projected to be approximately $15.7 million for general acute care and specialty heart hospitals (note—there were 71 total, but now 70 due to the closure of St. Francis Medical Center), and another approximately $223,000 for rehabilitation and long-term care acute hospitals (note—there are 28 total). The assessment amounts vary considerably from hospital to hospital as it is based on volume, so the Department cannot meaningfully provide an average cost to an individual hospital. As this assessment is specific to hospitals and does directly correlate to patient care, the Department does not anticipate that patients of these facilities would be affected in any way or realize an economic impact. The Department would incur administrative costs to administer and enforce the collection of the assessment and the receipt and review of reports.

Federal Standards Statement

There are no Federal standards applicable to the proposed amendments. The Department is not proposing the amendments pursuant to the authority of, or to implement, comply with, or participate in a program established pursuant to, Federal law or a State law that incorporates or refers to a Federal law, standard, or requirement. The Department proposes the amendment pursuant to N.J.S.A. 26:2H-18.57, as modified by the 2018 amendment. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not expect that the proposed amendment would result in the creation or loss of jobs in the State of New Jersey.

Agriculture Industry Impact

The proposed amendment would have no impact on the agriculture industry of the State of New Jersey.

Regulatory Flexibility Statement

The proposed amendment would establish requirements that only apply to hospitals, none of which is a "small business" within the meaning of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, the proposed amendment would impose no requirements on small businesses, and no regulatory flexibility analysis is necessary.

Housing Affordability Impact Analysis

The proposed amendment would have no impact on the affordability of housing in New Jersey and would not evoke a change in the average costs associated with housing because the proposed amendment would only address the adjusted admission assessment for hospitals and would not affect housing costs.

Smart Growth Development Impact Analysis

The proposed amendment would have no impact on the achievement of smart growth and would not evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, pursuant to the State Development and Redevelopment Plan in New Jersey because the proposed amendment would only address the adjusted admission assessment for hospitals and would not affect housing development.

Racial and Ethnic Community Criminal and Public Safety Impact

The Department has evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 3. FINANCIAL MONITORING AND REPORTING

8:31B-3.66 Adjusted admission assessment

(a) [A] **The Department annually shall assess each general and specialty heart hospital a** charge of $10.00 per adjusted admission[, as defined by the American Hospital Association, for each adjusted admission] in the most recent complete calendar year [shall be assessed annually] on a [calendar year] **calendar-year** basis [for each general hospital and each specialty heart hospital].

[(b) An adjusted admission, as defined by the American Hospital Association, means admissions multiplied by total gross revenue divided by inpatient gross revenue.]

1. Effective July 1, 2018, the Department annually shall assess each rehabilitation and long-term acute care hospital a charge of $10.00 per adjusted admission in the most recent complete calendar year on a calendar-year basis.

[(c)] **(b)** [In the event that] **If** a **general hospital or specialty heart** hospital[, which fails to] **does not** submit the most recent Acute Care Hospital Cost Report**, as defined at N.J.A.C. 8:31B-4.131, by the** due [on] **date of** June 30 of each year, **pursuant to N.J.A.C. 8:31B-4.6**, [has not submitted that report] **and** prior to the Department's calculation of the assessment for the following year, the Department shall use the hospital's most recent assessment, increased by 15 percent, for the calculation of the following year's assessment.

(c) Effective July 1, 2018, each rehabilitation and long-term acute care hospital, on an annual basis, shall submit revenue and admissions data using the Admissions and Revenue Report Form (known as the "ARR Form"), by July 31 of each year.

1. N.J.A.C. 8:31B-4.16, 4.64, and 4.65 identify the required revenue and admissions financial elements data that rehabilitation and long-term acute care hospitals are to report by means of the ARR, which are total admissions, skilled nursing facility (SNF) admissions, other admissions, inpatient revenue, outpatient revenue, SNF revenue, mobile intensive care unit (MICU) revenue, and services not related to patient care (SNRPC) revenue.

2. The ARR Form and instructions are available on the Department's website at https://www.nj.gov/health/forms.

(d) If a rehabilitation or long-term acute care hospital does not submit the information required pursuant to (c) above by the due date of July 31 of each year and prior to the Department's calculation of the assessment for the following year, the Department shall use the hospital's most recent assessment, increased by 15 percent, for the calculation of the following year's assessment.

(e) For purposes of annual data submission required pursuant to this section, all hospitals shall submit the revenue and admissions data using one of the following methods, in the following order of preference:

1. Using the Department's approved web-based portal, which is available on the Department's website at: https://www.nj.gov/health/hcf/financial-reports/index.shtml.

2. By electronic mail (email) to gmesa@doh.nj.gov.

3. By regular mail to:

Hospital Financial Reporting Unit
Office of Health Care Financing
NJ Department of Health
55 North Willow Street, 5th Floor
PO Box 360
Trenton, NJ 08625-0360

4. By hand-delivery or overnight delivery service to:

Hospital Financial Reporting Unit
Office of Health Care Financing
NJ Department of Health
55 North Willow Street, 5th Floor
Trenton, NJ 08608

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Psychological Services

Proposed Amendments: N.J.A.C. 10:67-1.2, 1.3, and 3

Proposed Repeal: N.J.A.C. 10:67-2.3

Authorized By: Sarah Adelman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.
Agency Control Number: 23-P-01.
Proposal Number: PRN 2023-047.

Submit comments by August 4, 2023, to:

Margaret M. Rose
Attn: 23-P-01
Division of Medical Assistance and Health Services
PO Box 712
Mail Code #26
Trenton, NJ 08625-0712
Fax: (609) 588-7343
Email: Margaret.Rose@dhs.nj.gov
Delivery: 6 Quakerbridge Plaza
Mercerville, NJ 08619

The agency proposal follows:

Summary

The Department of Human Services ("Department" or "DHS") is proposing amendments at N.J.A.C. 10:67, Psychological Services. These proposed amendments include codifying the requirement that the providers obtain a Federally required National Provider Identifier (NPI) and valid taxonomy code for their provider type and updating the list of Healthcare Common Procedure Code System (HCPCS) procedure codes, their descriptions, and maximum fee amounts. Providers were notified of the Federal requirement to obtain an NPI and taxonomy code through the Division of Medical Assistance and Health Services (DMAHS) Newsletter Volume 16, Number 18, in December 2006. The proposed amendments update the rules to memorialize this change. The Centers for Medicare and Medicaid Services (CMS) update the list of procedure codes in the HCPCS annually and the Department is proposing the amendments to be consistent with the most recent updates provided. The codes are also available on the website of the DMAHS' fiscal agent and all providers have access to that site.

The Department is proposing the repeal of N.J.A.C. 10:67-2.3, which addressed prior authorization requirements for psychological services, since prior authorization for psychological services is no longer required. The purpose of this repeal is to memorialize a change made with the approval of two State Plan Amendments (SPAs) that were done to ensure mental health parity and comply with the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Department filed two State Plan Amendments pursuant to Title XIX (Medicaid) and XXI (NJ FamilyCare) that were ultimately approved by the CMS. Title XIX SPA has an effective date of July 1, 2016, and Title XXI SPA has an effective date of July 1, 2018.

At N.J.A.C. 10:67-1.2, the following terms are being defined as they are used in this chapter: "face-to-face," "National Provider Identifier (NPI)," "National Plan and Provider Enumerations System (NPPES)," "taxonomy code," "type 1 NPI," and "type 2 NPI." At N.J.A.C. 10:67-1.2, the term "psychological specialist" is being amended to indicate that the term shall also apply to a psychologist who is eligible for admissibility to the examination by the American Board of Professional Psychology. This clarification is intended to ensure that the Medicaid/NJ FamilyCare fiscal agent properly assigns the specialty code to the provider to ensure appropriate billing is possible.

Proposed N.J.A.C. 10:67-1.3(d) and (e) list new requirements for participation in the Medicaid/NJ FamilyCare program. These include obtaining an NPI from the NNPPES, having a valid taxonomy code from the NPPES, and remaining in good standing as a Medicaid/NJ FamilyCare provider by completing a provider revalidation application, when requested.

N.J.A.C. 10:67-2.3 is proposed for repeal because prior authorization has been removed for all primary level mental health services to comply with the MHPAEA, as discussed above.

At N.J.A.C. 10:67-3.1(c), a proposed amendment changes the reference of HCPCS as a three-level system to read two-level system to accurately describe the program since Level III HCPCS codes are no longer recognized by CMS.

At N.J.A.C. 10:67-3.1(d), a proposed amendment adds the modifier "HA" to the list of modifiers. The use of this modifier with eligible psychological services HCPCS codes indicates that the service was rendered in a child or adolescent treatment program.

The CMS updates the list of procedure codes in the HCPCS annually and the Department is proposing the following changes to the list of HCPCS at N.J.A.C. 10:67-3.2 to be consistent with the most recent updates provided. At N.J.A.C. 10:67-3.2, the following HCPCS procedure codes and their corresponding reimbursement amounts are proposed to be added: 90791, 90832, 90833, 90834, 90836, 90837, 90838, 90839, and 90846 HA 22. At N.J.A.C. 10:67-3.2, the following HCPCS procedure codes and their corresponding reimbursement amounts are proposed to be deleted: 90801, 90804, 90806, 96100, 96111, 96115, and 96117. At N.J.A.C. 10:67-3.2, the HCPCS procedure codes listed below are having their reimbursement amounts adjusted to reflect the current maximum reimbursement amount provided by the Medicaid/NJ FamilyCare program when provided by a specialist or non-specialist.

HCPCS Code	Current Amount	Proposed Amount
90847	$37.00 (specialist)	$113.94 (specialist)
90853	$8.00 (specialist)	$27.50 (specialist)
90887	$19.00 (specialist)	$22.91 (specialist)
96153	$5.00 (specialist)	$3.68 (specialist)
	$4.00 (non-specialist)	$3.13 (non-specialist)

At N.J.A.C. 10:67-3.3, the HCPCS procedure codes 90801, 90804, and 90806, are being deleted to reflect their deletion from N.J.A.C. 10:67-3.2 and replaced, respectively, with HCPCS procedure codes 90791, 90832, and 90834, which are the codes that are now used to bill for those specific services. The qualifiers associated with the provision of the services have not changed.

At N.J.A.C. 10:67-3.3, proposed amendments to the qualifier for HCPCS code 90853 clarify that the therapy session shall be 60-90 minutes long and that a minimum 60-minute face-to-face contact with the group members is required for the code to be eligible to be reimbursed.

At N.J.A.C. 10:67-3.3, the HCPCS procedure codes 96100, 96111, 96115, and 96117, are being deleted to reflect their deletion from N.J.A.C. 10:67-3.2.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement, pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

During State Fiscal Year 2020, approximately 1,743 fee-for-service beneficiaries received psychological services each month from 180 participating providers.

The proposed amendments and repeal will have a positive social impact on Medicaid/NJ FamilyCare fee-for-service beneficiaries who require psychological services since access to these services will be more efficient with the removal of the prior authorization requirement and it is anticipated that access to psychological services will improve the quality of life for those beneficiaries who need them who otherwise may not have been able to access services.

Economic Impact

The total expenditures (State and Federal share combined) for State Fiscal Year 2020 totaled $4,415,100. There is no anticipated significant change in the volume or cost of services provided.

The adjustment of maximum fee allowances are normal components of Medicaid/NJ FamilyCare coverage and the proposed amendments and repeal are not expected to generate a significant increase or decrease in the reimbursements paid to the providers. The proposed amendments updating the list of the HCPCS codes and their reimbursement amounts will have a minimal economic effect on the budget of the Division of Medical Assistance and Health Services within the New Jersey Department of Human Services. The HCPCS codes are proposed to be revised to ensure that the codes for covered Medicaid/NJ FamilyCare services are consistent with the annual amendments to the national HCPCS coding system made by the Centers for Medicare and Medicaid Services.

The proposed amendments and repeal will have no economic impact on Medicaid/NJ FamilyCare fee-for-service beneficiaries because there is no cost to those beneficiaries for medically necessary psychological

services other than any previously established copayments or premiums of the Medicaid/NJ FamilyCare program and these proposed amendments do not change those requirements.

The proposed amendments and repeal will have a positive economic impact on providers of Medicaid/NJ FamilyCare psychological services because they will continue to be reimbursed for providing medically necessary Medicaid and NJ FamilyCare psychological services to Medicaid and NJ FamilyCare fee-for-service beneficiaries. The amended reimbursement amounts for services are consistent with the usual and customary reimbursement amounts that providers receive for these services. The amendments to reimbursement amounts may cause increases and/or decreases in actual revenue for specific providers; however, these will be dependent upon the volume of services provided and the number of claims filed and are not expected to be significant.

Federal Standards Statement

Section 1902(a)(10) of the Social Security Act, 42 U.S.C. § 1396a(a)(10), regulates program eligibility including the amount, duration, and scope of benefits. Section 1905(a)(6) of the Social Security Act, 42 U.S.C. § 1396d(a)(6), governs reimbursement pursuant to State medical assistance programs for remedial care recognized pursuant to State law which is furnished by licensed practitioners within the scope of their practice, as defined by State law. Federal regulations at 42 CFR 440.60(a) provide that remedial services rendered to a beneficiary by a licensed practitioner, practicing within the scope defined by State law, are reimbursable.

Title XXI of the Social Security Act allows states to establish a children's health insurance program for targeted low-income children. New Jersey elected this option through implementation of the NJ FamilyCare Children's Program. Section 2103, 42 U.S.C. § 1397cc, provides broad coverage guidelines for the program. Section 2103(c)(5), specifically requires mental health and substance abuse services for children.

Regulations at 42 CFR 162.404 through 4.14 require the use of a standard unique health identifier for health care providers, the National Provider Identifier (NPI).

The Department has reviewed the applicable Federal laws and regulations and that review indicates that the proposed amendments and repeal do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not anticipate that the proposed amendments and repeal will result in the creation or loss of jobs in the State of New Jersey.

Agriculture Industry Impact

As the proposed amendments and repeal concern the provision of fee-for-service psychological services to eligible Medicaid/NJ FamilyCare beneficiaries, the Department anticipates that the proposed rulemaking will have no impact on the agriculture industry in the State of New Jersey.

Regulatory Flexibility Analysis

The proposed amendments will affect those providers who provide psychological services on a fee-for-service basis to beneficiaries residing in the community. Most of these providers may be considered small businesses, as the term is defined by the Regulatory Flexibility Act at N.J.S.A. 52:14B-17 et seq., because they employ fewer than 100 full-time employees.

The proposed amendments impose no new reporting, recordkeeping, or compliance requirements on providers of psychological services with regard to patient records. The existing rules require that providers must maintain, and make available upon request, supporting documentation regarding the services provided. Providers must also use the HCPCS procedure codes contained in this chapter when requesting reimbursement. The documentation requirements and the requirement to use the HCPCS procedure codes for billing purposes are the same as those imposed by other service payers; therefore, psychological services providers would maintain these records and use these codes as a normal part of doing business. The Department has attempted to minimize any adverse economic impact on small businesses by requiring only that amount of recordkeeping, compliance, and reporting requirements necessary to ensure the safety of the beneficiaries and to protect the Medicaid/NJ FamilyCare programs from fraud. Providers are already required to maintain records to fully disclose the name of the beneficiary who received the service, date of service, and any additional information as may be required at N.J.A.C. 10:49 and N.J.S.A. 30:4D-1 et seq.

Additional proposed amendments also require the providers to obtain a Type 2 NPI and taxonomy code from the National Plan and Provider Enumeration System. The use of these nationally recognized identifying numbers will not increase the administrative burden on the providers because all health care providers and all health plans and health care clearinghouses must use NPIs in their administrative and financial transactions. As they were introduced as the national standard in 2004, the providers are already accustomed to using them on claims.

The requirements in the proposed amendments and repeal must be equally applicable to all providers, regardless of business size, because all providers must utilize the same billing procedures. Providers cannot be excused from the requirements in this chapter because a uniform quality of care must be provided to all beneficiaries, and because the Department must ensure that all reimbursements made conform to New Jersey statute and to applicable Federal laws and regulations.

The amendments update the rules and add new HCPCS codes used in the reimbursement process. The proposed amendments and repeal require no new capital costs, annual compliance costs, or professional services.

Housing Affordability Impact Analysis

As the proposed amendments and repeal concern the provision of fee-for-service psychological services to eligible Medicaid/NJ FamilyCare beneficiaries, the Department anticipates that the proposed rulemaking will have no impact on the affordability of housing, nor will it have an impact on average costs associated with housing.

Smart Growth Development Impact Analysis

As the proposed amendments and repeal concern the provision of fee-for-service psychological services to eligible Medicaid/NJ FamilyCare beneficiaries, the proposed amendments and repeal will have no impact on housing production within Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan and will have no impact on smart growth.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the rule proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:67-2.3.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. INTRODUCTION

10:67-1.2 Definitions

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

. . .

"Face-to-face" means direct contact between the provider and the patient during a treatment session, this shall include a telehealth visit.

"National Plan and Provider Enumerations System (NPPES)" means the system that assigns NPIs, maintains and updates information about health care providers with NPIs, and disseminates the NPI Registry and the NPPES Downloadable File. The NPI Registry is an online query system that allows users to search for a health care provider's information.

"National Provider Identifier (NPI)" means a unique 10-digit identification number issued to health care providers by the Centers for Medicare and Medicaid Services (CMS).

. . .

"Psychological specialist" means a psychologist who limits his or her practice to his or her specialty and who:

1. (No change.)

2. [Has] **Is eligible for or has** been notified of admissibility to the examination by the American Board of Professional Psychology (Diplomate Eligible).

. . .

"Taxonomy code" means a code that describes the provider or organization's type, classification, and the area of specialization.

"Type 1 NPI" means a code that describes an individual provider in the NPPES system.

"Type 2 NPI" means a code that describes an organizational provider in the NPPES system.

10:67-1.3 Conditions of participation

(a)-(c) (No change.)

(d) In order to be approved as a Medicaid/NJ FamilyCare-participating provider, the applicant shall have a valid National Provider Identifier (NPI) obtained from the National Plan and Provider Enumeration System (NPPES) and a valid taxonomy code for "psychologist" or "psychologist specialist" obtained from the NPPES.

(e) Once approved as a Medicaid/NJ FamilyCare provider, the provider shall remain a provider in good standing by successfully completing provider revalidation when requested by DMAHS.

SUBCHAPTER 2. GENERAL PROVISIONS

10:67-2.3 (Reserved)

SUBCHAPTER 3. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODE AND MAXIMUM FEE SCHEDULE FOR PSYCHOLOGICAL SERVICES

10:67-3.1 Introduction

(a)-(b) (No change.)

(c) The psychological services use exclusively Level I HCPCS codes of a [three-level] **two-level** coding system, as follows:

1. (No change.)

(d) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for psychologist services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," "FOLLOW-UP DAYS**,**" and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below:

1. Alphabetic and numeric symbols under "IND" and "MOD": These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. (No change.)

ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.

IND (No change.)

. . .

MOD = (No change.)

"22" = (No change.)

HA = Services provided in child and/or adolescent treatment program.

(e) (No change.)

10:67-3.2 HCPCS Codes and reimbursement rates for psychological services (Level I)

IND	HCPCS Code	MOD	Maximum Fee Allowance $ S	$ NS
[N	90801		$37.00	$26.00
N	90804		$19.00	$13.00
N	90806		$37.00	$26.00]
N	**90791**		**$167.21**	**$142.13**
N	**90832**		**$68.21**	**$28.83**
N	**90833**		**$70.33**	**$29.69**
N	**90834**		**$90.26**	**$37.83**
N	**90836**		**$88.79**	**$37.12**
N	**90837**		**$90.26**	**$36.73**
N	**90838**		**$89.04**	**$36.73**
N	**90839**			**$92.82**
N	**90846**	**HA 22**		**$24.50**
N	90847		[$37.00] **$113.94**	$26.00
. . .				
N	90853		[$8.00] **$27.50**	$ 6.00
N	90887		[$19.00] **$22.91**	$13.00
[N	96100		$37.00	$26.00]
. . .				
[N	96111		$37.00	$26.00
N	96115		$37.00	$26.00
N	96117		$37.00	$26.00]
. . .				
N	96153		[$5.00] **$3.68**	[$4.00] **$3.13**

. . .

10:67-3.3 HCPCS Code qualifiers for psychological services

Code	Narrative
[90801] **90791**	Initial Comprehensive Psychiatric Evaluation QUALIFIER: A Medicaid/NJ FamilyCare provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires, for reimbursement purposes, a minimum of 50 minutes of face-to-face contact with the patient or family member.
[90804] **90832**	Individual Psychotherapy—approximately 20 to 30 minutes face-to-face with the patient QUALIFIER: This code requires, for reimbursement purposes, a minimum of 20 minutes of face-to-face contact with the patient or family member.
[90806] **90834**	Individual Psychotherapy—approximately 45 to 50 minutes face-to-face with the patient QUALIFIER: This code requires, for reimbursement purposes, a minimum of 45 minutes of face-to-face contact with the patient or family member.
. . .	
90853	Group psychotherapy by a psychologist (other than of a multiple family group) **60-90 minutes** QUALIFIER: A Medicaid/NJ FamilyCare provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires, for reimbursement purposes, a minimum of [90] **60** minutes **of face-to-face contact with the group members** per session. One unit equals [90] **60** minutes for each person in the group with the maximum of eight persons in the group.
. . .	
[96100	Psychological testing with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.]

Code	Narrative
. . .	
[96111	Extended developmental testing with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.
96115	Neurobehavioral status exam with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring
96117	Neuropsychological testing battery with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.]
. . .	

INSURANCE

(a)

DEPARTMENT OF BANKING AND INSURANCE OFFICE OF SOLVENCY REGULATION

Insurance Holding Company Systems Proposed Amendment: N.J.A.C. 11:1-35.13 Proposed New Rule: N.J.A.C. 11:1-35.14

Authorized By: Marlene Caride, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, and 17:27A-3.k.

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

Proposal Number: PRN 2023-041.

Submit comments by August 4, 2023, to:

Denise M. Illes, Chief
Office of Regulatory Affairs
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
Email: legsregs@dobi.nj.gov

The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) proposes an amendment and a new rule at N.J.A.C. 11:1-35.14, to the insurance holding company systems rules, to reflect amendments to the National Association of Insurance Commissioners (NAIC) model regulation. The proposed amendment and new rule align New Jersey law with the national standard to ensure effective regulatory oversight of insurance holding company systems and the maintenance of New Jersey's NAIC accreditation status.

On December 9, 2020, the NAIC adopted revisions to the Insurance Holding Company System Regulatory Model Act #440 (Model Act) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions #450 (Model Regulation). These revisions implemented the Group Capital Calculation (GCC) for the purpose of group solvency supervision and the Liquidity Stress Test (LST) to enhance macroprudential surveillance. The inclusion of the GCC is additionally intended to comply with the covered agreements entered into by the United States and the European Union (E.U.) and the United Kingdom (U.K.). The NAIC has proposed adding the 2020 amendments to the Model Act and Model Regulation to the requirements for states to maintain accredited status in the NAIC Accreditation Program (Accreditation), effective January 1, 2026.

A covered agreement is a bilateral or multilateral agreement entered into between the United States and one or more foreign governments on prudential measures with respect to the business of insurance or reinsurance that achieves a level of protection for consumers that is "substantially equivalent" to the level of protection pursuant to state law. On September 22, 2017, and December 19, 2018, the United States entered into covered agreements with the E.U. (E.U. Covered Agreement) and the U.K., respectively (collectively, Covered Agreements). The Covered Agreements require that states have a "worldwide group capital calculation" in place to avoid the imposition of a group capital assessment or requirement at the level of the worldwide parent undertaking by the E.U. or U.K. Pursuant to the terms of the E.U. Covered Agreement, this calculation must be in place by November 7, 2022, to avoid the potential for imposition of E.U. capital requirements on U.S. insurers within an insurance group that operates in the E.U.

P.L. 2021, c. 366, which was approved on January 10, 2022, amends N.J.S.A. 17:27A-1 et seq., to reflect the 2020 amendments to the Model Act. Specifically, the legislative amendments add the GCC and LST to enterprise risk filings, and set forth filing requirements, at N.J.S.A. 17:27A-3.k(2) and (3). The legislative amendments also establish exemptions from filing the GCC for insurance holding company systems that meet certain criteria.

The amendment and new rule proposed in this rulemaking implement P.L. 2021, c. 366, and track the 2020 amendments to the Model Regulation to ensure consistency with the national standard and compliance with the requirements of the Covered Agreements.

A summary of the proposed amendment and new rule follows:

The Department proposes to amend N.J.A.C. 11:1-35.13 to revise the cross-reference from "N.J.S.A. 17:27A-3.k" to "N.J.S.A. 17:27A-3.k(1)," to reflect the new citation, as recodified at P.L. 2021, c. 366.

The Department proposes new N.J.A.C. 11:1-35.14 that tracks the NAIC's 2020 amendments to the Model Regulation. Proposed new N.J.A.C. 11:1-35.14 outlines the criteria for GCC filing exemptions and eligibility for the submission of a limited filing. The proposed new rule further sets forth special filing requirements for insurance holding companies that previously met an exemption or limited filing under certain circumstances. Additionally, the proposed new rule sets forth the criteria for non-U.S. jurisdictions to be considered to "recognize and accept" the GCC; and outlines the process for the publication, through the NAIC Committee Process, of a list of such jurisdictions.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

The proposed amendment and new rule implement P.L. 2021, c. 366, and reflect the national standard as adopted by the NAIC regarding insurance group solvency supervision. The proposed changes are strongly recommended by the NAIC and will eventually become necessary to maintain New Jersey's Accreditation status. Further, this rulemaking ensures conformity with the Covered Agreements, to avoid the imposition of foreign supervisory measures on U.S. insurers in a group with operations in the E.U. or U.K. The NAIC has recommended the 2020 amendments to the Model Act and Model Regulation be included as an Accreditation requirement effective January 1, 2026, however, it strongly recommends all states with an insurance group impacted by the Covered Agreements adopt the amendments effective November 7, 2022. The failure of any state to do so for any U.S. group operating in the E.U. potentially subjects all U.S. insurers in that group to the imposition of foreign group capital requirements.

This rulemaking incorporates the GCC into the regulatory framework, which will enhance transparency, allowing the Department to more easily identify and quantify risks emanating from a holding company system. The GCC was designed to address the lack of a consistent analytical framework to evaluate information regarding the capital positions of non-