INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Proposed Amendment: N.J.A.C. 11:20-12.4

Proposed New Rule: N.J.A.C. 11:20-12.4A

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 the exception to the rulemaking calendar requirements of N.J.S.A. 52:14B-3(4)(e) and N.J.A.C. 1:30-3.3.

Proposal Number: PRN 2011-____

Submit written comments by July 25, 2011 to:

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The agency proposal follows:

Summary

The New Jersey Individual Health Coverage Program Board of Directors (IHC

Board or Board) was given authority by the Legislature to implement and regulate the reformed individual health benefits coverage market pursuant to the Individual Health Insurance Reform Act, P.L. 1992, c. 161 as amended, and codified at N.J.S.A. 17B:27A-2 et seq. ("the IHC Act" or "the Act"). The IHC Board's rules are found in N.J.A.C. 11:20.

N.J.S.A. 17B:27A-2 defines "Open enrollment" as "the offering of an individual health benefits plan to any eligible person on a guaranteed issue basis, pursuant to procedures established by the board." N.J.A.C. 11:20-1.2 defines "Open enrollment" as "the continuous offering of a health benefits plan to any eligible person on a guaranteed issue basis, except as stated at N.J.A.C. 11:20-12." The "procedures" the statute requires the Board to establish are set forth in N.J.A.C. 11:20-12. In requiring the Board to establish procedures, the statute recognized that "open enrollment" would need to be regulated in order to create and maintain a sustainable individual market.

N.J.A.C. 11:20-12 establishes the standards for determining who is eligible to be covered under standard individual health benefits plans, the standards for obtaining a standard plan by persons covered by, or eligible for, a group health benefits plan and by persons already covered under another individual health benefits plan. The proposed amendment and new rule relate to the final standard, namely the standard for obtaining a plan by persons already covered under another individual health benefits plan. The rules set forth the timing within which a person can change from one individual plan to another at any time, and the timing within which there are restrictions to changes such that the person is limited to changes to a specified period of time. The specified period of time is called the "open enrollment period" and is defined as "the calendar month of November 1 through November 30 of each calendar year, beginning in 2006, and annually thereafter." Prior to 2006 the open enrollment period was the calendar month of October.

The goal of the current restrictions on the purchase of individual coverage by persons already with group or individual coverage is to allow individuals a designated opportunity to purchase coverage that better suits their needs and circumstances while still seeking to avoid "adverse selection," to the extent possible. Adverse selection describes the tendency of people with significant potential to file claims to seek to obtain coverage that would cover the claims. Adverse selection includes the desire a person may have to buy richer coverage (coverage of more services, or with less cost sharing) when the person experiences a change in health status and realizes that the coverage provided by an existing plan is not as generous as the coverage that could be provided by the richer plan.

Adverse selection has the potential to increase premiums, and therefore insurance systems are designed to reduce adverse selection. Common approaches to avoiding adverse selection include restrictions on the availability of coverage, increasing premiums and limiting plan choices. In designating an open enrollment period, the IHC Board chose to restrict the availability of increases in coverage to a designated month each year. The rationale for such a restriction is to limit adverse selection.

N.J.S.A. 17B:27A-6(a) provides eligible individuals and their dependents with a guarantee of coverage on a community rated basis. This right is commonly referred to as guaranteed issue. An individual who qualifies as an "eligible person" as defined in N.J.S.A. 17B:27A-2 is thus guaranteed that he or she has a right to purchase an individual health benefits plan. That right is qualified later in the law. In N.J.S.A. 17B:27A-11h the Board is given the authority to "establish, at the board's discretion, reasonable guidelines for the purchase of new individual health benefits plans by persons who are already enrolled in or insured by another individual health benefits plan." Thus, the Legislature recognized that guaranteed issue should not be a continuous right whereby an individual

would be guaranteed the opportunity to move from one plan to another at any time and without restriction.

The Board's guidelines for the purchase of new individual health benefits plans by persons who are already enrolled in or insured by another individual health benefits plan are set forth in N.J.A.C. 11:20-12, and specifically in N.J.A.C. 11:20-12.3 and N.J.A.C. 11:20-12.4.

The Board recognized that it was neither necessary nor appropriate to restrict movement in some situations. These situations are specified in N.J.A.C. 11:20-12.3 and include buying a plan with the same or higher cost sharing, buying a plan for which the filed monthly premium is lower than that of the current plan, buying an unridered basic and essential plan to replace another unridered basic and essential plan or buying a standard individual health benefits plan or basic and essential plan to replace a plan that was issued prior to August 1, 1993. The movement allowed by N.J.A.C. 11:20-12.3 does not allow a person to buy richer coverage or coverage better suited for a newly discovered health condition and thus does not result in adverse selection.

The Board likewise recognized that it is indeed necessary and appropriate to restrict movement in other situations. These situations are specified in N.J.A.C. 11:20-12.4 and very broadly include buying a plan for which the monthly premium is greater than the monthly premium for the existing plan, buying a plan with a lower copayment, replacing an HMO plan with a non-HMO plan, replacing a basic and essential plan with a standard plan or a basic and essential plan with rider, or adding a rider to a plan. With one exception as discussed later in this paragraph, the movement specified in N.J.A.C. 11:20-12.4 is movement to a richer plan and if allowed without restriction at any time would result in adverse selection. That risk of adverse selection is mitigated by the requirement that such movement may only occur during the November Open Enrollment

Period with the effective date of coverage beginning the following January 1. There is one circumstance discussed in N.J.A.C. 11:20-12.4 that would not result in adverse selection. N.J.A.C. 11:20-12.4(a) uses monthly premium as a basis to determine whether one plan is richer than another plan. Within plans offered by the same carrier the use of monthly premium is an accurate indication of whether a plan is richer than another plan. When considering plans offered by different carriers, however, the monthly premium is not necessarily a conclusive test to determine if the benefits of one plan are richer than the benefits of another plan. A review of the monthly rate sheets posted on the Board's website reveals that the rates for the same type of plan vary widely. The "same type of plan" considers the product. For example, an HMO plan is the same type of plan as an HMO plan and is not the same type of plan as a PPO plan or an indemnity plan. Replacing a plan with the same type of plan with the same deductible, same coinsurance and same copayment issued by another carrier whose rates are greater than the rates charged by the carrier issuing the plan being replaced does not result in adverse selection. For example, replacing a $30 copay HMO issued by one carrier with a $30 copay issued by another carrier does not result in adverse selection. As discussed in the Economic Impact statement, such a purchase decision may be made to access the network associated with the replacing carrier's plan. To address the possibility that a person may wish to replace a plan with the same type of plan issued by another carrier where the cost of the replacement plan is higher, the Board proposes amending N.J.A.C. 11:20-12.4(a) to allow replacement with the same type of plan at any time.

The following example considers a replacement that would result in adverse selection. A person who is covered under the limited benefits plan called the Basic and Essential Plan as mandated by N.J.S.A. 17B:27A-4.5 (this plan limits benefits for outpatient diagnostic tests to $500 per year, preventive services to $600 per year and

physician visits to $700 per year) who finds out he or she needs expensive diagnostic tests later in the month cannot be permitted simply drop the Basic and Essential Plan one day and replace it with a richer standard plan the following day so as to have coverage for the expensive tests. The same is true for any of the situations described in N.J.A.C. 11:20-12.4, except as discussed above with respect to a replacement with the same plan that is issued by another carrier.

N.J.S.A. 17B:27A-7(b)1 provides credit or waiver for pre-existing conditions for persons who have been covered under creditable coverage with no intervening lapse in coverage of more than 31 days. Coverage is thus "portable" allowing a person to move from one plan to another without having to be concerned with the imposition of a new pre-existing condition exclusion, provided there is no more than a 31 day lapse in coverage between the two plans. The fact that coverage is "portable" impacts the rule at N.J.A.C. 11:20-12.4 in that a person who recognizes that coverage is portable might seek to evade the restrictions on replacement by terminating coverage under a limited plan, waiting a day or two, then applying for coverage under a richer plan. The person would not be subject to a new pre-existing condition provision and could simply buy the richer plan containing the benefits the person then needs. Such an action creates the very situation of adverse selection which the Board sought to avoid when it promulgated N.J.A.C. 11:20-12.4.

The IHC Board has learned that carriers selling individual coverage have recently begun to identify a number of persons who have applied for richer coverage after having terminated coverage under a more limited plan. This is a recent practice and was not contemplated when the regulations at N.J.A.C. 11:20-12 were promulgated. To address the new practice which results in evasion of the protection against adverse selection created by the rules, the IHC Board finds it is necessary and appropriate to eliminate the

possibility an individual might drop coverage only to apply for a richer plan at any time during the 31 days after termination of coverage.

The proposed new rule, N.J.A.C. 11:20-12.4A, restricts the purchase of richer individual health benefits plans when the purchase occurs during the 31 day period following termination of another less rich individual health benefits plan. The restrictions set forth in N.J.A.C. 11:20-12.4A mirror those set forth in N.J.A.C. 11:20-12.4 because the risk of adverse section addressed in N.J.A.C. 11:20-12.4 is the same risk that this proposed new rule seeks to address.

While an individual who drops coverage and seeks to buy new coverage within the 31 day period would be precluded from purchasing a richer plan the individual could purchase a plan with the same or less rich benefits. This ability to purchase the same or a less rich plan means the person who terminates a plan would not be left uninsured and remains eligible to purchase coverage as described in N.J.A.C. 11:30-12.3.

IHC Rulemaking Procedures

The IHC Board is proposing the amendment and new rule 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 in the Administrative Procedures Act 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 if the IHC Board provides interested parties a minimum 20-day period during which to comment on the Board's intended action following the date of 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. 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*.

Social Impact

The proposed amendment and new rule will affect member carriers, producers, and individual consumers of health benefits coverage. Currently, there are approximately 90 Individual Health Coverage Program member carriers, of which approximately 10 carriers are currently offering individual coverage. "Member" carriers are defined at N.J.S.A. 17B:27A-2 and mean those carriers with accident and health premium in New Jersey, exclusive of those that are Medicaid only carriers. Approximately 128,000 persons are covered under individual health benefits plans.

The social impact of the rules at N.J.A.C. 11:20 is the continued implementation of New Jersey's health insurance reforms in the individual market. The proposed amendment and new rule refine the guidelines the Board is authorized to develop regarding the purchase of coverage. The objective of the proposed amendment is to

refine the existing regulation to allow for the possibility that a consumer may find it in his or her best interests to replace a plan with the same plan issued by another carrier where the premium is higher. The objective of the proposed new rule is to prevent adverse selection, to the extent possible, thus preserving the integrity of the individual market.

Economic Impact

The proposed amendment and new rule are expected to have a modest economic impact on the IHC Program member carriers, brokers and consumers.

Carriers have expressed serious concern with individuals dropping coverage under one plan then applying for coverage under a richer plan a day or two later. Individuals who have made such plan changes have done so in order to secure better coverage for conditions they found out existed. This adverse selection ultimately results in higher claims costs for the carriers. Additionally, there are administrative costs associated with the application and issue process. The movement from one plan to another adds to those administrative costs.

Brokers will be economically affected by the proposed amendment and new rule due to the time they must devote understanding the proposed amendment and new rule and how it might impact their recommendations as to which plan might be a good plan for a consumer. To the extent a broker sells coverage for which the carrier pays a commission, the broker will be compensated for assisting consumers with the purchase of individual coverage and will need to consider more carefully the coverage options recognizing it will no longer be possible to evade the open enrollment period in order to buy a richer plan.

Consumers will be economically affected by the proposed amendment which allows them to purchase the same plan from another carrier even if the cost of the replacement plan is higher than the cost of the existing plan. The Board assumes such a

decision would be made in order to access the network of the replacing carrier's plan. The opportunity to use providers in the carrier's network would result in reduced cost sharing for the consumer. Consumers will be economically affected by the proposed amendment and new rule in that they will no longer be able to buy an inexpensive plan one day only to drop it and buy a richer plan when they find out they need the richer coverage. The proposed amendment and new rule will encourage consumers to consider their long term insurance needs and potential risks and not just their needs at the moment of purchase.

Carriers are unlikely to require any new or additional professional or technical services to accommodate the proposed amendment and new rule beyond those already at their disposal.

Federal Standards Statement

The Board is not proposing the proposed amendment and new rule under the authority of, or in order to implement, comply with or participate in any program established under Federal law or under a State statute that incorporates or refers to Federal law, standards or requirements as set forth at N.J.A.C. 1:30-5.1(c)4. Accordingly, no Federal Standards Statement is required.

Jobs Impact

The IHC Board does not anticipate the creation or loss of any jobs as a result of the proposed amendment and new rule.

Agriculture Industry Impact

The proposed amendment and new rule will have no impact on the agriculture industry, other than the general impact felt by all industry groups and the general public.

Regulatory Flexibility Analysis

The IHC Board believes that all carriers subject to these rules have in excess of 100 full-time employees or are located outside of the State of New Jersey and thus are not "small businesses" as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, a regulatory flexibility analysis is not required. Nevertheless, to the extent that there may be carriers that meet the definition of a "small business," the following analysis applies.

The Individual Health Insurance Reform Act does not vary compliance requirements based on business size. To ensure consistency and uniformity in the market this proposed amendment and new rule 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 amendment and new rule.

Smart Growth Impact

The IHC Board does not believe the proposed amendment and new rule will have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact

The IHC Board does not believe the proposed amendment and new rule will have an impact on housing affordability in this State in that the rule relate to the provision of individual health insurance.

Smart Growth Development Impact

The IHC Board does not believe the proposed amendment and new rule will have an impact on the number of housing units or the availability of affordable housing in the State, or that the proposal 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 amendment and new rule relates to the purchase of health benefits plans offered in New Jersey.

Full text of the proposed amendment and new rule (additions indicated in boldface **thus**; deletions indicated in brackets **[thus]:**

_____ _____

Date Ellen DeRosa, Executive Director

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

. . .

11:20-12.4 Covered under an individual plan: replacement only during Open Enrollment Period

(a) **Except as stated below, a** [A] person who is covered under a standard individual health benefits plan may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or basic and essential healthcare services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan. **Exception: A person who is covered under a standard individual health benefits plan may elect to replace the plan with the same type of plan issued by another carrier using the same deductible, same coinsurance and**

same copayments even if the monthly premium is greater than the monthly premium for the existing health benefits plan at any time.

(b) – (i) No Change.

11:20-12.4A Terminated an individual plan during the 31 days prior to the application for or enrollment in another individual health benefits plan: replacement only during Open Enrollment Period

(a) Except as stated below, a person who terminated a standard individual health benefits plan during the 31 days prior to application for or enrollment in a standard individual health benefits plan or basic and essential healthcare services plan may only elect during the Open Enrollment Period to apply for or enroll in such standard individual health benefits plan or basic and essential healthcare services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan. Exception: A person who is covered under a standard individual health benefits plan or basic and essential healthcare services plan may apply for the same type of plan issued by another carrier using the same deductible, same coinsurance and same copayments even if the monthly premium is greater than the monthly premium for the existing health benefits plan at any time.

(b) A person who terminated a standard individual health benefits plan issued as an HMO plan during the 31 days prior to application for enrollment in a standard individual health benefits plan or basic and essential healthcare services plan may only elect during the Open Enrollment Period to purchase an HMO plan featuring a lower copayment than the copayment under the HMO plan.

(c) A person who terminated a standard individual health benefits plan issued as an HMO plan during the 31 days prior to application for or enrollment in a standard individual health benefits plan or basic and essential healthcare services

plan may only elect during the Open Enrollment Period to purchase an indemnity, preferred provider (PPO) or point of service (POS) plan.

(d) A person who terminated a basic and essential healthcare services plan without a rider during the 31 days prior to application or enrollment in a standard individual health benefits plan or basic and essential healthcare services plan may only elect during the Open Enrollment Period to purchase a standard individual health benefits plan or a basic and essential healthcare services plan with a rider.

(e) A person who terminated a standard individual health benefits plan without a rider during the 31 days prior to application for or enrollment in a standard individual health benefits plan or basic and essential healthcare services plan may only elect during the Open Enrollment Period to purchase a standard individual health benefits plan with a rider or a basic and essential healthcare services plan with a rider.

(f) A person who terminated a basic and essential healthcare services plan with a rider during the 31 days prior to application for or enrollment in a standard individual health benefits plan or basic and essential healthcare services plan may only elect during the Open Enrollment Period to purchase a standard individual health benefits plan or a basic and essential healthcare services plan with a different rider.

(g) The effective date of the new plan issued as a result of (a) though (f) above will be January 1 of the year following the Open Enrollment Period.

(h) A person who terminated a standard individual health benefits plan during the 31 days prior to application for a standard individual health benefits plan or basic and essential healthcare services plan who wants to purchase another a standard individual health benefits plan or basic and essential healthcare services

plan under circumstances that are not described in (a) though (f) above may purchase a new plan at any time.