchase coverage.

The IHC Board proposes to amend N.J.A.C. 11:20-3.6(a)2i to delete the reference to the "Covered Charges with Special Limitations" section because that section is proposed to be deleted in the standard plans as discussed below.

The IHC Board proposes an amendment to N.J.A.C. 11:20-3.6(a)7vi(5) to correct an incorrect citation to N.J.A.C. 11:4-37.3 and to delete an incorrect citation.

The IHC Board proposes an amendment to N.J.A.C. 11:20-8.2(c) to simplify the filing process by allowing assessment reports to be filed by mail, removing the requirement to follow by mail if filed by facsimile, and allowing electronic filing.

The IHC Board proposes an amendment to the caption of N.J.A.C. 11:20-12 to delete the Basic and Essential Health Care Services Plan for the reasons stated above.

The IHC Board proposes to delete N.J.A.C. 11:20-12.3 which addressed replacement of coverage during the initial enrollment period since such period ended on March 31, 2014 and is no longer relevant.

The IHC Board proposes an amendment to N.J.A.C. 11:20-12.5(b) to state that the effective date of the replacement plan will be no later than the first of the month following receipt of the application. The amendment recognizes the flexibility carriers have with respect to assigning an effective date for a person who lost coverage on a date other than the end of the month. By allowing the effective date to be no later than the end of the month, a carrier may assign an effective date that occurs before the first of the month. In addition the IHC Board proposes to amend N.J.A.C. 11:20-12.5(b) to state the effective date of coverage as required by court order is the date stated in the order.

The IHC Board proposes new N.J.A.C. 11:20-12.5(c) to state that carriers may require proof of a triggering event. The new item memorializes the practice of requiring proof of a triggering event.

The IHC Board proposes amending N.J.A.C. 11:20-17(a) to delete the requirement for an annual submission of enrollment reports and the requirement that carriers use a reporting format set forth in the subchapter. As discussed with respect to N.J.A.C. 11:20-17.3(c) and N.J.A.C. 11:20-17.4(b) below, the annual report is no longer necessary.

The IHC Board proposes amending N.J.A.C. 11:20-17(b) and N.J.A.C. 11:20-17.3(a) to delete the reference to the Basic and Essential Healthcare Services Plan, for the reasons stated above.

The IHC Board proposes to amend the definition of "Enrollment status report" in N.J.A.C. 11:20-17.2 to delete references to Exhibit L Parts 1 and 2 and instead refer to the information listed in N.J.A.C. 11:20-17.

The IHC Board proposes to amend N.J.A.C. 11:20-17.3(b) to delete the reference to the format of Part 1 of Exhibit L since the IHC Board proposes the repeal of Exhibit L, as discussed below.

The IHC Board proposes deleting N.J.A.C. 11:20-17.3(c) and N.J.A.C. 11:20-17.4(b) which deal with the annual enrollment status report filing because the IHC Board determined it is not necessary to require carriers to provide data with respect to zip codes, ages and genders of persons covered particularly since rating by zip code and gender is no longer permitted with respect to individual coverage. The IHC Board believes the data provided on the quarterly reports provides more meaningful information to enable to the Board and interested persons to analyze enrollment. With the deletion of item (c) the subsequent items are being adjusted accordingly.

The IHC Board proposes to amend newly designated N.J.A.C. 11:20-17.3(c) to require the reports to be submitted electronically and extend the time allowed to prepare the report from 45 days following the end of each quarter to 60 days following the end of the quarter. Electronic filing will ensure greater accuracy of the data since it eliminates the need to review and copy data from a paper filing. The IHC Board recognizes the myriad reporting requirements imposed

on carriers from a variety of regulators. The IHC Board expects that the additional time to prepare the quarterly reports will be welcomed by carriers.

The IHC Board proposes amendments to N.J.A.C. 11:20-17.4 to delete all references to Exhibit L parts 1 and 2 and to the Basic and Essential plan, as discussed above. In addition, the IHC Board proposes to simplify the reporting by deleting the requirement for carriers to report previous insured status since this information is self-reported by the applicants, and often unreliable. To further simplify reporting and capture more meaningful data the IHC Board proposes to require reporting by PCP cost sharing as opposed to the plan deductible, copayment and coinsurance. The IHC Board proposes that enrollment be separately reported as marketplace and off-marketplace enrollment. The IHC Board proposes to require carriers to separately report the number of contracts sold as high deductible health plans and the number of contracts by actuarial value in new N.J.A.C. 11:20-17.4(a) 5 and 6.

The IHC Board proposes to add N.J.A.C. 11:20-19.2(d) to affirm that any petition for rulemaking would be posted on the Board's website.

The IHC Board proposes the repeal of Subchapter 22 that addressed requirements for the Basic and Essential Health Care Services Plan for the reasons stated above.

The IHC Board proposes to update the website address at N.J.A.C. 11:20-23.2(a)2 and N.J.A.C. 11:20-23.5 and to correct the citation in N.J.A.C. 11:20-23.2(c) to refer to N.J.A.C. 11:20-2.1(h).

The IHC Board proposes to amend N.J.A.C. 11:20-23.4(c) to remove the erroneous reference to a form prescribed by the Board and instead refer to the information listed below.

The IHC Board proposes adding new N.J.A.C. 11:20-23.4(d) to note that any request for a public hearing must be filed with the Office of Administrative Law.

The IHC Board proposes to amend N.J.A.C. 11:20-24.2(b)1 to delete the reference to the initial enrollment period which expired in 2014 and re-number the following items.

The IHC Board proposes an amendment to N.J.A.C. 11:20-24.2(e) to clarify that coverage under a catastrophic plan ends when any person covered under the plan attains age 30.

The IHC Board proposes to amend N.J.A.C. 11:20-24.2A(b) to add a new item 8 addressing a court order requiring coverage as required by 45 CFR 155.420(b)(2)(v).

The IHC Board proposes to delete N.J.A.C. 11:20-24.2A(c) which addresses 2014 enrollment since the time period has passed and adjusting the following item accordingly.

The IHC Board proposes deleting N.J.A.C. 11:20-24.4(b) which addresses the initial enrollment period which ended in 2014 and adjusting the following items accordingly.

The IHC Board proposes amending newly numbered N.J.A.C. 11:20-24.4(c) to state the effective date of coverage as required by court order is the date stated in the order.

The IHC Board proposes deleting N.J.A.C. 11:20-24.5 which addresses paying benefits. Current N.J.A.C. 11:20-24.5(a) requires carriers to use a standard that has not been updated since 2010. The standard is used solely with respect to the out of network benefits provided under an individual plan that features out of network benefits such as a preferred provider organization plan (PPO) or point of service plan (POS). The application of the standard is further limited by the fact that New Jersey law precludes payment of benefits at the out of network level in emergency situations (N.J.A.C. 11:4-37.3, 11:24-5.3, N.J.A.C. 11:24-9.1(d),

N.J.A.C. 11:24A-2.5 and 2.6) and while the member is an inpatient with respect to services provided during the hospitalization such as anesthesia and radiology (N.J.A.C. 11:22-5.8(b)). The IHC Board refers to the small percent of claims to which out of network reimbursement is applied as voluntary out of network claims to distinguish them from out of network claims that are processed subject to New Jersey law cited above such that the member is held harmless.

Because the IHC Board has defined the basis for paying voluntary out of network benefits for over 20 years, it is important to consider why this has been the case. P.L. 1992 c. 161 charged IHC Board with the development of standard policy forms. When developing the standard policy forms in early 1993 the IHC Board reviewed policy forms from a host of carriers to ensure that the benefits included in the standard plans would be comparable to the benefits small employers purchased prior to standardization. At that time the only plans using network negotiated rates were HMO plans, and HMO coverage was not widely selected. For the most part, individual consumers bought indemnity plans which had no networks, no requirements for referrals and patients selected doctors and hospitals at will. Carriers paid the allowed charge for the submitted bills subject to applicable cost sharing. Because an allowed charge determination was a key element of the insurance benefit for every claim, the IHC Board determined that standardization of the policy forms necessitated standardization of the determination of allowed charge. Some of the larger carriers such as Prudential and Horizon (at the time known as Blue Cross Blue Shield) had sufficient claims data to develop their own allowed charge data bases. Smaller carriers relied on Health Insurance Association of America (HIAA) data. To ensure all carriers could have access to and be able to use the same basis to determine the allowed charge, the IHC Board proposed and adopted regulations that required carriers to use the 80th percentile

of HIAA data. Through purchases the data later became known as the Prevailing Healthcare Charges System (PHCS) and was owned by Ingenix.

In 2016, all plans offered in the individual market are network-based managed care plans. The vast majority are HMO and Exclusive Provider Organization (EPO) plans which are network only plans and do not cover any voluntary out of network services. Since 2014 only one individual carrier offers plans that include out of network benefits. Total individual market enrollment as of 1Q16 is 359,173 lives. Only 10,184, or 2.8 percent of those lives are covered under plans with out of network benefits.

As a result of legal action in New York the PHCS data base was eliminated in 2010. No updated data has been produced since that time. As required by N.J.A.C. 11:20-24.5, individual market carriers that already had the 2010 data have continued to process voluntary out of network claims using 2010 data. Carriers that did not exist in 2010 have no ability to access the 2010 PHCS data and thus have not been able to offer plans with out of network benefits, impeding consumer choice and potentially skewing market competition.

Although many individual consumers prefer plans with out of network benefits most do not buy them because of the very limited choices and the fact that the plans that are available are more expensive than EPO and HMO plans. The IHC Board believes that allowing carriers to use a carrier-determined basis to determine the allowed charge would encourage more carriers to offer pans with out of network benefits and help bring the premiums for such plans closer to the premiums for comparable EPO and HMO plans. The result would be an expansion of consumer choice.

The IHC Board notes that individual plans feature cost sharing incentives for patients to use network providers and as a result most care is rendered by network providers and is paid

based on the negotiated fee. However, carriers offering coverage in the small employer market where there are more carriers offering plans with out of network benefits, report that from 10 percent to 20 percent of claims dollars are spent on out of network services and have explained that low utilization of out of network services does not equate to low claims dollars because of the higher cost of out of network services. Thus a low volume of claims produces significant claims expenses which have an impact on premiums. The one carrier selling individual market plans with out of network benefits reports similar experience. Thus, there are multiple inequities in having some carriers using increasingly outdated data that other carriers cannot even purchase. The IHC Board believes that elimination of the reimbursement standard at N.J.A.C. 11:20-24.5 would be more equitable for the individual market as a whole.

The IHC Board believes the necessity to standardize the determination of allowed charge that arose from the indemnity plan products available in 1993 does not exist in 2016. As explained above, most care is provided by network providers. The IHC Board considered mandating a replacement for PHCS but determined that a standardized basis to determine the allowed charge for a low volume of claims is not warranted. The IHC Board hopes to encourage all carriers to offer plans with out of network benefits. Carriers in the large group market already offer many plans with out of network benefits and have multiple methods to determine the allowed charge for out of network benefits under such plans. The IHC Board believes giving individual market carriers the opportunity to determine the allowed charge for voluntary out of network benefits under individual plans will encourage individual carriers to make plans with out of network benefits available. It is worth noting that New Jersey has been unique as compared to other states in terms of regulating the basis for the determination of the allowed charge for voluntary out of network claims. As a result, carriers offering plans in the individual market

have been required to use a basis that is specific to the New Jersey individual market for that small segment of business whereas in the large group market in New Jersey as well as all markets in which the carriers offer plans in other states, have used the basis the carrier determined to be best suited for voluntary out of network claims.

The IHC Board notes a common concern with PHCS was its lack of transparency. Thus, as part of proposed amendments to the standard plans set forth in exhibits in the Appendix to N.J.A.C. 11:20, the IHC Board proposes to require carriers to specifically identify the standard for the determination of allowed charges within the definition of allowed charge contained in the standard plans. The IHC Board is proposing that the standard used by a carrier must allow consumers the opportunity to learn the allowed charge amount for any given service or supply.

The IHC Board notes that N.J.A.C. 11:20-24.5 also includes language in paragraph (b) establishing an exemption from the reimbursement method with respect to the payment of claims for prosthetics and orthotics, because a different standard for paying claims for those services is required by statute. The Board is proposing to delete the exemption, because there would be no reason for an exemption if the general out-of-network reimbursement method is deleted. In addition, carriers must comply with the prosthetic and orthotic statutes (see N.J.S.A. 17B:27A-19.17) whether or not the IHC Board sets forth the obligation in its rules.

The IHC Board proposes amending the standards for a good faith marketing effort set forth in N.J.A.C. 11:20-24.6(c) to clarify that a submission of the application must include a demonstration as to how the application is made available, that a marketing effort must be individual consumer directed, and that other methods a carrier may use must be outbound approaches.

Discussion of Proposed Amendments to the Appendix Exhibits A, B and Repeal of L Parts 1 and 2

Standard Health Benefits Plans set forth in Appendix Exhibits A and B

The IHC Board is proposing numerous grammatical changes throughout the forms to enhance accuracy and consistency in the texts. Among other things, these proposed changes include more consistent capitalization of defined terms, and numerical changes primarily to reflect changes in years.

To comply with 45 CFR 155.205(c)(2)(iii)(A) the IHC Board proposes including direction to carriers to include language tagline information to alert consumers that are not English speakers and/or readers to resources for obtaining information and help in other languages.

As required by 45 CFR 147.126(a)(2) the annual limits specified for out of network preventive services in Exhibit A are proposed to be deleted. The IHC Board notes that while annual limits cannot be applied to non-network preventive services carriers may apply non-network cost sharing to non-network preventive services.

The IHC Board proposes an amendment to the definition of "allowed charge" to replace the text referring to a standard approved by the Board with direction for carriers to specify the methodology for determining allowed charges and requiring carriers to explain how a consumer can learn the allowed charge for services to be received. This amendment to the standard plans is being proposed for the reasons already stated with respect to the proposed repeal of N.J.A.C. 11:20-24.5. In addition, the IHC Board proposes removing the statement that the section of the standard plans discussing coordination of benefits contains a distinct definition of allowed

charge, because this statement unnecessarily emphasizes the fact that the coordination of benefits provision contains specific definitions.

The IHC Board proposes combining the section entitled Covered Charges with the section entitled Covered Charges with Special Limitations. Since inception the non-HMO standard plans have included distinct sections to specify covered charges and covered charges with special limitations. Benefits were generally included in the Covered Charges with Special Limitations section because of internal limits such as dollar limits. Since 45 CFR 147.126(a)(2) prohibits the imposition of dollar limits on essential health benefits the distinction between covered charges and covered charges with special limitations is less important. For simplicity, the IHC Board proposes combining the Covered Charges under one section called covered charges. Throughout the standard plans all references to covered charges with special limitations are proposed to be deleted.

The IHC Board previously adopted amendments to the standard plan provision for treatment of autism and other developmental disability to address the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity Equity and Addiction Act of 2008 (MHPAEA), Public Law 110-343;, section 511 and 512; as implemented in regulations by the U.S. Department of Labor at 29 CFR 2590.712; and the U.S. Department of Health and Human Services at 45 CFR 147.160. The IHC Board neglected to similarly amend the definition of developmental disability to remove the age 22 limit. In addition, to comply with Rosa's Law (Pub. L. 111-256) the term mental retardation as used in the definition of developmental disability is replaced with intellectual disability.

The IHC Board proposes to amend the standard plans throughout to recognize a change in the name of the Joint Commission on the Accreditation of Health Care Organizations to The Joint Commission, and is relocating the related definition alphabetically.

The IHC Board proposes to add a definition of primary care provider consistent with the definition in N.J.A.C. 11:22-5.2. All references in the standard plans to primary care physician are proposed to be amended to use the term primary care provider instead.

The IHC Board is proposing to amend the definition of Skilled Nursing Facility to remove reference to specific types of nurses, and simply refer to Nurse and nursing services, because the specificity is unnecessary for purposes of defining the type of facility in question and the term Nurse is a defined term in the standard plans.

The IHC Board proposes to expand the optional definition of telemedicine to address audiovisual means.

The IHC Board proposes an amendment to the Continuation of Care provision to address a situation in which the provider attests that discontinuance of care would worsen the patient's condition or interfere with anticipated outcomes. The proposed amendment is consistent with 45 CFR 156.230(d)(2)(i)(D).

The IHC Board proposes to delete the provision entitled Payment Limits because dollar limits are prohibited by 45 CFR 147.126(a)(2).

The IHC Board proposes to include optional text in the prescription drug provision of the Covered Charges section to address the option for a "split-fill" of certain specialty drugs. Carriers may elect whether to use the optional text. The split fill is intended to help manage the

use of medications that often have side-effects and may need to be changed before the supply of the medication is completely used; split fill avoids leaving the patient with unused medication for which the patient has paid the cost sharing.

In order to be consistent with 42 U.S.C. 399gg-3(a), 29 CFR 2590.701-3(a) and 45 CFR 147.108, which prohibit both actual preexisting condition exclusions and provisions that may have the effect of excluding coverage of preexisting conditions, the IHC Board proposes an amendment to the dental care and treatment provision to state that all treatment must be finished within six months following the later of the date of the injury or the effective date of the person's coverage. This amendment would assure treatment of injuries occurring prior to the effective date of coverage is not excluded.

The IHC Board proposes to delete all references in the standard plans to sole discretion belonging to the carrier in certain decision-making in order to be compliant with N.J.A.C. 11:4-58.3.

To comply with provisions of the ACA addressing nondiscrimination (42 U.S.C. 18116), and guidance from the Office of Civil Rights within the Department of Health and Human Services, including recently adopted 45 CFR 92.1 et seq. implementing 42 U.S.C. 18116, the IHC Board is proposing to delete the exclusion of coverage for surgery, hormones, and related medical, psychological and psychiatric services to change a covered person's gender, including services and supplies arising from complications of sex transformation. The recently adopted Federal regulations at 45 CFR 92.207, and other Federal guidance, would not permit discrimination in the provision of coverage or claims payment based on the fact that an individual's sex assigned at birth is different from the one to which particular health care

services are ordinarily or exclusively available, and further, would prohibit categorical exclusion or limitation of coverage for all health services related to gender transition. Neither the Federal law nor removal of the exclusion requires carriers to cover services they do not otherwise cover; rather, carriers would not be permitted to exclude benefits for covered services based on the underlying health condition or the covered person's gender.

The IHC Board is proposing amendments to the Renewal Privilege – Termination provision to clarify the time coverage starts and ends. Coverage begins on the effective date at 12:01 a.m. and ends at midnight on the termination date.

The IHC Board proposes an amendment to the payment of claims provision to allow carriers to address reimbursement policy guidelines as commonly used by the industry and Medicare. For example, reimbursement policy guidelines address circumstances of charges being included within another charge such that there should not be a separate liability. The text is proposed as variable meaning a carrier may choose whether or not to include the text.

Enrollment Status Reports set forth in Appendix Exhibit L Parts 1 and 2

The IHC Board proposes to repeal the standardized format of the Quarterly and Annual Enrollment Reports set forth in Exhibits L Parts 1 and 2. Although the IHC Board continues to require carriers to file quarterly enrollment status reports, the IHC Board believes the information listed in the proposed amendments to N.J.A.C. 11:20-17.4 better captures essential data than the information set forth in Part 1 of Exhibit L. As discussed above, the IHC Board has determined the annual report is not necessary and is therefore proposing to delete the annual filing requirement. Thus, Part 2 of Exhibit L is proposed to be repealed.

IHC Rulemaking Procedures

The IHC Board is proposing these amendments in accordance with the special action process established at N.J.S.A. 17B:27A-16.1, as an alternative to the common rulemaking process specified at N.J.S.A. 52:14B-1 et seq. Pursuant to N.J.S.A. 17B:27A-16.1, the IHC Board may expedite adoption of certain actions, including modification of the IHC Program's health benefits plans and policy forms, if the IHC Board provides interested parties a minimum 20-day period during which to comment on the Board's intended action following notice of the intended action in three newspapers of general circulation, with instructions on how to obtain a detailed description of the intended action and the time, place, and manner by which interested parties may present their views regarding the intended action. Concurrently, the IHC Board must forward notice of the intended action to the Office of Administrative Law (OAL) for publication in the New Jersey Register, although the comment period runs from the date the notice is submitted to the newspapers and OAL, not from the date of publication of the notice in the New Jersey Register. The IHC Board also sends notice of the intended action to affected trade and professional associations, carriers, and other interested persons who may request such notice. In addition, for intended modifications to the health benefits plans, the IHC Board must allow for testimony to be presented at a public hearing prior to adopting any such modifications. Subsequently, the IHC Board may adopt its intended action immediately upon the close of the specified comment period or close of a public hearing (whichever is later) by submitting the adopted action to the OAL for publication. The adopted action is effective upon the date of its submission to the OAL, or such later date as the Board may designate. If the Board does not respond to commenters as part of the notice of adoption, the Board will respond to the comments timely submitted within a reasonable period of time thereafter in a separately-prepared report which will be submitted to OAL for publication in the New Jersey Register. Pursuant to

N.J.S.A. 17B:27A-51, all actions adopted by the Board are subject to the requirements of this special rulemaking procedure notwithstanding the provisions of the Administrative Procedure Act. As a result, the quarterly calendar requirement set forth at N.J.A.C. 1:30-3.1 is not applicable when the Board uses its special rulemaking procedures.

Please note that while this procedure allows a comment period as brief as 20 days the IHC Board is allowing a comment period of 45 days.

Social Impact

The IHC Board anticipates that the proposal to eliminate N.J.A.C. 11:20-24.5 will have a positive social impact. Since 1994 N.J.A.C. 11:20-24.5 has required carriers to use data currently known as PHCS data to pay allowed charges for voluntary out-of-network services. However, the requirement has become untenable because the PHCS data became unavailable after 2010, meaning that some carriers now offering standard health benefits plans in the individual market have never had the opportunity to procure the PHCS data which means they cannot offer plans with out of network benefits, while at least one carrier that has been in the IHC market for a longer time has continued to make reimbursements based on data that is increasingly outdated. The use of outdated data to pay out-of-network benefits is not beneficial for anyone: health care providers are not reimbursed using a current standard, members may not receive the benefits to which they would otherwise be entitled, and carriers are required to maintain a claims payment methodology of limited utility while establishing alternate systems for other lines of business in New Jersey, and in all markets in other jurisdictions for those carriers that also do business outside New Jersey. Further, all carriers consider the PHCS requirement to be a barrier to offering individual health benefits plans with out-of-network benefits. The IHC Board's proposal to eliminate the requirement, and instead permit carriers to

determine the allowed charge methodology which carriers will be required to explain in the policies, certificates or evidences of coverage issued to employers and employees will provide transparency to the out of network benefit calculation. The IHC Board expects that the proposed deletion of N.J.A.C. 11:20-24.5 will encourage carriers to offer more plans with out-of-network benefits, the pricing of such plans will be more competitive than it is now, and consumers will have information to make informed decisions regarding whether to voluntarily use out-of-network providers. It may be noted that the IHC Board recognizes that the underlying purpose of N.J.A.C. 11:20-24.5 which was to enhance standardization in the provision of benefits in the individual market is no longer necessary or appropriate. As explained earlier in this proposal, the Board is not proposing a specific alternative reimbursement methodology in light of the relatively low utilization of voluntary out-of-network services today, which is a far different situation from the market that existed in 1993. In addition, the methodologies carriers use for reimbursement of voluntary out of network claims in the large employer market in New Jersey and in other states has enabled carriers to offer plans with out of network benefits that provide meaningful benefits for persons who choose to use out of network providers. Both of these developments ease the concerns the Board had in the 1990s regarding the standardization of benefits and payment practices with respect to non-contracted health care providers.

The IHC Board believes the proposed deletion of the exclusion with respect to services related to sex transformation will have a positive social impact with respect to consumers and providers since medically necessary services and supplies that are currently covered to treat other types of medical conditions will be covered in connection with sex transformation. Carriers have noted that coverage of these services is being included under many large group plans and thus support a consistent approach with respect to small employer plans.

Economic Impact

The IHC Board believes that the proposal to eliminate N.J.A.C. 11:20-24.5 will have a positive economic impact.

Use of the 2010 PHCS data modules has required carriers to bear the cost of maintaining multiple claims payment processes. In order to address the data gaps that exist with the 2010 PHCS data, carriers have been allowing full billed charges for voluntary out of network services. While considering the full billed charge as allowable may seem to benefit consumers such perception is flawed because such a structure necessarily results in increased premiums that are borne by all small employers and it discourages carriers from offering competitively priced plans with out-of-network benefits. In addition, carriers that entered the New Jersey individual market after 2010 that cannot buy any PHCS modules and are thus at a competitive disadvantage in that they cannot offer plans with out of network benefits.

The proposal to remove N.J.A.C. 11:20-24.5 will allow carriers to use carrier-determined methodologies to determine allowed charges for voluntary out of network services. Those carriers that have been maintaining the system will save costs by eliminating that administrative burden, and all carriers will benefit by integrating their claims payment processes for the individual market into their systems for other lines of business. Many health care providers are also likely to benefit economically from the proposed change because it will eliminate one methodology and bring the payment system more in line with what each payer is doing in other markets (typically, the large group business, where far more claims are generated) allowing providers to better anticipate the allowed charge for services. In addition, the transparency of the methodology will provide access to information that was previously unknown to out of network providers.

It is more difficult to discern the actual economic impact on covered members/patients. However, the proposal seeks to increase transparency in the allowed charge methodology for all parties concerned, including members. The IHC Board is proposing that carriers explain what the methodology is, and how members can obtain more information about the allowed charges for particular services. The Board anticipates that as members become more aware of the ability to access this information, they will benefit in the decision whether to seek voluntary services out-of-network, and find lower costs when they are able, or at least be knowledgeable about what costs to expect, and what costs they will need to finance themselves. Overall, the IHC Board believes that increased information will benefit consumers economically.

Federal Standards Statement

State agencies that propose to adopt or amend State rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. As discussed in the Summary above, these proposed amendments are subject to Federal requirements addressing certain standards for health insurance contracts. The IHC Board does not believe the proposed amendments exceed the Federal requirements.

Jobs Impact

The IHC Board does not anticipate that any jobs will be generated or lost as a result of the proposed amendments. Commenters may submit data or studies on the potential jobs impact of the proposed amendments together with their comments on other aspects of the proposal.

Agriculture Industry Impact

The IHC Board does not believe the proposed amendments will have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The IHC Board does not believe the proposed amendments apply to "small businesses," as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., but acknowledges the possibility that one or more carriers might meet that definition. The proposed amendments do not establish new or additional reporting or recordkeeping requirements, but have the effect of establishing new compliance requirements, as described in the Summary above.

No differentiation in compliance requirements is provided based on business size. The requirements of and the goals to be achieved by the Federal law in question does not vary based on business size of a carrier, and the IHC Board would not be at liberty to make such a distinction even if the IHC Board were to consider such a distinction warranted. Accordingly, the proposed amendments provide no differentiation in compliance requirements based on business size. No additional professional services would have to be employed in order to comply with the proposed amendments.

Housing Affordability Impact Analysis

The IHC Board does not believe the proposed amendments will have an impact on housing affordability in this State in that the proposed amendments relate to the benefit levels and terms of standard health benefits plans offered in New Jersey for purchase by individuals.

Smart Growth Development Impact Analysis

The IHC Board does not believe the proposed amendments will have an impact on the number of housing units or the availability of affordable housing in the State, or that the

proposed amendments will have an effect on smart growth development in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan. The proposed amendments relate to the benefit levels and terms of standard health benefits plans offered in New Jersey.

Full text of the proposal follows:

TITLE 11. INSURANCE

CHAPTER 20. INDIVIDUAL HEALTH COVERAGE PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.), the Individual Health Insurance Reform Act, as amended. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A-2 et seq.

(b) Provisions of the New Jersey Individual Health Insurance Reform Act and of this chapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term member is defined in this subchapter, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Individual Health Insurance Reform 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 August 1, 1993, except as the specific provisions of this chapter, the New Jersey Individual Health Insurance Reform Act, or applicable Federal laws state otherwise.

11:20-1.2 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 the New Jersey Individual Health Insurance Reform Act, P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 through 16.5), as it may be amended and supplemented from time to time.

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another.

"Annual open enrollment period" means the Federally-designated period of time each year during which:

1. Individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and

2. Individuals who already have coverage may replace current coverage with a different standard health benefits plan or standard health benefits plan with rider.

["Basic and essential health care services plan" means the health benefits plan set forth in N.J.S.A. 17B:27A-4.4 through 4.7.]

"Board" means the Board of Directors of the New Jersey Individual Health Coverage 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 a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this chapter, carriers that are affiliated carriers shall be treated as one carrier.

"Catastrophic plan" means a standard health benefit plan that is designed and offered in accordance with the requirements of Federal regulations at 45 CFR 156.155.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, without regard to age, sex, health status, occupation and geographical location.

"Conversion health benefits plan" means a group conversion contract or policy issued on or after August 1, 1993 that is not subsidized by either:

1. A single charge or ongoing increase in premium rates chargeable to the group policy or contract, identifiable as an excess morbidity charge in the group rating formula to cover group conversion excess morbidity costs; or

2. A reduction in dividends or returns paid to a group policy or contract holder, identifiable as a charge to or reduction in the group dividend or return formula to cover group conversion excess morbidity costs.

"Deferral" means a deferment, in whole or in part, of payment by a member of any assessment issued by the IHC Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-12a(3) and N.J.A.C. 11:20-11.

"Department" means the New Jersey Department of Banking and Insurance.

"Dependent" means:

1. The applicant's spouse;

2. The applicant's same-gender domestic partner as that term is defined in P.L. 2003, c. 246;

3. The applicant's civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage;

4. The applicant's child, legally-adopted child, step child, foster child including a child placed in foster care, or child under a court-appointed guardianship;

5. A child of the applicant's domestic partner subject to applicable terms of the individual health benefits plan;

6. A child of the applicant's civil union partner subject to applicable terms of the individual health benefits plan; or

7. **With respect to coverage that is not issued through the Marketplace, any** [Any] other child over whom the applicant has legal custody or legal guardianship or with whom the applicant has a legal relationship or a blood relationship provided the child depends on the applicant for most of the child's support and maintenance and resides in the applicant's household.

"Director" means a Director of the Individual Health Coverage Program Board who, in accordance with N.J.S.A. 17B:27A-10 as amended by P.L. 1993, c.164, § 5:

1. Has been elected by the members of the Individual Health Coverage Program and approved by the Commissioner;

2. Has been appointed by the Governor and confirmed by the Senate; or

3. Sits ex officio on the Board of Directors.

"Eligible person" means a person who is a resident of New Jersey who is not [eligible to be] covered under Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.), commonly referred to as "Medicare."

"Enrollment date" means the effective date of coverage under the individual health benefit plan.

"Essential health benefits" or "EHB" means the categories of health care services required to be covered in accordance with 45 CFR 156.110.

"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. § 300e et seq.).

"Fiscal year" means the time period beginning on July 1st of each year and ending on June 30th of the following calendar year.

"Group health benefits plan" means a health benefits plan for groups of two or more persons.

"Group health plan" means an employee welfare benefit plan, as defined in Title I, 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 a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, 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; stop loss or excess risk 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. § 1395ss(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. The term "health benefits plan" specifically includes:

1. Standard health benefits plans as defined in this section;

2. Closed blocks of business otherwise meeting the definition of health benefits plan;

3. Executive medical plans;

4. Student coverage which provides more than accident-only coverages;

5. All prescription drug plans whether or not written on a stand alone basis;

6. Plans that cover both active employees and retirees eligible for Medicare for which separate statutory reporting is not made by the carrier; **and**

[7. The basic and essential health care services plan; and]

[8]7. All other health policies, plans or contracts not specifically excluded.

"HMO" means a health maintenance organization authorized in accordance with N.J.S.A. 26:2J-1 et seq.

"Hospital confinement indemnity coverage" means coverage that is provided on a stand alone basis, contains no elimination period greater than three days, provides coverage for no less than 31 days during one period of confinement for each person covered under the policy, and provides no less than $ 40.00 but no more than $ 250.00 in daily benefits except that the benefit for the

first day of hospital confinement may exceed $ 250.00 as long as the following formula is satisfied:

1st day benefit--2nd day benefit + 2nd day benefit <$ 250.00

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"IHC Program" means the New Jersey Individual Health Coverage Program.

"Individual health benefits plan" means: (a) a health benefits plan for eligible persons and their dependents; and (b) a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy of contract pursuant to continuation of benefits provisions applicable under Federal or State law. The term "individual health benefits plan" shall include a policy, contract, or certificate evidencing coverage by a policy or contract issued to a trust or association, issued to an eligible person described in, but not limited to, the following examples: a student, except coverage issued to an institution of higher education for coverage of students and their dependents in New Jersey if such policy has been filed by the Commissioner as a discretionary group pursuant to N.J.S.A. 17B:27-49, an unemployed individual or part-time employee, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.3; a self-employed person; an employer, when he or she (and dependents) is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.6; any person who is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21-7.6; and an employee who is one of several employees of the same employer who are covered by

certificates, contracts or policies issued by the same carrier, trust or association, if the employer does not contribute to, and remit payment for, the coverage of such employees.

The term "individual health benefits plan" shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan as defined by the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §§ 1001 et seq.), to the extent that the Employee Retirement Income Security Act preempts the application of the Act to that plan.

["Initial enrollment period" means October 1, 2013, through March 31, 2014, which is the period during which applications for standard health benefits plans or standard health benefits plans with riders must be received by the carriers.]

"Marketplace" means the Federally-facilitated exchange as defined in Federal regulations at 45 CFR 155.20, through which qualified individuals can purchase qualified health plans and obtain a determination of eligibility for a premium tax credit, cost-sharing reduction, or exemption from the requirement to purchase health insurance.

"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 a disease, illness, or medical condition 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 Part A or Part B of Title XVIII of the Federal Social Security Act, Pub.L. 89-97 (42 U.S.C. §§ 1395 et seq.) and amendments thereto.

"Medicare Advantage" means policies and contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1853 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.) and any amendments thereto.

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. A member shall not include a carrier whose combined average Medicare, Medicaid and NJ FamilyCare enrollment represents more than 75 percent of its average total enrollment for all health benefits plans or whose combined Medicare, Medicaid and NJ FamilyCare net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare, Medicaid and NJ FamilyCare enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum of these enrollment figures, as measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight.

"Minimum essential coverage" means any of the following types of coverage:

1. Government sponsored programs. Coverage under:

i. The Medicare program under Part A of Title XVIII of the Social Security Act;

ii. The Medicaid program under Title XIX of the Social Security Act;

iii. The Children's Health Insurance Program (CHIP) program under Title XXI of the Social Security Act;

iv. Medical coverage under Chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;

v. A health care program under Chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary;

vi. A health plan under section 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers); or

vii. The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. § 1587 note);

2. Employer-sponsored plan. Coverage under an eligible employer-sponsored plan;

3. Plans in the individual market. Coverage under a health plan offered in the individual market within a state;

4. Grandfathered health plan. Coverage under a grandfathered health plan; and

5. Other coverage. Such other health benefits coverage, such as a state health benefits high risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes.

Minimum essential coverage shall also include those additional types of coverage designated by the Secretary of the United States Department of Health and Human Services at 45 CFR 156.602, including, but not limited to: self funded student health coverage offered by an institution of higher education; Refugee Medical Assistance supported by the Administration for Children and Families; and Medicare Advantage plans.

"Modified community rated" means, with respect to coverage under standard health benefit plans, a rating system in which the premium for all persons covered under a policy or contract

for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical location, or any other factor or characteristic of covered persons, other than age.

The rating system provides that the premium rate charged by a carrier for the highest rated individual or class of individuals shall not be greater than 300 percent of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits plan shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with rules promulgated by the Commissioner, which include age classifications.

["NAIC" means the National Association of Insurance Commissioners.]

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid or NJ FamilyCare contracts with the State or federal government, but shall not include any premium associated with the benefits enumerated in Section 2 of Part C of the Premium Data Worksheet which is set forth as chapter Exhibit K[, incorporated herein by reference].

"NJ FamilyCare" means the FamilyCare Health Coverage Program established pursuant to P.L. 2005, c. 156 (N.J.S.A. 30:4J-8 et al.).

"Open enrollment" means the offering of a health benefits plan to any eligible person on a guaranteed issue basis during the [initial enrollment period or an] annual open enrollment period.

"Plan" means the plan of operation of the IHC Program, an individual health benefits plan, or a group health benefits plan, as the context indicates.

"Plan sponsor" shall have 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(16)(B)).

["Pre-existing condition" means for a plan issued or renewed prior to January 1, 2014, for a covered person age 19 or older a condition that, during a specified period of not more than six months immediately preceding the enrollment date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to a pregnancy existing on the enrollment date of coverage.]

"Premium earned" means premium received, adjusted for the changes in premium due and unpaid, and paid in advance, and unearned premium, net of refunds or dividends paid or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.

"Program" means the New Jersey Individual Health Coverage Program established pursuant to the Act.

"Qualified health plan" or "QHP" means a health benefits plan certified to meet the requirements specified at 45 CFR 156.200 et seq. for participation on a marketplace in accordance with 45 CFR 155.1000 et seq.

"Renewal date" means January 1 of the year immediately following the effective date of a policy and each succeeding January 1 thereafter.

"Resident" means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of each calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of each calendar year.

"Special enrollment period" means a period of time that is no less than 60 days following the date of a triggering event during which:

1. Individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and

2. Individuals who already have coverage are allowed to replace current coverage with a different standard health benefits plan or standard health benefits plan with rider.

With respect to a loss of coverage, the special enrollment period also includes the 60 days preceding the loss of coverage.

"Standard health benefits plan" means a health benefits plan, including riders, if any, each of which is adopted by the IHC Program Board.

"Standard health benefits plan with rider" means a standard health benefits plan as amended with one or more optional benefit riders as permitted by N.J.A.C. 11:20-3.6.

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement 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 Individual Health Insurance Reform 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.

"Subsidy" means a premium tax credit or a cost sharing reduction pursuant to 26 CFR 1.36B, 45 CFR 156.410, and 45 CFR 156.425.

"Triggering event" means an event that results in an individual becoming eligible for a special enrollment period. Triggering events are:

1. The date the eligible person loses eligibility for minimum essential coverage, or the eligible person's dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a QHP by the marketplace;

2. The date a dependent child's coverage ends as a result of attaining age 26 whether or not the dependent is eligible for continuing coverage in accordance with Federal or state laws;

3. The date a dependent child's coverage under a parent's group plan ends as a result of attaining age 31;

4. The effective date of a marketplace redetermination of an eligible person's subsidy, including a determination that an eligible person is newly eligible or no longer eligible for a subsidy;

5. The date an eligible person acquires a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care;

6. The date an eligible person who is covered under a standard health benefits plan or standard health benefits plan with rider or group health benefits plan moves out of that plan's service area; [and]

7. The date of a marketplace finding that it erroneously permitted or denied an eligible person enrollment in a QHP.

8. The date of the court order that requires coverage of a dependent; and

[8]**9**. The date the eligible person demonstrates to the marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

Exception: A loss of coverage resulting from nonpayment of premium, fraud, or misrepresentation of material fact shall not be a triggering event.

"Two-year calculation period" means a two calendar year period, the first of which shall begin January 1, 1997 and end December 31, 1998.

11:20-1.3 Closing of noncomplying individual health benefits plan

(a) All coverage under individual health benefits plans delivered or issued for delivery with an effective date of August 1, 1993 or thereafter shall comply with this chapter.

(b) Health benefits plans not subject to the Act shall remain subject to the full review and approval of the Commissioner in accordance with N.J.S.A. 17B:26-1 et seq., N.J.S.A. 17:49-1 et seq., N.J.S.A. 17:48A-1 et seq., N.J.S.A. 17:48E-1 et seq., N.J.S.A. 26:2J-1 et seq. and rules promulgated pursuant thereto.

11:20-1.4 Other laws of this State

All health benefits plans delivered or issued for delivery in New Jersey, as defined by this subchapter, shall be subject to the New Jersey Individual Health Insurance Reform Act, as well as all relevant statutes and rules of New Jersey not inconsistent with, amended or repealed by this Act.

11:20-1.5. (Reserved)

11:20-1.6. Mission statement

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

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

11:20-2.1 Purpose and structure

(a) The "IHC Program" created pursuant to the N.J.S.A. 17B:27A-2 to 16, as amended, has as its members all insurance companies, health service corporations, hospital service corporations, medical service corporations, and health maintenance organizations that issue or have in force health benefits plans in this State. The IHC Program's purpose is:

1. To assure the availability of standardized individual health benefits plans in New Jersey on an open enrollment, modified community-rated basis; and

2. To reimburse certain losses of member companies for the calendar year ending December 31, 1992 pursuant to N.J.S.A. 17B:27A-13, for each calendar year ending December 31, 1993 through December 31, 1996, and for each two-year calculation period through the 2007-2008 calculation period pursuant to N.J.S.A. 17B:27A-12, as amended.

(b) The Board of the IHC Program has been charged pursuant to the Act to administer the IHC Program reasonably and equitably under law.

(c) The IHC Program Plan of Operation sets forth as completely as possible the fair, reasonable and equitable manner in which the Board will administer the IHC Program under law.

(d) The Board shall consist of nine directors, including the Commissioner or his or her designee, who shall serve ex officio.

(e) The Board shall appoint an insurance producer licensed to sell health insurance pursuant to N.J.S.A. 17:22A-1 et seq. to advise the Board on issues related to sales of individual health benefits plans issued pursuant to the Act.

(f) Neither the Plan of Operation nor the IHC Program creates any contractual or other rights and obligations between the IHC Program and any entity or other person insured by any carrier.

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

(h) All documents or other communications directed to the Board shall be sent to the Executive Director of the IHC Program at the address set forth below. Communications sent by regular mail must be sent to the PO Box:

New Jersey Individual Health Coverage Program

20 West State Street, 11th Floor

PO Box 325

Trenton, NJ 08625-0325

Telephone: (609) 633-1882 x50302

Fax: (609) 633-2030

Email: **Ellen.derosa@dobi.nj.gov**

11:20-2.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 as amended, and N.J.A.C. 11:20-1, 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:

"Action" means an action by the Board adopted, in the Board's discretion, in accordance with the procedures set forth either in the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., or in sections 7 and 8 of P.L. 1993, c.164. "Action" includes, but is not limited to: the establishment and modification of health benefits plans; procedures and standards for assessment of members and the apportionment thereof and policy form filings; and the promulgation or modification of policy forms. "Action" shall not include the hearing and resolution of contested cases, personnel matters or applications for exemptions.

"Plan" means the plan of operation of the IHC Program.

11:20-2.3 Powers of the IHC Program and Board

(a) The IHC Program shall have the general powers and authority granted under the laws of this State to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the IHC Program shall not have the power to issue health benefits plans directly to either groups or individuals.

(b) The Board shall have the authority to do the following:

1. Define the provisions of standard health benefits plans in accordance with the requirements of the Act and the Plan of Operation;

2. Establish benefit levels, including any optional deductibles and copayments, and exclusions and limitations for standard health benefits plans in accordance with law;

3. Establish standard policy forms for standard health benefits plans and rider packages;

4. Establish a procedure for the joint distribution of information on standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended;

5. Establish reasonable guidelines for the purchase of new individual health benefits plans by persons who are already enrolled or insured by another individual health benefits plan;

6. Review filings submitted by carriers in accordance with the Act and rules promulgated pursuant thereto and the Plan of Operation;

7. Establish standards for a means test for standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended by P.L. 1993, c.164, section 3;

8. Make application on behalf of member carriers for benefits, subsidies, discounts or funds that may be provided either by any health care provider or under State or Federal law or regulation;

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

10. Enter into contracts which are necessary or proper to carry out the provisions and purposes of the Act and the Plan of Operation;

11. Employ or retain such persons, firms or corporations to perform such administrative functions as are necessary for the Board's performance of its duties;

12. Provide procedures for receiving oral and written comments from the public, which may include rules relating to the time and place of any public hearing, and for the length and format of testimony from individuals, groups and organizations;

13. Establish rules, conditions and procedures pertaining to the sharing of IHC Program administrative expenses among the members of the IHC Program;

14. Calculate assessments and assess member carriers their proportionate share of IHC administrative expenses in accordance with N.J.S.A. 17B:27A-12 and this Plan, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses;

i. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

ii. The Board may provide for other credits against assessments as appropriate;

15. Establish and maintain the appropriate accounts necessary to administer the IHC Program;

16. Impose interest penalties upon members for late payment of assessments as authorized by N.J.S.A. 17B:27A-10(f)(4);

17. Recommend to the Commissioner that actions be instituted in accordance with the Commissioner's authority to impose penalties for violations of the Act;

18. Sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member carrier;

19. Pursuant to P.L. 1993, c. 164, adopt "actions" necessary to execute the Board's powers pursuant to the provisions of N.J.S.A. 17B:27A-2 et seq.;

20. Borrow money to effect the purposes of the IHC Program;

i. Any notes or other evidence of indebtedness of the Program not in default shall be legal investments for carriers and may be carried as admitted assets; and

21. Contract for an independent actuary and any other professional services the Board deems necessary to carry out its duties under N.J.S.A. 17B:27A-2 et seq. as amended.

11:20-2.4. Plan of Operation

(a) The Plan of Operation and amendments thereto shall become effective upon approval by the Commissioner and submission of final action to the Office of Administrative Law for publication. The Commissioner may amend the Plan of Operation by providing written notice to the Board of amendments and their effective dates and upon adoption of amendments in accordance with applicable law.

(b) Upon the submission of a Plan by the Board and approval of the Plan by the Commissioner pursuant to N.J.S.A. 17B:27A-10(d) and (e) as amended by P.L. 1993, c.164, section 6, the Commissioner shall rescind the Temporary Plan.

11:20-2.5 Board of Directors

(a) The Board shall consist of nine Directors, including the Commissioner or his or her designee, who shall sit ex officio.

1. Four Directors shall be appointed by the Governor, with the advice and consent of the Senate.

i. One of the Governor's appointees shall be a representative of an employer, appointed upon the recommendation of a business trade association, who has experience in the management or administration of an employee health benefits plan. One of the Governor's appointees shall be a representative of organized labor, appointed upon the recommendation of the AFL-CIO, who has experience in the management or administration of an employee health plan. Two of the Governor's appointees shall be consumers of a health benefits plan who are reflective of the population in the State.

ii. The term of the initial appointment shall be for the period as set forth in the appointment.

2. Four Directors shall represent carriers and shall be elected by the members subject to the approval of the Commissioner.

i. To the extent a Carrier elected by the members is willing to serve on the Board, a representative of each of the following types of carrier shall be elected:

(1) A health service corporation or a domestic stock insurer which converted from a health service corporation pursuant to the provisions of P.L. 2001, c. 131 and is primarily engaged in the business of issuing health benefit plans in this State;

(2) A health maintenance organization;

(3) An insurer authorized to write health insurance in this State subject to Subtitle 17B of the New Jersey Statutes; and

(4) A foreign health insurance company authorized to do business in this State.

ii. The Board shall hold a meeting, at least annually, of the members of the IHC Program for the purpose of electing Directors to 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.

(1) On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the IHC 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.

(2) Following the close of the nomination period, the Board shall determine from among the carriers nominated those carriers that are eligible and willing to serve in the position for which nominated. A carrier may be placed on the ballot for only one Board 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 before the election as to the single position for which it will accept the nomination, and be designated on the ballot.

(3) 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 via absentee ballot on or before the date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

(4) 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.

(5) Elections shall be by the highest number of those votes properly cast in person and absentee.

(6) 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. 11:20-2.9.

iii. Prior to the Board's annual meeting set forth at (c) below, or no later than 30 calendar days subsequent to the date of the election meeting, whichever date is later, the Board shall send a written notice to IHC Program members of the names of the Directors of the Board, their respective designees, if any.

3. The Commissioner shall file with the Board a letter naming his or her designee, if any.

4. A carrier elected to the Board shall file with the Board a letter naming the person authorized to vote on behalf of the carrier and may name one or more alternates.

5. Appointed Directors shall promptly notify the Board of any change in circumstance that may affect the representative capacity in which they were appointed. Upon receipt of such notice, the Board shall notify the Governor of the appointed Director's change in circumstance.

6. The Directors representing carriers on the Board shall promptly notify the Board of any change in circumstance that may affect the representative capacity of the entity elected by the members. Upon receipt of such notice, the Board shall provide notice of the same to the members of the IHC Program.

7. Directors shall serve their terms of office until their replacements are duly appointed or elected, as appropriate.

(b) The Board shall elect a Chair from among its Directors, and may elect other officers it deems appropriate. As authorized by the Board, such officers may act as signatories on behalf of the

Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(c) The Board shall hold an annual meeting at which it shall:

1. Elect officers of the Board;

2. Appoint Directors to committees of the Board; and

3. Take action on such other matters that it deems appropriate.

(d) A majority of the Directors shall constitute a quorum for the transaction of business.

[1.]Each Director shall have one vote. The acts of a majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board[, except as provided in (d)2 below].

[2. The affirmative votes of five Directors shall be required to act upon the following:

i. Amendments to the Plan of Operation;

ii. Amendments to the standard health benefits plans;

iii. Adoption of any actions, as defined by section 8 of P.L. 1993, c. 164, (N.J.S.A. 17B:27A-16.1) or amendments to the actions of the IHC Program;

iv. Removal of any Director from membership on any committee;

v. Recommendations by the Board to the Commissioner regarding amendments to the Act; and

vi. An assessment or interim assessment.]

(e) All meetings of the Board at which a quorum is present, including special meetings, shall be subject to the provisions of the Open Public Meetings Act, N.J.S.A. 10:4-6 to 21.

(f) In addition to the annual meeting and any regularly scheduled meeting, the Board may hold special meetings upon the request of the Chair or of three or more Directors.

(g) Directors shall not receive compensation for attendance at Board and Committee meetings. Directors may be reimbursed for reasonable unreimbursed travel and other reasonable expenses incurred in attending Board and Committee meetings using the State Travel Regulations issued by the Department of the Treasury as a guide.

(h) The Board shall hold meetings either in person or by teleconference.

(i) The Board shall provide for the taking of written minutes of each Board meeting, including teleconferences and closed sessions, and distribute a copy of the minutes to the Directors. The Board shall retain the original of the minutes.

1. The staff of the Board shall take and maintain the written minutes of the proceedings of the Board meetings, including teleconferences and closed sessions. Board meeting minutes shall set forth as a minimum the following:

i. The time, date and place of the meeting;

ii. The names of all persons attending the meeting, the organizations they represent, if any, and the identity of the person presiding;

iii. A narrative describing what occurred at the meeting including subjects considered and actions taken;

iv. The recorded votes of each member on each matter including abstentions;

v. The complete text of any resolutions adopted by the Board; and

vi. Any other information required to be shown in the minutes by law.

(j) All Board members shall be subject to the State of New Jersey Uniform Ethics Code and any supplemental code of ethics the Board adopts.

11:20-2.6 Committees

(a) The Board shall make appointments to standing and other committees from among Directors. Each of the standing committees shall include no more than four Directors, but the Chair may appoint additional Directors as needed subject to ratification by the Board at the next subsequent meeting.

(b) The Board may, by resolution:

1. Determine the size of a standing committee, appoint Directors, and fill a vacancy;

2. Appoint a Director to serve as an alternate member of any standing committee to act in the absence of a committee member with all the powers of such absent member;

3. Abolish any standing committee; and

4. Appoint or authorize the use of IHC Program staff, consultants, or other advisors to work with any standing committee.

(c) Committees may not take final action; however, within the scope of their purpose and duties, committees may make recommendations and reports to the Board for decision.

(d) Standing committees shall include the following:

1. A Technical Advisory Committee, which shall make recommendations to the Board with respect to:

i. Methods for calculating assessments;

ii. A uniform Audit Program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier; and

iii. Any other reports or recommendations to the Board as may be appropriate regarding the possible impact of suggested plan designs;

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

i. Rules to be promulgated by the Board pursuant to the Act;

ii. Amendments to the Plan of Operation and the various individual health benefits plans proposed by the Board;

iii. Any proposed amendments to the Act;

iv. Contracts and legal documents for the IHC Program;

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

vi. Coordination with the Office of the Attorney General on matters relating to IHC Program operations; and

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

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 individual health benefits plans to eligible persons;

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

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

[iv]**iii**. Submissions of good faith marketing reports as required by N.J.A.C. 11:20-24.6 by those members that are small employer carriers demonstrating marketing of all of the standard health benefits plans the member elects to offer;

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

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

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

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

ii. The Plan of Operation and amendments thereto;

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

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

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

vi. Methods for calculating assessments; and

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

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

(f) All committee members shall be subject to the State of New Jersey Uniform Ethics Code and any supplemental code of ethics the Board adopts.

11:20-2.7 Financial administration

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

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

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

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

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

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

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

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

ii. All investment income earned on loss assessment funds shall be credited to the IHC Program and shall be applied to reduce assessments of members of the IHC Program, except as provided in N.J.A.C. 11:20-2.17(a).

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

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

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

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

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

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

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

ii. Any adjustments as set forth in this Plan;

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

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

v. Other records required by the Board.

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

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

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

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

11:20-2.8 Audits

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

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

2. The annual audit shall include the following items:

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

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

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

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

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

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

(b) The Board may, from time to time, direct that a member carrier arrange, or the Board may arrange, to have an audit conducted by an independent certified public accountant and a copy of

the audit report of the member carrier delivered to the Board. All information regarding an audit of a member carrier conducted pursuant to this subsection shall be confidential and protected from disclosure by the member carrier, by the auditing firm, by the Board and the Commissioner.

11:20-2.9. Records

(a) The Board shall provide for the maintenance and retention of its official records, and may delegate this function to the Executive Director.

(b) The Board's records shall consist of 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. The rulemaking file on rules 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. Determinations on requests for exemption by carriers;]

[8]**7**. Other actions by the Board required by the Act; and

[9]**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 N.J.S.A. 47:1A-1 et seq., except that **the following documents shall not be subject to public inspection and copying pursuant to N.J.S.A. 47:1A-1 et seq:**

1. [information] **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]

2. [written]**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 or copying].

3. Any other information that is not subject to inspection or copying pursuant to N.J.S.A. 47:1A-1 et seq. or any other law.

11:20-2.10 Standard health benefits plans

(a) The Board shall establish the policy and contract forms and benefit levels (standard health benefits plans) to be made available by members.

1. In designing and amending the standard health benefits plans, the Board shall give consideration to the types of coverage currently in force and/or available in the marketplace, [individual's] **individuals'** preferences and the evolution of the marketplace towards managed care.

2. The Board shall discuss amendments to the standard policy forms at a meeting open to the public prior to any vote by the Board to adopt, or modify any aspect of, a standard health benefits plan design.

3. The Board shall hold a public hearing on the standard health benefits plans or any amendments thereto prior to adopting or changing a standard health benefits plan.

i. The Board shall provide to all members and interested parties reasonable advance notice of a public hearing in accordance with the procedures set forth in the Act as amended.

ii. The Board may establish procedures for a public hearing and publish them with the notice of the public hearing.

iii. The Board shall maintain a written record of any public hearing and make it available for inspection at the office of the Executive Director.

4. The Board shall adopt or amend a standard health benefits plan in accordance with the procedures set forth in the Act, as amended, or in accordance with the procedures set forth in the Administrative Procedures Act.

i. In accordance with the procedures for taking action set forth in the Act, as amended, the Board may adopt a standard health benefits plan or modifications thereto and thereafter shall address in writing such comments as were received within a reasonable period following the adoption of the proposed action. The Board shall give due consideration to all comments received. Pursuant to the Act as amended, the Board shall, within a reasonable period of time following submission of the comments, prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the Board's response to the data views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

(1) The Board shall identify whether it made a change in the action proposed at its own initiative or in response to one or more comments.

ii. Except as may be required by law, members shall implement amendments to the standard health benefits plans in the time prescribed by the Board.

5. The Board shall take action as necessary to keep the standard health benefits plans in compliance with State and Federal law.

6. No member shall issue or renew a standard health benefits plan [or the basic and essential healthcare services plan] until a rate filing has been filed with the Department in accordance with N.J.A.C. 11:20-6.

11:20-2.11. (Reserved)

11:20-2.12. Assessments for administrative expenses and organizational and operating expenses

(a) Except as described in (a)4 below, every member shall be liable for a portion of the administrative expenses of the IHC Program. Within 90 days of approving a final audited statement of the IHC Program financial statements and the conclusion of all appeals of assessments for administrative expenses, the IHC Program Board shall notify each member by separate invoice of the dollar amounts being assessed against the member for its portion of the final administrative expense total for the applicable fiscal year or years. To the extent that an interim assessment has been made for that period, the notice shall provide reconciliation between the original invoice and the final invoice.

1. Such notice shall include a brief summary of the final administrative expenses and shall credit the member for any interim administrative expense assessments paid.

2. If a member has advanced a sum or sums of money to the IHC Program to cover some portion of the IHC Program's administrative expenses, those sums advanced shall be credited against the member's assessment amounts.

3. Each member's final assessment for administrative expenses shall be reduced by any deferral assessment paid by assessed carriers in proportion to the original assessment made to cover the deferred amount.

4. A member shall not be liable for an assessment that is less than the minimum assessment set forth in N.J.A.C. 11:20-2.18.

(b) The Board, at its discretion, may make an interim assessment on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses as well [as to cover estimated losses].

(c) Through fiscal year 1997 (that is, July 1, 1996 through June 30, 1997), all members shall be assessed for a proportionate share of final administrative expenses for the fiscal year on the basis of the ratio of the member's health benefits plans net earned premiums for the calendar year which includes the first six months of the fiscal year to the total of all members health benefits plans net earned premiums for that same calendar year. Beginning with fiscal years 1998 and 1999, all members shall be assessed for a proportionate share of final administrative expenses for two-year fiscal periods on the basis of the ratio of the member's health benefits plans net earned premiums for the two-year calculation period which begins six months prior to the beginning of the first fiscal year to the total of all members' health benefits plans net earned premiums for that same two-year calculation period. Thus, for example, for fiscal years 1998 and 1999, all

members will be assessed based on 1997 and 1998 net earned premium. Net earned premiums shall be determined as reported by each member to the IHC Program Board in the Exhibit K Assessment Report as set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit an Exhibit K Assessment Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement or Statements, as appropriate, filed with the Department.

(d) Interim assessments beginning with fiscal years 1998 and 1999 shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding two-year calculation period.

(e) Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by the member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members on the same basis as set forth in (c) above.

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

1. Pursuant to N.J.S.A. 17B:27A-10(f)(4), members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

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

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

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

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

(g) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with procedures established by the Commissioner, which are set forth at N.J.A.C. 11:20-11.

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

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

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

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

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

11:20-2.13 (Reserved)

11:20-2.14. Failure to pay assessments

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 IHC Program Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

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

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

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

11:20-2.16. Indemnification

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

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

11:20-2.17 Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998 and ending with 2007 and 2008

(a) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for assessments. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for two-year calculation periods through 2007/2008, when the net paid loss audit is complete.

Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of loss assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the applicable two-year calculation period, until such time as the dispute has been resolved against the disputing member, or the deferral denied, except that any portion of a loss assessment not in dispute or subject to a deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses for the applicable two-year calculation period year.

2. Upon receipt of notice that amounts of loss assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate the proportionate amount of interest, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held by the Board and provide notice to the member of the principal amount and interest amount. The Board shall calculate the amount to be returned to the member, which amount shall be paid within 30 days and shall include the payment of interest up until the date of the expected payment.

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than $ 5.00 in the case of an administrative assessment, the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12.

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

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

1. Plan A/50, Appendix Exhibit A with pages identified as unique to Plan A/50;
2. Plan B, Appendix Exhibit A with pages identified as unique to Plan B;
3. Plan C, Appendix Exhibit A with pages identified as unique to Plan C;
4. Plan D, Appendix Exhibit A with pages identified as unique to Plan D; and
5. HMO Plan, Appendix Exhibit B.

(b) Members that offer individual health benefits plans in this State and members that offer small employer health benefits plans in this State pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21 shall offer at least three of the standard health benefits Plans A/50, B, C, D, and HMO as set forth in chapter Appendix Exhibits A and B, [incorporated herein by reference] with variable text as specified on the Explanation of Brackets, which is set forth as chapter Appendix

Exhibit C[, incorporated herein by reference,] subject to the provisions set forth in (b)1 through 9 below and except as provided in (c) below.

1. Members shall offer Plan A/50 which is designated as the basic plan.

2. Members shall offer at least two of the Plans designated as Plans B, C, D and HMO.

3. Members offering Plan A/50, and at least two of the plans designated as Plans B, C, D, and HMO shall offer at least two of the selected plans B, C, and/or D if not also offering HMO, and at least one of the selected Plans B, C, and/or D if offering the HMO, with annual deductible provisions as follows:

i. For a network-based plan, the network per covered person annual deductible shall not exceed $ 2,500.

ii. For a plan without a network, the per covered person annual deductible shall not exceed the maximum out of pocket as defined in (b)5 below.

iii. For a plan to be offered as a catastrophic plan, the per covered person annual deductible shall equal the greatest permissible maximum out of pocket as defined in (b)5 below except the deductible shall be waived for three physician visits per calendar year and shall not apply to preventive health services.

iv. The corresponding per covered family annual deductible shall be an amount equal to two times the per covered person annual deductible, satisfied on an aggregate basis.

4. Members offering Plans A/50, B, C, and D may offer the plans with deductible provisions such that the plans may qualify as high deductible health plans:

i. In the case of single coverage, an amount to qualify as a High Deductible Health Plan under Internal Revenue Code § 223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered person;

ii. In the case of other than single coverage, an amount to qualify as a High Deductible Health Plan under Internal Revenue Code § 223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered family, with single and other than single deductibles accumulated in accordance with the requirements of Federal law.

5. When issued using deductible provisions set forth in (b)3 and 4 above, Plans A/50, B, C, and D shall contain maximum out of pocket provisions as follows:

i. The per covered person maximum out of pocket shall not exceed the maximum out of pocket specified in sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986;

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

iii. Deductible, coinsurance, and copayment under a standalone pediatric dental benefit plan issued to replace the pediatric dental benefits contained in Plans A/50, B, C, and D shall not count toward the maximum out of pocket.

6. Plan A/50 features 50 percent coinsurance, Plan B features 40 percent coinsurance, Plan C features 30 percent coinsurance, and Plan D may feature coinsurance of 20 percent or 10 percent.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu of offering at least three of Plans A/50, B, C, and D in (a) above. State qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix,

in addition to at least two of Plans A/50, B, C, and D in (a) above. HMO carriers offering the HMO Plan may offer a copayment plan design set forth in (c)1 below and/or the HMO plan using deductible and coinsurance provisions set forth in (c)2 below. All options offered by the HMO member shall be made available to every eligible individual seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (c)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (d) below.

1. Carriers issuing HMO plans with a Copayment Design shall use the copayments consistent with the copayments permitted in N.J.A.C. 11:22-5.5 with no copayment required for preventive care.

2. Carriers issuing HMO plans with a Deductible and Coinsurance Design shall use the copayments, cash deductible, and coinsurance consistent with the requirements of N.J.A.C. 11:22-5.3 through 5.5. The maximum out of pocket shall be consistent with the maximum out of pocket described in (b)5 above.

(d) Carriers issuing Plans A/50, B, C, D, and HMO shall include the following features which are common to all plans:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall not exceed $ 100.00.

ii. Pediatric dental and pediatric vision benefits may be subject to cost sharing at the discretion of the carrier provided any copayments for providers who qualify as specialists do not exceed the copayment as permitted by N.J.A.C. 11:22-5.5.

iii. Prescription drugs may be subject to 50 percent coinsurance or other types of cost sharing provisions such as copayments.

(e) The standard health benefits Plans A/50, B, C, and D may be offered through or in conjunction with a selective contracting arrangement approved pursuant to P.L. 1993, c. 162, § 22. The standard health benefits Plans A/50, B, C, and D may be offered with the same selective contracting arrangement by a carrier that is exempt from the requirements of P.L. 1993, c. 162, § 22, pursuant to N.J.A.C. 11:4-37.1(b), but is permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through or in conjunction with an approved selective contracting arrangement and plans with selective contracting arrangement features issued by an entity exempt from the requirements of P.L. 1993, c. 162, § 22 shall be subject to the following:

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

2. The network annual deductible shall be no greater than $ 2,500 per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied 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 HMO Plan copayment amounts for physician visits and hospital confinements and the prescription drug coinsurance may be substituted for deductibles applicable to network benefits;

4. The coinsurance for network services shall be consistent with the coinsurance for one of Plans A/50, B, C, or D and the coinsurance for non-network services must be consistent with the coinsurance for one of Plans A/50, B, C, or D;

5. The network maximum out of pocket shall be no greater than the amount specified in (b)5 above per covered person, and for a covered family shall be no greater than two times the per covered person network 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;

6. If a separate non-network deductible is included, the non-network annual deductible shall be two times or three times the network annual deductible per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis; and

7. If a separate non-network maximum out of pocket is included, the non-network maximum out of pocket shall be two times or 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.

(f) Network plans as permitted in (d) above and HMO plans may feature a tiered network.

1. If the deductibles for tier 1 and tier 2 are separately satisfied, the sum of the tier 1 deductible and the tier 2 deductible shall not exceed $ 2,500.

2. If the tier 1 deductible may be separately satisfied and is also applied toward the tier 2 deductible, the tier 2 deductible shall not exceed $ 2,500.

3. If the tier 1 and tier 2 maximum out of pocket amounts are separately satisfied, the sum of the tier 1 maximum out of pocket and the tier 2 maximum out of pocket shall not exceed the maximum out of pocket specified in sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986.

4. If the tier 1 maximum out of pocket may be separately satisfied and is also applied toward the tier 2 maximum out of pocket, the tier 2 maximum out of pocket shall not exceed the maximum out of pocket specified in sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986.

11:20-3.2 Sample schedule page text

(a) The standard plans set forth in Appendix Exhibits A and B include sample schedule page text. The sample schedule pages highlight some covered services. Carriers may include additional covered services on the schedule. Features included on one sample schedule page may be included on any schedule page, as appropriate to the plan design being offered.

(b) The standard plans set forth in Appendix Exhibit A may be issued to a covered person who qualifies for a cost sharing reduction. Carriers may include cost sharing amounts on the schedule that are appropriate to the cost sharing reduction a covered person receives.

11:20-3.3 Compliance and variability rider

(a) Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO contract, and standard riders through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix[, incorporated herein by reference,] if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms that Compliance and Variability Riders may be used. Carriers may only use the Compliance and Variability Rider to incorporate Board designated text for the period of time

specified by the Board in the rule adoption of the regulatory changes to the standard policy forms.

(b) Members may make any changes to the standard policy forms, standard HMO contract, or standard riders promulgated by the Board consistent with the permitted as variable text set forth in Exhibits A and B of the Appendix to this Chapter, as described in the Explanation of Brackets, Exhibit C, through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix.

(c) Members may incorporate text for benefits required to be offered to the Policyholder through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms to address the mandated offer that carriers may issue the optional coverage by rider in lieu of including the coverage in the standard policy forms. For example, coverage for autologous bone marrow transplant, as required to be offered pursuant to P.L. 1995, c. 100, may be included using the Compliance and Variability Rider.

(d) Members may address the cost sharing reduction amounts referred to in N.J.A.C. 11:20-3.2(b) on the Compliance and Variability Rider.

(e) Members may not use the Compliance and Variability rider to accomplish benefit modifications as outlined in N.J.A.C. 11:20-3.6.

11:20-3.4 (Reserved)

11:20-3.5 **(Reserved)** [Basic and essential health care services plan

The basic and essential health care services plan established by the Legislature contains the benefits, limitations, and exclusions set forth in N.J.S.A. 17B:27A-4.5. Rules regarding this plan are set forth at N.J.A.C. 11:20-22. A specimen policy form is set forth in Appendix Exhibit F. The basic and essential health care services plan shall not be issued after December 31, 2013.]

11:20-3.6 Optional benefit riders to standard plans

(a) Members may offer riders that revise the coverage offered by Plans A/50, B, C, D, and HMO, subject to the provisions set forth in (a)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans A/50, B, C, D, or HMO, the member shall file the rider or amendment thereof with the Board for informational purposes.

2. For purposes of optional benefit riders filed pursuant to (a)1 above, "coverage" offered by Plans A/50, B, C, D, or HMO means:

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/50, B, C, and D or the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan;

ii. Deductibles, coinsurance, copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans A/50, B, C, D and HMO 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.

3. For purposes of optional benefit riders filed pursuant to (a)1 above, "coverage" offered by Plans A/50, B, C, D, or HMO does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:20-1.2, 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. 11:20-1.2.

4. In addition to (a)1, 2 and 3 above, any benefit rider [or amendments thereof] shall be subject to the provisions of N.J.S.A. 17B:27A-4 and 17B:27A-6.

5. The inclusion of an optional benefit rider with Plan A/50, B, C, D or HMO creates Plan A/50, B, C, D or HMO as amended by the rider **and while a plan amended by a rider creates a unique plan, such unique plan** [and the Plan] continues to be **known as** Plan A/50, B, C, D or HMO. The inclusion of an optional benefit rider **resulting in a unique plan** does not create another standard plan.

6. An individual seeking to purchase Plan A/50, B, C, D or HMO must be given the opportunity to purchase Plan A/50, B, C, D or HMO without a rider [or with any] **as well as all plans created by the inclusion of the** rider [that is available to amend the plan being purchased].

7. A member making an informational filing to the Board pursuant to (a)1 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. 11:20-2.1;

ii. Submit one copy of the rider or riders which amend the standard plans, which rider or riders shall include cross-references to the standard plan 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/50, B, C, D or HMO and provide clear and conspicuous notice of such on the forms submitted for each rider;

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

v. Submit the standard plan 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. Submit 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/50, B, C, D, or HMO;

(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 **plans created by the inclusion of the** rider [or amendment thereof] to [any] **all** [individual] **individuals** seeking to purchase the health benefits [plan it modifies] **plans**;

(4) That a rate filing for the plans **created by the inclusion of the** rider has been made with the Commissioner pursuant to N.J.A.C. 11:20-6; and

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement, 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 11:24-14.4(c), as applicable] **N.J.A.C. 11:4-37.3.**

8. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in compliance with the requirements of this subchapter within 45 days of the Board's receipt of the member's submission of a rider. 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 and in compliance.

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

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, the filing shall be deemed to be complete and in compliance.

11:20-3.7 Plan or plan option withdrawal by IHC Board

(a) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall cease issuing that plan, plan option, or deductible/copayment option within 90 days after the rules take effect.

(b) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall nonrenew that individual plan, plan option, or deductible/copayment option pursuant to the procedures set forth in (c) and (d) below.

(c) Not more than 60 days after the Board has promulgated rules withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal by mail to every policy or contractholder. Following the initial notice of nonrenewal to each policy or contractholder, the carrier shall 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 statement is transmitted, send a notice at least 30 days prior to nonrenewal. Nonrenewal notices for policy or contractholders shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of N.J.A.C. 11:20-3.7;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option, or deductible/copayment option withdrawal; and

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

(d) Not more than 60 days after the Board has promulgated regulations withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal to the producer of record, if any, for each policy or contract. Nonrenewal notices for producers shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of N.J.A.C. 11:20-3.7;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

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

6. The date upon which the carrier will begin to cease the issuance of the plan, plan option, or deductible/copayment option.

SUBCHAPTER 4. (RESERVED)

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

11:20-8.1 Scope and applicability

(a) This subchapter sets forth reporting and certification requirements for premium data of Program members and other carriers with reportable accident and health premium in New Jersey.

(b) This subchapter shall apply to all carriers with reportable accident and health premium in New Jersey for any portion of the two-year calculation period for which reports under this subchapter are required to be filed.

11:20-8.2 Filing of the assessment report form

(a) Every carrier with reportable accident and health premium in New Jersey shall file the Exhibit K Assessment Report form and a copy of the Exhibit K Part C Premium Data

Worksheet, which are set forth as Exhibit K in the Appendix to this chapter[, incorporated herein by reference,] on or before April 1 of the year immediately following every two-year calculation period.

(b) If a carrier with reportable accident and health premium in New Jersey is an affiliated carrier, the Exhibit K Assessment Report and the Part C Premium Data Worksheet shall be filed as follows:

1. Each affiliated carrier shall file one copy of the Exhibit K Part C Premium Data Worksheet whether or not that affiliated carrier reported accident and health premium in New Jersey during the two-year calculation period.

2. The combined affiliated carriers, identified using a single carrier name, shall file one copy of the Exhibit K Assessment Report. The information specified on the Exhibit K Assessment Report shall be the aggregated information supplied on the Premium Data Worksheets for all affiliated carriers.

3. The Exhibit K Assessment Report along with the Premium Data Worksheet(s) shall be filed together. For example, a carrier with three affiliates with reportable accident and health premium in New Jersey but only two of which issue non-group coverage, shall file one Exhibit K Assessment Report with the aggregated information for all affiliated carriers and three copies of the Exhibit K Part C Premium Data Worksheet.

(c) Certified Exhibit K Assessment Reports shall be submitted [either] by **mail, email,** facsimile[, with paper copy to follow by mail,] or by hand delivery to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

11:20-8.3. Calculation of net earned premium and determination of program membership for the two-year calculation period

(a) In Part C of the Exhibit K Assessment Report, each member shall set forth its total net earned premium from plans issued, continued or renewed for all affiliated carriers during the preceding two-year calculation period. Net earned premium reported in Part C of Exhibit K shall be consistent with the data set forth on the Exhibit K Part C Premium Data Worksheet(s).

(b) In Part C of the Exhibit K Assessment Report, each carrier with no net earned premium in the preceding two-year calculation period shall assert its status as a non-member by checking the box designated for non-members on the Exhibit K Assessment Report. Carriers either with no net earned premium or whose Section 3 Calculation of Net Earned Premium on the Exhibit K Part C Premium Data Worksheet is equal to 0 are non-members.

(c) Every carrier, whether a member or not, shall complete an Exhibit K Part C Premium Data Worksheet for each affiliate and shall attach each Worksheet to its Exhibit K Assessment Report.

1. In Section 1 of the Premium Data Worksheet, the carrier shall report the total accident and health premium reported on its annual statement blank for each calendar year of the two-year calculation period.

2. In Section 2 of the Premium Data Worksheet, the carrier shall report the total net earned premium in each calendar year of the two-year calculation period for each of the excepted types of coverage which are specifically identified in Section 2 of the Worksheet.

3. In Section 3 of the Premium Data Worksheet, the carrier shall calculate the affiliate's net earned premium by subtracting the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1 of the Worksheet.

4. The carrier shall report the aggregated two-year net earned premium on Exhibit K Part C by taking the sum of each affiliate's two-year net earned premium total as calculated on the Exhibit K Part C Premium Data Worksheet.

11:20-8.4 (Reserved)

11:20-8.5 (Reserved)

11:20-8.6 Certifications

In Part D of the Exhibit K Assessment Report, the Chief Financial Officer, or other duly authorized officer of the carrier, shall certify that the Exhibit K Assessment Report and all Exhibit K Part C Premium Data Worksheets filed with the IHC Board are accurate and complete and conform with the requirements of this subchapter. Every duly authorized officer who provides a certification for the reporting required under this subchapter shall be responsible for errors contained therein.

11:20-8.7 Failure to file Exhibit K Assessment Report

Failure to file in a timely manner the Exhibit K Assessment Report and certification required by this subchapter shall result in the Board's using the premium set forth in the member's most recent Annual Statements filed with the Department as the premium base to calculate that member's market share allocation of assessments for that calculation period.

11:20-8.8 (Reserved)

11:20-8.9 (Reserved)

SUBCHAPTERS 9 THROUGH 10. (RESERVED)

SUBCHAPTER 12. PURCHASE OF A STANDARD INDIVIDUAL HEALTH BENEFITS PLAN [OR A BASIC AND ESSENTIAL HEALTHCARE SERVICES PLAN] BY A PERSON COVERED UNDER AN INDIVIDUAL PLAN OR ELIGIBLE FOR OR COVERED UNDER A GROUP PLAN

11:20-12.1 Purpose and scope

This subchapter sets forth the standards for purchasing a standard health benefits plan or a standard health benefits plan with rider by a person who is covered under an individual plan or a group health benefits plan.

11:20-12.2 (Reserved)

11:20-12.3 **(Reserved)** [Replacement during initial enrollment period

(a) A person who is covered under a standard health benefits plan, or a standard health benefits plan with rider, a basic and essential health care services plan, a basic and essential health care services plan with rider, or a group health benefits plan may elect to replace the plan or the coverage with a standard individual health benefits plan or a standard individual health benefits plan with a rider. The application must be received during the initial enrollment period.

(b) The effective date of the replacement plan will be January 1 if the application is received by December 31, 2013. The effective date will be the first of the following month for applications received January 1, 2014, through March 31, 2014. In addition, carriers may permit effective dates as of the 15th of the month in January, February, and March.

(c) The standard health benefits plan, or a standard health benefits plan with rider, a basic and essential health care services plan, a basic and essential health care services plan with rider, or a group health benefits plan coverage must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan or coverage will terminate the existing plan or coverage as of the midnight on the day before the effective date of the replacement plan if the existing carrier is notified of the replacement within 30 days after the effective date of the replacement plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the replacement plan, the replacement plan shall be of no force and effect and premium paid shall be refunded.]

11:20-12.4 Replacement during annual open enrollment period

(a) Except as stated in N.J.A.C. 11:20-12.5 with respect to the special enrollment period, a person who is covered under a standard health benefits plan, standard health benefits plan with rider, or group health benefits plan may only elect during the annual open enrollment period to replace the plan or coverage with a standard health benefits plan or a standard health benefits plan with rider. The application must be received during the annual open enrollment period.

(b) The effective date of the replacement plan will be January 1 of the year following the annual open enrollment period **if the application is submitted prior to January 1. The effective date with respect to applications submitted later in the open enrollment period will be assigned based on N.J.A.C. 11:24.4(b).**

(c) The existing standard health benefits plan, standard health benefits plan with a rider, or group health benefits plan coverage must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan or coverage as of the midnight on the day before the effective date of the replacement plan if the existing carrier is notified of the replacement within 30 days after the effective date of the replacement plan. The new carrier issuing the replacement plan may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan or coverage is not before the effective date of the replacement plan, the replacement plan shall be of no force and effect and premium paid shall be refunded.

11:20-12.4A (Reserved)

11:20-12.5 Replacement during special enrollment period

(a) A person covered under a standard health benefits plan or a standard individual health benefits plan with a rider or group health benefits plan may enroll for coverage under a different standard health benefits plan or standard individual health benefits plan with a rider during a 60-day special enrollment period that follows a triggering event. **With respect to a loss of coverage the special enrollment period also includes the 60 days prior to the loss of coverage.**

(b) The effective date of the new standard health benefits plan or standard health benefits plan with a rider will be **no later than** the first of the month following the date the carrier receives the application. In addition to the first of the month effective date, carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption, or placement for adoption or the date of placement in foster care. **The effective date of coverage issued pursuant to a court order shall be the date stated in the court order.**

(c) Carriers may require that an applicant submit proof of the triggering event.

SUBCHAPTERS 13 THROUGH 16. (RESERVED)

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

11:20-17.1 Purpose and scope

(a) This subchapter provides for the quarterly [and annual] submission of enrollment status reports by all members of the IHC Program, and sets forth the procedures [and format] for **filing** those reports.

(b) This subchapter applies to all members of the IHC Program that issue or renew standard health benefits plans [or the basic and essential health care services plans] to individuals.

11:20-17.2. Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 and N.J.A.C. 11:20-1, 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.

"Enrollment status report" means a complete and accurate document that is prepared and filed in accordance with the requirements of this subchapter and sets forth the information [in the format of Part 1 of Exhibit L for the quarterly submission and Part 2 of Exhibit L for the annual submission in the Appendix to this chapter, which is incorporated herein by reference.] **listed in N.J.A.C. 11:20-17.4**

"Insured" or "insured individual" means any individual covered under an individual health benefits plan.

11:20-17.3. Filing requirements

(a) Every member of the IHC Program issuing or renewing standard health benefits plans [and the basic and essential health care services plan] shall complete and file with the Board the enrollment status reports required by this subchapter.

(b) Members shall file enrollment status reports on a quarterly basis reflecting the information set forth in N.J.A.C. 11:20-17.4 [and in the format of Part 1 of Exhibit L] which shall reflect data as of March 31, June 30, September 30 and December 31 of each year.

[(c) Members shall file enrollment status reports on an annual basis reflecting the number of contracts by zip code category, and insured persons by age and gender category in the format of Part 2 of Exhibit L which shall reflect data as of December 31 of the prior year.]

[(d)] **(c)** Members shall submit completed enrollment status reports **by email** to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h) no later than [45] **60** days following the end of the quarter[or end of the year (for annual reporting purposes)].

[(e)]**(d)** Affiliated carriers shall submit the enrollment status reports only on a combined basis. Each affiliated carrier shall be identified on the report.

11:20-17.4 Contents of the enrollment status report

(a) Members shall report the following information on a quarterly basis on the enrollment status report form [set forth as Part 1 of Exhibit L in the Appendix,] separately for each of the standard health benefits plans, broken out into [indemnity or]PPO or POS **or EPO** for Plans A/50, B, C and D, the HMO plans reported by copay or coinsurance, as well as [indemnity, PPO, EPO or HMO coverage under the basic and essential health care services plan, and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to

August 1, 1993] **catastrophic plans. Carriers shall separately report enrollment through the Marketplace and enrollment outside the Marketplace.**

1. [In section A of Part 1 of Exhibit L, Report By]Contracts **inforce** shall be calculated **and reported** by adding the number of contracts in force at the beginning of the period to the number of contracts issued during the period, and subtracting the number of contracts lapsed during the period. **The enrollment at the start of a quarter shall equal the enrollment at the end of the prior quarter.**

[i. Contracts issued shall be reported according to previous insured status. Previous insured status shall be separated into three categories: previously insured, previously uninsured, and unknown. Previous insured status shall be obtained from the section of the application that requires the applicant to indicate if the applicant had previous coverage. If the response is yes, then the contract shall be reported as previously insured. If the response is no, then the contract shall be reported as previously uninsured. If the question has not been answered, the contract shall be reported as unknown.]

2. [In section B of Part 1 of Exhibit L, Report By] Persons Insured shall be calculated **and reported** by adding the number of persons insured at the beginning of the period and the number of new insureds during the period, and subtracting the number of insureds lapsed during the period.

i. The number of lives insured should be reported [in this section]. For those [members] **carriers** who do not maintain actual dependent data, the following factors shall be used to convert contracts to persons insured: single = 1; two adults = 2; adult and child(ren) = 2.8; family = 3.9;

3. [In section C of Part 1 of Exhibit L, Report of]**Inforce** Contracts [By Rating Tier] shall be reported separately by rating tier, that is: single **person**;[two adults; adult and child(ren); and family] **or multiple person. The sum of the contracts by rating tier shall equal the number of contracts inforce;** and

4.[In section D of Part 1 of Exhibit L, Report of] **Inforce** Contracts [By Deductible/Copayment Option,]shall be reported separately by the [required and permitted] **PCP cost sharing, that is,** deductible [options for Plans A/50, B, C, and D] or [the required and permitted] copayment options **applicable to PCP services**. [for the HMO Plan. Members issuing PPO or POS plans shall report according to the copayment or deductible applicable to network physician visits. Members issuing HMO plans that include deductible and coinsurance provisions shall report according to the deductible applicable to services and supplies for which coinsurance applies. Members issuing basic and essential health care plans shall report contracts for plans issued with and without riders.] **The sum of the contracts by PCP cost sharing shall equal the number of contracts inforce.**

5. The number of contracts sold as a high deductible health plan (HDHP) which are included in (a)4 above shall be reported separately.

6. Inforce plans shall be reported according to actuarial values of the inforce plans.

[(b) Members shall report the following information on an annual basis on the enrollment status report form set forth at Part 2 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken down by indemnity or PPO or POS for Plans A/50, B, C and D, the HMO plans, as well as the indemnity, PPO, POS or EPO or HMO basic and essential health care services plan, both with and without any rider:

1. In section A of Part 2 of Exhibit L, Report of Inforce Contracts by Zip Code, categorized by Territory A - F or the first three digits of the zip code;

2. In section B of Part 2 of Exhibit L, Report of insured males, separated by age distribution as of December 31 of the previous year;

3. In section C of Part 2 of Exhibit L, Report of insured females, separated by age distribution as of December 31 of the previous year; and

4. In section D of Part 2 of Exhibit L, Report of Contracts as amended by one or more optional benefit riders.]

11:20-17.5. (Reserved)

SUBCHAPTER 19. PETITIONS FOR RULEMAKING

11:20-19.1. Scope

This subchapter shall apply to all petitions to the Board by interested persons to adopt a new rule, or amend or repeal any existing rule by the Board, pursuant to N.J.S.A. 52:14B-4(f).

11:20-19.2. Procedure for petitioner

(a) Any person who wishes to petition the Board to adopt a new rule or amend or repeal any existing rule shall submit to the Board, in writing, the following information:

1. Name, address, phone, fax, and email address of the petitioner;

2. The substance or nature of the rulemaking which is requested, which may include suggested text of the proposed new rule, amended rule or repealed rule;

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. 11:20-2.1(h).

(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 rulemaking requiring further Board action pursuant to N.J.S.A. 52:14B-4(f).

11:20-19.3. Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:20-19.2, the Board shall file, within 15 days, 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 the petition in compliance with N.J.A.C. 11:20-19.2, 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) The Board's action on a petition may include:

1. Denying the petition and providing a written statement of the Board's reasons to the petitioner, and including such reasons in its notice of action;

2. Granting the petition and initiating a rulemaking proceeding within 90 days of the granting of the petition; or

3. Referring the matter for further deliberations which shall be concluded within 90 days of referring the matter for further deliberations. Upon conclusion of such further deliberations, the Board shall either deny the petition and provide a written statement of its reasons or grant the petition and initiate a rulemaking proceeding within 90 days.

(d) The Board shall publish its action on the petition for rulemaking on the Board's website no later than the date the action is to be published in the New Jersey Register.

SUBCHAPTER 20. APPEALS FROM ACTIONS OF THE BOARD

11:20-20.1. Scope

This subchapter shall apply to all appeals from Board determinations and requests for hearing as expressly provided pursuant to this chapter.

11:20-20.2. Appeals procedures

(a) A member may request a hearing on a final determination by the Board within 20 days from the date of receipt of such final determination as expressly permitted by this chapter 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 disputed adjudicative facts warranting a hearing and describing the basis for the member's contention 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 disputed adjudicative facts.

3. The Board 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., 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 may transmit the matter to the Office of Administrative Law for a hearing consistent with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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.

iii. If the Board finds that there are no good-faith disputed adjudicative 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.

SUBCHAPTER 21. (RESERVED)

SUBCHAPTER 22. **(RESERVED)** [BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

11:20-22.1. Purpose and scope

(a) This subchapter implements provisions of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.4 through 4.7), an Act that supplements the Individual Health Insurance Reform Act, P.L. 1992, c.161. This subchapter establishes procedures and standards for carriers to meet their obligations under P.L. 2001, c.368, and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the P.L. 2001, c.368. The other subchapters in this chapter should be consulted for procedures and standards that also have application to the basic and essential health care services plan required by P.L. 2001, c.368.

(b) The provisions of this subchapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term "member" is defined in N.J.A.C. 11:20-1.2 and N.J.S.A. 17B:27A-2.

(c) The provisions of this subchapter shall be applicable to the marketing, sale, issue and administration of all basic and essential health care services plans.

11:20-22.2. Definitions

Words and terms contained in N.J.S.A. 17B:27A-2 et seq., when used in this chapter, shall have the meanings as defined in the N.J.S.A. 17B:27A-2 et seq., and N.J.A.C. 11:20-1.2 unless the context clearly indicates otherwise, or as such words and terms are further defined by this subchapter, as follows:

"Copayment" means a specified dollar amount which a person covered under a basic and essential health care services plan must pay for certain charges covered under such plan. A covered person may be required to pay an amount in excess of the copayment if the charge the provider bills exceeds the reasonable and customary charge.

"Good faith effort" means the demonstrated efforts a carrier undertakes to make the basic and essential health care services plan available to residents of New Jersey, as evaluated by the Board pursuant to the standards set forth in this subchapter.

"Modified community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, except that a rate differential may be applied on the basis of age, gender and geography, as detailed in section 2.c of P.L. 2001, c.368, and in this subchapter.

11:20-22.3 Obligation to offer a basic and essential health care services plan

(a) Every member that writes individual health benefits plans in New Jersey shall offer the basic and essential health care services plan through December 31, 2013. No member shall offer the basic and essential healthcare services plan as of January 1, 2014, or thereafter.

(b) Members that write individual health benefits plans as HMO coverage and as indemnity coverage may choose to offer the basic and essential health care services plan as an HMO plan or as an indemnity plan and are not required to write the plan as both an HMO plan and as an indemnity plan. Carriers that choose to offer the basic and essential health care services plan as an indemnity plan may include provisions to create an indemnity-based preferred provider organization (PPO) plan or an exclusive provider organization (EPO) plan.

11:20-22.4 (Reserved)

11:20-22.5 Riders to amend the basic and essential health care services plan

(a) Members may develop optional benefit riders to amend the basic and essential health care services plan provided the riders increase the benefits provided under the basic and essential health care services plan and do not contain any feature that would represent a decrease in the coverage or the actuarial value of the plan. The enhanced or additional rider benefits must be included in a manner which will avoid adverse selection to the extent possible. No new optional benefit riders may be developed after December 31, 2013.

(b) Before a member may offer or issue a rider to amend the basic and essential health care service plan, the member shall file the rider with the Board for approval. The member shall submit:

1. A copy of the rider to amend the basic and essential health care services plan to the Board at the address specified at N.J.A.C. 11:20-2.1(h);

2. A copy of the provision from the basic and essential health care services plan that the rider is amending, notated to highlight the area of the change;

3. A certification signed by a duly authorized officer of the member that states clearly that:

i. The member shall make the basic and essential health care services plan available to residents of New Jersey and will make a good faith effort to market the plan both with and without the rider;

ii. Rates for the rider amending the basic and essential health care services plan have been submitted pursuant to the requirements of N.J.A.C. 11:20-6;

iii. The rider increases a benefit or benefits and does not decrease any benefits or the actuarial value of the basic and essential health care services plan;

iv. The member shall offer the rider in a manner which will avoid adverse selection to the extent possible;

v. None of the ridered benefits exceed the benefits in the standard Plan A/50 through Plan D plans, or HMO plan, as applicable (benefits would include any benefits set forth in the standard Plan A/50 through Plan D "Covered Charges" or "Charges Covered with Special Limitations" sections of the policy or set forth in the standard HMO "Covered Services and Supplies" section of the contract); and

vi. If an HMO, none of the ridered benefits are provided with a copayment that is lower than the lowest HMO copayment option allowed by the Board's rules; and

4. A comprehensive list of benefits in the proposed rider compared with the carrier's standard A/50 through D plan or standard HMO plan, as applicable.

(c) The Board shall notify a member in writing of its determination whether the rider filing is approved within 30 days of the date the filing is received. If the Board does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

(d) A member seeking to challenge the Board's disapproval of a rider filing must do so within 20 days of receiving the notice of the disapproval pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

(e) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later than 60 days following the close of each calendar quarter. The final quarterly report shall be due March 1, 2015.

1. For standard indemnity plans, standard PPO plans, standard POS plans, standard HMO plans, basic and essential health care services plans issued without a rider, and all basic and essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar quarter;

ii. Paid claims for the calendar quarter;

iii. New business enrollment reporting both the number of contracts and number of lives for the calendar quarter, which shall include the enrollment of persons who applied for and were issued coverage, whether or not the persons were new customers to the carrier or had coverage under other plans issued by the carrier and terminated the prior plans in favor of the plan for which application was made; and

iv. Total enrollment (total in force) reporting both number of contracts and number of lives as of the last day of the calendar quarter.

(f) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) no later than 90 days following the close of the calendar year. The final annual report shall be due April 1, 2015.

1. For standard indemnity plans, standard PPO plans, standard POS plans, standard HMO plans, basic and essential health care services plans, plans issued without a rider, and all basic and

essential health care services plans issued with a rider, the carrier shall submit, for each type of plan:

i. Earned premium for the calendar year; and

ii. Incurred claims for the calendar year.

(g) The Board shall evaluate the filings to determine whether the carrier has avoided adverse selection to the extent possible.

(h) If the Board finds that a carrier's rider has resulted in adverse selection, then the carrier shall cease issuing the rider within 60 days of receipt of the Board's written determination letter, but shall continue to renew the plan and rider for contractholders that had already purchased the plan with the rider.

(i) A member seeking to challenge the Board's finding that the rider has resulted in adverse selection must do so within 20 days of receiving the Board's written determination pursuant to the procedures for appeals set forth at N.J.A.C. 11:20-20.2.

11:20-22.6 Good faith effort to market the basic and essential health care services plan

(a) In order for the Board to determine whether a member has made a good faith effort to market the basic and essential health care services plan, as required by section 2g of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.5g), every member shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year a report detailing the activities the member undertook during the prior calendar year to market the basic and essential health care services plan. Members may satisfy the requirement by marketing the plan as an HMO plan, a

PPO plan, an EPO plan, or as an indemnity plan. The final report required under this section shall be due May 1, 2014.

(b) The report shall include only those marketing activities which were in direct support of the sale of the basic and essential health care services plan during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the report submitted by each member to determine whether the member has demonstrated that it made a good faith effort to market the basic and essential health care plan and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a carrier has marketed in good faith if:

i. The carrier provides evidence that that it has included the basic and essential health care services plan on the carrier's standard application in the prior calendar year;

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the basic and essential health care services plan during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes or other communications advising the producers of the availability of the plan; or information specific to the basic and essential health care services plan on the carrier's website. Members may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the basic and essential health care services plan; and

iii. The carrier provides a certification in which it certifies that it either did or did not use any New Jersey individual market marketing materials during the prior year that identified a list of plan choices. If the carrier did use any marketing materials that included a list of plan choices, the carrier shall provide evidence that the basic and essential health care services plan was listed as one of the plan choices.

2. A member will be found to have not to have made a good faith effort if the report does not meet the standards set forth in (c)1 above or if the member fails to submit a report by May 1 of each year.

11:20-22.7. Penalties

Members found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plan will be subject to the provisions of N.J.S.A. 17B:30-1.]

SUBCHAPTER 23. RULEMAKING; INTERESTED PARTIES; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

11:20-23.1. Purpose and scope

(a) The purpose of N.J.A.C. 11:20-23.2 through 23.5 is to establish the procedures that the Board uses in rulemaking made pursuant to the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The purpose of N.J.A.C. 11:20-23.6 is to establish procedures for public notice regarding Board meetings. The purpose of N.J.A.C. 11:20-23.7 is to establish the

procedures that the Board uses in placing parties and entities on the Board's in interested parties mailing list.

(b) N.J.A.C. 11:20-23.2 through 23.5 shall apply only to rulemaking of the Board made pursuant to New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and shall not apply to rules made pursuant to N.J.S.A. 17B:27A-16.1, a special rulemaking procedure set forth in the IHC Act. N.J.A.C. 11:20-23.7 shall apply to any person that wishes to be placed on the Board's interested parties mailing list.

11:20-23.2. Public notice regarding proposed rulemaking

(a) The Board shall provide the following types of public notice for rule proposals pursuant to 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 web site at: [http://www.njdobi.org] **www.dobi.nj.gov** and in the Department of Banking and Insurance's Library, which is located on the 1st Floor 20 West State Street, Trenton, NJ 08625.

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 web site; and

4. 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 parties by e-mail or hard copy.

11:20-23.3. Extension of the public comment period

(a) The Board, pursuant to 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 indicate a previously unrecognized impact on a regulated entity or persons; or

2. Comments received raise unanticipated issues related to the notice of proposal.

11:20-23.4. 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] **N.J.A.C. 11:20-2.1(h) containing** 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)] **(e)** below.

(d) In addition to complying with (c) above, the person submitting a request for a public hearing shall submit a copy of the request to the Office of Administrative Law as required by N.J.A.C. 1:30-5.5

[(d)]**(e)** The Board shall determine that 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.

11:20-23.5. Public notice of new rules, amendments, repeals or adoptions

The Board shall provide notice of new rules, amendments, repeals or adoptions by posting these rules on its website at [http://www.nj.gov/dobi/reform.htm] **www.dobi.nj.gov** and to the news media maintaining a press office in the State House complex.

11:20-23.6. 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 a notice at the office of the Secretary of State;

2. Posting a notice at the office of the Board at the address set forth at N.J.A.C. 11:20-2.1(h);

3. Posting of a notice on the Department of Banking and Insurance web site at: http://www.njdobi.org; and

4. Posting of the notice in two newspapers of general circulation designated by the Board.

11:20-23.7. Board mailing list of interested parties

(a) For the purpose of disseminating information about the IHC Program, including, but not limited to, information about meeting dates and rulemaking made pursuant to either the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. or N.J.S.A. 17B:27A-16.1, the Board shall maintain a mailing list of member carriers and other interested parties.

1. The mailing list of members shall be based upon the members addresses filed with its most recently filed Exhibit K Assessment 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 in (a)1i above, the name and mailing address of a member shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member.

2. Persons other than member carriers who wish to receive communications from the Board, including, but not limited to, proposed rules, actions and public notices, may send a written request to the IHC Board at the address set forth at N.J.A.C. 11:20-2.1(h) 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 from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

SUBCHAPTER 24. PROGRAM COMPLIANCE

11:20-24.1 Purpose and scope

(a) This subchapter sets forth the standards all carriers must meet in offering and issuing standard health benefits plans and standard health benefits plans with riders to eligible persons off the marketplace in New Jersey.

(b) This subchapter sets forth requirements with which carriers must comply in administering standard health benefits plans and standard health benefits plans with riders in New Jersey.

11:20-24.2 Eligibility, issuance, and continued coverage

(a) The policyholder of a standard health benefits plan or a standard health benefits plans with rider shall be a resident, as defined at N.J.A.C. 11:20-1.2. A carrier may require reasonable proof of residency. A dependent of the policyholder may be a nonresident of New Jersey, but is not eligible to be covered under the policy if he or she resides outside of the United States.

(b) An eligible person may apply for coverage under a standard health benefits plan or standard health benefits plan with rider during:

[1. The initial enrollment period;]

[2] **1**. An annual open enrollment period; or

[3] **2**. A special enrollment period.

(c) An eligible person may apply for coverage under a catastrophic plan only if:

1. The person is either under 30 years old as of the date the coverage would take effect; or

2. The person has received a certificate of exemption through the marketplace.

(d) After obtaining coverage under a standard health benefits plan or standard health benefits plan with rider, a covered person may elect to retain his or her coverage if he or she later becomes eligible for or covered under Medicare.

(e) After obtaining coverage under a catastrophic plan, a covered person may elect to retain his or her coverage until the effective date of a marketplace redetermination of exemption eligibility that finds the person is no longer eligible for an exemption or until the end of the plan year in which [the] **any** person **covered under the contract** attains age 30, whichever occurs first.

(f) A carrier shall issue a standard health benefits plan or standard health benefits plan with rider to any eligible person who requests it and pays the premiums therefor, except that an HMO carrier may refuse to issue coverage to an eligible person that does not live in the carrier's approved service area, and except as provided in N.J.A.C. 11:20-11 and 12.

11:20-24.2A Triggering events that result in special enrollment periods

(a) A special enrollment period begins on the date of the triggering event and continues for 60 days. **With respect to a loss of coverage the special enrollment period also includes the 60 days prior to the loss of coverage.** During this period, an eligible person may apply for coverage for himself or herself and his or her eligible dependents.

(b) The dates listed below are triggering events. A loss of coverage resulting from nonpayment of premium, fraud, or misrepresentation of material fact shall not be a triggering event.

1. The date the eligible person loses eligibility for minimum essential coverage, or the eligible person's dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan (QHP) by the marketplace;

2. The date a dependent child's coverage ends as a result of attaining age 26 whether or not the dependent is eligible for continuing coverage in accordance with Federal or State laws;

3. The date a dependent child's coverage under a parent's group plan ends as a result of attaining age 31;

4. The effective date of a marketplace redetermination of an eligible person's subsidy, including a determination that an eligible person is newly eligible or no longer eligible for a subsidy;

5. The date an eligible person acquires a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care;

6. The date an eligible person who is covered under a standard health benefits plan or standard health benefits plan with rider or group health benefits plan moves out of that plan's service area;

7. The date of a marketplace finding that it erroneously permitted or denied an eligible person enrollment in a qualified health plan (QHP); [and]

8. The date of a court order that requires coverage for a Dependent; and

[8] **9**. The date the eligible person demonstrates to the marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

[(c) For purposes of 2014 only, enrollment in a non-calendar year standard health benefits plan, standard health benefits plan with rider, basic and essential health care services plan, or basic and essential healthcare service plan with rider creates a limited enrollment period 30 days prior to the date the policy year ends. If an eligible person does not make a selection of new coverage before the policy year ends, the eligible person shall be considered to have experienced a loss of minimum essential coverage, as stated in (b)1 above, as of the date the policy year ends.]

[(d)] **(c)** The carrier may require proof of the triggering events listed in (b) above.

11:20-24.3 Payment of premium

(a) A carrier may offer a credit card or debit card payment option or an automatic checking withdrawal option to individuals for the monthly or quarterly payment of premiums. In the event that a carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all individuals.

(b) A carrier may offer a discount to individuals that pay premium on a quarterly basis.

(c) A carrier shall accept payment in the form of a check, a money order, a cashier's check, or cash.

11:20-24.4 Effective date of coverage

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

1. A completed individual application form;

2. Proof of the applicant's residency;

3. If a person is applying during a special enrollment period, evidence of the triggering event;

4. If a person is applying for a catastrophic plan and is not under age 30, a copy of the certificate of exemption from the marketplace; and

5. Premium payment not to exceed one month's premium, which shall be refunded to the individual if the health benefits plan is not issued by the carrier.

[(b) With respect to applications submitted during the initial open enrollment period, the effective date of coverage shall be January 1 if the application is received by December 31, 2013. The effective date will be the first of the following month for applications received January 1, 2014, through March 31, 2014. In addition, carriers may permit effective dates as of the 15th of the month.]

[(c)] **(b)** With respect to applications submitted during the annual open enrollment period, the effective date of coverage shall be January 1 of the following calendar year if the application is received prior to January 1. Whenever the annual open enrollment period extends beyond December 31, the effective date of coverage shall be the first of the month following the date the application is received. In addition, a carrier may permit effective dates as of the 15th of the month.

[(d)] **(c)** With respect to applications submitted during the special enrollment period, the effective date of coverage shall be the 1st of the month following the date the carrier receives the application. In addition to the 1st of the month effective date, carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including

placement for adoption, or placement in foster care shall be the date of birth, adoption, or placement for adoption or the date of placement in foster care. **The effective date of coverage issued as a result of a court order shall be the date stated in the court order.**

11:20-24.5 **(Reserved)** [Paying benefits

(a) Except as stated in (b) below for prosthetic and orthotic appliances, in paying benefits for covered services under the terms of the individual health benefits plans provided on an out-of-network basis by health care providers not subject to capitated or negotiated fee arrangements, carriers shall pay covered charges for services based on the allowed charges or actual charges except as required by applicable law including, but not limited to, N.J.A.C. 11:22-5.6(b). Allowed charge 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, published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

1. The maximum allowed charge shall be the 80th percentile of the profile.

2. Carriers shall update their databases within 60 days after receipt of periodic updates released by Ingenix.

(b) In paying benefits for prosthetic and orthotic appliances as required by P.L. 2007, c. 345, reimbursement shall be at the same rate as reimbursement for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or out-of-network basis. However, if the carrier's contract rate with a network provider of orthotic and prosthetic appliances exceeds the Medicare reimbursement rate, the carrier's contract rate should be paid.]

11:20-24.6 Good faith effort to market individual health benefits plans

(a) In order for the Board to determine whether a member that is a small employer carrier as defined in N.J.S.A. 17B:27A-17 has offered and made a good faith effort to market the standard health benefits plans pursuant to N.J.S.A. 17B:27A-19a, every small employer carrier shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year, a report detailing the activities the small employer carrier undertook during the prior calendar year to market at least three of the standard health benefits plans, whether through the marketplace or off the marketplace, or in the case of a Federally qualified HMO, the standard individual HMO plan. If a member offers one or more standard health benefits plans with rider, the member may include information regarding efforts to market the standard health benefits plan with rider in the report.

(b) The report shall include only those marketing activities which were in direct support of the sale of individual health benefits plans whether through the marketplace or off the marketplace during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the report submitted by each member to determine whether the small employer carrier has demonstrated that it made a good faith effort to market the standard individual health benefits plans including standard health benefits plans with rider, if applicable, and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a small employer carrier has marketed in good faith if:

i. The carrier provides evidence that it listed at least three standard individual health benefits plans, or in the case of a Federally qualified HMO, the HMO plan, on the carrier's standard application for individual coverage in the prior calendar year **and demonstrates how the individual application was made available to individual consumers during the prior calendar year**; and

ii. The carrier provides evidence that it has undertaken at least one **individual consumer directed** marketing effort in direct support of the sale of the standard individual health benefits plans or standard health benefits plans with rider during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes, or other communications advising the producers of the availability of the plans; or information specific to the standard individual health benefits plans on the carrier's website. Carriers may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the standard individual health benefits plans **provided such other method is an outbound consumer marketing approach**.

2. A small employer carrier will be found to have not made a good faith effort if the report does not meet the standards set forth in (c)1 above or if the member fails to submit a report by May 1 of each year.

(d) Small employer carriers found not to have demonstrated that they satisfied the requirement to make a good faith effort to market the plans will be required to withdraw from the small employer market pursuant to N.J.A.C. 11:21-16 within 60 days following receipt of a

determination from the Board that the carrier was found to have not made a good faith effort to market the standard individual health benefits plans.

11:20-24.7 (Reserved)

APPENDIX

OFFICE OF ADMINISTRATIVE LAW NOTE: The New Jersey Individual Health Coverage Program Board is proposing amendments to N.J.A.C. 11:20 Appendix Exhibits A and B. Pursuant to N.J.S.A. 52:14B-7(c) and N.J.A.C. 1:30-5.2(a)2, the Exhibits as proposed are not published herein, but may be reviewed by contacting:

New Jersey Individual Health Coverage Program

20 West State Street, 11th Floor

PO Box 325

Trenton, NJ 08625-0325

New Jersey Office of Administrative Law

9 Quakerbridge Plaza

PO Box 049

Trenton, NJ 08625-0049