INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Individual Health Benefits Plans

Proposed Amendments: N.J.A.C. 11:20-1, 3, 12, 22 and 24 and N.J.A.C. 11:20 Appendix Exhibits A, B and C

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

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

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

Proposal Number: PRN 2013-____.

As required by N.J.S.A. 17B:27A-16.1, interested parties may testify with respect to the standard health benefits plans set forth in Exhibits A, B and C of the Appendix to N.J.A.C. 11:20, at a **public hearing** to be held at 9:30 A.M. on September 24, 2013 at the New Jersey Department of Banking and Insurance, 11th floor Conference Room, 20 West State Street, Trenton, New Jersey.

Submit comments by September 30, 2013 to:

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The agency proposal follows:

Summary

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

The IHC Board proposes amendments to the regulations including the standard plans to comply with the requirements of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (collectively, PPACA). The requirements of PPACA necessitate amendments to definitions, the purchase of coverage and replacement of coverage, eligibility and effective date rules as well as rules governing the use of the standard health benefits plans and the basic and essential health care services plan. These regulations are found in N.J.A.C. 11:20-1, 3, 12, 22 and 24. The text for standard plans A/50, B, C and D is set forth in Appendix Exhibit A and the text for the standard HMO plan is set forth in Appendix Exhibit B. The Explanation of Brackets for the standard plans is set forth in Appendix Exhibit C. The IHC Board previously proposed and adopted amendments to the standard plans to comply with various provisions of PPACA that were effective in September 2010 and August 2012. At this time the IHC Board proposes

amendments to comply with the requirements of PPACA that will be effective for policies issued on or after January 1, 2014. It is the specific and overarching intention of the Board that the standard plans that are the subject of this proposal fully comply with the requirements imposed and the standards established by the PPACA for health insurance policies issued to individuals. It is also the specific intention of the Board that the standard plans shall include content that will reconcile any conflicts between current New Jersey law and the PPACA in a manner which will render the standard plans consistent with the PPACA, and provide for the most practical means by which to implement its provisions. Since the Board approved the proposal of the standard plans, federal Health and Human Services (HHS) and various agencies within have made numerous pronouncements through rulemaking, bulletins question and answer documents and the like on the correct construction and interpretation of certain provisions in the PPACA that relate to several of the amendments being proposed. The Board's analysis of those pronouncements is ongoing. However, because the ability to apply for individual policies through the insurance marketplaces to be established in accordance with the PPACA will commence on October 1, 2013, the Board has determined to proceed with the proposal of the standard plans at this time. Upon concluding its analysis of the various federal pronouncements on the PPACA and, after considering any comments submitted on this proposal, the Board will make appropriate changes upon adoption, in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1, et seq. and N.J.A.C. 1:30-3.6(c), so as to have the adopted forms fulfill its intentions as set forth above. The statements below that refer to the requirements of and standards established by the PPACA with respect to the standard plans reflect the Board's understanding of its provisions that pertain to the proposed amendments at the time of the Board's approval of this proposal for publication. The IHC Board takes this opportunity to

propose some additional amendments designed to give both carriers and consumers more options in terms of plan design as well as affordability.

PPACA-Related Changes to Chapter 20

The Board proposes amendments to N.J.A.C. 11:20-1.2, which is the Definitions section for the chapter.

In order to provide for the operation of the individual health coverage market as required by PPACA the Board proposes the addition of the following defined terms:

"Annual open enrollment period," which carriers are required to provide for all individual health benefits plans pursuant to 45 C.F.R. 147.104(b)(1)(ii), in accordance with the timeframe for the period set forth at 45 C.F.R. 155.410(e)). The Board proposes adding a definition consistent with these laws.

"Catastrophic plan," which carriers may offer consistent with 42 U.S.C. 18022(e). The specifications for the catastrophic plan, including limitations with respect to who may purchase the plan, are set forth in 45 C.F.R. 156.155. The Board proposes adding a definition that identifies such plan and refers to the federal regulation for the requirements associated with the plan.

"Essential health benefits," which, in accordance with 42 U.S.C. 300gg-6, carriers are required to offer in all health benefit plans. 42 U.S.C 18022(a) and 45 C.F.R. 156.110 specify the list of essential health benefits. The Board proposes adding a definition that introduces the term and refers to the federal requirements.

"Initial enrollment period," which carriers are required to comply with pursuant to 45 C.F.R. 147.104(b)(1)(ii)and further specifications found in 45 C.F.R. 155.410(b). The Board proposes adding a definition consistent with these laws.

"Marketplace," which is the term that is being used by the federal government when referring to a federally-facilitated exchange. Recognizing that marketplace is the term that will be most familiar to regulated community, the Board proposes to define marketplace to mean the exchange as defined in 45 C.F.R. 155.20.

"Minimum essential coverage," which is defined at 26 U.S.C. 5000A(f), and is the level of health coverage that individuals are required to maintain under federal law. Since loss of minimum essential coverage gives rise to an opportunity for a special enrollment period in individual health benefits plans, the Board proposes to include the definition of minimum essential coverage.

"Qualified health plan," describes the status of the coverage offered through the marketplace (plans offered outside of the marketplace may or may not also be qualified health plans, depending upon how the carrier chooses to structure its plan offerings). Since enrollment status in a qualified health plan is one of the events that gives rise to an opportunity for a special enrollment period the Board proposes to include the definition of qualified health plan from 45 C.F.R. 156.200.

"Special enrollment period," which carriers are required to provide for enrollment in all individual health benefits plans in accordance with 45 C.F.R. 147.104(b)(1)(ii), following the occurrence of specified triggering events. The Board proposes adding a definition consistent with such requirement.

"Standard health benefit plan with rider," which the Board proposes adding to better identify the plans an individual might purchase during the initial enrollment period, annual open enrollment period or special enrollment period.

"Subsidy," which the Board proposes to use to refer to both advanced premium tax credits and cost sharing reductions available to income-eligible individuals (and/or members of Indian tribes) in accordance with Sections 1402 and 1412 of PPACA (42 U.S.C. 18071 and 18082, respectively) and the details of 26 C.F.R. 1.36B and 45 C.F.R. 156.410, respectively. Loss of eligibility for a subsidy gives rise to a special enrollment period, as set forth at 45 C.F.R. 155.420(d).

"Triggering event," is the term used to describe what events give rise to a special enrollment period, as set forth at 45 C.F.R. 155.420 (d).

In order to provide for the operation of the individual health coverage market in a manner that is consistent with the provisions of PPACA and for other reasons as discussed below, the Board proposes to amend the definitions of following terms:

"Dependent," to which the Board proposes specifically adding foster child to assure consistency with 45 C.F.R. 155.420(d)(2). The additional revisions proposed by the Board to the definition of "dependent" regarding adopted children, and children with whom the eligible person has a legal or blood relationship, are intended to conform to the definition in the rules with the definition set forth in the standard health benefit plans at Appendix Exhibits A and B

"Eligible person," in order to harmonize the rules inside and outside of the marketplace to the extent possible. Currently, individuals who are eligible for group coverage in New Jersey are not eligible to purchase individual coverage as a general rule. However, the requirements of N.J.S.A. 17B:27A-3d and N.J.A.C. 11:20-12.5 result in the opportunity for persons who are eligible for coverage under a group, church or governmental plan to purchase individual coverage during the Board-specified November open enrollment period notwithstanding the definition of eligible person at N.J.S.A. 17B:27A-2. Recognizing that N.J.S.A. 17B:27A-3d and

N.J.A.C. 11:20-12.5 have already allowed persons who are eligible for group, church or governmental coverage the opportunity to enroll in individual coverage, and that the federal eligibility standard at 45 C.F.R. 155.305 will not preclude a person eligible for coverage under a group, church or governmental plan from purchasing individual coverage through the marketplace, the Board proposes to amend the Board's definition of eligible person to remove the stipulation that the person must not be eligible to be covered under a group health benefits plan, group health plan, governmental plan or church plan. The definition, as amended, will conform to the federal eligibility standard.

Enrollment date. The Board proposes to amend this definition to delete separate rule governing a federally defined eligible individual. As discussed below, the term federally defined eligible individual is proposed for deletion.

"Modified community rated," in order to reflect the variations permitted for age as specified in 45 C.F.R. 147.102(a) and to remove the family rating structure as required by 45 C.F.R. 147.102(c).

"Open enrollment," in order to align the periods during which coverage must be guaranteed with the requirements of 45 C.F.R. 147.104(b)(1)(ii). The Board notes that such alignment is necessary to mitigate against adverse selection with respect to coverage issued off the marketplace. Additionally, the Board believes that consistency between the marketplace and off the marketplace in terms of open enrollment periods will avoid confusion.

"Pre-existing condition," to clarify that this term applies only to plans issued or renewed prior to January 1, 2014, as required by 42 U.S.C. 300gg-3 and 45 C.F.R. 147.108.

The Board proposes deletion of terms and their definitions that the Board considers to be no longer necessary, as follows:

"Church plan," which is part of the existing (limiting provisions) in the definition of eligible person, but because the proposed definition of eligible person would eliminate use of the term church plan, it is no longer necessary to define the term.

"Family Unit," which currently clarifies the family structures permitted for purposes of rating standard individual health benefits plans. Since 45 C.F.R. 147.102(c) prohibits rating by family structure for individual plans offered for 2014 and thereafter, the term family unit and its definition will no longer be necessary.

"Federally defined eligible individual," which arose because of different treatment of credits for prior coverage and their application against preexisting conditions exclusion periods between state and federal law (in this case, the federal Health Insurance Portability and Accountability Act of 1996). The distinction between an eligible individual and a federally defined eligible individual is eliminated with the prohibition of pre-existing condition exclusions by 42 U.S.C. 300gg-3.

"Governmental plan," which is part of the existing (limiting provisions) in definition of eligible person. The proposed amendment to the definition of eligible person eliminates use of the term governmental plan and therefore it is no longer necessary to define the term.

"Medicare cost and risk contracts," which define a type of arrangement that no longer exists.

"Medicare plus choice," which defines a type of arrangement that no longer exists.

"Non-group person," which refers to a status that, with the elimination of certification of non-group persons no longer has meaning.

The following definitions are amended for clarity:

"Act," which is proposed to refer specifically to amendments to P.L. 1992, c. 161.

"Basic and essential health care services plan," which is proposed to remove reference to the most recent amendatory pamphlet law citation in lieu of the specific statutory codifications which include subsequent amendments.

"Individual health benefits plan," which is proposed to be amended with respect to several law citations.

"Plan," which is proposed to be amended to include additional uses of the term plan for other reasons, based on context.

The IHC Board proposes amendments to N.J.A.C. 11:20-3 which addresses Benefit Levels and Policy Forms.

In N.J.A.C. 11:20-3.1 the Board proposes amendments that would allow carriers the opportunity to include cost sharing features consistent with parameters set forth in N.J.A.C. 11:22-5.3 through 5.5, except the maximum out of pocket is limited by the requirements of Internal Revenue Code §§ 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II).

The IHC Board proposes deleting the requirement in N.J.A.C. 11:20-3.1(e) for a carrier to file an identification of standard plans. The IHC Board believes carrier offerings will be listed in publicly available sources such that this filing will not be necessary.

The Board proposes new N.J.A.C. 11:3.2 to address sample schedule page text. In item (a) the Board acknowledges that the sample schedule pages are merely samples and not exhaustive indications of the information that may be contained on a schedule page. The schedule page may specify as many covered services from among those listed in the covered charges and covered services and supplies provisions as a carrier may wish to include. In item (b) the Board addresses the opportunity for carriers to include applicable cost sharing reduction deductible, coinsurance and copayments in the schedule.

The IHC Board proposes amending N.J.A.C. 11:20-3.3(d) to allow carriers to include cost sharing reduction amounts on the rider as an alternative to issuing a new policy with an amended schedule page.

The IHC Board proposes deleting N.J.A.C. 11:20-3.4 since the Plan Update Rider is no longer necessary.

The IHC Board proposes amending N.J.A.C. 11:20-3.5 since the basic and essential Health care Services plan will not be available for sale after December 31, 2013 since such plan does not comply with the essential health benefits requirements under PPACA.

The IHC Board proposes amendments to N.J.A.C. 11:20-12.1 to state that the subchapter addresses the purchase of standard health benefits plans and standard health benefits plan with rider. References to the basic and essential health care services plan are deleted since such plan cannot be sold after December 31, 2013. The reference to "covered by or eligible to participate in a group plan" is deleted since the proposed rule does not make any distinction between a person who is eligible for or covered by a group plan.

The IHC Board proposes deleting all of the definitions in N.J.A.C. 11:20-12.2. Any definition necessary for this subchapter is proposed for inclusion in N.J.A.C. 11:20-1.2. The Board is proposing to reserve the section, rather than renumbering subsequent sections.

The IHC Board proposes rewriting N.J.A.C. 11:20-12.3 in its entirety to address possible replacement of a policy during the initial enrollment period, which period is required by 45 C.F.R. 147.104(b)(ii) and 45 C.F.R. 155.410(b).

To accomplish the proposed rewriting of the rule, the IHC Board proposes deleting N.J.A.C. 11:20-12.3(a) through (e) because the existing rules generally do not comply with the requirements for the initial enrollment period.

In place of the existing language of N.J.A.C. 11:20-12.3, the Board proposes adding new N.J.A.C. 11:20-12.3 (a) through (c) to regulate the initial enrollment period. The new provision addresses who may take advantage of the initial enrollment period, when the application must be received, when coverage will be effective and the requirement to terminate the old plan within 30 days after the new plan is effective.

The IHC Board proposes substantially revising N.J.A.C. 11:20-12.4 to address replacement during the annual open enrollment period, which period is required by 45 C.F.R. 147.104(b)(1)(ii) and 45 C.F.R. 155.410(e).

The IHC Board proposes amending N.J.A.C. 11:20-12.4(a), which specifies that a standard health benefits plan or a standard health benefits plan with rider may be replaced with a standard health benefits plan or a standard health benefits plan with rider, by proposing to delete the existing replacement restrictions regarding copay, deductible and coinsurance amounts since such restrictions are inconsistent with the federal rules governing the annual open enrollment period; in addition, the Board proposes permitting replacement of a group health plan with a standard health benefits plan or a standard health benefits plan with rider.

The IHC Board proposes deleting N.J.A.C. 11:20-12.4 (b) through (f) and (i) because the existing rules do not comply with the requirements for the annual open enrollment period.

The Board proposes renumbering N.J.A.C. 11:20-12.4(g) as (b) and amending the paragraph to state that the effective date of coverage will be January 1 of the year following the annual open enrollment period.

The Board proposes renumbering N.J.A.C. 11:20-12.4(h) as (c) and amending the paragraph to include reference to a standard health benefits plan with rider and to allow for notice to the prior carrier from any source.

The Board proposes deleting N.J.A.C. 11:20-12.4A. This rule addresses voluntary termination and re-enrollment within a specified period of time, but the provisions of this rule are not consistent with the initial and annual open enrollment periods and and special enrollment periods required for standard health benefits plans pursuant to 45 C.F.R. 147.104(b)(1)(ii) and 45 C.F.R. 155.420.

The Board proposes renaming N.J.A.C. 11:20-12.5 as Replacement during the Special Enrollment period and replacing (a) through (c) with new items (a) and (b). The text to be replaced addresses the circumstances under which a person who is covered under or eligible for coverage under a group plan could elect individual coverage. As discussed above with respect to the definition of eligible person, a person's eligibility for or coverage under a group plan is not a factor in determining whether a person is an eligible person, making the existing language unnecessary and inappropriate.

New sections N.J.A.C. 11:20-12.5(a) and (b) provide for a 60-day enrollment period following a triggering event and specify the effective date as the first of the month following the date the carrier receives the application. The regulation, as proposed, permits carriers to also allow for a 15th of the month effective date.

The IHC Board proposes amendments to N.J.A.C. 11:20-22 which is the subchapter governing the basic and essential healthcare services plan. Because the federal law (section 1201 of PPACA, codified at 42 U.S.C. 300gg-6) requires that health benefits plans offered in the individual market as of January 1, 2014, provide essential health benefits, and the essential health benefits required to be offered per section 1302 of PPACA (42 U.S.C. 18022(a)) exceed the statutory specifications for basic and essential plans set forth in New Jersey law at N.J.S.A. 17B:27A-4.5 through 4.7, such plans cannot be issued after December 31, 2013.

The Board proposes to amend N.J.A.C. 11:20-22.3(a) to require the offer of the plan only through December 31, 2013.

The Board proposes to amend N.J.A.C. 11:20-22.5(a) to state that no new riders may be developed after December 31, 2013.

The Board proposes to amend the reporting requirements in N.J.A.C. 11:20-22.5(a) and (e) to state the dates for the final reports.

The Board proposes to amend N.J.A.C. 11:20-22.6 to state the date by which the final good faith marketing report will be due.

The Board proposes amendments to N.J.A.C. 11:20-24 which addresses Program Compliance to conform to various requirements of PPACA.

The IHC Board proposes amending N.J.A.C. 11:20-24.1 to clarify the purpose and scope of the subchapter as applicable to the offering of standard health benefits plans and standard health benefits plans with riders.

The Board proposes expanding N.J.A.C. 11:20-24.2 to address not just eligibility and issuance but also continued coverage.

The Board proposes amending N.J.A.C. 11:20-24.2(a), which specifies that residency is a requirement for eligibility for an individual health benefits plan, to add reference to standard health benefits plans with rider and remove the reference to the basic and essential health care services plan.

The Board proposes adding new sections N.J.A.C. 11:20-24.2(b) and (c) to address the initial, annual and special enrollment periods during which individuals are eligible to enroll in standard plans. Carriers are required to offer these enrollment periods for all individual health benefits plans by federal law at 45 C.F.R. 147.104(b)(1)(ii), with further specifications at 45

C.F.R. 155.410(b) and (e) (for the initial enrollment period and annual enrollment periods, respectively), and 45 C.F.R. 155.420 (c) and (d) (for special enrollment periods). In addition, the amendments at N.J.A.C. 11:20-24.2(b) and (c) address eligibility for the catastrophic plan, which carriers may offer in accordance with 42 U.S.C. 18022(e), subject to the eligibility limitations set forth at 45 C.F.R. 156.155.

The Board proposes renumbering N.J.A.C. 11:20-24.2(b) as (d) and amending it to add a reference to standard health benefits plan with rider and remove the reference to the basic and essential health care services plan.

The Board proposes adding a new paragraph (e) to N.J.A.C. 11:20-24.2 to address conditions that allow continued coverage under the catastrophic plan in an effort to be consistent with 45 C.F.R. 155.605 and 155.620, which set forth standards for determinations and redeterminations of eligibility for exemptions (from compliance with the federal requirement to have and maintain minimum essential coverage); eligibility for an exemption is a criterion for eligibility to purchase a catastrophic plan.

The Board proposes deleting existing N.J.A.C. 11:20-24.2(c), which prohibits carriers from requiring a purchaser to purchase a specific rating tier, because rating tiers are no longer an issue under the rating requirements of 42 U.S.C. 300gg as amended by section 1301 of PPACA and further specified at 45 C.F.R. 147.102(c). Likewise, the Board proposes deleting current N.J.A.C. 11:20-24.2(e), which allows carriers to apply a preexisting condition limitation period under certain conditions, because 42 U.S.C. 300gg-3 prohibits application of preexisting condition exclusion or limitation periods for standard plans issued with plan years beginning in 2014.

The Board proposes renumbering N.J.A.C. 11:20-24.2(d) as (f) and amending the paragraph to add reference to a standard health benefits plan with rider.

The Board proposes adding a new section N.J.A.C. 11:20-24.3A to identify the triggering events that result in special enrollment periods, and to clarify that the date of the triggering event is the beginning of the special enrollment period. The requirement for all individual health benefits plans is set forth at 45 C.F.R. 147.104(b)(1)(ii), with further explanation of triggering periods and dates set forth at 45 C.F.R. 155.420(c) and (d).

In addition, the Board proposes new N.J.A.C. 11:20-24.3A(c), requiring carriers to provide a one-time limited open enrollment period as required by 45 C.F.R. 147.104(b)(2).

The Board proposes amending N.J.A.C. 11:20-24.3, which addresses premium payments, to allow the possibility of payment using a debit card.

The IHC Board proposes amending N.J.A.C. 11:20-24.4(a), which specifies what a carrier may require from an individual prior to issuing a plan. As proposed, N.J.A.C. 11:20-24.4(a)3 would allow a carrier to require evidence of a triggering event prior to honoring a special enrollment period, and proposed N.J.A.C. 11:20-24.4(a)4 would allow a carrier to require a copy of the certificate of exemption from the marketplace prior to issuing a catastrophic plan to someone who is 30 years old or older.

The IHC Board proposes replacing existing N.J.A.C. 11:20-24.4(b) with new text to describe the effective date of coverage elected during the initial enrollment period.

The Board proposes amending N.J.A.C. 11:20-24.4(c) to add a reference to the annual open enrollment period, and remove reference to the existing November open enrollment period, because the two enrollment periods do not cover precisely the same time periods.

The IHC Board proposes amending N.J.A.C. 11:20-24.4(d) to describe the effective date of coverage elected during a special enrollment period.

The IHC Board proposes amending N.J.A.C. 11:20-24.6, which specifies reporting requirements for carriers to meet in order to demonstrate good faith efforts to market individual health benefits plans. The proposed amendments note that the plans a carrier issues may be through the marketplace or off the marketplace, and clarify that the efforts the carrier reports may include efforts associated with marketing a standard health benefits plan with rider.

In addition, the IHC Board proposes deleting the requirement in N.J.A.C. 11:20-24.6(c)1iii. The IHC Board has other means to effectively determine whether a carrier filed rates.

The IHC Board proposes deleting the provisions of N.J.A.C. 11:20-24.7, which addressed a limited conversion period in 2009, and as such, are outdated. The section is proposed to be reserved.

PPACA-Related Changes to the Standard Plans

In accordance with section 1302 of PPACA (42 U.S.C. 18022(a)), all health benefits plans offered in a state for individuals and small employers must comply with essential health benefits (EHB) standards. In addition, section 1401 of PPACA (Internal Revenue Code § 36B) mandates that, in order for an individual whose income is less than 400% of the federal poverty level to purchase a health benefits plan using an advance premium tax credit (thereby, reducing the premium paid by the individual), a health benefits plan must be certified as a Qualified Health Plans (QHP). QHPs are a category of EHB-compliant health benefits plans.[1] Although EHB-compliant health benefits plans, including QHPs, are not required to be issued until January

[1] QHPs must meet certain requirements in addition to EHB standards, including quality requirements that take into consideration network adequacy and consumer satisfaction issues, among other things, as well as certain actuarial value standards.

2014, PPACA authorizes the federal Secretary of the U.S. Department of Health and Human Services (HHS) to establish open enrollment periods for QHPs in advance of the January 1 date, so that individuals may purchase the coverage and have it take effect as of the beginning of 2014. HHS promulgated regulations establishing an initial open enrollment period beginning October 1, 2013 (45 C.F.R. 155.410). The IHC Board is proposing the following specific amendments to Appendix Exhibits A and B:

The federal regulations at 45 C.F.R. 156.130 set forth the annual limit on network cost sharing applicable to all health benefits plans in 2014, pursuant to sections 1302 of PPACA (42 U.S.C. 18022). The standard plans refer to the annual cost limitations as the Maximum Out of Pocket, which for 2014 is estimated to be $6,350 for single coverage and $12,700 for other than single coverage. The amount for 2015 and subsequent years will adjust consistent with sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986, as prescribed by section 1302 of PPACA (42 U.S.C. 18022(c)(1)(A).[2] All copays, deductible and coinsurance payments must accumulate toward the Maximum Out of Pocket. The amendments to the permissible dollar amount of the Maximum Out of Pocket and to what charges accumulate toward the Maximum Out of Pocket appear on the schedule page text, the covered charges and covered services and supplies text. Consistent with the annual limit on cost sharing the IHC Board proposes an amendment to the range of permissible deductibles such that the maximum deductible may not exceed the annual limit on cost sharing. As required by N.J.A.C. 11:22-5.3 the maximum permissible deductible for network services is further limited to $2,500. However, for the catastrophic plan required by section 1302 of PPACA (42 U.S.C. 18022(e)) the cost

[2] The amount is consistent with the tax-favored contribution limits permitted for high deductible health plans issued in conjunction with a federally tax-favored Health Savings Account.

sharing (which could be deductible only) must equal the maximum permissible maximum out of pocket.

As required by 45 C.F.R.147.126(a)(2), which prohibits the use of annual dollar limits for EHBs, Plans A/50, B, C, D and HMO are being amended to remove the annual dollar limits for applied behavior analysis and hearing aids The amendments appear on the schedule page text and the covered charges and covered services and supplies text.

As required by section 1001 of PPACA (42 U.S.C. 300gg-13) which requires coverage of preventive services without cost sharing, the specific copayment associated with pre-natal care has been removed. The amendment appears on the Schedule page.

Because EHB includes benefits for treatment of mental and behavioral health disorders and substance abuse (see section 1302(b)(1)(E) of PPACA (42 U.S.C. 18022(b)(1)(E)), the plans also must comply with the requirements of the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), part of Public Law 110-343. MHPAEA precludes the application of aggregate lifetime and/or annual dollar limits for mental illness and substance abuse treatment that are different from the lifetime and/or annual dollar limits applicable to treatment of other conditions and requires: a) parity in other financial requirements (deductibles, copayments, etc.) between treatment of mental health and substance abuse disorders and treatment of other conditions; b) parity in other treatment limitations (for example, treatment visits, hospitalization and use of formularies); and, c) that treatment for mental health and substance abuse disorders be available out-of-network if a policy provides out-of-network medical/surgical benefits. The IHC Board proposes that the existing separate coverages of alcohol abuse, biologically based mental illness, non-biologically based mental illness and substance abuse be replaced with a single provision addressing mental Illness or Substance

Abuse. The amendments appear on the schedule pages with the deletion of day and visit limits and in the definitions section with the deletion of the definitions of alcohol abuse, biologically based mental illness, non-biologically based mental illness, the addition of the definition of mental illness and the amendment to the definition of substance abuse. The proposed changes include an amendment to the Covered Charges and Covered Services and Supplies provision to include a new provision entitled Mental Illness or Substance Abuse.

One of the required EHBs is habilitative services. See 42 U.S.C. 18022(b)(1)(G)). While the standard plans already include coverage for services that qualify as habilitative services, they are not specially identified as such. Recognizing that consumers might expect to see coverage for a service that at least notes the services that are habilitative the Board proposes specifically identifying the services as habilitative. The amendments appear on the schedule page and the Covered Services and Supplies provision.

The IHC Board proposes amending the definition of eligible person to delete the stipulation that the person must not be eligible to be covered under a group health benefits plan, group health plan, governmental plan or church plan. As discussed above with respect to the definition of eligible person in N.J.A.C. 11:20-1.2, the proposed amended definition conforms to 45 C.F.R. 155.305. Related to the amended definition of eligible person, the Board proposes deleting the terms church plan and governmental plan as such terms are no longer used with the amended definition of eligible person.

The IHC Board proposes amending the definition of dependent to include a foster child, as required by 45 C.F.R. 155.420(d)(2).

The IHC Board proposes adding definitions of annual open enrollment period and special enrollment period as required by 45 C.F.R. 147.104(b)(1)(ii). Related to the special enrollment period is the new definition of triggering events as provided in 45 C.F.R. 155.420(d).

The Board proposes amending the Adding Dependents to this Policy provision to address the timing allowed by the annual open enrollment period and a special enrollment period as required by 45 C.F.R. 147.104(b)(1)(ii).

42 USC 18032(f)(3) of PPACA permits only persons who are, or are reasonably expected to be for the entire period for which enrollment is sought, citizens, nationals and individuals who are lawfully present in the United States to be covered under a policy offered in the American Health Benefit Exchange created by section 1311 of PPACA (42 U.S.C. 18031(b)) referred to as the Marketplace. Consequently, the definition of Eligible Person and the eligibility provision is being amended for policies to be issued in the Marketplace to address the requirement that in order to be an eligible person for purposes of being covered in the Marketplace the person must be a U.S. citizen, national or lawfully present in the United States. The amendment appears in the definition section and the Who is Eligible provision of the standard plans.

As required by federal law and regulations (See 42 U.S.C. 300gg-14 and 45 C.F.R. 147.120), which specify that children may be covered based on relationship to the insured rather than based on a dependency test, clarifying amendments to the Eligibility provision allow for single coverage as well as various combinations of coverage with spouse and/or child dependents.

Sections 1402 and 1412 of PPACA (42 U.S.C. 18071 and 18082, respectively) establish a cost-sharing reduction requirement on EHBs for some low- to moderate income individuals. Federal regulations at 45 C.F.R. 156.410 and 156.425 further specify ways in which cost-sharing

reductions may be achieved. The Deductible Credit provision is being amended to address coinsurance credit in the event of a cost sharing reduction. The provision notes that there would be no lapse in coverage between the initial plan and the new plan in order for the coinsurance credit to apply. In addition, as discussed in proposed N.J.A.C. 11:20-3.2(b) the schedule page may include the cost sharing reduction amounts.

Federal statutes and regulations (See 42 U.S.C. 18022 and 45 C.F.R. 156.115) require that covered benefits for health benefits plans be substantially equal to those contained in the selected EHB benchmark plan.[3] Since the benchmark plan used to define essential benefits features an unlimited benefit for extended care or rehabilitation charges the 120 day limit that currently exists has been removed. The amendments appear on the schedule page and in the Covered Charges and Covered Services and Supplies provisions. Similarly, because the benchmark plan used to define essential benefits features a limited benefit to enhance fertility the same benefit has been added to the standard plans. The amendment appears in the Covered Charges and Covered Services and Supplies and Exclusions provisions.

42 U.S.C. 18022 states that EHB includes coverage of pediatric dental and vision services. Federal regulations at 45 C.F.R. 156.110, recognizing that many benchmark plans do not typically include dental and vision services, requires supplementing benchmark plans with election of pediatric dental and vision services substantially similar to those contained in either a State's CHIP package of services or the Federal Employee Vision and Dental Insurance Plan package of services. Based on the election made by New Jersey to supplement the EHB benchmark plan with CHIP dental services, the standard plans include a listing of pediatric dental benefits consistent with the dental benefits provided under the New Jersey FamilyCare

[3] States select a benchmark plan that is EHB-compliant. In New Jersey, the benchmark plan is a standard small employer HMO plan.

program. The Exclusions are amended to remove exclusion of service added by the new provision. The provision is variable since policies issued on the Marketplace may exclude coverage for pediatric dental services if such services are available on the Marketplace under a stand alone dental policy. Consistent with N.J.A.C. 11:22-5.8 the pediatric dental services may be covered as network only benefits.

Similarly, New Jersey elected to supplement the benchmark plan using the FEDVIP for pediatric visions services, so amendments to the standard plans include a listing of pediatric vision benefits consistent with the benefits under the Federal Vision program. The Exclusions are amended to remove exclusion of service added by the new provision.

As required by PHS Act section 2709(a) and addressed in the FAQs about Affordable Care Act Implementation (Part XV) dated April 29, 2013 coverage is provided for persons participating in clinical trials.

As required by 42 U.S.C. 300gg-3 and 45 C.F.R. 147.108, preexisting condition exclusions are prohibited. Accordingly, all definitions of a pre-existing condition and all exclusions of a pre-existing condition have been deleted. The amendments appear in the definitions and exclusions provisions.

As required by section 1412 of PPACA (42 U.S.C. 18082) and the Federal regulations at 45 C.F.R. 156.270 regarding notices of termination and grace periods, the Grace Period provision is being amended to include a 90 day grace period for persons who receive advance payment tax credits.

The Term of the Policy-Renewal Privilege-Termination provision is amended to include decertification of a plan, as required by 45 C.F.R. 156.270.

The Termination of Dependent Coverage provision is amended to remove termination in the event of becoming eligible for group coverage, consistent with the amendment to the definition of eligible person.

The Contract provision is being amended to replace the existing provision with a provision based on N.J.S.A. 17B:26-4. The current provision requires that the application be attached. With respect to coverage issued on the marketplace, the application will not be provided to the carriers and therefore will not be available to be attached.

Other IHC Board-Initiated Proposed Changes

The IHC Board is proposing the following specific amendments to Appendix Exhibits A and B:

The IHC Board is proposing new optional text to allow the potential for a tiered network. With a tiered network one or more types of network providers are separated into two "tiers" of network providers. The proposed amendments calls them Tier 1 and Tier 2. Carriers may use alternate terms. Carriers establish the criteria for a Tier 1 or Tier 2 designation using a combination of quality and cost measures. The covered person is encouraged to use a Tier 1 provider by means of lower cost sharing. The proposed amendments allow a carrier to accumulate deductible and maximum out of pocket provisions to further encourage use of Tier 1 providers. The proposed amendments appear on the Schedule page, the text describing HMO, PPO, POS and EPO delivery systems and in the benefit provision.

The Board proposes deleting the "Eligibility if you have or are eligible for other coverage" provision. The Board recognizes that it is unnecessary to include such a provision in a policy that is issued to a consumer who has already satisfied the requirements for eligibility. The

requirement to be deleted must be satisfied at the time of purchase and is not an ongoing requirement as is the case with other eligibility requirements such as residency.

The IHC Board proposes optional text that would accommodate a mail order pharmacy benefit. The amendments appear on the Schedule and in the Definitions section.

The IHC Board proposes including alternate text to describe the prescription drug coverage. The alternate text may be used by carriers that prefer to describe the prescription drug coverage in terms more commonly found in group prescription drug benefits. In addition, the Board proposes specifically including a "dispense as written" requirement which will require a consumer to pay a greater cost if the prescription allows a generic substitution but the customer insists on the brand name drug.

The IHC Board proposes adding text that would allow the carrier to provide detailed information regarding required pre-approvals on the carrier's website.

The IHC Board proposes adding an optional definition of Specialty Pharmaceuticals and a corresponding requirement that pre-approval be required for such drugs. The amendments appear on the Schedule and the Definitions section.

The IHC Board proposes deleting the definition of health center, care manager and all references to these terms. Such terms are no longer consistent with the ways carriers provide coverage.

The second surgical opinion benefit states that the services is covered without application of the deductible. For consistency, the Board proposes adding second surgical opinion to the schedule text to show no deductible.

Since rates for coverage are provided to the consumer when the consumer is making a purchase selection the IHC Board proposes referring to that rate document on the premium rates

page rather than repeating the same rate information in the body of the policy form. The amendment appears on the Schedule.

The IHC Board proposes an amendment to the definition of Enrollment Date to remove the separate timing that was associated with a person who qualifies as a Federally Defined Eligible Individual since the enrollment date will coincide with the effective date for all persons.

The IHC Board proposes adding a new definition of Complex Imaging Services. These services are a subset of diagnostic services and are services for which a carrier may wish to require pre-approval and greater cost sharing.

The IHC Board proposes expanding the examples listed in the definition of Durable Medical Equipment to include hearing aids.

The IHC Board proposes an amendment to the definition of Network Provider to remove the text for Associated Medical Groups since the text is no longer necessary. In addition, the IHC Board proposes clarifying that lists of providers are available.

The IHC Board proposes an amendment to the Preventive Care provision to allow network only plans to eliminate all references to the limited benefits payable for use of an out of network provider. This amendment only applies to Appendix Exhibit A.

The Coordination of Benefits provision is being amended to add references to Exclusive Provider Organization (EPO) coverage. The proposed amendment would treat EPO coverage the same as HMO coverage. This amendment applies only to Appendix Exhibit A.

Corresponding Amendments

Amendments are proposed to the Explanation of Brackets (Appendix Exhibit C) to address the new areas of variability introduced by the amendments, as proposed.

As addressed in the proposed amendments to N.J.A.C. 11:20-3, the Schedule pages included in Appendix Exhibits A and B are sample pages. The cost sharing provisions carrier include must comply with the cost sharing requirements of 45 C.F.R. 156.130 as well as N.J.A.C. 11:22-5.3 Further, a carrier must not employ cost-sharing designs that will have the effect of discouraging the enrollment of individuals with significant health needs (45 C.F.R. 156.225).

The Explanation of Brackets identifies areas of variability that are unique to plans issued on the Marketplace established under PPACA.

IHC Rulemaking Procedures

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

Subsequently, the IHC Board may adopt its intended action immediately upon the close of the specified comment period or close of a public hearing (whichever is later) by submitting the adopted action to the OAL for publication. The adopted action is effective upon the date of its submission to the OAL, or such later date as the Board may designate. If the Board does not respond to commenters as part of the notice of adoption, the Board will respond to the comments timely submitted within a reasonable period of time thereafter in a separately-prepared report which will be submitted to OAL for publication in the New Jersey Register. Pursuant to N.J.S.A. 17B:27A-51, all actions adopted by the Board are subject to the requirements of this special rulemaking procedure notwithstanding the provisions of the Administrative Procedure Act. As a result, the quarterly calendar requirement set forth at N.J.A.C. 1:30-3.1 is not applicable when the Board uses its special rulemaking procedures.

Social Impact

The IHC Board notes that the majority of the amendments being proposed are required by PPACA. As discussed in the Summary, among the requirements of PPACA is the requirement that all plans must include the essential health benefits. For example, the expanded coverage for substance abuse and non-biologically-based mental illness could have a positive social impact with respect to the patients who require such services as well as their families. The added coverage for pediatric dental and vision services could improve medical and dental outcomes for children.

Economic Impact

The IHC Board cannot conclude with certainty the economic impact of these amendments which substantially are required by federal law. The IHC Board notes that the

amendments may potentially impact the cost of the standard plans, primarily because of the limitations imposed on cost-sharing, and the removal of dollar limitations on specific covered services and the inclusion of essential health benefits such as full benefits for mental illness and substance abuse as well as pediatric dental and vision benefits and the elimination of the pre-existing conditions exclusion.

The IHC Board notes that among the proposed amendments are amendments to plan designs intended to provide consumer options. The impact on Carriers will depend on how these new designs are received by consumers.

Federal Standards Analysis

State agencies that propose to adopt or amend State rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. These proposed amendments are subject to Federal requirements addressing certain standards for health insurance contracts in PPACA and the corresponding rules governing the individual market. Specifically, PPACA requires that health benefits plans offered to individuals and small groups include coverage for certain categories of services, referred to earlier as EHB. Because HHS permitted States to establish the benefits for the EHB benchmark plan (within parameters), and the amendments are bringing the IHC standard plans into compliance with the selected EHB benchmark, the IHC Board does not believe the proposed amendments exceed the Federal standards. The amendments the Board proposes to N.J.A.C. 11:20-1, 3, 12, 22 and 24 are required to implement the various provisions of PPACA, as discussed above. Consequently, the IHC Board does not believe any further Federal Standards Analysis is required.

Jobs Impact

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

Agricultural Industry Impact

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

Regulatory Flexibility Analysis

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

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

Smart Growth Impact

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

Housing Affordability Impact

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

Smart Growth Development Impact

The IHC Board does not believe the proposed amendments will have an impact on the number of housing units or the availability of affordable housing in the State, or that the proposed amendments will have an effect on smart growth development in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan. The proposed amendments relate to the benefit levels and terms of standard health benefits plans offered in New Jersey.

Full text of the proposal follows:

TITLE 11. INSURANCE

CHAPTER 20. INDIVIDUAL HEALTH COVERAGE PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

§ 11:20-1.1 Purpose and scope

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

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

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after August 1, 1993, except as the specific provisions of **[the statute and of]** this chapter, **or the New Jersey Individual Health Insurance Reform Act, or applicable federal laws** state otherwise.

§ 11:20-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

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

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

"Annual open enrollment period" means October 15 through December 7 of each year beginning in 2014.

"Basic and essential health care services plan" means the health benefits plan **[pursuant to]set forth in [P.L. 2001, c.368,**] N.J.S.A. 17B:27A-4.4 through 4.7.

"Board" means the Board of Directors of the New Jersey Individual Health Coverage Program established by the Act.

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this chapter, carriers that are affiliated carriers shall be treated as one carrier.

“Catastrophic plan” means a standard health benefit plan that is designed and offered in accordance with the requirements of federal regulations at 45 C.F.R. 156.155.

["Church plan" has the same meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(33)).]

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

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

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

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

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

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

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

"Dependent" means:

1. The applicant's spouse;

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

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

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

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

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

7. any other child over whom the applicant has legal custody or legal guardianship or with whom the applicant has a legal relationship or a blood relationship provided the child depends on the applicant for most of the child's support and maintenance and resides in the applicant's household.

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

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

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

3. Sits ex officio on the Board of Directors.

"Eligible person" means a person **who** is a resident **of New Jersey** who is not eligible to be covered under [**a group health benefits plan, group health plan, governmental plan, church plan, or]** Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.), **commonly referred to as** "Medicare." **[An eligible person shall include a person who is a resident who is eligible for continuation of group coverage under COBRA or a state continuation law, so long as the person elects to be covered under the individual health benefits plan in lieu of continuation coverage.]**

"Enrollment date" means**[, with respect to a Federally defined eligible individual, the date the person submits a substantially complete application for coverage. With respect to all other persons, enrollment date means]** the effective date of coverage under the individual health benefit plan.

“Essential Health Benefits” or “EHB” means the categories of health care services required to be covered in accordance with 45 C.F.R. 156.110.

["Family unit" means:

1. A legally married man and woman;

2. A person and his or her same-gender civil union partner;

3. A person and his or her same gender domestic partner;

4. A legally married man and woman and their dependent children;

5. A person and his or her same-gender civil union partner and their dependent children, as the term dependent is defined in the individual health benefits plan;

6. A person and his or her same gender domestic partner and their dependent child(ren), as the term dependent is defined in the individual health benefits plan;

7. An adult and his or her dependent child(ren), as the term dependent is defined in the individual health benefits plan; and

8. Dependent children only who are members of the same household as the term dependent is defined in the individual health benefits plan].

["Federally defined eligible individual" means an eligible person:

1. For whom, as of the date on which the individual seeks coverage under P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months during which time the eligible person has not had any significant break in coverage (significant break in coverage means a break in coverage of 63 days or more during which time the eligible person has no creditable coverage);

2. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan;

3. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C.

§§ 1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan;

4. With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

5. Who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and

6. Who has elected continuation coverage described in 5 above and has exhausted that continuation coverage.]

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub. L. 93-222 (42 U.S.C. § 300e et seq.).

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

["Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §§ 1002(32)) and any governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of that government.]

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

"Group health plan" means an employee welfare benefit plan, as defined in Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(1)), to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability

insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan. The term "health benefits plan" specifically includes:

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

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

3. Executive medical plans;

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

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

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

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

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

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

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

(1st day benefit--2nd day benefit) + (2nd day benefit <$

250.00)/5

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

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

The term "individual health benefits plan" shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan **as defined by[, to the extent]** the "Employee Retirement Income Security Act of 1974" (29 U.S.C. §§ 1001 et seq.)**, to the extent that the Employee Retirement Income Security Act** preempts the application of **[P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.)] the Act** to that plan.

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

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

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

"Medical care" means amounts paid:

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

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

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

["Medicare cost and risk contracts" means policies or contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.) and amendments thereto.

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

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

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

“Minimum essential coverage” means any of the following types of coverage:

(1) Government sponsored programs. Coverage under:

(a) the Medicare program under part A of title XVIII of the Social Security Act ,

(b) the Medicaid program under title XIX of the Social Security Act,

(c) the CHIP program under title XXI of the Social Security

(d) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(e) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(f) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(g) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under

section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(2) Employer-sponsored plan. Coverage under an eligible employer-sponsored plan.

(3) Plans in the individual market. Coverage under a health plan offered in the individual market within a State.

(4) Grandfathered health plan. Coverage under a grandfathered health plan.

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

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

"Modified community rated" means, with respect to coverage under standard health benefit plans, a rating system in which the premium for all persons covered under a policy or contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical location or any other factor or characteristic of covered persons, other than age.

The rating system provides that the premium rate charged by a carrier for the highest rated individual or class of individuals shall not be greater than **[350] 300** percent of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits plan shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with rules promulgated by the Commissioner, which include age classifications **[as set forth in N.J.A.C. 11:20-6. There may be a reasonable differential among the premium rates charged for different family structure rating tiers within an individual health benefits plan or different health benefits plans offered by a carrier.**

There is a separate definition in N.J.A.C. 11:20-22.2].

"NAIC" means the National Association of Insurance Commissioners.

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

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

["Non-group persons" or "non-group persons covered" means coverage by an individual health benefits plan or conversion policy or contract subject to P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.), a basic and essential health care services plan pursuant to P.L. 2001, c. 368, Medicare cost or risk contract, Medicare Plus Choice or Medicare Advantage contract, Medicare Demonstration Project plan or Medicaid contract.]

"Open enrollment" means the **[continuous]** offering of a health benefits plan to any eligible person on a guaranteed issue basis**[, except as stated in N.J.A.C. 11:20-12]** **during the initial enrollment period oran annual open enrollment period.**

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

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

"Pre-existing condition" means **for a plan issued or renewed prior to January 1, 2014**, for a covered person age 19 or older a condition that, during a specified period of not more than six months immediately preceding the enrollment date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to

seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the enrollment date of coverage.

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

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

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

"Resident" means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of each calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of each calendar year. **[For purposes of identifying a Federally defined eligible individual, actual and intended presence in the State for a minimum period may not be considered, but a carrier may require an applicant to demonstrate that New Jersey is his or her primary residence as defined by law.]**

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

1. **individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and**
2. **individuals who already have coverage are allowed to replace current coverage with a different standard health benefits plans or standard health benefits plan with rider.**

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

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

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party

beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Individual Health Insurance Reform Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 11:20-1.4 Other laws of this State

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

§ 11:20-1.5. (Reserved)

§ 11:20-1.6. Mission statement

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

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

§ 11:20-3.1 The standard health benefits plans

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

1. Plan A/50, Appendix Exhibit A with pages identified as unique to Plan A/50;

2. Plan B, Appendix Exhibit A with pages identified as unique to Plan B;

3. Plan C, Appendix Exhibit A with pages identified as unique to Plan C;

4. Plan D, Appendix Exhibit A with pages identified as unique to Plan D; and

5. HMO Plan, Appendix Exhibit B.

(b) Members that offer individual health benefits plans in this State and members that offer small employer health benefits plans in this State pursuant to N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21 shall offer at least three of the standard health benefits Plans A/50, B, C, D and HMO as set forth in chapter Appendix Exhibits A and B, incorporated herein by reference with variable text as specified on the Explanation of Brackets, which is set forth as chapter Appendix Exhibit C, incorporated herein by reference, subject to the provisions set forth in (b)1 through 9 below and except as provided in (c) below.

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

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

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

i. **For a network-based plan, [The] the network** per covered person annual deductible shall **[be]not exceed** $ 2,500;

ii. F**or a plan without a network, the per covered person annual deductible shall not exceed the Maximum Out of Pocket as defined in b5 below.**

iii. For a plan to be offered as a catastrophic plan the per covered person annual deductible shall equal the greatest permissible maximum out of pocket as defined in b5 below except the deductible shall be waived for three physician visits per calendar year.

[ii] iv. The corresponding per covered family annual deductible shall be **[$ 5,000] an amount equal to two times the per covered person annual deductible**, satisfied on an aggregate basis.

[4. Members offering Plans A/50, B, C, and/or D may offer the plans with one or more of the following annual deductible provisions in addition to the deductible provisions specified in (b)3 above:

i. Per covered person annual deductible equal to $ 1,000, $ 5,000 or $ 10,000; and

ii. Per covered family annual deductible equal to two times the applicable per covered person annual deductible, satisfied on an aggregate basis.]

[5] 4. Members offering Plans A/50, B, C, and D may offer the plans with **[one or more of the following annual deductible provisions in addition to the]** deductible provisions **[required in (b)3 above]** such that the plans may qualify as high deductible health plans:

i. In the case of single coverage **[, the greater of: $ 1,200; or the lowest deductible]** an amount to qualify as a High Deductible Health Plan under Internal Revenue Code §223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered person;

ii. [and in] In the case of other than single coverage**[, the greater of: $ 2,400; or the lowest deductible] an** amount to qualify as a High Deductible Health Plan under Internal Revenue Code §223(c)(2)(A) for the calendar year in which coverage is issued or renewed, per covered family, with single and other than single deductibles accumulated in accordance with the requirements of Federal law;

[ii. In the case of single coverage, $ 2,000, and in the case of other than single coverage, $ 4,000 with single and other than single deductibles accumulated in accordance with the requirements of Federal law;

iii. In the case of single coverage, $ 2,800 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted, per covered person; and in the case of other than single coverage, $ 5,600 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal

Revenue Code §223(c)(2)(A) are permitted with single and other than single deductibles accumulated in accordance with the requirements of Federal law; and

iv. In the case of single coverage, $ 5,000, and in the case of other than single coverage, $ 10,000 with single and other than single deductibles accumulated in accordance with the requirements of Federal law.]

[**6. Members offering Plans C and D may renew plans that were issued with the following annual deductible provisions:**

i. $ 1,500, or the lowest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A)of the Internal Revenue Code per individual or in the case of a family unit, $ 3,000, or the lowest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per family unit with single and family unit deductibles accumulated in accordance with the requirements of Federal law; and

ii. $ 2,250, or the highest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per individual or in the case of a family unit, $ 4,500, or the highest inflation-adjusted amount for the calendar year in which the coverage is renewed, determined by the Federal Internal Revenue Service pursuant to §220(c)(2)(A) of the Internal Revenue Code per family unit with single and family unit deductibles accumulated in accordance with the requirements of Federal law.]

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

i. The per covered person maximum out of pocket **[for Plan A/50 shall be the sum of the annual deductible and $ 5,000;] shall not exceed the maximum out of pocket specified in sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986,**

[ii. The per covered person maximum out of pocket for Plan B shall be the sum of the annual deductible and $ 3,000;

iii. The per covered person maximum out of pocket for Plan C shall be the sum of the annual deductible and $ 2,500;

iv. The per covered person maximum out of pocket for Plan D shall be the sum of the annual deductible and $ 2,000;]

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

[vi] iii. **Deductible**, Coinsurance **and Copayment under a standalone pediatric dental benefit plan issued [**paid for covered prescription drugs under Plans A/50, B, C, and D, issued using deductibles set forth in (b)3 and 4 above] **to replace the pediatric dental benefits contained in Plans A/50, B, C and D** shall not count toward the maximum out of pocket. **[Coinsurance for prescription drugs must continue to be paid even after the maximum out of pocket has been reached.]**

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

[8. When issued using deductible provisions set forth in (b)5 above, Plans C and D shall contain maximum out of pocket provisions as follows:

i. In the case of single coverage, the greater of $ 5,100 or the highest maximum out of pocket amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted, per covered person; and

ii. In the case of other than single coverage, $ 10,200 or the highest maximum out of pocket amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code §223(c)(2)(A) are permitted.

9. When renewed using deductible provisions set forth in (b)6 above, Plans C and D shall contain maximum out of pocket provisions as follows:

i. In the case of single coverage, $ 3,000 or the highest maximum out of pocket amount for the calendar year in which coverage is renewed for which deductions under Internal Revenue Code §220(c)(2)(A) are permitted, per covered person; and

ii. In the case of other than single coverage, $ 5,500 or the highest maximum out of pocket amount for the calendar year in which coverage is renewed for which deductions under Internal Revenue Code Section 220(c)(2)(A) are permitted.]

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu of offering at least three of Plans A/50, B, C, and D in (a) above. State qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in addition to at least two of Plans A/50, B, C, and D in (a) above. HMO carriers offering the HMO Plan **[shall]** **may** offer [**the $ 30.00]** **a** copayment plan design set forth in (c)1 below and**/ or** [**may, at the option of the HMO, also offer other copayments or may also offer**] the HMO plan using deductible and coinsurance provisions **set forth in(c)2 below.** All options offered by the HMO member shall be made available to every eligible individual seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (c)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (c)3 below.

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

[i. Members offering the HMO Plan shall offer the plan with a $ 300.00 per day hospital inpatient copayment, $ 100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $ 30.00 copayment for all other services, except that the copayment for pre-natal care may be $ 25.00 as required by (c)3ii below;

ii. In addition to the HMO plan required by (c)1i above, members may offer one or more of the following copayment arrangements:

(1) $ 150.00 per day hospital inpatient copayment, $ 100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $ 15.00 copayment for all other services, except that the copayment for pre-natal care may be $ 25.00 as specified in (c)3ii below;

(2) $ 400.00 per day hospital inpatient copayment, $ 100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $ 40.00 copayment for all other services, except that the copayment for pre-natal care may be $ 25.00 as specified in (c)3ii below; and

(3) $ 500.00 per day hospital inpatient copayment, $ 100.00 copayment for emergency room, 50 percent coinsurance for prescription drugs, and a $ 50.00 copayment for all other services, except that the copayment for pre-natal care may be $ 25.00 as specified in (c)3ii below.]

2. Carriers issuing HMO plans with a Deductible and Coinsurance Design shall use the copayments, cash deductible, **and** coinsurance **[and maximum out of pocket set forth below] consistent with the requirements of N.J.A.C. 11:22-5.3 through N.J.A.C. 11:22- 5.5. The maximum out of pocket shall be consistent with the maximum out of pocket described in b5 above.**

[i. Members offering the HMO Plan may, in addition to the HMO plan required by (c)1i above, offer HMO Plans that include deductible and coinsurance provisions, subject to the following:

(1) The copayment for primary care physician services shall be: $ 15.00; $ 30.00; $ 40.00; or $ 50.00;

(2) The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care, or prescription drugs shall be $ 1,000 or $ 2,500 per person. The covered family deductible shall be two times the per person deductible, satisfied on an aggregate basis;

(3) The coinsurance, which shall not apply to services to which a copayment applies or to prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in 10-percent increments; and

(4) The maximum out of pocket shall be no greater than $ 7,500 per person, and for a covered family two times the per person maximum out of pocket.]

[3] (d). Carriers issuing Plans A/50, B, C, D and HMO plans**[, whether with copayment or Deductible and Coinsurance Design,]** shall include the following features which are common to all **[HMO]** plans:

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

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

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

iii. Prescription drugs [**covered under the HMO plan shall] may** be subject to 50 percent coinsurance **or other types of cost sharing provisions such as copayments**. **[For plans that include a maximum out of pocket, coinsurance for prescription drugs shall not count toward the maximum out of pocket and must continue to be paid after the maximum out of pocket has been reached.]**

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

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

2. The network annual deductible shall be no greater than $ 2,500 per covered person, and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies;

3. The HMO Plan copayment amounts for physician visits,[**pre-natal care**] and hospital confinements and the prescription drug coinsurance may be substituted for deductibles applicable to network benefits;

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

5. The network maximum out of pocket shall be no greater than [$ 7,500**] the amount specified in b5 above** per covered person, and for a covered family shall be no greater than two times the per covered person network

maximum out of pocket. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies;

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

7. If a separate non-network maximum out of pocket is included, the non-network maximum out of pocket shall be two times or three times the network maximum out of pocket per covered person, and for a covered family shall equal two times the per covered person maximum out of pocket.

[(e) No later than July 1, 2009, each Carrier shall submit to the Board an Identification of Standard Plans set forth in the Appendix to this chapter as Exhibit H, incorporated herein by reference, that identifies the standard health benefits plans such Carrier is offering to individual consumers. Each carrier shall file an amended Identification of Standard Plans with the Board within 60 days of any change in the plans being offered to individual consumers.]

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

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

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

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

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

§ 11:20-3.2 **Sample Schedule Page Text**

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

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

§ 11:20-3.3 Compliance and variability rider

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

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

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

(d) Members may address the cost sharing reduction amounts referred to in 3.2(b) above on the Compliance and Variability Rider

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

§ 11:20-3.4 **[Plan update rider RESERVED**

(a) Members electing to force convert existing standard plans pursuant to N.J.A.C. 11:20-24.7 and issuing new standard plans, as set forth in Exhibit A or B of the Appendix to this chapter, shall issue the Plan Update Rider, as set forth in Appendix Exhibit G, incorporated herein by reference. Such rider shall be issued to policyholders who:

1. Have coverage under a plan utilizing deductible and coinsurance provisions on the day before the plan anniversary date the forced conversion is effective; and

2. Elect to enroll in the standard health benefits plan which is offered as a conversion plan by the same carrier.

(b) The Plan Update Rider shall expire at midnight on December 31 of the calendar year in which it was issued.]

§ 11:20-3.5 **Basic and essential health care services plan**

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

§ 11:20-3.6 Optional benefit riders to standard plans

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

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

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

i. The types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations" and "Exclusions" sections of Plans A/50, B, C, and D or the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan;

ii. Deductibles, coinsurance, copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans A/50, B, C, D and HMO as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident.

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

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:20-1.2, except for dental coverage where the additional dental coverage is subject to the standard plan's deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:20-1.2.

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

5. The inclusion of an optional benefit rider with Plan A/50, B, C, D or HMO creates Plan A/50, B, C, D or HMO as amended by the rider and the Plan continues to be Plan A/50, B, C, D or HMO. The inclusion of an optional benefit rider does not create another standard plan.

6. An individual seeking to purchase Plan A/50, B, C, D or HMO must be given the opportunity to purchase Plan A/50, B, C, D or HMO without a rider or with any rider that is available to amend the plan being purchased.

7. A member making an informational filing to the Board pursuant to (a)1 above shall:

i. Submit one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:20-2.1;

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

iii. Specify whether the rider or amendment thereof is to be used in connection with standard health benefit Plans A/50, B, C, D or HMO and provide clear and conspicuous notice of such on the forms submitted for each rider;

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

v. Submit the standard plan page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

vi. Submit a certification signed by a duly authorized officer of the member that states clearly:

(1) That the rider or amendment thereof increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan A/50, B, C, D, or HMO;

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

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

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

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement, that the plan as ridered continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and 11:24-14.4(c), as applicable.

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

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

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

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

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

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

(c) Not more than 60 days after the Board has promulgated rules withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal by mail to every policy or contractholder. Following the initial notice of nonrenewal to each policy or contractholder, the carrier shall send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium statement is transmitted, send

a notice at least 30 days prior to nonrenewal. Nonrenewal notices for policy or contractholders shall contain the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 11:20-12.1. Purpose and scope

This subchapter sets forth the standards for purchasing a standard [individual] health benefits plan **[or a basic and essential healthcare services plan]**<u>**or a standard health benefits plan with rider**</u> by a person who is covered under an individual plan **[, and standards for purchasing a standard individual health benefits plan or a basic and essential healthcare services plan by a person who is either covered by**] or **[eligible to participate in]** a group health benefits plan.

§ 11:20-12.2 [Definitions

For the purposes of this subchapter, words and terms used herein shall have the meanings set forth in the Act, or as may be more specifically defined in N.J.A.C. 11:20-1.2, unless otherwise defined below, or the context clearly indicates otherwise.

"Covered under an individual plan" means a person is covered under a standard individual health benefits plan, or a basic and essential health care services plan or under an individual plan issued prior to August 1, 1993.

"Eligible to participate in a group health benefits plan" means, with respect to a group health benefits plan offered by an employer to an employee and to the employee's dependents, if any, that the employee is a member of a class of persons eligible for coverage, works at least the minimum number of hours required for coverage and that the employee has been employed for at least the minimum period required by the employer to be eligible for coverage, and the employee's dependents have satisfied all lawful standards for participation in the group health benefits plan. With respect to group coverage issued by an HMO carrier, a person who resides outside the HMO's service area shall not be considered eligible to participate in a group health benefits plan.

"Group health benefits plan" means a health benefits plan as defined in N.J.A.C. 11:20-1.2 as well as a self-funded health benefits plan for groups of two or more persons.

"Open enrollment period" means the calendar month of November 1 through November 30 of each calendar year, beginning in 2006, and annually thereafter.

"Same as or similar to the individual plan" means the group plan under which a person is covered or eligible to participate features cost sharing provisions consistent with those in the standard individual health benefits plan or basic and essential healthcare services plan for which the person has made application.

1. For a plan that uses coinsurance and deductible cost provisions, this means the coinsurance percentage in the group plan is identical to the coinsurance requirement in the individual plan and the deductible under the group plan differs from the deductible in the individual plan by no more than $ 100. When comparing coinsurance provisions in a plan that features network and non-network benefits, the coinsurance and deductible applicable to network services and supplies must be considered. Plans that feature different cost sharing provisions, such as coinsurance and deductible in one plan and copayment in the other plan, are not the same or similar.

2. For a plan that uses copayment provisions, this means the copayment for primary care services under the group plan is either: the same as the copayment for primary care services under the individual plan; or less than $ 10 more or less than the copayment for primary care services under the individual plan. When reviewing copayment provisions in a plan that features network and non-network benefits, the copayment applicable to network services and supplies must be considered. Plans that feature different cost sharing provisions, such as coinsurance and deductible in one plan and copayment in the other plan, are not the same or similar.

3. In addition to 1 and 2 above, for contributory group plans, the group plan is only the same or similar to the individual plan if the employee's share of the cost for the group plan differs from the cost of the individual plan by $ 100.00 or less per month.

4. Notwithstanding 1 and 2 above, for group plans that are closed panel HMO plans, the group plan is not the same or similar to the individual plan if the provider network for the group plan is not the same as the provider network for the individual plan.]

RESERVED

§ 11:20-12.3 [Covered under an individual plan or replacement at any time] Replacement during Initial Enrollment Period

[(a) Except as stated in N.J.A.C. 11:20-12.4(c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with the same type of plan using the same or greater deductible, same or greater coinsurance or same or greater copayments from another carrier, where there is no lesser deductible, coinsurance or copayment.

(b) Except as stated in N.J.A.C. 11:20-12.4(b) or (c), a person who is covered under a standard individual health benefits plan may elect at any time to replace the plan with any standard individual health benefits plan [or basic and essential healthcare services plan] for which the filed monthly premium is less than the filed monthly premium for the existing standard individual health benefits plan.

(c) A person who is covered under a basic and essential health care services plan without rider may elect at any time to replace the plan with a basic and essential healthcare services plan without rider.

(d) A person who is covered under an individual plan issued prior to August 1, 1993 may elect at any time to replace the plan with a standard individual health benefits plan or a basic and essential healthcare services plan.

(e) The existing standard health benefits plan, basic and essential healthcare services plan or plan issued prior to August 1, 1993 must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan as of the midnight on the day before the effective date of the new plan if the person covered under the new plan notified the existing carrier of the replacement within 30 days after the effective date of the new plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the new plan, the new plan shall be of no force and effect and premium paid shall be refunded.]

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

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

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

§ 11:20-12.4 [Covered under an individual plan: replacement only] Replacement during Annual Open Enrollment Period

(a) Except as stated in **12.5 below with respect to the special enrollment period**, a person who is covered under a standard **[individual]** health benefits plan **or standard health benefits plan with rider or group health benefits plan** may only elect during the **annual open enrollment period** [Open Enrollment Period] to replace the plan **or coverage** with a standard [**individual**] health benefits plan or **a standard health benefits plan with rider. The**

application must be received during the annual open enrollment period. [or basic and essential healthcare services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan. Exception: A person who is covered under a standard individual health benefits plan may elect to replace the plan with the same type of plan issued by another carrier using the same deductible, same coinsurance and same copayments even if the monthly premium is greater than the monthly premium for the existing health benefits plan at any time.]

[(b) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period to replace the HMO plan with an HMO plan featuring a lower copayment.

(c) A person who is covered under a standard individual health benefits plan issued as an HMO plan may only elect during the Open Enrollment Period to replace the HMO plan or with an indemnity, preferred provider (PPO) or point of service (POS) plan. However, a person whose initial purchase in the individual market is an HMO plan may elect, at any time during the 90 days following the effective date of the individual plan, to replace the HMO plan with an indemnity, preferred provider (PPO) or point of service (POS) plan.

(d) A person who is covered under a basic and essential healthcare services plan without a rider may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a rider.

(e) A person who is covered under a standard individual health benefits plan without a rider may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan with a rider or with a basic and essential healthcare services plan with a rider.

(f) A person who is covered under a basic and essential healthcare services plan with a rider may only elect during the Open Enrollment Period to replace the plan with a standard individual health benefits plan or with a basic and essential healthcare services plan with a different rider.]

([g] b) The effective date of the replacement plan [**issued as a result of (a) though (e) above**] will be January 1 of the year following the **annual open enrollment period**[Open Enrollment Period].

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

[(i) Notwithstanding (a), (b), (d), (e) and (f) above, a person covered under a standard individual health benefits plan or a basic and essential health care services plan may elect to replace the standard individual health benefits plan or a basic and essential health care services plan with a standard individual health benefits plan that is a high deductible health plan sold in conjunction with a Health Savings Account, at any time during the 60 days following the date a high deductible health plan is first made available by the carrier to whom the person makes application for the high deductible health plan.]

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

(a) Except as stated below, a person who terminated a standard individual health benefits plan during the 31 days prior to application for or enrollment in a standard individual health benefits plan or basic and essential healthcare services plan may only elect during the Open Enrollment Period to apply for or enroll in such standard individual health benefits plan or basic and essential healthcare services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan. Exception: A person who is covered under a standard individual health benefits plan or basic and essential healthcare

services plan may apply for the same type of plan issued by another carrier using the same deductible, same coinsurance and same copayments even if the monthly premium is greater than the monthly premium for the existing health benefits plan at any time.

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

(c) A person who terminated a standard individual health benefits plan issued as an HMO plan during the 31 days prior to application for or enrollment in a standard individual health benefits plan or basic and essential healthcare services plan may only elect during the Open Enrollment Period to purchase an indemnity, preferred provider (PPO) or point of service (POS) plan.

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

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

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

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

(h) A person who terminated a standard individual health benefits plan during the 31 days prior to application for a standard individual health benefits plan or basic and essential healthcare services plan who wants to purchase another a standard individual health benefits plan or basic and essential healthcare services plan under circumstances that are not described in (a) through (f) above may purchase a new plan at any time.]

§ 11:20-12.5[Covered under or eligible to participate in a group health benefits plan] Replacement during Special Enrollment Period

[(a) A person who is covered under or eligible to participate in a group health benefits plan that is not the same as or similar to the individual plan for which application has been made may elect only during the Open Enrollment Period to be covered under a standard health benefits plan, or a basic and essential healthcare services plan. The effective date of the individual plan will be January 1 of the year following the Open Enrollment Period.

(b) A person who is covered under or eligible to participate in a group health benefits plan that is the same as or similar to the individual plan for which the person has applied is not eligible to be covered under a standard individual health benefits plan or basic and essential healthcare services plan.

(c) A person who is covered under a group plan pursuant to State or Federal continuation laws may elect [at any time] to be covered under a standard individual health benefits plan or basic and essential healthcare services plan.

(c) When an application for individual coverage is made during the Open Enrollment Period, coverage under the group plan must be terminated no later than midnight on December 31 immediately prior to the effective date of the standard individual health benefits plan standard individual health benefits plan or basic and essential healthcare services plan except as may be required under an extension of benefits under the group plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of coverage under the group plan is not before the effective date of the standard individual policy health benefits plan or basic and essential healthcare services plan], the standard individual health benefits

plan or basic and essential healthcare services plan shall be of no force and effect and premium paid shall be refunded.]

(a) A person covered under a standard health benefits plan or a standard individual health benefits plan with a rider or group health benefits plan may enroll for coverage under a different standard health benefits plan or standard individual health benefits plan with a rider during a 60-day special enrollment period which follows a triggering event.

(b) The effective date of the new standard health benefits plan or standard health benefits plan with a rider will be the 1st of the month following the date the carrier receives the application In addition to the 1st of the month effective date carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption or placement for adoption or the date of placement in foster care.

SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

§ 11:20-22.1. Purpose and scope

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

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

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

§ 11:20-22.2. Definitions

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

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

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

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

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

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

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

§ 11:20-22.4 (Reserved)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. Earned premium for the calendar quarter;

ii. Paid claims for the calendar quarter;

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

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

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

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

i. Earned premium for the calendar year; and

ii. Incurred claims for the calendar year.

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

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

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

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

(a) In order for the Board to determine whether a member has made a good faith effort to market the basic and essential health care services plan, as required by section 2g of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.5g), every member shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year a report detailing the activities the member undertook during the prior calendar year to market the basic and essential health care services plan. Members may satisfy the requirement by marketing the plan as an HMO plan, a PPO plan, an EPO plan, or as an indemnity plan. **The final report required under this section shall be due May 1, 2014.**

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

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

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

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

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the basic and essential health care services plan during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices,

brochures, faxes or other communications advising the producers of the availability of the plan; or information specific to the basic and essential health care services plan on the carrier's website. Members may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the basic and essential health care services plan; and

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

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

§ 11:20-22.7. Penalties

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

SUBCHAPTER 24. PROGRAM COMPLIANCE

11:20-24.1 Purpose and scope

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

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

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

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

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

1. during the initial enrollment period;

2.` during an annual open enrollment period; or

3. during a special enrollment period.

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

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

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

([(b)](d) After obtaining coverage under a standard health benefits plan **or standard health benefits plan with rider [or a basic and essential health care services plan]**, a covered person may elect to retain his or her coverage if he or she later becomes eligible for or covered under Medicare **[or a group health plan**].

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

[(c) A carrier shall not require a person or persons who are eligible for coverage under more than one rate tier to obtain coverage under any specific rate tier. For example, a carrier shall not require a married couple to apply for two adult coverage, if the husband and wife wish to obtain separate coverage.]

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

[(e) Persons shall be accepted for coverage by any carrier without any restrictions or limitations on coverage related to their risk characteristics or those of their dependents except that a carrier may exclude coverage for preexisting conditions consistent with the applicable terms of the individual health benefits plan.]

11:20-24.3A Triggering events that result in special enrollment periods

(a) A special enrollment period begins on the date of the triggering event and continues for 60 days. During this period an eligible person may apply for coverage for himself or herself and his or her eligible dependents.

(b) The dates listed below are triggering events.

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

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

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

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

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

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

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

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

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

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

11:20-24.3. Payment of premium

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

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

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

11:20-24.4 Effective date of coverage

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

1. A completed individual application form;

2. Proof of the applicant's residency;

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

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

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

[(b) A carrier shall make coverage effective no later than the 1st or the 15th of the month, [whichever comes first,] after the receipt of the information set forth in (a) above that it may require. However, if a carrier allows additional effective dates and an applicant request a later effective date, a carrier shall make coverage effective no later than such requested effective date.]

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

(c) With respect to applications submitted during the **[November open enrollment period] annual open enrollment period**, the effective date of coverage shall be January 1 of the following calendar year.

(d) With respect to applications submitted during the **special enrollment period** [Open Enrollment period], the effective date of coverage shall be **[no later than April 1, 2009] the 1st of the month following the date the carrier receives the application. In addition to the 1st of the month effective date carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption or placement for adoption or the date of placement in foster care.**

11:20-24.5 Paying benefits

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

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

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

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

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

(a) In order for the Board to determine whether a member that is a small employer carrier as defined in N.J.S.A. 17B:27A-17 has offered and made a good faith effort to market the standard **[individual]** health benefits plans pursuant to N.J.S.A. 17B:27A-19a, every small employer carrier shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year a report detailing the activities the small employer carrier undertook during the prior calendar year to market at least three of the standard health benefits, **whether through the marketplace or off the marketplace**, or in the case of a Federally qualified HMO, the standard individual HMO plan. **If a member offers one or more standard health benefits plans with rider the member may include information regarding efforts to market the standard health benefits plan with rider in the report**. [**The first reports shall be due on May 1, 2010.]**

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

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

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

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

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

[iii. The small employer carrier provides evidence that it filed rates and forms for the standard individual health benefits plans. Such evidence may be in the form of a copy of the cover letter for such rates or forms filing.]

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

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

16 within 60 days following receipt of a determination from the Board that the carrier was found to have not made a good faith effort to market the standard individual health benefits plans.

§ 11:20-24.7 [Conversion of in force contracts

(a) A carrier may convert plans that were in force as of January 5, 2009 subject to the following requirements:

1. No more than 25 percent of a carrier's total in force plans may be converted during a calendar year;

2. The plan offered on conversion must be of equal or greater actuarial value than the plan being converted; and

3. The selection of plans to be converted must not be based on a health status related factor of persons covered under such plans.

(b) A carrier desiring to convert in force plans shall provide notice to the Board of its intent to convert plans at least 90 days prior to the commencement of the conversion. The notice shall:

1. Identify the plan or plans being converted;

2. Specify the plan or plans to which conversion is being made;

3. Identify the number of policies or contracts that were issued such plans and evidence that the number does not exceed 25 percent of the total in force policies or contracts; and

4. Include a copy of the notice to be provided to in force policyholders or contractholders.

(c) Conversion may only occur following at least 60 days advance notice of the conversion to each policyholder or contractholder.

1. Carriers must provide policyholder or contractholder with a comparison of the plan being converted to the plan to which conversion is being made.

2. Carriers must advise the policyholder or contractholder that the rate increase limitation applies to the converted plan to the same extent it would have applied to the plan that was converted.] **RESERVED**

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

New Jersey Individual Health Coverage Program

20 West State Street, 10th Floor

PO Box 325

Trenton, NJ 08625-0325

New Jersey Office of Administrative Law

9 Quakerbridge Plaza

PO Box 049

Trenton, NJ 08625-0049