INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH

Individual Health Coverage Program

Policy Forms; Carriers Informational Rate Filing Requirements; Loss Ratio and Refund Reporting Requirements; Withdrawals of Carriers from the Individual Market and Withdrawal of Plan, Plan Option or Deductible/Copayment Option

Proposed New Rules: N.J.A.C. 11:20-3A, 6, 7 and 18 and 11:20 Appendix Exhibits E and J

Authorized By: Steven M. Goldman, Commissioner, Department of Banking and Insurance

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B:27A-2 et seq., and P.L. 2008, c. 38.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2009 –16

Submit comments by March 6, 2009 to:

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The agency proposal follows:

Summary

N.J.S.A. 17B:27A-2 (the IHC Act), originally effective November 30, 1992, established the New Jersey Individual Health Coverage (IHC) Program to provide requirements for the provision of individual health coverage plans in this State. Various responsibilities for the implementation of the Act were assigned to either the Commissioner of Banking and Insurance

(Commissioner) or the IHC Board. Administrative rules to implement the IHC Act were adopted and codified at N.J.A.C. 11:20, originally effective 1993 and amended subsequently since that time. P.L. 2008, c. 38, approved July 8, 2008, amended various sections of the IHC Act. These changes include:

(i) Rate caps for in-force business and for certain new business for four years following the effective date of the statute (N.J.S.A. 17B:27A-3a);

(ii) IHC rates for new contracts and policy forms are now filed with the Commissioner for informational purposes rather than with the IHC Board (N.J.S.A. 17B:27A-9c);

(iii) Rates are to be formulated with an anticipated minimum loss ratio of not less than 80 percent, increased from 75 percent, and the loss ratio report is now to be filed with the Commissioner rather than with the IHC Board (N.J.S.A. 17B:27A-9e(1) and (2));

(iv) The IHC Board no longer has the authority to review rate applications and form filings (repeal of N.J.S.A. 17B:27A-11c); and

(v) Rate changes are now filed with the Commissioner (N.J.S.A. 17B:27A-9d).

In order to implement the amendments to the IHC Act, the IHC Board has proposed to repeal various rules that no longer apply. See 40 N.J.R. 6904(a). The Department of Banking and Insurance (Department) is proposing new rules to provide for the implementation of the amendments to the IHC Act and to reflect the Department's new responsibilities under the amended law. The proposed new rules generally reflect the rules that were previously adopted by the IHC Board, with appropriate changes to implement the IHC Act, as amended. The

Department anticipates coordinating the operative date of the adoption of this proposal with that of the IHC Board proposal. A summary of the proposed new rules follows.

N.J.A.C. 11:20-3A

These proposed new rules reflect existing N.J.A.C. 11:20-3.2(a), (b) and (c).

Proposed N.J.A.C. 11:20-3A.1 sets forth the purpose and scope of the proposed new rules, which is to establish the requirements and procedures by which carriers seeking to participate in the individual plan market as members of the IHC Program and member carriers issuing plans in the individual plan market shall file policy or contract forms with the Commissioner and certify to the Commissioner that the health benefits plans to be used by the carrier are in substantial compliance with the provisions in the approved individual plans, as required by N.J.S.A. 17B:27A-7d.

Proposed N.J.A.C. 11:20-3A.2 sets forth the requirements for the filing of a certification of compliance. Specifically, before marketing, issuing or renewing any standard policy forms, a member shall file with the Department a certification of compliance as set forth in proposed Exhibit E to the Appendix to the chapter.

Proposed N.J.A.C. 11:20-3A.3 sets forth requirements for basic and essential health care services policy forms. The rule requires that members file such policy forms with the Department before offering or issuing such a form. The proposed new rule sets forth the information that shall be contained in a filing and provides for the Department to notify a member in writing if the policy form filing is disapproved. Absent such notification within 30 days after a filing is received, a policy form will be deemed approved. These provisions reflect existing N.J.A.C. 11:20-22.4.

N.J.A.C. 11:20-6

These proposed new rules are intended to replace the existing N.J.A.C. 11:20-6 related to IHC informational rate filing requirements.

Proposed N.J.A.C. 11:20-6.1 sets forth the purpose and scope of the proposed new rules.

Proposed N.J.A.C. 11:20-6.2 sets forth definitions of terms used in the subchapter. The definition of "informational filing" now includes reference to actuaries with other professional designations. This reflects the evolution of professional standards for qualified actuaries in the United States. Members of the three named organizations are subject to the same standards.

Proposed N.J.A.C. 11:20-6.3 sets forth the requirements for informational rate filings. These requirements include that all members issuing standard health benefits plans on a new contract or policy form and the basic and essential health care services plan shall make, prior to issuing any standard health benefits plan or basic and essential health care services plan, an informational rate filing with the Department which includes the supporting data specified in the proposed new rules. This data includes: rate manuals; monthly premium rates and factors; a detailed actuarial memorandum; a certification signed by a member of the American Academy of Actuaries, Society of Actuaries or Casualty Actuarial Society that includes the information specified in the rule; and such other information and data that may be required or requested by the Department analyzing a particular filing. In addition, proposed N.J.A.C. 11:20-6.3(a)3 is changed from the existing rule to clarify the experience that should be provided in the memorandum if experience of a plan other than the plan being rated is used, list the specific expense assumptions required, and to clarify how the percentage change in rates is to be calculated. This will provide more complete information with respect to the data required.

Proposed N.J.A.C. 11:20-6.4 sets forth the procedures for informational rate filings.

N.J.A.C. 11:20-6.5 sets forth permissible rate classification factors, including age factor categories and geographic categories.

N.J.A.C. 11:20-7

These proposed new rules relate to loss ratio and refund reporting requirements, and reflect the prior N.J.A.C. 11:20-7.

Proposed N.J.A.C. 11:20-7.1 sets forth the purpose of the proposed new rules.

Proposed N.J.A.C. 11:20-7.2 sets forth the definitions of terms used in this subchapter.

Proposed N.J.A.C. 11:20-7.3 requires that members file with the Commissioner an annual loss ratio report on the form appearing as proposed Exhibit J in the Appendix to the chapter.

Proposed N.J.A.C. 11:20-7.4 sets forth the specific contents required to be included in the loss ratio report, which includes: a member's name and address; a member's net earned premium for the preceding calendar year; a statement of the member's total losses incurred; the member's loss ratio; and a certification by a member of the Society of Actuaries, Casualty Actuarial Society, or American Academy of Actuaries that the information provided in the report is accurate, complete and that the carrier is in compliance with the requirements in N.J.S.A. 17B:27A-9. The Department is changing the reserve calculation to require the use of what were formerly called safe-harbor residual reserves. This is consistent with the manner by which reserves are required to be calculated by carriers under the small employer health program, and will promote uniformity in the manner by which carriers calculate reserves.

Proposed N.J.A.C. 11:20-7.5 provides that if the loss ratio determined pursuant to proposed N.J.A.C. 11:20-7.4 is less than 80 percent, a member shall include with the report a

plan to be approved by the Commissioner for a refund to policy or contact holders of an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amounts of dividends and credits equal 80 percent of the aggregate premiums collected for the policy or contract forms in the previous calendar year. The proposed new rule also sets forth the requirements for any refund plan.

Proposed N.J.A.C. 11:20-7.6 sets forth specific requirements related to unclaimed loss ratio refunds.

Proposed N.J.A.C. 11:20-7.7 provides that, within 30 days of providing refunds to all policy or contractholders, a carrier required to provide a loss ratio refund pursuant to the subchapter shall provide a certification to the Department.

N.J.A.C. 11:20-18

These proposed rules apply to withdrawals of carriers from the individual market and the withdrawal of plans, plan options or deductible/co-payment options. These proposed rules reflect and replace the existing N.J.A.C. 11:20-18.

Proposed N.J.A.C. 11:20-18.1 sets forth the purpose and scope of the proposed new rules.

Proposed N.J.A.C. 11:20-18.2 sets forth the definitions of terms used in this subchapter.

Proposed N.J.A.C. 11:20-18.3 provides that no carrier with in-force individual plans shall cancel an individual plan, except in accordance with N.J.S.A. 17B:27A-6, or non-renew an individual plan upon the plan's anniversary date, except in accordance with N.J.A.C. 11:20-18.5, 18.6 or 18.7.

Proposed N.J.A.C. 11:20-18.4 sets forth specific requirements for carriers wishing to cease to offer and issue individual plans. Specifically, a carrier may not cease to offer all of its

individual plans to an eligible person unless the Commissioner has determined, pursuant to N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11, that the carrier does not have the financial resources necessary to underwrite additional coverage, and the carrier has provided written notice to the IHC Board and its plan policyholders in accordance with the proposed new rule. The proposed rule also provides that a carrier that notifies the Board shall continue to renew all in-force individual plans until it obtains the Department's approval for market withdrawal in accordance with N.J.A.C. 11:20-18.5. A carrier that has ceased offering and issuing individual plans, but that has not withdrawn from the market in accordance with N.J.A.C. 11:20-18.5, may resume issuing standard individual health plans after it has notified the Department and the IHC Board that it intends to resume offering such plans. Finally, the proposed rule provides that a carrier with in-force individual plans that has ceased to issue and offer all of its individual plans pursuant to the rules shall nevertheless continue to comply with all applicable provisions of law.

Proposed N.J.A.C. 11:20-18.5 sets forth general provisions for market withdrawal. These requirements include: a carrier may not refuse to issue or renew an individual plan, except in accordance with applicable law, unless the carrier seeks approval from the Department to withdraw all of its individual plans; and a carrier that seeks to withdraw shall file with the Department an application for market withdrawal as set forth in the proposed new rule including the information set forth therein.

Proposed N.J.A.C. 11:20-18.6 sets forth general provisions for withdrawal of plan, plan options or deductible/co-payment options. Specifically, the proposed new rule provides that no carrier shall cease to issue or nonrenew an individual plan, plan option or deductible/co-payment option required or permitted to be offered by N.J.A.C. 11:20-3.1 until the carrier submits a notice of intent to withdraw a plan, plan option or deductible/co-payment option with the Department,

and the Commissioner approves such withdrawal in accordance with the proposed new rule. The proposed new rule also sets forth the prerequisites for ceasing to renew individual plans.

Proposed N.J.A.C. 11:20-18.7 provides that a carrier that ceases to do business pursuant to N.J.A.C. 11:20-18.5 shall be prohibited from writing new individual plans and new small employer plans in New Jersey for a period five years beginning on the termination date of the last standard individual health plan not renewed.

Proposed N.J.A.C. 11:20-18.8 provides that a carrier issuing all of the standard individual plans in the IHC market on and before January 4, 2009 that elects to offer at least three but not all of the standard individual plans after January 4, 2009, as permitted by N.J.S.A. 17B:27A-4b, may either withdraw the plan or plans that the carrier elects to no longer offer, convert the in-force business in the plan or plans the carrier no longer offers pursuant to N.J.A.C. 11:20-24.7, or make a one-time election to continue to renew the in-force business in the plan or plans the carrier will no longer offer, provided the requirements in the rule are satisfied. The purpose of this rule is to minimize disruptions to policyholders that may result from carriers ceasing to offer coverages currently offered, as otherwise permitted pursuant to N.J.S.A. 17B:27A-4b.

Proposed N.J.A.C. 11:20-18.9 provides that nothing in the rules shall be construed to contravene any rights of policy or contractholders concerning other obligations set forth in the policy or contract issued by a carrier.

In brief, N.J.A.C. 11:20-3A and 18 essentially restate existing N.J.A.C. 11:20-3 and 18, with changes to reflect reviews of such actions by the Department, rather than the IHC Board. Proposed N.J.A.C. 11:20-6 and 7 essentially restate existing requirements in those subchapters, with appropriate changes to reflect review by the Department and the new minimum loss ratio requirements established by the IHC Act, as amended by P.L. 2008, c. 38. Thus, the

requirements imposed by the proposed new rules generally continue those provided under the existing regulatory framework, as modified to reflect the new statutory requirements under the IHC Act, as amended.

A 60-day comment period is provided for this notice of proposal, and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The proposed new rules generally continue the existing regulatory framework that applies to IHC Program policy forms, rate and form filings, loss ratio requirements, and withdrawal requirements, as modified to reflect changes to the IHC Act, as amended by P.L. 2008, c. 38, and as discussed in the Summary above. The proposed new rules therefore will have a beneficial social impact by continuing the existing protections to policy and contractholders that help ensure adequate access to health insurance coverage by individuals of this State.

Economic Impact

Members of the IHC Program will be required to incur any costs associated with compliance with the proposed new rules. This includes costs related to filing policy forms, loss ratio reports, certifications of compliance, and withdrawals from the individual health market. Members of the IHC Program will also incur additional costs related to the increase in the minimum loss ratio from 75 percent to 80 percent. However, these costs, as well as the other costs, are either imposed directly by the IHC Act or reflect the existing filing and compliance requirements for carriers that are members of the IHC Program. Professional services that will

be required to comply with the proposed new rules will be those currently required for compliance with the applicable IHC rules and include professional, accounting, legal, and actuarial services. Member insurers should already utilize these services for compliance with the existing IHC Program rules. The Department may experience additional costs in the review of form, loss ratio, and withdrawal filings currently reviewed by the IHC Board which will now be reviewed by the Department pursuant to the IHC Act as amended.

Federal Standards Statement

The proposed new rules comply with the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191. The proposed new rules do not expand the requirements set forth in Federal law.

The proposed new rules comply with the following Federal laws: Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. §1395(b) (1994) and implementing regulations at 45 CFR Part 411; the Public Health Service Act, 42 U.S.C. §§300gg et seq. (incorporating the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191; the Newborns' and Mother's Health Care Protection Act of 1998, Pub. L. 104-204, 110 Stat. 1935 (1996); and the Women's Health and Cancer Rights Act of 1998, Pub. L. 105-277, Title IX, §903, 112 Stat.), and implementing regulations at 45 CFR Parts 145 and 146.

The proposed rules do not expand upon the requirements set forth in these Federal laws. There are no other Federal laws that apply to these rules.

Jobs Impact

The Department does not anticipate that any jobs will be generated or lost as a result of the proposed new rules.

The Department invites commenters to submit any data or studies on the potential jobs impact of the proposed new rules together with their comments on other aspects of the proposal.

Agriculture Industry Impact

The proposed new rules will not have an impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The proposed new rules will apply to "small businesses," as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the proposed new rules apply to small businesses, they will apply to domestic insurers and health maintenance organizations providing individual health insurance in this State that are subject to the IHC Act. The costs for compliance and professional services required to comply with the proposed new rules are as set forth in the Economic Impact above. The proposed new rules provide no differentiation in compliance requirements based on business size. As noted above, the proposed new rules essentially reflect the existing requirements as set forth in the IHC Program rules, modified to reflect changes to the IHC Act, as amended, related to filings with the Department rather than with the IHC Board, and the minimum loss ratio requirements being increased from 75 percent to 80 percent. The purpose of the IHC Act and the proposed new rules is to continue the regulatory framework for the provision of individual health insurance coverage in this State

to help ensure that individuals have adequate access to such coverage. These goals do not vary based on business size.

Smart Growth Impact

The proposed new rules will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Housing Affordability Analysis

The proposed new rules will not have an impact on housing affordability in this State in that the proposed new rules relate to the provision of individual health insurance.

Smart Growth Development Impact

The Department believes that there is an extreme unlikelihood that these proposed new rules would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan because the proposed new rules relate to the provision of health insurance.

Full text of the proposed new rules follows:

SUBCHAPTER 3A. POLICY FORMS

11:20-3A.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers seeking to enter the individual plan market and carriers issuing plans in the individual plan market shall file individual policy or contract forms with the Commissioner and certify to the Commissioner that the health benefit plans to be used by the carrier are in substantial compliance with provisions in the approved individual plans, as required by N.J.S.A. 17B:27A-7d.

(b) This subchapter applies to all carriers, whether or not affiliated with other carriers doing business in the individual plan market in New Jersey, that seek to offer and are offering individual plans pursuant to the IHC Act.

11:20-3A.2 Certification of Compliance

(a) Before marketing, issuing or renewing any of the standard policy forms, a member shall file with the Department, the Certification of Compliance set forth in the Appendix to this subchapter as Exhibit E, incorporated herein by reference. Each affiliated carrier must file a separate Certification of Compliance. A Certification of Compliance must be filed upon entry into the individual market and annually on or before March 1.

(b) Carriers that submit an Exhibit E Certification of Compliance may issue and make effective individual health benefits plans upon filing such Certification with the Department and may continue to do so until such time as the filing is disapproved in writing by the Department.

The Department may disapprove an Exhibit E Certification of Compliance if the Certification is inaccurate or incomplete.

(c) Any carrier whose Certification of Compliance is disapproved may file an appeal of the Department's determination and request a hearing within 20 days of receipt of written notification of the Department's final determination.

11:20-3A.3 Basic and essential health care services plan policy form

(a) Before a member may offer or issue the basic and essential health care services plan policy form, the member shall submit the information set forth below to the Department at Department of Banking and Insurance, Life and Health, Basic and Essential Health Care Services Plan Form Filing, 20 West State Street, P. O. Box 325, Trenton, New Jersey 08625.

1. One copy of the policy form for the basic and essential health care services plan, unless filing a certification as set forth in (b)1 below; and

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

i. The member will make the basic and essential health care services plan available to eligible persons and will make a good faith effort to market the plan;

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

iii. The benefits in the policy form being submitted include all of the coverages enumerated in section 2.a. of P.L. 2001, c. 368, but do not include any additional benefits.

(b) The Department makes available to members a specimen policy form for the basic and essential health care services plan, set forth in chapter Appendix Exhibit F, incorporated herein by reference. The Department has determined that the plan set forth in Exhibit F includes the coverages required for a basic and essential health care services plan.

1. Members that choose to use the plan specimen policy form as set forth in Exhibit F shall submit, in lieu of a copy of the basic and essential health care services plan policy form, a certification, signed by a duly authorized officer of the company, stating that the company is using the basic and essential health care services plan specimen policy form as included in Exhibit F, including the carrier name, and similar variable text, as appropriate. The certification regarding use of the specimen policy form shall also include the statements required by (a)2 above.

2. Members that choose to use the plan specimen policy form as set forth in Exhibit F with some modifications to the text shall submit the form, redlined to show any differences between the submitted form and the form as contained in Exhibit F. The redlined text of the form shall be submitted with the information set forth in (b)1 above.

(c) The Department shall notify a member in writing of its determination whether the policy form 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.

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

11:20-6.1 Purpose and scope

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to section 3 of the Act (N.J.S.A. 17B:27A-4) as well as the basic and essential health care services plan pursuant to P.L. 2001, c. 368.

11:20-6.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20-1.2, or as further defined below, unless the context clearly indicates otherwise.

"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates including a certification by a qualified member of the American Academy of Actuaries, the Society of Actuaries, or the Casualty Actuarial Society, all supporting data for the premium rates and such other information as specified in this subchapter.

11:20-6.3 Informational rate filing requirements

(a) All members issuing standard health benefits plans on a new contract or policy form and the basic and essential health care services plan shall make, prior to issuing any standard health benefits plan (or rider for a standard health benefits plan), or basic and essential health care services plan (or rider for a basic and essential plan), an informational rate filing with the Department, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other factors prohibited by the Act, except that the rates for a standard plan and any riders thereto may consider age as permitted by N.J.S.A. 17B:27A-2 and 6a and the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by N.J.S.A. 17B:27A-4.5 and N.J.A.C. 11:20-6.5;

2. Monthly premium rates and any factors used in the calculation of the premium rates and the effective dates for the rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date. Unless a carrier amends the rate filing to specify an alternative effective date, carriers shall use the rates shown in the rate filing as of the stated effective date. Rates may be developed on different rate tiers for: single; two adults; adult/child(ren); and family. A description of the rating methodology or plan and the numerical value of the classification factors used in determining a policyholder's rates that addresses the use of the factors of age, gender (basic and essential only) and geography (basic and essential only) as discussed in (a)2i, ii and iii below. The filing shall include:

i. The numerical value of the classification factors utilized in the calculation of an individual's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of each covered adult in accordance with the factors set forth in N.J.A.C. 11:20-6.5;

ii. A written description which may include elementary formulas of the rating method so that a knowledgeable member of the public may understand how to translate the basic rates into the rates charged for an individual policy; and

iii. A detailed example calculation, in the proposal format used by the carrier, including any rider option(s), showing all the steps to develop premiums for a policy and demonstrating the adjustment, if any, to achieve the required 350 percent maximum ratio between premiums for the highest rated individual policyholder and the lowest rated individual policyholder in the State;

3. A detailed actuarial memorandum, which shall include the following:

i. The monthly rates being submitted for each period addressed in the rate filing along with factors or actual rates for quarterly or semi-annual modes, if such modes are available;

ii. Identification of the plans and riders affected, using the alphabet name if indemnity or PPO, and the copay and coinsurance, if applicable, if HMO, and using a descriptive code for each rider;

iii. Application of the rates to new business and renewal business, including a description of the application of any limits on renewal increases pursuant to N.J.S.A. 17B:27A-3;

iv. The duration of the rate guarantee period, and if none, so state;

v. A sample of the notice(s) that will be sent to policyholders to advise them of a rate change, including any adjustments for limits pursuant to N.J.S.A. 17B:27A-3;

vi. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including:

(1) Historical experience. The historical experience should specify enrollment, premium, claims and loss ratio data from the period used in the development of the anticipated loss ratio, where the period should be at least 12 months. If premiums are based on some other experience base, the enrollment, premium, claims, and loss ratio data for that other experience base;

(2) Medical cost trend assumptions, for each plan or type of benefit;

(3) Plan relativity assumptions, if a carrier uses plan relativity assumptions in calculating anticipated loss experience;

(4) Any other factors used in developing the anticipated loss experience, such as selection factors or adjustments to experience of other plans; and

(5) The anticipated enrollment, premium, claims, and loss ratio for the rating period;

vii. Specific identification of the administrative expense, premium tax and commission payment assumptions, and other margins;

viii. Specification of the percentage change(s) in rates as compared to the prior rating period; and the prior year and the average change for all plans; and

ix. The anticipated distribution by age and family tier (in the case of standard plans) or age, gender, location, and family tier (in the case of basic and essential plans)

4. A certification signed by a member of the American Academy of Actuaries, Society of Actuaries, or Casualty Actuarial Society, which shall include the following:

i. A statement that the informational filing is complete and complies with all of the requirements of this section;

ii. A statement that the carrier's loss ratio is expected to be at least 80 percent for standard plans over the rating period, and at least 80 percent for basic and essential plans over the rating period; and

iii. A statement that the rating methodology will not produce rates (for each rate tier) for the highest rated policyholder which are greater than 350 percent of the rates (for each rate tier) for the lowest rated policyholder for each plan and rider option; and

5. Such other information or data as may be required or requested by the Department to analyze the adequacy of the rate filing submitted.

(b) Any member which seeks to change its rates for its standard health benefits plans (including riders) or its basic and essential health care services plan (including riders) shall, prior to the effective date of the revised rates, submit to the Department an informational rate filing, which shall include all the supporting data set forth in (a) above.

(c) Unless a carrier submits an amended rate filing to specify an alternate effective date, carriers shall use the rates shown in the rate filing as of the stated effective date.

11:20-6.4 Informational rate filing procedures

(a) A member shall file one copy of the informational rate filing with the Department pursuant to N.J.A.C. 11:20-6.3(a) or (b) at the following address.

New Jersey Dept. of Banking and Insurance

Life & Health Actuarial: IHC Rate Filings

PO Box 325

20 West State Street

Trenton, NJ 08625

(b) If the Commissioner determines that an informational filing filed pursuant to N.J.A.C. 11:20-6.3(a) or (b) is incomplete but in substantial compliance with N.J.S.A. 17B:27A-2 et seq., the Commissioner shall provide written notice to the member specifying those portions of the filing which are deficient and the information required to be submitted or resubmitted by the member.

(c) Within 30 days of receipt of a written notice as referenced in (b) above, the member shall provide the Department with the information required to complete the filing. Failure to provide this information may result in the imposition of penalties specified in N.J.S.A. 17B:27A-43 and/or revision of rates to the last filed rate.

(d) If the Commissioner determines that a filing is incomplete and not in substantial compliance, that the rates are inadequate, or that the rates are unfairly discriminatory, the Commissioner shall provide written notice to the member specifying the information required to be submitted, and specifying in addition the basis for the finding that the filing is not in substantial compliance, or, if applicable, that the rates are inadequate or unfairly discriminatory. The rate filing shall not become effective until the Commissioner has confirmed in writing that the basis for disapproval is cured.

(e) Upon the issuance of a notice as set forth in (d) above, the member shall submit any additional information required to make the filing complete in accordance with (c) above. A carrier may appeal the Commissioner’s determination that the filing is not in substantial compliance or that the rates are inadequate or unfairly discriminatory and request a hearing within 20 days of receipt of the written notice set forth in (d) above.

11:20-6.5 Permissible rate classification factors

(a) A carrier shall not differentiate premium rates charged to different individuals except on the basis of age (in the case of standard plans and riders) and age, gender, and geography (in the case of basic and essential plans and riders) in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 19 and under; 20-24; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; and 65 and over.

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

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

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

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

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

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

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

(b) Notwithstanding (a) above, a carrier may differentiate premium rates on the basis of family structure according to only the following four rating tiers:

1. Single;

2. Two adults;

3. Adult and child(ren); and

4. Family.

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20-7.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

11:20-7.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20-1.2, or as further defined below, unless the context clearly indicates otherwise.

"Claims paid" means a dollar amount determined in accordance with statutory annual statement reporting and consistent with N.J.A.C. 11:20-8.5(c), adjusted as required by this subchapter.

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

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

11:20-7.3 Filing of Loss Ratio Report

(a) Each member that had a standard health benefits plan or a basic and essential health care services plan in force during the preceding calendar year shall file with the Commissioner an annual Loss Ratio Report on the form appearing as Exhibit J in the Appendix to this chapter, incorporated herein by reference. Affiliated carriers shall file a separate report for each carrier that had standard health benefits plans or the basic and essential health care services plans in force during the preceding calendar year plus a combined report reflecting the combined data for all affiliated carriers.

(b) The Report shall be filed on the basis of the combined total of the standard health benefits plans and the basic and essential health care services plans written by the member.

(c) The Report shall be completed and filed with the Board on or before August 15 of the reporting year for the preceding calendar year.

11:20-7.4 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form set forth at Appendix Exhibit J shall be completed by August 15 of each year by each member and shall include the following information with respect to standard health benefits plans and basic and essential health care services plans:

1. The reporting member's name and address;

2. The member's net earned premium for the preceding calendar year; and

3. A statement of the member's total losses incurred consisting of:

i. Claims paid during the preceding calendar year, regardless of the year incurred;

ii. Less residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;

iii. Less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year's Loss Ratio Report;

iv. Plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;

v. Plus residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year;

4. The member's loss ratio (determined by dividing the total losses incurred in (a)3 above by the net earned premium as determined in (a)2 above) calculated as a percentage to one decimal place (for example, 81.2 percent); and

5. Certification by a member of the Society of Actuaries, Casualty Actuarial Society, or American Academy of Actuaries that the information provided in the Loss Ratio Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-9 in accordance with this section.

(b) The residual reserve reported in (a)3ii and v above shall be calculated as 3.3 percent of the combination of (a)3i, iii and iv above.

11:20-7.5 Refund plan

(a) If the loss ratio determined in N.J.A.C. 11:20-7.4 is less than 80 percent, the member shall include with the Report a plan to be approved by the Commissioner for a refund to policy and contractholders of an amount equal to the difference between 80 percent of reported premiums and reported claims.

(b) The refund plan shall conform with the following:

1. Refunds shall be made to all contractholders who were covered for any period during the preceding calendar year whose refund is $5.00 or greater.

2. The refund amount per contractholder may be determined by multiplying the earned premium from each contractholder's standard health benefits plan and rider or basic and essential health care services plan and rider by the percentage resulting from dividing the total refund calculated in accordance with (a) above by the carrier's total net earned premium from the standard health benefits plans and basic and essential health care services plans, or on the basis of a practical and equitable alternative formula proposed by the carrier and approved by the Commissioner.

3. Refund payments shall be made within 60 days of written approval of the refund plan by the Commissioner.

11:20-7.6 Unclaimed loss ratio refunds

(a) Any loss ratio refund issued by a carrier to a policy or contractholder pursuant to this subchapter which remains unclaimed by that policy or contractholder shall be deemed abandoned two years from the date upon which the Commissioner approves the refund plan as set forth in N.J.A.C. 11:20-7.5(b).

(b) Refunds deemed abandoned pursuant to (a) above shall be subject to all applicable provisions of the Uniform Unclaimed Property Act, N.J.S.A. 46:30B-1 et seq., including, but not limited to, N.J.S.A. 46:30B-30, 46, 47, 49, 50 and 57. All carriers shall follow the procedures set forth in the Uniform Unclaimed Property Act with respect to the disposition of refunds deemed abandoned.

(c) Carriers which comply with the applicable provisions of the Uniform Unclaimed Property Act and this subchapter shall be relieved of liability to the extent of any unclaimed refunds upon payment of any unclaimed refunds to the State administrator designated pursuant to the Uniform Unclaimed Property Act.

11:20-7.7 Certification of loss ratio refunds

Within 30 days of issuing refunds to all policy or contractholders for a specific calendar year, any carrier required to provide a loss ratio refund pursuant this subchapter shall provide a certification to the Commissioner at the address in N.J.A.C. 11:20-6.4(a), stating the following: "The loss ratio refund, as set forth in the Loss Ratio Report, was issued by (name of company) to all policy or contractholders eligible for reimbursement with refund checks mailed, or premiums credited, on (date)."

SUBCHAPTER 18. WITHDRAWALS OF CARRIERS FROM THE INDIVIDUAL MARKET AND THE WITHDRAWAL OF PLAN, PLAN OPTION, OR DEDUCTIBLE/COPAYMENT OPTION

11:20-18.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers issuing plans pursuant to the IHC Act may cease doing business in the individual plan market in this State. Additionally, this subchapter establishes the requirements and procedures by which carriers may cease issuing and renewing: all individual plans; a specific plan, by issuing the same plan through a different delivery mechanism; a specific plan option, by offering an alternative approved plan option; or a specific deductible/copayment option that is optional pursuant to N.J.A.C. 11:20-3.1.

(b) This subchapter applies to all carriers, whether or not affiliated with other carriers doing business in the individual plan market in New Jersey, that seek to cease offering or renewing individual plans issued pursuant to the IHC Act, and carriers that seek to cease issuing a specific standard plan, plan option, or deductible/copayment option as permitted herein.

11:20-18.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings set forth in the Act or at N.J.A.C. 11:20-1.2, unless defined below or unless the context clearly indicates otherwise:

"Cease doing business" for purposes of this subchapter means market withdrawal.

"Individual plan" means a plan developed by the Individual Health Coverage Program Board offered pursuant to N.J.S.A. 17B:27A-4b and the basic and essential health care services plan developed by the Legislature and offered pursuant to P.L. 2001, c. 368, including any rider offered with such a plan.

"Market withdrawal" means a carrier's, or one or more affiliated carriers', cessation of the issuance of all individual plans and nonrenewal of all in force individual plans and pre-reform plans upon their respective anniversary dates without the carrier's offering a replacement with an individual plan.

"Plan option withdrawal" means a carrier's cessation of the issuance of an individual plan option, and the nonrenewal of all in force individual plans issued with that option upon their respective anniversary dates.

"Plan withdrawal" means a carrier's cessation of the issuance of one of the individual plans, and the nonrenewal of all in force individual plans of that type upon their respective anniversary dates.

"Pre-reform plan" means an individual health benefits plan issued in New Jersey prior to August 1, 1993.

"State" means the State of New Jersey.

11:20-18.3 Carrier cancellation of individual plans

No carrier with in force individual plans shall cancel an individual plan, except in accordance with N.J.S.A. 17B:27A-6, or nonrenew an individual plan upon the plan's anniversary date, except in accordance with N.J.A.C. 11:20-18.5, 18.6, or 18.7.

11:20-18.4 Cessation of offer and issuance of individual plans

(a) No carrier with in force individual plans shall cease to offer and issue all of its individual plans to an eligible person unless the Commissioner has determined pursuant to

N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11 that the carrier does not have the financial resources necessary to underwrite additional coverage, and it has provided written notice to:

1. The IHC Board at least 30 days before it intends to cease offering and issuing individual plans. Upon receipt of such notice, the Board shall no longer distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide; and

2. Its individual plan policyholders, in conjunction with each notice of an adjustment of rates provided to such policyholders following the date the carrier ceases to offer and issue such plans. The notice to policyholders shall state that:

i. The carrier intends to cease offering and issuing individual plans in New Jersey;

ii. The carrier will continue to renew the policyholder's health benefits plan at the policyholder's option; and

iii. The policyholder may obtain information about individual health benefits plans offered by other carriers by calling 1-800-838-0935 for a free Individual Health Coverage Program Buyer's Guide or may obtain information on the Department of Banking and Insurance website at: www.nj.gov/dobi/reform.htm

(b) A carrier that notifies the Board under this section shall continue to renew all in force individual plans until it obtains the Department's approval for market withdrawal in accordance with N.J.A.C. 11:20-18.5.

(c) A carrier that has ceased offering and issuing individual plans pursuant to N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11, but has not withdrawn from the market in accordance with N.J.A.C. 11:20-18.5, may resume offering and issuing standard individual

health benefits plans to eligible persons after it has notified the Department and the Board, in writing, that it intends to resume offering individual plans. Upon receipt of such notice, the Board shall distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide.

(d) A carrier with in force individual plans that has ceased to offer and issue all of its individual plans pursuant to this section shall nevertheless continue to comply with all other provisions of the law.

11:20-18.5 General provisions for market withdrawal

(a) No carrier with in force individual plans, whether or not affiliated with other carriers doing business in the individual plan market in New Jersey, shall refuse to issue or refuse to renew an individual plan, except in accordance with N.J.S.A. 17B:27A-6, or in accordance with N.J.A.C. 11:20-18.4 or 18.6, unless the carrier receives approval from the Commissioner to withdraw all of its individual plans and pre-reform plans in accordance with the provisions of this subchapter.

(b) A carrier that seeks to withdraw shall file with the Department an application for market withdrawal in the format described in (c) below. A carrier with more than one affiliated carrier doing business in the individual plan market in New Jersey may apply for market withdrawal on behalf of one or more affiliated carriers. Until the withdrawal process is complete, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A-2 et seq. and all rules promulgated thereunder, including, but not limited to, the minimum loss ratio and policyholder refund requirements and liability for a proportionate share of assessments for reimbursable losses and administrative expenses.

(c) The application for market withdrawal shall be sent to the Department at Department of Banking and Insurance, Life and Health, IHC Withdrawal, 20 West State Street, P.O. Box 325, Trenton, New Jersey 08625, and shall include the following information:

1. The name of the carrier seeking to withdraw;

2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for market withdrawal;

3. A statement, describing with specificity, the carrier's reasons for withdrawing from the individual market in this State;

4. A statement of the carrier's percentage market share in the individual plan market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;

5. A statement indicating whether the carrier has applied for an exemption pursuant to N.J.A.C. 11:20-9 in the two-year calculation period during which the application for market withdrawal was filed;

6. A copy of the carrier's most recent loss ratio filing submitted pursuant to N.J.A.C. 11:20-7;

7. A copy of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20-17;

8. A statement indicating whether the carrier has any affiliated carriers writing any health benefits plans in this State, the names of such affiliated carriers and the lines of insurance written, and whether any such affiliated carriers will continue to offer individual plans after the carrier's withdrawal;

9. A statement indicating whether the carrier is withdrawing from other lines of business in this State, and if so, the lines from which it is withdrawing, its authority do so, and whether it has sought and obtained approval for such withdrawal;

10. A statement indicating whether the carrier has guaranteed rates to its policyholders and for what period of time;

11. A copy of the proposed nonrenewal notices the applicant intends to send to its policy or contractholders if the application for market withdrawal is approved. Nonrenewal notices for policy or contractholders shall contain the following information:

i. That the carrier has elected to withdraw;

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

iii. That the policy or contract is being nonrenewed under the authority of this subchapter;

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

v. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan nonrenewal;

vi. A statement that a person who fails to obtain subsequent individual coverage within 31 days of the nonrenewal may be subject to a pre-existing condition exclusion period of 12 months; and

vii. A statement that, pursuant to N.J.S.A. 17B:27A-6, all carriers offering individual plans must issue coverage to any individual who requests coverage, meets the eligibility requirements, and pays the required premium for the coverage;

12. Copies of the proposed nonrenewal notices the applicant intends to send to its producers if the application for market withdrawal is approved. Nonrenewal notices for producers shall contain the following information:

i. That the carrier has elected to withdraw;

ii. The date upon which the policies or contracts shall be nonrenewed;

iii. That the policies or contracts are being nonrenewed under the authority of this subchapter;

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

v. A statement that a person who fails to obtain subsequent individual coverage within 31 days of the nonrenewal may be subject to a pre-existing conditions exclusion period of 12 months;

vi. A statement that, pursuant to N.J.S.A. 17B:27A-6, all carriers offering individual plans must issue coverage to any individual who requests coverage, meets the eligibility requirements, and pays the required premium for the coverage; and

vii. The date upon which the carrier will begin to nonrenew all individual plans and pre-reform plans;

13. An explanation of whether the carrier has any in-force small employer health benefits plans and, if so, a statement of whether the carrier has filed a notice of intent to withdraw from the small employer market with the Department; and

14. Any additional information which the carrier believes is relevant for the Department to review the carrier's application for market withdrawal.

(d) The Department shall not begin its evaluation of an application for market withdrawal until the applicant has complied with the requirements contained in this section for its submission.

1. Within 45 days of receipt of an application for market withdrawal or a subsequent amendment thereto, filed pursuant to (c) above, the Department shall provide written notice to the carrier indicating that the filing is complete or incomplete. If the Department determines that the filing is incomplete, the Department's written notice shall identify the information that was not provided.

2. Following receipt of a complete application for market withdrawal filed pursuant to (c) above, the Department either shall approve or disapprove the application in writing within 60 days of the date of the Department's written notice to the carrier indicating that the filing is complete.

i. In determining whether to approve or disapprove a carrier's application for market withdrawal, the Department shall consider the following factors:

(1) Whether a sufficient number of carriers necessary to sustain a competitive market would continue to offer individual health benefits plans following the carrier's withdrawal;

(2) Whether the withdrawing carrier's policy or contractholders would be able to replace their health benefits plan with the same or similar plan offered by another carrier at a comparable rate;

(3) Whether the withdrawing carrier reported net paid losses in the preceding two-year period;

(4) Whether a carrier's anticipated losses in the current calendar year would jeopardize its financial solvency;

(5) Whether an affiliated carrier intends to continue to offer individual health benefits plans;

(6) Whether the withdrawing carrier intends to continue to offer health benefits plans in New Jersey, or in other states; and

(7) Any other factors deemed relevant and appropriate by the Commissioner.

3. The Commissioner shall approve an application for market withdrawal unless it is determined, based on the factors listed in (d)2i(1) through (7) above, that the carrier's withdrawal would be unjust, unfair, inequitable, or contrary to law or public policy.

i. If the Commissioner approves an application for market withdrawal, the Department shall notify the carrier in writing and the carrier shall proceed to institute a withdrawal pursuant to (e) below.

ii. If the Commissioner disapproves an application for market withdrawal, the Department shall provide, in writing, the reasons for the disapproval. A carrier may appeal the Commissioner's determination and request a hearing within 20 days of receipt of written notification of the Commissioner.

(e) A carrier that has received approval of its application for market withdrawal shall:

1. Not more than 60 days after the date of the Department's approval letter, cease issuing individual plans;

2. Not less than 180 days in advance of the effective date of the nonrenewal on the anniversary date of the policy or contract, mail a notice, in the same format and with the

same content submitted to and approved by the Department pursuant to (c)11 above, to every individual plan and pre-reform plan policy or contractholder, informing the policy or contractholder that the policy or contract will be nonrenewed on the anniversary date. This initial notice to each policy or contractholder shall include a copy of the Individual Health Coverage Buyer's Guide and current premium comparison chart. A carrier shall begin to send notices of nonrenewal not more than 60 days after the date of the Department's approval letter;

3. Following the mailing of the initial notice to each policy or contractholder, send a subsequent notice confirming the nonrenewal to each individual plan and pre-reform plan 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, at least 30 days prior to nonrenewal;

4. Not less than 180 days in advance of the effective date of the nonrenewal on the anniversary date of the policy or contract, mail a notice, in the same format and the same content submitted to and approved by the Department pursuant to (c)12 above, to the producer of record, if any, for each policy or contract; and

5. Not more than 10 days after receipt of the Department's approval letter, send a letter to the IHC Board at the address in N.J.A.C. 11:20-2.1, requesting to purchase copies of the IHC Program Buyer's Guide and price comparison chart and requesting a quantity sufficient to comply with the requirement that each policy or contractholder receive a copy of the Buyer's Guide and current premium comparison chart with the initial notice of nonrenewal. Alternatively, the carrier may arrange to obtain from the IHC Board a copy of the Buyer's Guide and price comparison chart to reproduce at its own cost a sufficient quantity of copies. Carriers shall not alter the text or format of the Buyer's Guide or premium comparison chart in any way.

11:20-18.6 General provisions for withdrawal of plan, plan option, or deductible/copayment option

(a) No carrier shall cease to issue or nonrenew an individual plan, plan option, or deductible/copayment option required or permitted to be offered by N.J.A.C. 11:20-3.1 until the carrier submits a notice of intent to withdraw a plan, plan option, or deductible/copayment option to the Department and the Commissioner approves such withdrawal in accordance with the provisions of this subchapter.

(b) A carrier may cease to issue and nonrenew an individual plan pursuant to this section only if:

1. The deductible/copayment option is not required to be offered pursuant to N.J.A.C. 11:20-3.1(b); or

2. In the case of a deductible/copayment option required to be offered pursuant to N.J.A.C. 11:20-3.1, the carrier meets its obligations to offer at least three standard individual plans and required deductible/copayment options either by offering the plans as indemnity plans or by making the plan or plans available through or in conjunction with a selective contracting arrangement to all New Jersey residents.

(c) A carrier may cease to issue and nonrenew a standard plan option pursuant to this section by offering another approved plan option. Examples of plan options include, but are not limited to, a carrier's option to offer autologous bone marrow transplant coverage in either the policy or contract or in a rider, and an HMO's option to offer plans subject to deductible and coinsurance provisions.

(d) A carrier that seeks to withdraw a plan, plan option, or deductible/copayment option pursuant to this section shall provide the Department with written notification of its intent to withdraw a plan, plan option, or deductible/copayment option. The notice of intent to withdraw a plan, plan option, or deductible/copayment option shall be sent to the Department at the address set forth in N.J.A.C. 11:20-6.4(a), and shall include the following information:

1. The name of the carrier;

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

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

4. A statement of the number of in force plans affected by the withdrawal;

5. Copies of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20-17;

6. Copies of a nonrenewal notice the applicant intends to send to its policy or contractholders. Nonrenewal notices for policy or contractholders shall contain the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option, or deductible/copayment option;

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

iii. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this subchapter;

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

v. 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

vi. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan, plan option, or deductible/ copayment option withdrawal; and

7. Copies of the proposed nonrenewal notices the applicant intends to send to its producers. Nonrenewal notices for producers shall contain the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option, or deductible/copayment option;

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

iii. A statement that the plan, plan option, or deductible/ copayment option is being nonrenewed under the authority of this subchapter;

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

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

vi. The date upon which the carrier will begin to cease to issue the plan, plan option, or deductible/copayment option.

(e) The Department shall review the notice of intent to withdraw a plan, plan option, or deductible/copayment option to determine whether it complies with the filing requirements of (d) above. The Department shall notify the carrier within 30 days of receipt of a notice of intent to withdraw a plan, plan option or deductible/copayment option, of any deficiencies and the requirements which are necessary to bring the notice into compliance with this section. The Department shall notify the carrier in writing that the withdrawal is either approved or disapproved.

(f) A carrier which has submitted a notice of intent to withdraw a plan, plan option, or deductible/copayment option shall:

1. Not more than 60 days following the Commissioner's approval of a plan, plan option, or deductible/copayment option withdrawal cease issuing the individual plan, plan option, or deductible/copayment option;

2. Not more than 60 days following the Commissioner's approval of a plan, plan option, or deductible/copayment option withdrawal, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option, or deductible/copayment option, mail a notice, in the same format submitted to the Department pursuant to (d)6 above, to every policy or contractholder, informing the policy or contractholder that the plan, plan option, or deductible/copayment option will be nonrenewed on the anniversary date;

3. Following the initial notice to each policy or contractholder, send a subsequent notice confirming 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; and

4. Not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan or plan option, or deductible/copayment option, mail a notice, in the same format submitted to the Department pursuant to (d)7 above, to the producer of record, if any, for each policy or contract.

11:20-18.7 Restrictions on writings

A carrier that ceases to do business pursuant to N.J.A.C. 11:20-18.5 shall be prohibited from writing new individual plans and new small employer plans in New Jersey for a period of five years beginning on the termination date of the last standard individual health benefits plan not renewed.

11:20-18.8 Election to offer at least three plans, effect on in force-plans

(a) A carrier issuing all of the standard individual plans in the IHC market on and before January 4, 2009 that elects to offer at least three but not all of the standard individual plans after January 4, 2009, as permitted by N.J.S.A. 17B:27A-4b, that has in-force business in the plan or plans that it elects to no longer offer may:

1. Withdraw the plan or plans it elects to no longer offer pursuant to N.J.A.C. 11:20-18.6;

2. Convert the in-force business in the plan or plans it no longer offers pursuant to N.J.A.C. 11:20-24.7; or

3. Make a one-time election to continue to renew the in-force business in the plan or plans it chooses to no longer offer; provided:

i. The carrier notifies the Department in writing on or before March 1, 2009 of the plan or plans for which it will renew in-force business but which it will no longer offer; and

ii. The carrier does not withdraw such plan or plans pursuant to N.J.A.C. 11:20-18.6 until such time as the rate cap for in-force individual business established at N.J.S.A. 17B:27A-3a expires.

11:20-18.9 Other policy or contractholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policy or contractholders concerning other obligations set forth in a policy or contract issued by a carrier.

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EXHIBIT E

CERTIFICATION OF COMPLIANCE WITH INDIVIDUAL HEALTH COVERAGE PLANS

In accordance with N.J.A.C. 11:20-3A.2, submit this form, upon entry into the market and by March 1 of every year, to the Department at Department of Banking and Insurance, Life & Health, IHC Certification of Compliance, 20 West State Street, P. O. Box 325, Trenton, New Jersey 08625. Carriers must complete the certification as set forth in this Exhibit; the words in the certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name:_____ NAIC #:_____

Respondent Information:

Name: _____ Title: _____

Address:_____ _____

_____ _____

Telephone:_____ FAX:_____ Email address: _____

2. COMPLIANCE

Check the appropriate response(s).

_____(a) Plans A/50, B, C, and D comply fully with the IHC Board's individual health benefits plans forms and Explanation of Brackets set forth at Exhibits A and C of the Appendix to N.J.A.C. 11:20.

_____(b) The HMO Plan complies fully with the IHC Board's individual health benefits plans form and Explanation of Brackets set forth at Exhibits B and C of the Appendix to N.J.A.C. 11:20.

3. PLAN OPTIONS AND VARIABLES

Complete each relevant section. Attach additional pages as necessary.

(a) Plans A/50 through D

On the attached worksheet for Plans A/50 through D, provide information regarding all of the plans carrier makes available using Plans A/50 through D. Add or delete rows under each plan designation, and provide all applicable information regarding each offering of each plan. Refer to N.J.A.C. 11:20-3.1 for information regarding permissible options.

Delivery System: Identify whether each plan is sold as Traditional Indemnity (Designate as Indem) or Preferred Provider Organization (Designate as PPO).

Copayment: For all plans that use a copayment, specify the applicable copayments for Physician Visits, Maternity, Specialist and Outpatient Surgery.

Deductible: List the available deductible options. Indemnity plans as well as PPO plans that use a common deductible should list that amount under the Indemnity/Common column. PPO plans that use separate deductible for network and non-network services should list such dollar amounts under the appropriate column headings

Coinsurance: List the available policyholder coinsurance options as specific percentages. Indemnity plans as well as PPO plans that use a common coinsurance should list that amount under the Indemnity/Common column. PPO plans that use separate coinsurance for network and non-network services should list such percentages under the appropriate column headings.

1. Do contracts provide for direct payment to health care practitioners without assignment? ☐ Yes ☐ No

2. Specify how coverage for autologous bone marrow transplants is offered.

☐ Plan benefit; or ☐ Rider benefit

(b) HMO Plans

On the attached worksheet for HMO Plans, provide information regarding all of the plans carrier makes available using the HMO plan. Add or delete rows under each plan type, and provide all applicable information regarding each offering of each plan. Refer to N.J.A.C. 11:20-3.1 for information regarding permissible options.

Copayment: Specify the applicable copayments for Physician Visits, Maternity, Specialist Visit and Outpatient Surgery.

Deductible: List the available deductible options as specific amounts.

Coinsurance: List the available policyholder coinsurance options as specific percentages.

1. Specify how coverage for autologous bone marrow transplants is offered.

☐ Plan benefit; or ☐ Rider benefit

4. CERTIFICATION

I, the undersigned, certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

_____

_____

Signature Title

_____

_____

Printed Name Date

Exhibit J
Loss Ratio Report Form
New Jersey Individual Health Coverage Program
For Calendar Year Ending December 31, _____

Carrier Name:	NAIC Number(s):
Carrier Address:	

	Complete and submit a separate Report Form for each affiliate and a Report Form combining all affiliates no later than August 15 annually to: New Jersey Department of Banking and Insurance, Life and Health Actuarial, P.O. Box 325, Trenton, NJ 08625. See N.J.A.C. 11:20-7 for further instructions. Please print clearly.		
A.	Net Earned Premium		$
B.	Total Losses Incurred (1. – 2. – 3. + 4. + 5.)		$
	1.	Claims paid during the preceding calendar year regardless of the year incurred	$
	2.	Residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding year	$
	3.	Claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year's loss ratio report	$
	4.	Claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year	$
	5.	Residual reserve for claims paid prior to January 1 of the reporting year, not paid as of June 30 of the reporting year	$
C.	Loss ratio (B÷A) (to 1 decimal place, for example, 81.3%)		
	If the loss ratio is less than 80%, complete D and E below, AND attach a refund plan that conforms with N.J.A.C. 11:20-7.5.		
D.	Amount entered on line A multiplied by .80 (A*.80)		
E.	Refund amount to policy or contractholders (line D minus line B).		$

I certify that the above information is accurate and complete, and has been prepared in accordance with N.J.S.A. 17B:27A-9e(1) and (2) and N.J.A.C. 11:20-7.

Actuary's Signature:	Date:
Printed Name:	Title:
Phone No:	Fax No:
Email:	