INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Adopted Repeals: N.J.A.C. 11:20-8.1, 8.2, 8.3, 8.4, 13 and 11:20 Appendix Exhibit K

Adopted Amendments: N.J.A.C. 11:20-1.2, 3.1, 4.1, 6.1, 6.3, 7.3, 7.4, 8.1, 8.2, 8.3, 8.4, 8.5 through 8.8, 9.2, 9.3, 9.4, 9.5, 12.1, 12.3, 12.4, 12.5, 17.1, 17.3, 17.4, 18.2 and Appendix Exhibits G and L.

Adopted New Rules: N.J.A.C. 11:20-6.5, 8.1 through 8.4, 22 and Appendix Exhibit K and Appendix Exhibit V.

Proposed: at 35 N.J.R. 73(a).

Adopted: January 16, 2003 by the New Jersey Individual Health Coverage Program Board, Wardell Sanders, Executive Director.

Filed: January 16, 2003 as R.2003, d. ___, with technical changes not requiring additional public notice and comment (see N.J.A.C. 1:30-4.8).

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

Effective Date: January 28, 2003

Operative Date: January 28, 2003

Expiration Date:

The New Jersey Individual Health Coverage Program Board held a public hearing on December 9, 2002 to receive oral testimony with respect to the proposed specimen policy form for the basic and essential health care service plan. The proposed specimen policy form, proposed as Exhibit V, was included in the Board's rule proposal. Wardell Sanders, the executive director of the IHC Board, served as hearing officer. One person attended, but did not provide testimony at the hearing. W. Sanders provided no recommendations regarding the proposal.

Summary of Public Comments and Agency Responses:

Comments were received from the law firm of Windels, Marx, Lane & Mittendorf on behalf of Fortis Insurance Company ; the law firm of Riker, Danzig, Scherer, Hyland, Perretti on behalf of CIGNA Healthcare of New Jersey, Inc., CIGNA Healthcare of Northern New Jersey, and Connecticut General Life Insurance Company ; and Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare of New Jersey .

COMMENT 1: The commenter noted that the proposed amendment to N.J.A.C. 11:20-8.5(d)(2) defining "inception to date" in the calculation of net investment income was at odds with the fundamental intent, purpose and operation of the IHC Act. Net investment income is used to determine an individual market carrier's net paid loss or gain on individual health benefits plan, which may be reimbursable. Specifically, the commenter objected to the proposed definition of "inception to date," which encompasses cash flows received prior to a carrier's participation in what the commenter called "the reimbursement Program." The commenter also alleges that the proposed rule contradicts case law and industry standards, but did not cite any case law or industry standards to support this contention.

RESPONSE: The Board notes that the IHC Act does not provide a definition or a formula for determining "net investment income," which along with premium and claims is part of the calculation of a reimbursable loss which is set forth at N.J.S.A. 17B:27A-12a(1)(b). The term "inception to date" is similarly not set forth in the IHC Act.

The IHC Act does require the Board to "establish procedures for the equitable sharing of program losses among all members…" N.J.S.A. 17B:27A-12. In

promulgating a regulation to set forth the reporting requirements for carriers issuing individual health coverage, and specifically the reporting requirements for net investment income, the Board needed to balance the interests of all IHC Program members, both those carriers seeking reimbursement and as those paying an assessment, to ensure the equitable distribution of losses.

The "inception to date" language identified by the commenter was included in the Board's regulations as part of amendments that were effective on August 7, 1998. See 30 N.J.R. 2581(a) (Jul. 20, 1998) and 30 N.J.R. 3298(a) (Sept. 8, 1998). This regulatory language was not effective during the 1992 through 1996 one-year assessment calculation periods. The 1997/1998 two-year calculation period was the first application of this regulation to any reported net paid losses. The purpose of the inclusion of that language, along with other amendments, was to standardize the reporting requirements for net investment income.

The Board has consistently interpreted that language as meaning that the date of "inception" that should be used in the calculation of cash flows should be the first date that the carrier experienced any cash flow for the standard individual health benefits plans. The commenter has indicated that it believes that the date of "inception" should refer to its first participation in the reimbursement program. The Board understands this comment to mean the first day of the assessment period for which the carrier first sought reimbursement. Thus, the commenter asserts that if, at the beginning of a carrier's participation in the IHC Program, it was a carrier seeking an exemption, and thus not eligible for reimbursement, the date of inception for measuring cash flows should be delayed until the carrier first seeks reimbursement.

Webster's Dictionary defines "inception" as "a beginning or commencement." The Board believes that the plain reading of the phrase "inception to date" is the beginning of the carrier's participation in the IHC Program rather than some later date. Moreover, the commenter's position fails to account for the fact that a carrier must make a separate decision to seek an exemption for every assessment cycle. A carrier could seek an exemption in cycle one, not seek an exemption in the next cycle and perhaps be in a position to seek reimbursement in cycle two, seek an exemption in cycle three, not seek an exemption in the next cycle and perhaps be in a position to seek reimbursement in cycle four, and so on. If, as the commenter seems to contend, cash flow only becomes relevant when the carrier is seeking reimbursement, the measurement of "inception to date" would simply be impossible if the carrier alternates between exempt status and non-exempt status as described above because “inception” to date contemplates cash flow over an unbroken period of time.

The Board's interpretation of "inception to date" provides for what the Board believes is the equitable distribution of losses because it more equitably identifies what should be a reimbursable loss. That interpretation is clarified in the proposed regulation. Take, for an example, a carrier that entered the IHC market in 1995 as a carrier seeking an exemption which had positive cash flow for two years but then sought an exemption beginning with the 1997/1998 two-year calculation period, and began to have negative cash flow beginning in 1997. For the 1999/2000 Exhibit K, the commenter would assert that this carrier's cash flow should not be measured until 1997 when it began losing money. The Board interprets the "inception to date" language to mean that the carrier should begin to measure the carrier's cash flow in 1995. It would not be fair to the

carriers paying loss assessments to permit a carrier to disregard the two years of positive cash flow while at the same time selectively including only the period of negative cash flow in determining that carrier's net investment income. In order calculate reimbursable losses in the most equitable manner, it is essential that both positive and negative cash flow be treated in like manner and that carriers not inflate the reimbursable loss amount by failing to consider periods of positive cash flow.

For these reasons, the proposed regulation (nor the existing regulation, for that matter) is not at odds with the fundamental intent, purpose and operation of the IHC Act; nor does the proposal contradict either the plain language or the intent of the IHC Act. The Board can not comment on the commenter's contention that the proposed rule contradicts case law and industry standards since the commenter did not cite any case law or industry standards to support this contention. The Board is not aware of any case law or industry standards that the rule would contradict.

COMMENT 2: The commenter asserted that the proposed amendment to N.J.A.C. 11:20-6.3 providing that a carrier "shall use the rates shown in the rate filing, as of the stated effective date," and to N.J.A.C. 11:20-8.8(c) which "allows the IHC Board to adjust the carrier's reimbursement" for failing to charge premium consistent with a carrier's informational filing contradicts the plain language and intent of the New Jersey Individual Health Insurance Reform Act ("IHC Act"), N.J.S.A. 17B:27A-2 et seq., as well as case law and industry standards. The commenter contends that the proposed amendment does not require a carrier even to include an effective date in its informational rate filing. The commenter contends that the IHC Act merely contemplates that carriers provide an informational rate filing to the Board on any proposed rate change

sometime before the change is made. The commenter contrasted the "file and use" standard set forth in the IHC Act with other insurance statutes (N.J.S.A. 17:29A-6 and N.J.S.A. 17:29A-15) which require prior approval by a State agency before use, and asserted that the proposed changes to the rate filing rules and the audit rules effectively create a prior approval rate system. The commenter contended that it believed that the proposed amendments contradict case law and industry standards, but did not cite any case law or industry standards to support this point.

RESPONSE: As a threshold matter, the IHC Board has the authority to require carriers to provide an effective date as part of the informational rate filing. N.J.S.A. 17B:27A-16.1a(1)(c) and (g), and N.J.S.A. 17B:27A-9e(1) authorize the Board to promulgate a rule or "action" relating to the making of rate filings and to determine the supporting data that is to be included in those filings. An effective date is an integral aspect of an informational rate filing. The New Jersey Department of Banking and Insurance, for example, in implementing the informational rate filing scheme for carriers in the small employer health insurance market set forth at N.J.S.A. 17B:27A-25f, requires that carriers identify an effective date, even though that statute does not expressly identify an effective date as something that may or must be in an informational rate filing. N.J.A.C. 11:21-9.3(a)4ii. The IHC Act requires carriers to provide a certification that the rates are formulated so that the anticipated minimum loss ratio for the policy is not less than 75 percent of the premium. N.J.S.A. 17B:27A-e(1). Certainly, such a certification would require the rates to be tied to a designated time period.

Further, the unamended text of N.J.A.C. 11:20-6.3 already requires carriers to provide a rate manual, premium rates and factors, a detailed actuarial memorandum, and

a certification signed by a member of the American Academy of Actuaries as part of the informational rate filing. This information can not be effectively provided without the identification of an effective date since premium, claims and loss experience only have meaning when tied to a specified period in time, which period must have a designated commencement which is identified as the effective date. As a matter of practice, carriers have identified an effective date in their filings. The phrase "as of the stated effective date" in the amendments to N.J.A.C. 11:20-6.3(a)2 and the reference to the "effective date" in the amendment to N.J.A.C. 11:20-6.3(a)2i serve as explicit reminders that carriers need to provide an effective date in the informational rate filing. Nevertheless, to address the concerns of the commenter, the Board has added on adoption a further express requirement that carriers provide an effective date as part of the rate filing in N.J.A.C. 11:20-6.3.

While N.J.S.A. 17:29A-6 requires prior approval of automobile rates and requires carriers to use rates as of the date of the "filing of [the] rating systems," the Board disagrees that one should conclude from that law that the IHC Act's silence with respect to effective dates effectively permits carriers to file incomplete and/or inaccurate information in its rate filing. On a common sense level, an "informational" rate filing is not of much utility to a regulator or to users of the information, such as consumers, if the information contained therein is not complete and/or accurate.

The Board does not agree with the commenter that requiring carriers to include an effective date in the informational rate filing is tantamount to creating a prior approval rating mechanism. The Board is only asking that a carrier submit a filing that accurately identifies an effective date for changes in rates in advance of charging the changed rates.

In no way does the Board, under the amended rule (or the existing rule for that matter,) have the authority to "approve" or "disapprove" a rate filing or the rates charged by a carrier. The Board has the authority to require accurate and complete information. If a carrier finds that it will not be in a position to implement the rate change as of the effective date noted in a prior filing, it must submit a revised filing or an amendment to the prior filing with the Board in advance of the effective date.

There is a strong consumer interest in the accurate filing of an effective date of a rate change. To assist consumers in shopping for individual health coverage, the IHC Board publishes on a monthly basis an up-to-date premium comparison chart that lists all individual market carriers, their rates, their addresses, and their toll-free phone numbers. The premium rates that are included in the premium comparison chart are premiums that are effective during the month specified on the chart. The IHC Board relies on the information, including the effective date, provided in each carrier's rate filings to determine the appropriate rates to include on the chart for each month. This premium comparison chart is distributed by the IHC Board to persons calling a toll free number (800.838.0935), it is mailed to persons that have asked to receive the rates monthly, and it is published on the New Jersey Department of Banking and Insurance web site (www.nj.gov/dobi/reform.htm). If a carrier were to fail to implement a rate increase by the date in its filing, then consumers would not be aware of a less expensive option that exists in the market. Such a result would frustrate the purpose of publishing and distributing the premium comparison charts, which is to allow consumers to make an informed choice when purchasing coverage. That in turn is consistent with the intent of

the IHC Act, which is to expand availability of individual health coverage over as broad a spectrum of the market as possible, fostering both competition and choice.

For these reasons, the Board does not believe that the existing regulation or the proposed amendments contradict either the plain language or the intent of the IHC Act. The Board can not comment on the commenter's contention that the proposed amendments contradict case law and industry standards since the commenter does not cite any case law or industry standards to support this point. The Board is not aware of any case law or industry standards that the rule would contradict.

COMMENT 3: The commenter objected to the proposed amendments to N.J.A.C. 11:20-8.8(c) permitting the IHC Board to adjust a carrier's net paid loss for "failure to pay claims consistent with the terms of the applicable contract or applicable law." The commenter asserted that there is no statutory authority for the Board to "second-guess" a carrier's claims decisions. The commenter contended that the proposed rule would effectively deprive the carrier of its own decision-making authority. The commenter cited common law principles and industry standards that have been developed to safeguard a carrier's autonomy with respect to claims handling. Specifically, the commenter referred to a "follow the settlements" doctrine, which "dictates that a reinsurer may not challenge the good faith decision of its reinsured to settle a claim, provided the settlements are not fraudulent, collusive or made in bad faith." The commenter stated the proposed amendment to N.J.A.C. 11:20-8.8(c) implies that a carrier should seek the IHC Board's approval before settling claims.

RESPONSE: The Legislature provided the Board with the authority to review and audit a carrier seeking reimbursement of losses. N.J.S.A. 17B:27A-11i provides the

Board with the specific authority to "establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the program and provide for performance audits from time to time." Since the inception of the IHC Program, the Board has audited or reviewed the net paid losses reported on Exhibit K of every carrier that has sought reimbursement of losses. As part of these audits, among other things, the auditors have reviewed both the accuracy and the appropriateness of the data reported.

The reason for such review should be clear: the Board has an obligation to the carriers paying loss assessments to undertake a thorough review to help ensure that the paying carriers are not paying more than they should. N.J.S.A. 17B:27A-12 requires the IHC Board to "establish procedures for the equitable sharing of program losses among all members in accordance with their market share. . ." If, for example, a carrier provides benefits under an IHC contract to an ineligible person, the carriers paying an assessment should not be required to fund losses of a carrier that has inappropriately covered an ineligible person. An assessed carrier should also not be required to fund losses to a carrier that has provided benefits to insureds when those benefits are not covered under the policy form. The Board believes that claim payments made in excess of that which the law or the policy form provides should not be included in a carrier's paid claims for purposes of reimbursement. The Legislature did not intend to fund a carrier's losses resulting from improperly paid claims - for example, to persons residing in other states, or for benefits not covered in the contract.

Because the Board developed and promulgated the standard policy forms that carriers are required to issue, the Board is uniquely qualified to determine whether carriers seeking reimbursement have paid claims in a manner consistent with the terms of

the policy forms that the carriers issued. It is not the Board's intention to have its professional auditors review claims to "second-guess" good faith determinations by carriers where there is some ambiguity in the law or the contract, or where some significant level of subjective analysis is required. Rather, the purpose of the claims audit is to ensure both that a carrier requesting reimbursement provide some documentation to support its claims decisions, and that payments are consistent with the terms of the contract and the law. In any event, if a carrier believes that the audit or reimbursement provided by the Board is based on the Board's overreaching with respect to the claims portion of the audit or some other aspect of the audit, the carrier may appeal the Board's action pursuant to N.J.A.C. 11:20-20.

The Board has considered the commenter's analogy to reinsurance contracts and the "follow the settlements" doctrine, but the analogy is inapposite. Reinsurance agreements bring together two parties on a voluntary basis. The parties are free to contract as they see fit with respect to the reinsurer's level of review of the claims handling of the insured. The IHC Program reimbursement mechanism does not bring the payors and the payees together on a voluntary basis. The paying carriers are subject to assessment by operation of law, and it is the law that entrusts the IHC Board to promulgate rules that provide for the fair and equitable distribution of program losses.

COMMENT 4: The commenter contended that in the event the proposed amendments to N.J.A.C. 11:20-6.3 and 8.8(c) are promulgated, they should be applied prospectively.

RESPONSE: As was noted in the rule proposal, the amendments to N.J.A.C. 11:20-6.3 and 8.8(c) merely clarify the existing regulations and are consistent with prior Board practice and interpretation of those regulations.

COMMENT 5: The commenter urged the Board to repeal N.J.A.C. 11:20-9.5(f)2, the regulatory provision which provides that if an individual market carrier that has been granted a conditional exemption enrolls or insures fewer than 50 percent of the minimum number of non-group persons allocated to it by the Board, the carrier must demonstrate that it has made a good faith effort to enroll or insure the minimum number of non-group persons allocated to it by the Board. The commenter contended that P.L.2001, c.368, “confirms” that the Legislature's intent in enacting the original IHC Act did not include the intent that carriers must make a showing of a good-faith effort to market individual health benefits plans in order to qualify for an exemption. The commenter asserted that the Board should cease implementing this requirement that was "now inconsistent with both the IHC Act and its supplement, P.L.2001, c.368."

RESPONSE: Because the Board did not propose any amendments to N.J.A.C. 11:20-9.5(f)2, the comment is beyond the scope of the proposal. Further, the Board notes that in a decision dated May 24, 2002, after the enactment of P.L. 2001, c.368, the Appellate Division upheld the Board's authority to promulgate a good faith marketing requirement and upheld N.J.A.C. 11:20-9.5(f)2. The Supreme Court has denied the appellant's cross petition for certification on that issue. In the Matter of the New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1 et seq., 353 N.J. Super. 494 (App. Div.), certif. denied, ___ N.J. ___ (2002).

COMMENT 6: The commenter asked the Board to amend the rule proposal to maintain inclusion of the definition of "reimbursement for losses," which is set forth at N.J.A.C. 11:20-1.2. The commenter alleged that the Board errs when it states that the repeal of this definition was a change required by P.L.2001, c.368. The commenter contended that the long-standing regulatory definition of "Reimbursement for losses" accurately sets forth "the statutory reality that losses 'incurred by members applying for reimbursements' may be covered 'in whole or in part.'" The commenter alleged that the repeal of this definition is "a transparent attempt to eliminate the IHC's own long-standing regulatory definitions that contradict its more recent litigation strategy and arguments raised by [the commenter]."

RESPONSE: The Board agrees with the commenter that the repeal of the phrase "reimbursement for losses" was not explicitly required by the enactment of P.L.2001, c.368. However, in reviewing the text of existing definitions in light of P.L. 2001, c. 368, the Board recognized that the definition for “reimbursement for losses” would need to be revised to address reimbursement for losses sustained under the basic and essential health care services plan. The Board also recognized that the definition may in fact be an oversimplification of the loss reimbursement process and could even be potentially misleading. A complete understanding of “reimbursement for losses” is not found in the definition, but is rather set forth in N.J.A.C. 11:20-2 and 8. The Board disagrees with the alleged link between the repeal of the definition and any litigation strategy. The proposed repeal does not affect in any way either the way losses are calculated or how reimbursement is provided.

COMMENT 7: The commenter states that it "appears" that the IHC Board is changing certain unspecified “other rules and Exhibits,” particularly Exhibit K, to eliminate the Board's own regulatory references to "reimbursable losses" and "loss reports," because that terminology conflicts with the positions the Board has taken in litigation. The commenter argued that these proposed changes should not be adopted.

RESPONSE: The Board notes that the commenter has not identified to what "other rules" it is referring. As a result, the Board cannot respond to that aspect of the comment.

The commenter did specifically referred to the deletion of the terms "reimbursable losses" and "loss reports" in Exhibit K. The commenter expressed general concern with the elimination of the terms "reimbursable losses" and "loss reports." The Board was able to identify its use of the term "reimbursable losses" in the rule proposal only in changes to N.J.A.C. 11:20-8.7(a), 8.8(b) and 9.6(a) and (d). In none of the proposed changes did the Board eliminate existing references to the phrase "reimbursable losses." The Board did not use the term "loss reports" anywhere in the proposal, and that term does not appear in the existing regulations.

The commenter did not identify specifically what positions the Board has taken in litigation that conflict with the "other rules and Exhibits” that the Board proposes to amend. Therefore, the Board is unable to provide a specific response to the comment. In any event, the Board's proposal set forth in detail a statement of the proposed rulemaking, including a summary statement that clearly explains its purpose and effect.

COMMENT 8: The commenter stated that Exhibit K requires the reporting of losses for exempt and non-exempt carriers, but states that under the IHC Act carriers that

seek an exemption are not eligible for reimbursement. The commenter contended that it has demonstrated in its briefing before the New Jersey Supreme Court, that the Legislature never intended to create a system for full reimbursement of Program losses, and that the IHC Board should not repeal or replace its forms and rules.

RESPONSE: The Board believes that the comment is beyond the scope of the proposal. However, in any event, the Board agrees that its proposal and the existing rule require the reporting of losses for exempt carriers and non-exempt carriers. That requirement is set forth in the IHC Act at N.J.S.A. 17B:27A-12a(1)(b). The Board further agrees with commenter that losses incurred by carriers applying for an exemption are not eligible for reimbursement through the IHC loss assessment mechanism. N.J.S.A. 17B:27A-12d(1). The Board agrees that carriers applying for an exemption that sustain losses are not eligible for reimbursement. However, none of the proposed changes modify that existing statutory and regulatory scheme. To the extent that the commenter contends that a carrier that has not filed for an exemption and has suffered losses that are reimbursable as defined by N.J.S.A. 17B:27A-12a(1)(b) may not have those losses fully reimbursed, the Board disagrees. The Appellate Division too rejected this argument. Although the commenter may have advanced that argument in briefing to the New Jersey Supreme Court, the commenter's cross-petition for certification to the Supreme Court on this issue was denied. In the Matter of the New Jersey Individual Health Coverage Program's Readoption of N.J.A.C. 11:20-1 et seq., supra, 353 N.J. Super. 494 (App. Div.), certif. denied, ___ N.J. ___ (2002). This is now a settled matter of law.

COMMENT 9: For consistency, the commenter suggested adding “Medicare Demonstration plans” at N.J.A.C. 11:20-1.2 – definition of “Non-group persons”, and at

11:20-8.4(b)(4), and adding, “Medicare Plus Choice and Medicare Demonstration plans” at 11:20-9.5(b) in the second-to-last sentence.

RESPONSE: The Board agrees that references to "Medicare Demonstration plans" should be included in the sections the commenter noted. For consistency with terminology used elsewhere, the Board has added references to "Medicare Demonstration Project lives."

COMMENT 10: The commenter noted that N.J.A.C. 11:20-21.4 (a)2ii (published in the New Jersey Register as N.J.A.C. 11:20-22.4(a)2ii) requires that the officer certification accompanying a carrier’s basic and essential health care service plan policy form filing include the anticipated loss ratio for the basic and essential health care services plan. Since this may change from one rate filing to the next, the commenter suggested changing the requirement to certify that “the anticipated loss ratio is expected to be at least 75 percent” to be consistent with the rate filing at 11:20-6.1(a)4ii. The commenter noted that if the Board believes the actual anticipated loss ratio must be filed, the commenter would suggest placing it with the rate filing rather than the officer certification (which would otherwise only be filed once).

RESPONSE: The Board agrees with the commenter that a certification specifying the anticipated loss ratio should be required in the context of the rate filing. Therefore the Board has modified N.J.A.C. 11:20-22.4(a) 2ii to delete the requirement and has added the requirement that a carrier certify as to the anticipated loss ratio in the rate filing in N.J.A.C. 11:20-6.1(a)4iv. Thus, the rate filing for all plans must include a statement that the anticipated loss ratio is expected to be at least 75 percent, and the rate filing for

the basic and essential health care service plan must include an additional statement to specify the anticipated loss ratio.

COMMENT 11: The commenter suggested that N.J.A.C. 11:20-12.5(d)5 should be re-labeled subsection 11:20-12.5(e), and not indented, since 12.5(d) applies exclusively to HMO plans. The current (e), (f) and (g) would then be re-labeled (f), (g), (h), and the new (h) should read, "Notwithstanding (b), (c), (d) and (e) above...."

RESPONSE: The Board notes that the change the commenter requested was made upon publication of the proposal in the *New Jersey Register*.

COMMENT 12: The commenter recommended that “section” be inserted after “pursuant to” in the third line of N.J.A.C. 11:20-6.1.

RESPONSE: The text the commenter cites was modified upon publication of the proposal in the *New Jersey Register* to eliminate the “pursuant to” phrase. The Board notes that the existing text refers to “section” and should refer to “sections.” That change is being made upon adoption.

COMMENT 13: The commenter recommended that the Board insert “services” after “health care” at the end of the first full paragraph of N.J.A.C. 11:20-6.3(a)2.

RESPONSE: The Board agrees with the commenter and has made the requested change.

COMMENT 14: The commenter recommended that the Board insert “plan” after “health care services” in N.J.A.C. 11:20-9.5(b)2.

RESPONSE: The Board agrees with the commenter and has made the requested change.

COMMENT 15: The commenter recommended that the Board change “under” to “or” and change “standard” to “individual” in N.J.A.C. 11:20-12.1(c).

RESPONSE: The Board agrees with the commenter and has made the suggested changes.

COMMENT 16: The commenter suggested that the disclaimer on the cover page of Appendix Exhibit V be modified to: "This policy is a limited benefits plan and does not provide comprehensive major medical coverage." Since the benefits are severely reduced from standard plans, consumers must be informed as to the plan's limitations.

RESPONSE: The Board agrees and has made the requested change.

COMMENT 17: The commenter contended that the definition of “Admission” in Exhibit V refers to a definition of “Period of Confinement” which does not exist. The commenter suggested that Admission is sufficiently self-defining, and its definition be omitted.

RESPONSE: The Board agrees and has made the requested change.

COMMENT 18: The commenter suggested that the definition of “Covered Services and Supplies” in Exhibit V be bracketed to allow for its omission for non-HMO plans.

RESPONSE: The Board agrees and has made the requested change.

COMMENT 19: The commenter suggested that the definition of “Hospice” in Exhibit V should end after the first sentence. Since the plan excludes hospice coverage, accreditation should not be relevant, and “recognition” by the carrier may create the mistaken impression of coverage.

RESPONSE: The Board agrees and has made the requested change.

COMMENT 20: The commenter recommended that the “Note to carriers” in the definitions of Network and Non-Network Provider of Exhibit V be revised to replace the reference to “managed care plan” with a reference to “plans with participating providers” to accommodate traditional Blue Cross plans.

RESPONSE: The Board agrees and has made the requested changes.

COMMENT 21: The commenter recommended that the definition of Reasonable and Customary in Exhibit V should be bracketed as variable text, so that it can be removed for HMO plans. The same is true in the reference to Reasonable and Customary in the “Copayment” Section in “Benefit Deductibles, Copayments and Coinsurance”, and to the Exclusion for “Any charge to the extent it exceeds the Reasonable and Customary Charge”.

RESPONSE: The Board agrees and has made the requested changes.

COMMENT 22: The commenter suggested adding definitions of "Hospital Admission Review" and "Premium" to Exhibit V for clarity and consistency with the Individual Health Care standard plans.

RESPONSE: The Board refers the commenter to plan provisions entitled “Premium Rates and Provisions” and “Utilization Review.” The Board believes that the provisions are sufficiently clear and do not require the addition of defined terms. The Board further notes that the basic and essential health care services plan is not one of the standard plans and as such differs in many respects as compared to the standard plans.

COMMENT 23: The commenter suggested changing the reference to “Period of Confinement” to “hospital stay” in the Copayments section of the Coverage Schedule of

Exhibit V. As the commenter had noted, “Period of Confinement” is not defined; “hospital stay” would be consistent with the underlying statute.

RESPONSE: The Board thanks the commenter for noting the use of an undefined term in the Coverage Schedule. The Board has added a definition of ‘Period of Confinement,’ upon adoption. The Board notes that the term “Period of Confinement” is commonly used in policies and contracts to identify the period during which a covered person is actually confined in a hospital and would be charged for room and board. Given the context in which “hospital stay” is used in P.L. 2001, c. 368 in reference to benefits for room and board, the Board believes that the term “Period of Confinement” is consistent with the coverage required by P.L. 2001, c. 368.

COMMENT 24: The commenter suggested changing the reference to “Outpatient diagnostic tests” to “Out-of-hospital diagnostic tests” in the “Maximum Benefits” under the Coverage Schedule in Exhibit V. The commenter contended that this would be consistent with the language of the statute, and would be consistent with the coverage described for pre-admission testing, which is not subject to the maximum.

RESPONSE: The Board agrees and has made the requested change. In addition, the Board has amended the corresponding coverage text in Exhibit V to use the term “out-of-hospital” rather than “outpatient.” The Board notes that while outpatient tests would include tests done in the outpatient department of a hospital, out-of-hospital tests would not include tests performed in the outpatient department of a hospital.

COMMENT 25: The commenter recommended that the heading “Service area” in Exhibit V be bracketed to allow its omission for non-managed care plans.

RESPONSE: The Board agrees and has made the requested change.

COMMENT 26: In the coverage for “Immunizations and Lead Screening” in the “Covered Charges/Services” section of Exhibit V, the commenter recommended inclusion of an item “c) adult immunizations”, as required by the underlying statute. The commenter further commented that it is not clear how coverage for immunizations and lead screening is coordinated with the wellness benefit. The commenter noted that if they are intended to be mutually exclusive, the commenter would suggest changing the last sentence of “Immunizations” section to read, “These charges are not subject to the Wellness benefit deductible, Coinsurance or Maximum,” and excluding immunizations and lead screening from the wellness benefit.

RESPONSE: The Board agrees with the requested change regarding adult immunizations and has made the suggested change. Regarding the coordination of the wellness benefit and the benefit for immunizations and lead screening, the Board notes that P.L. 2001, c.368 requires coverage for wellness benefits and for immunizations. Since there is cost sharing and a limited benefit associated with wellness benefits the Board intends that carriers will cover immunizations and lead screening under the immunizations and lead screening benefit since that would produce a better result for consumers.

COMMENT 27: In the Exclusions section of Exhibit V, the commenter suggested an affirmative exclusion for “Any service or supply not specifically included in the ‘Covered [Charges][Services or Supplies]’ Section of this Policy,” since the plan must by law be limited to these benefits.

RESPONSE: The Board agrees and has made the requested change.

COMMENT 28: The commenter indicated that the Exclusions section of Exhibit V includes outright exclusions for transplants, treatment of hemophilia, and treatment of Wilm's tumor. While these exclusions would reduce the cost of the plan, the commenter asserted that their legal authority is unclear, and the average consumer may not fully appreciate the ramifications of these exclusions. Since the statute mandates coverage of hospital room and board, physician fees for surgery, diagnostic tests, etc., the commenter contended that it is not clear what provides the authority for excluding these covered services when associated with medically necessary transplants or treatment of hemophilia or Wilm's tumor. The commenter suggested omitting these exclusions.

RESPONSE: It is the Board's understanding that the Legislature intended that the basic and essential health care services plan cover only those services listed in P.L.2001, c.368. Since transplants are not among the listed services, the Board believes the exclusion of transplants is consistent with the statute. As a matter of industry practice, coverage for transplants is considered a covered service that is distinct from coverage for surgery even though transplants involve surgery. For example, the standard health benefits plans offered in both the individual market and the small employer market provide coverage for transplants pursuant to a specific covered charge which lists the types of transplants that are covered. It is the Board's understanding that the basic and essential health care services plan is intended to provide coverage that is more affordable than the standard plans currently available in the individual market. Adding coverage for transplants to the basic and essential health care services plan would significantly add to the cost of the plan and reduce the effectiveness of the Legislature's goal of providing

for a more affordable coverage option. Carriers that wish to offer coverage for transplants may file an optional benefit rider.

Nevertheless, the Board recognizes that the basic and essential health care services plan does specifically provide coverage for some services and supplies a transplant patient may require. Thus, the Board is amending the transplants exclusion to state that transplants are excluded except to the extent that a service or supply associated with a transplant is specifically covered under the policy form. With respect to the commenter's suggested changes regarding treatment of hemophilia and Wilm's Tumor, the Board agrees with the commenter and has made the suggested changes. The Board notes that regarding hemophilia, the policy form, as proposed in Exhibit V, includes coverage for blood that is not replaced and thus the deletion of the exclusion for treatment of hemophilia makes it clear that blood is available for the treatment of hemophilia. With respect to treatment of Wilm's Tumor, the Board notes that some of the treatments associated with Wilms Tumor are expressly excluded in the basic and essential health care services plan policy form. To the extent that medically necessary care or treatment for hemophilia or Wilm's Tumor is not expressly excluded, it would be covered.

COMMENT 29: The commenter suggested excluding the second paragraph of the "Appeals Procedure" section of Exhibit V, as the Department of Labor claim rules would only apply to employment-based benefit plans.

RESPONSE: The Board agrees and has made the requested change.

COMMENT 30: On the Quarterly enrollment form set forth as Exhibit L, the commenter suggested deleting the reference to Plan A which has been eliminated as a plan option.

The commenter asserted that this would be consistent with the deletion to the reference to Plan E, which was eliminated at the same time that the Board eliminated Plan A. In Section D, row IX (the first line IX), the commenter suggested eliminating the deductible/copay language, as all basic and essential health care services plans will appear in the two "B&E" columns. The commenter suggested changing the next IX line to X.

RESPONSE: The Board agrees and has made the requested changes. In addition, the Board removed references to Plans A and E from the corresponding regulation, N.J.A.C. 11:20-17.4(a).

COMMENT 31: On the annual enrollment form set forth at Exhibit L, the commenter suggested deleting references to Plan A and Plan E. The commenter also noted that in the annual form, the B&E Plan is listed after the HMO plan, but in the quarterly form, B&E is listed before the HMO plan. The Board may wish to consider making them consistent.

RESPONSE: The Board agrees and has made the requested change to delete references to Plans A and E. In addition, the Board removed references to Plans A and E from the corresponding regulation, N.J.A.C. 11:20-17.4(b). Since the basic and essential health care services plan is not a standard plan, the Board believes that the most appropriate placement of the plan on the two enrollment reporting forms, Exhibit L part 1 and Exhibit L part 2 is for the "B&E" plan to appear after the HMO plan. On adoption, the Board has moved the "B&E" column to follow the "HMO" plan column on Exhibit L part 1.

Agency Initiated Changes

1. In N.J.A.C. 11:20-12.1(c) the Board replaced the preposition “in” with “under” so the text now refers to applying for coverage under standard health benefits plans.

2. In order to clarify the date on which carriers must begin to file the report required by N.J.A.C. 11:20-22.6(a) the Board included text to state that the first report is due May 1, 2004.

3. The draft basic and essential health care services plan as proposed at Appendix Exhibit V included an exclusion for hemodialysis. The Board is deleting that exclusion upon adoption and is adding a sentence to the dialysis benefit to address coverage for both hemodialysis and peritoneal dialysis. The Board believes that the dialysis treatment specified in P.L. 2001, c. 368 was intended to include these types of dialysis.

4. The specimen basic and essential health care services plan as proposed at Appendix Exhibit V includes a provision entitled Continuation of Care. The second paragraph of that provision contained a sentence regarding postpartum care. Since the plan specifically excludes prenatal and postnatal care, the statement in the Continuation of Care provision regarding coverage for postpartum care is being deleted upon adoption since it conflicted with the express exclusion.

5. The form and rates filings carriers have submitted indicate that some carriers intend to offer the basic and essential health care services plan as a preferred provider organization (PPO) plan or as an exclusive provider organization (EPO) plan. The captions on the enrollment reports, Exhibit L part 1 and Exhibit L part

2 addressed only indemnity and HMO. On adoption, the Board is expanding those captions to include both “PPO” and “EPO.” In addition, the corresponding regulation, N.J.A.C. 11:20-17.4 (a) and (b) has been amended to address the possibility that carriers may issue the basic and essential health care services plan as a PPO or EPO plan. The Board is also amending N.J.A.C. 11:20-22.3(b) to include PPO and EPO options.

6. The Board has made grammatical and punctuation changes.

7. In section N.J.A.C. 11:20-8.5(a), the Board has amended the text to note that for purposes of completing Part E of the Assessment Report form, carriers should include data for the basic and essential healthcare services plan. The Board had inadvertently omitted including the reference to the plan in the proposal.

8. In section N.J.A.C. 11:20-8.6(a), the Board has changed the reference of "member" to "carrier" since the certification portion of the Exhibit K Assessment Report will need to be signed by a carrier whether or not it is a member of the IHC Program to certify to the data and information contained therein.

9. In section N.J.A.C. 11:20-8.6(b), the Board has added "Exhibit K" before "Assessment Report" to more clearly identify the document and to conform to other references throughout the rules.

10. In section N.J.A.C. 11:20-22.4, the Board has added words to standardize references to the policy form for the basic and essential health care services plan, set forth in chapter Appendix Exhibit V.

Federal Standards Statement

The standard individual health benefits plans comply with the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191. The standard plans, and the rules describing the standard plans, do not expand upon the requirements set forth in the Federal law.

Full text of the adoption follows (additions to the proposal indicated in boldface with asterisk ***thus***; deletions from proposal indicated in brackets with asterisks ***[thus]***):

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.2 Definitions

. . .

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

. . .

“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.§1395§§(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. – 5 (no change)

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.

. . .

"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 contract, *__**Medicare Demonstration Project plan**__* or Medicaid contract.

. . .

. . .

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

(a) – (e) (No change.)

11:20-3.4 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.A.C. 11:20-22. A specimen policy form is set forth in Appendix Exhibit V.

SUBCHAPTER 4. STANDARD APPLICATION FORM

11:20-4.1 Standard application form

All members offering standard health benefits plans with an effective date on or after August 1, 1993, and the basic and essential health care services plan with an effective date on or after January 1, 2003**,** shall use the standard application form approved by the Board and specified in Exhibit G with the variable text explained on the Explanation of Brackets, Exhibit T of the Appendix to this chapter.

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

11:20-6.1 Purpose and scope

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to section**s** 2b(1) and 3 of the Act (N.J.S.A. 17B:27A-3b(1) and 17B:27A-4)**,** as well as the basic and essential health care services plan pursuant to P.L. 2001, c. 368.

11:20-6.3 Informational rate filing requirements

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

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other factors prohibited by the Act; except that the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by P.L. 2001, c. 368 and N.J.A.C. 11:20-6.5.

2. Premium rates and any factors used in the calculation of the premium rates *__and the effective dates for the rates*__. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date. Unless a carrier amends the rate filing to specify an alternative effective date, carriers shall use the rates shown in the rate filing, as of the stated effective date. Rates may be developed on different rate tiers for: single, husband/wife; adult/child(ren); family; and with respect to the basic and essential health care services plan, and any riders thereto, a description of the rating methodology or plan and the numerical value of the classification factors utilized in determining a policyholder's rates that addresses the use of the factors of age, gender and geography as discussed in (a)2i, ii and iii below, provided that all proposed rates applicable in the State have been filed with the Board before being used to quote new business or renewals. The filing for the basic and essential health care *__services__* plan shall include:

i. The numerical value of the classification factors utilized in the calculation of an individual's premium rate or rates, limited to: age, gender,

geographic location, effective date, and rating tier of each covered adult in accordance with the factors set forth in N.J.A.C. 11:20-6.5 below;

ii. A written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates into the rates charged for an individual policy; and

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

3. (No change.)

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

i. A statement that the informational filing is complete;

ii. A statement that the carrier's loss ratio is expected to be at least 75 percent; ***[and]***

iii. For rates to be charged for the basic and essential health care services plan, and any optional benefit riders thereto, a statement that the rating methodology will not produce rates (for each rate tier) for the highest rated policyholder which are greater than 350 percent of the rates (for each rate tier) for the lowest rated policyholder for each basic and essential health care services plan and rider option;

iv. For rates to be charged for the basic and essential health care services plan, and any optional benefit riders thereto, the anticipated loss ratio for the plan; and

5. (No change.)

(b) Any member which seeks to change its rates for its standard health benefits plans, its basic and essential health care services plan, or its community rated health benefits plans issued prior to August 1, 1993 shall, prior to the effective date of the revised rates, submit to the Board an informational rate filing, which shall include all the supporting data set forth in (a) above.

11:20-6.5 Permissible rate classification factors

(a) For a basic and essential health care services plan issued or renewed on or after January 1, 2003, a carrier shall not differentiate premium rates charged to different individuals for the basic and essential health care services plan and rider(s), if any, except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; 70 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first three digits of the U.S. Postal Service zip codes or the counties listed below. A carrier shall determine which territory applies to a

policyholder on the basis of the address of the policyholder's place of residence. The six territories are the following:

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

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

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

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

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

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

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

1. Single;

2. Husband and wife;

3. Adult and child(ren); and

4. Family.

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20-7.3 Filing of Loss Ratio Report

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

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

(c) (no change)

11:20-7.4 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form shall be completed annually by each member and shall include the following information with respect to standard health benefits plans and the basic and essential health care services plan:

1. – 2 (no change)

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

i. – v (no change)

vi. Plus a pro rata share of the reimbursable net paid loss assessment paid by the carrier pursuant to N.J.A.C. 11:20-2.17 during the preceding calendar year, if any, determined as the member's total net paid loss assessment multiplied by the ratio resulting from dividing the member’s net earned premium for

standard health benefits plans and the basic and essential health care services plan for the preceding calendar year by the net earned premiums for all of the member's health benefits plans for the preceding calendar year;

4. – 6 (no change)

(b) (no change)

11:20-7.5 Refund plan

(a) If the loss ratio determined in N.J.A.C. 11:20-7.4 is less than 75 percent, the member shall include with the Report a plan to be approved by the Board for a prompt refund to policy and contract holders of the difference between the amount of net earned premium it received that year on the standard health benefits plans and net earned premium received that year on the basic and essential health care services plan and the amount that would have been necessary to achieve the 75 percent loss ratio.

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

1. (no change)

2. The refund amount per contract holder shall be determined by multiplying the earned premium from each contract holder’s standard health benefits plan or basic and essential health care services plan by the percentage resulting from dividing the total refund calculated in accordance with (a) above by the carrier’s total net earned premium from the standard health benefits plans and basic and essential health care services plans, or on the basis of a practical and equitable alternative formula proposed by the carrier for approval by the Board; and

3. (no change)

(c) (no change)

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

11:20-8.1 Scope and applicability

(a) This subchapter sets forth reporting and certification requirements for premium and non-group enrollment data of Program members and other carriers with reportable accident and health premium in New Jersey. This subchapter also sets forth reporting and certification requirements for premium, claims, and net investment income data of Program members issuing individual health benefits plans.

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

11:20-8.2 Filing of the assessment report form

(a) Every carrier with reportable accident and health premium in New Jersey shall file the Exhibit K Assessment Report form, a copy of the Exhibit K Part C Premium Data Worksheet, and a copy of the Exhibit K Part D Enrollment Data Worksheet which are set forth as Exhibit K in the Appendix to this chapter incorporated herein by reference, on or before March 1, 2003 and on or before March 1 of the year immediately following every two-year calculation period thereafter.

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

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

2. Each affiliated carrier shall file one copy of the Exhibit K Part D Enrollment Data Worksheet if the carrier issued or renewed any of the coverages specified on the Enrollment Data Worksheet. If an affiliated carrier neither issued nor renewed any of the coverages specified on the Enrollment Data Worksheet, it is not necessary for that affiliated carrier to file the Exhibit K Part D Enrollment Data Worksheet.

3. The combined affiliated carriers, identified using a single carrier name, shall file one copy of the Exhibit K Assessment Report. The information specified on the Assessment Report shall be the aggregated information supplied on the Premium Data Worksheets for all affiliated carriers and the Enrollment Data Worksheets for those affiliated carriers with non-group person enrollment.

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

Part C Premium Data Worksheet, and two copies of the Exhibit K Part D Enrollment Data Worksheet.

(c) Certified report forms shall be submitted by facsimile, with paper copy to follow by mail, or mailed or delivered to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

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

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

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

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

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

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

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

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

11:20-8.4 Calculation of average non-group enrollment for the two-year calculation period

(a) In Part D of the Exhibit K Assessment Report, each carrier shall report its aggregated average non-group enrollment for all affiliates for the preceding two-year calculation period.

(b) Each carrier shall complete an Exhibit K Part D Enrollment Data Worksheet for each affiliate that issued or renewed the categories of non-group enrollment listed on the worksheet and shall attach each Worksheet to its Exhibit K.

1. In Section a of the Enrollment Data Worksheet, the carrier shall report all community rated persons covered under individual health benefits plans, and all persons covered under the basic and essential health care services plan as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters. For contracts issued prior to August 1, 1993, where a carrier's administrative systems cannot provide the number of actual covered persons, the following factors shall be used to convert contracts or subscribers to the total number of covered persons: single = 1; husband and wife = 2; adult and child(ren) = 2.8; family = 3.9. If a husband and wife category is not used, a carrier shall use a compromise factor of 3.33 in order to reflect the husband and wife category in the family factor.

2. In Section b of the Enrollment Data Worksheet, the carrier shall report all community rated conversion policy persons as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

3. In Section c of the Enrollment Data Worksheet, the carrier shall report all Medicaid recipients, including NJ KidCare Part A recipients and NJ FamilyCare Plan A recipients, but no recipients of any other plans through NJ KidCare or NJ FamilyCare, as of the last day of the end of each calendar quarter during the two-year calculation period, and shall report the total of all eight quarters.

4. In Section d of the Enrollment Data Worksheet, the carrier shall report all Medicare Plus Choice and Medicare cost and risk lives *__**and Medicare Demonstration Project lives**__* as of the last day of the end of each calendar quarter during the Two-Year Calculation Period, and shall report the total of all eight quarters.

5. In Section e of the Enrollment Data Worksheet, the carrier shall calculate the two-year non-group enrollment total by adding the totals from a through d of the Worksheet.

6. In section f of the Enrollment Data Worksheet, the carrier shall calculate the average two-year non-group enrollment to be reported on Exhibit K Part D by dividing the total two-year non-group enrollment total by eight.

11:20-8.5 Calculating net paid losses or gains

(a) For purposes of completing Part E of the Assessment Report form, each member issuing individual health benefits plans shall provide data for its individual health benefits plans issued or renewed pursuant to sections 2b(1) or 3 of the Act (N.J.S.A. 17B:27A-3b(1) or 4), or ***the basic and essential heath care services plan*** pursuant to the requirements of P.L. 2001, c. 368 for the preceding two-year calculation period.

1. – 2 (no change)

(b) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report premium earned. Premium earned shall be adjusted:

1. By any changes in non-admitted premium assets consistent with statutory report requirements, except that any change in non-admitted assets associated with premium accrued shall be reported consistent with the bases, as appropriate to the member, from the member's NAIC annual statement, adjusted for the individual health benefits plan for which the report is being made, as necessary; and

2. To reflect the premium that a carrier should have earned based on charging premiums consistent with the rate filings the member filed with the Board for the applicable time period.

(c) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report claims paid. Claims paid shall be reported on a basis consistent with statutory reporting, as is appropriate for the member based on the member's NAIC annual statement, adjusted as necessary for the individual health benefits plans for which the report is being made. Claims paid as reported on Exhibit K shall include reimbursement for charges made by providers for services and supplies; surcharges mandated pursuant to the New York Health Care Reform Act of 2000, P.L. 1999, c. 1, codified in the New York Public Health law, section 2807-c through 2807-w; and network access fees where such fees may be demonstrated to have reduced specific claim payments and where the carrier has reported such fees as claims on its NAIC annual statement blank. In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. Claims paid shall be adjusted to only include claims that should have been paid according to the terms and conditions of the individual health benefits policy and N.J.S.A. 17B:27A-2 et seq.

(d) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits shall report its net investment income. Net investment income shall be calculated in accordance with statutory reporting requirements. For purposes of Exhibit K reporting, and notwithstanding how a carrier allocates net investment income to individual lines in other statutory reports or filings, carriers shall allocate net investment

income consistent with the following basis, adjusted for the individual health benefits plans for which the report is being made as necessary.

1. (no change)

2. Net investment income, after adjustment, if any, as permitted by (d)1 above, shall be distributed to major and secondary lines of business in proportion to the mean funds of each line of business, after suitable adjustment, if any, on account of policy loans, except that any miscellaneous interest income arising from policy or annuity transactions may be allocated directly to the line of business producing such income. Mean funds refers to the average net cash flow balance over the two-year calculation period for which the calculation is being made, with the average net cash flow balance determined on a monthly or quarterly basis. The average net cash flow balance is the sum of the beginning of the month or quarter and end of month or quarter cash flow balances divided by two. The **"*cash flow balance*" at the beginning of the month or quarter is equal to the inception to date paid premiums, plus the net investment income at the beginning of the month or quarter, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid, and less paid expenses. The "cash flow balance" at the end of the month or quarter is equal to the inception to date paid premiums, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid and less paid expenses, plus net investment income at the beginning of the month or quarter. **"*Inception to date*" shall mean a measurement of cash flow from the first date the carrier receives premium for standard individual health benefits plans until the end of the most recent two-year calculation period.

(e) In Part E of the Exhibit K Assessment Report, each member issuing individual health benefits plans shall report its net paid gain or net paid loss. The net paid gain or loss for the two-year calculation period shall be determined by taking the claims paid on individual health benefits plans (as set forth on line b in Part E of Exhibit K), less 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans (as set forth in lines a and c, respectively, in Part E of Exhibit K). If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is greater than claims paid on individual health benefits plans, the amount shown of line C3d represents a net paid gain. If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is less than claims paid on individual health benefits plans, the amount shown on line C3d represents a net paid loss.

11:20-8.6 Certifications

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

(b) The Chief Financial Officer, or other duly authorized officer, of a member which has filed for reimbursement of losses shall certify, on or before March 1 of the year

following every two-year calculation period that: The net investment income reported on the *__Exhibit K__* Assessment Report has been allocated on a basis consistent with N.J.A.C. 11:20-8.5(d) or, if not, the changes have been outlined in detail including the impact and reason for the change.

11:20-8.7 Penalties for failure to file market share and net paid loss report

(a) Failure to file in a timely manner the Assessment Report and certifications required by this subchapter shall result in:

1. – 2 (no change).

11:20-8.8 Audits

(a) (no change)

(b) The IHC Program Board shall review, and may audit, a member's reimbursable losses reported in the member's Assessment Report. The IHC Program Board shall choose and direct the independent auditor. The IHC Program Board and the member being audited shall share equally the cost of an independent audit.

(c) The IHC Program Board shall adjust a member's reported net paid losses, for purposes of determining reimbursement for losses for the preceding two-year calculation period, for the member's failure to meet the certification requirements of this subchapter or as a result of the findings of an independent audit conducted pursuant to (b) above. Such findings shall include the failure of a carrier to pay claims consistent with the terms of the applicable contract or applicable law, or to collect premium consistent with the terms of its informational rate filing or applicable law.

SUBCHAPTER 9. EXEMPTIONS

11:20-9.2 Filing for an exemption from assessments for reimbursements

(a) (No change.)

(b) Written requests for exemptions shall be certified by the Chief Financial Officer, or other duly authorized officer, of the member, and shall include affirmative statements that the member agrees:

1. (no change)

2. To enroll or insure the minimum number of non-group persons in New Jersey under:

i. Standard health benefits plans and the basic and essential health care services plan;

ii. – iii (no change)

iv. Medicare cost and risk contracts with the Federal government, Medicare Plus Choice and Medicare Demonstration plans with respect to Medicare recipients, if offered; and

3. (no change)

(c) – (e) (No change.)

11:20-9.3 Minimum enrollment share

(a) – (b) (No change.)

(c) The Board shall calculate each member's minimum number of non-group persons as follows:

1. For each two-year calculation period beginning with 1997/1998, the total number of community rated, individually enrolled or insured persons, including Medicare cost and risk lives, Medicare Plus Choice lives and Medicare Demonstration Project lives and enrolled Medicaid lives, NJ KidCare Part A lives and NJ FamilyCare Part A lives of all members subject to the Act, and all individually enrolled or insured persons covered under a basic and essential health care services plan, except for hospital and medical service corporation carriers**,** covered on the last day of each of the eight calendar year quarters of that preceding two-year calculation period, divided by eight, and multiplied by the proportion that the member's net earned premium bears to the net earned premium of all members for the preceding two-year calculation period.

11:20-9.4 Satisfaction of minimum number of non-group persons

(a) Persons counted under the following may be counted by a member in meeting its minimum number of non-group persons in New Jersey:

1. Standard health benefits plans and the basic and essential health care services plan;

2. Conversion policies issued pursuant to the Act; and

3. Medicare cost and risk contracts**,** Medicare Plus Choice contracts and Medicare Demonstration Project contracts and contracts with the State of New Jersey covering Medicaid recipients, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's minimum number of non-group persons.

(b) (no change)

11:20-9.5 Procedures for granting or denying final (full or pro rata) exemptions

(a) (No change.)

(b) So that the Board can determine whether the member has satisfied its minimum enrollment share, members seeking final (full or pro rata) exemptions shall report to the Board, on or before March 1 of the year following each two-year calculation period, the number of non-group persons covered by that member on the last day of each calendar quarter of the preceding two-year calculation period, taking into account the limitations on counting the number of Medicaid recipients and Medicare cost and risk lives Medicare Plus Choice lives and Medicare Demonstration Project lives as described in N.J.A.C. 11:20-9.4(a)3 and (b); except that members seeking final (full or pro rata) exemptions for the first two-year calculation period shall report to the Board the number of non-group persons covered by that member as of December 31 of the two preceding calendar years, taking into account the limitations on counting the number of Medicaid recipients and Medicare cost and risk lives ***and Medicare Plus Choice and Medicare Demonstration Project lives*** as described in N.J.A.C. 11:20-9.4(a)3 and (b) above. The member shall report separately the number of non-group persons in each category of non-group person enumerated in N.J.A.C. 11:20-9.4. The Chief Financial Officer, or other duly authorized officer of the member, shall certify that the covered non-group persons reported therein:

1. Were counted in accordance with N.J.A.C. 11:20-9.4;

2. If covered by standard health benefits plans and conversion health benefits plans, were enrolled on an open enrolled and community rated basis or if covered under a basic and essential health care services *__plan__* were enrolled on an open enrolled basis;

3.- 6. (No change.)

(c) – (h) (No change.)

11:20-9.6 Good faith marketing report

(a) In order for the Board to determine whether a carrier has made a good faith marketing effort as required by N.J.A.C. 11:20-9.5(f)2, members that have received conditional exemptions from assessments for reimbursable losses and have enrolled less than 50 percent of the minimum number of non-group persons determined by the Board shall submit to the Board a marketing report on or before July 1 of the year immediately following the two-year calculation period to which the conditional exemption applies containing the following information pertaining to advertising, marketing and promotion efforts in direct support of sales of standard individual health benefits plans and basic and essential health care services plans in New Jersey during the two-year calculation period and the calendar quarter immediately preceding the two-year calculation period to which the conditional exemption applies provided such efforts were directed toward sales during the two-year calculation period to which the exemption applies.

1. – 3. (No change.)

4. With respect to sales through producers licensed by the State of New Jersey, details of efforts to recruit and educate producers to sell standard health

benefits plans and the basic and essential health care services plan; the number of producers through whom such sales were made; the total cost of commissions and other incentives paid to producers for sales of standard health benefits plans and the basic and essential health care services plan;

5. With respect to other forms of marketing or promotion of standard health benefits plans and the basic and essential health care services plan, describe the methods of media used; the frequency of use; the total cost of such efforts;

(b) (no change)

(c) The Board will review the marketing reports submitted and determined that a carrier has made a good faith marketing effort as required by N.J.A.C. 11:20-9.5(f)2 if the carrier has demonstrated that it has either:

1. Undertaken a significant media advertising or other marketing campaign, in proportion to its minimum enrollment share, in direct support of sales of standard individual health benefits plans and the basic and essential health care services plan in New Jersey; or

2. Undertaken significant efforts, in proportion to its minimum enrollment share, to educate licensed insurance producers about its standard individual health benefits plans and the basic and essential health care services plan in New Jersey and offered to pay competitive commission schedules for sales of such plans and competitive rates.

(d) (no change)

SUBCHAPTER 12. ELIGIBILITY FOR AND REPLACEMENT OF STANDARD HEALTH BENEFITS PLANS AND THE BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

11:20-12.1 Purpose and scope

(a) This subchapter establishes the standards for determining who may be covered by a standard health benefits plan and a basic and essential health care services plan, as defined at N.J.A.C. 11:20-1.2.

(b) This subchapter sets forth the standards for obtaining a standard health benefits plan and the basic and essential health care services plan by persons covered by, or eligible for, group health benefits plans and persons covered by individual health benefits plans.

(c) This subchapter shall apply to persons applying for coverage ***[in]* *<u>under</u>*** standard health benefits plans in New Jersey ***[under]*** ***<u>or</u>*** a basic and essential health care services plan in New Jersey, all carriers which are members of the program, insurance producers selling ***[standard]*<u>individual</u>*** health benefits plans, and employers offering group health benefits plans to their employees.

11:20-12.3 Eligibility for coverage under a standard health benefits plan or a basic and essential health care services plan

(a) The policyholder of a standard health benefits plan or a 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, but may not reside outside of the United States.

(b) A person shall not be eligible to be covered by a standard health benefits plan or a basic and essential health care services plan, as the policyholder or a dependent, if the person is eligible for Medicare, a group health benefits plan, group health plan, governmental plan, or church plan, except as provided in N.J.A.C. 11:20-12.4, or if the person is covered by any other individual health benefits plan, except as provided in N.J.A.C. 11:20-12.5(a). After obtaining coverage under a standard health benefits plan 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.

(c) (no change)

11:20-12.4 Replacement of a group health benefits plan with a standard health benefits plan or a basic and essential health care services plan

(a) A person who is a participant, or is eligible to participate, in a group health benefits plan that does not cover general services may choose, only during the open enrollment period, to be covered by a standard health benefits plan or a basic and essential health care services plan.

(b) A person who is a participant, or is eligible to participate, in a group health benefits plan that covers general services may choose, only during the open enrollment period, to be covered by a standard health benefits plan with a higher deductible and policyholder coinsurance requirement or lower deductible and policyholder coinsurance requirement than the group health benefits plan or by the basic and essential health care services plan.

1. – 2 (no change).

(c) With respect to coverage under an HMO contract, the following apply, notwithstanding (a) and (b) above:

1. A person who participates, or is eligible to participate, only in a group health benefits plan under an HMO contract may choose, only during the open enrollment period to be covered under any standard health benefits plan or ***the*** basic and essential health care services plan, other than the standard HMO benefit plan.

(d) – (g) (no change).

(h) Notwithstanding (a), (b) and (c) above, a carrier shall not offer a person coverage ***[by]****under*** a standard health benefits plan or a basic and essential health care services plan unless:

1. (no change)

2. The person's coverage by a group health benefits plan has been terminated or will terminate no later than the day before the effective date of the standard health benefits plan or a basic and essential health care services plan, except as extension of benefits provisions under the group health benefits plan or by law may be applicable.

i. A person who is eligible only for continuation of coverage under an employer's group health benefits plan required by State or Federal law, including, but not limited to, N.J.S.A. 17B:27A-27 or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and amendments thereto, may choose to be covered by any standard health benefits plan or a basic and essential health care services plan in lieu of continuing to participate in the group health benefits plan.

j. (no change)

11:20-12.5 Selection of a standard health benefits plan or a basic and essential health care services plan by a person covered by an individual health benefits plan

(a) A person who is covered by an individual health benefits plan other than one of the standard health benefits plans or a basic and essential health care services plan issued pursuant to this chapter may choose at any time to replace that health benefits plan with a standard health benefits plan or a basic and essential health care services plan. A carrier shall not offer a person coverage by a standard health benefits plan or a basic and essential health care services plan unless the person's coverage by the individual health benefits plan being replaced has been terminated or will terminate no later than the effective date of the standard health benefits plan or a basic and essential health care services plan. As long as the covered person notifies the carrier that issued the prior individual health benefits plan of the replacement within 30 days after the effective date of the new standard health benefits plan or a basic and essential health care services plan, the prior plan will terminate as of 12:01 A.M. on the effective date of the new standard health benefits plan or a basic and essential health care services plan, and the carrier shall refund any unearned premium. A carrier may require evidence of such termination. If a person fails to terminate a prior individual health benefits plan as required above, the standard health benefits plan or a basic and essential health care services plan that was intended to replace it shall be of no force and effect.

(b) – (c) (no change)

(d) The following rules apply to the HMO standard health benefits plan, notwithstanding (a), (b) and (c) above:

1. – 4 (no change)

(e). A person covered by a standard health benefits plan may replace that coverage at any time with coverage under a basic and essential health care services plan. A person covered under a basic and essential health care services plan may replace that coverage, only during the open enrollment period, with coverage by a standard health benefits plan or with coverage under a basic and essential health care services plan either with or without a rider.

(f) – (g) (no change).

(h) Notwithstanding (b), (c) (d), and (e) above, a carrier shall not offer a person coverage ***[by]****under** a standard health benefits plan or a basic and essential health care services plan unless the person's coverage by the standard health benefits plan or basic and essential health care services plan being replaced has been terminated or will terminate no later than the effective date of ***the*** replacement standard health benefits plan or basic and essential health care services plan.

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

11:20-17.1 Purpose and scope

(a) (no change)

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

11:20-17.3 Filing requirements

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

(b) – (e) (no change)

11:20-17.4 Contents of the enrollment status report

(a) Members shall report the following information on a quarterly basis on the enrollment status report form set forth as Part 1 of Exhibit L in the Appendix, separately for each of the standard health benefits plans, broken out into indemnity for ***[Plan A, and indemnity for]*** Plan A/50, indemnity or PPO for Plan B, or indemnity, PPO and POS delivery systems for Plans C ***[through E]*** ***and D***, the HMO plans, ***[and]******as well as*** indemnity ***, PPO, EPO*** or HMO coverage under the basic and essential health ***care*** services plan and, if applicable, the individual health benefits plans issued on a community rated, open enrollment basis prior to August 1, 1993:

1. – 4. (No change.)

(b) Members shall report the following information on an annual basis on the enrollment status report form set forth at Part 2 of Exhibit L in the Appendix, cumulatively for all years to date and separately for each of the standard health benefits plans, broken down by indemnity for ***[Plan A, and indemnity for]*** Plan A/50, indemnity or PPO for Plan B, or indemnity PPO and POS delivery systems for Plans C ***[-E]*** ***and D***, the HMO plans, ***[and]******as well as*** the indemnity ***, PPO or EPO*** or HMO basic and essential health care services plan:

1. – 3. (No change.)

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

11:20-18.2 Definitions

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

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

SUBCHAPTER 21. (RESERVED)

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. Carriers should consult the other subchapters in this chapter 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. 1:20-1.1 ***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 on or after January 1, 2003.

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. 11:20-1.1 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.

(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 Filing the basic and essential health care services plan policy form

(a) Before a member may offer or issue the basic and essential health care service plan policy form, the member shall submit the information set forth below to the Board at the address specified at N.J.A.C. 11:20-2.1(h):

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

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

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

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

[iii. The anticipated loss ratio for the plan; and]

[iv.]**__iii.__* The benefits in the ***__policy__ form being submitted include all of the coverages enumerated in section 2.a. of PL 2001, c. 368, but do not include any additional benefits.

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

1. Members that choose to use the ***__specimen policy form__*** as set forth in Exhibit V shall submit, in lieu of a copy of the basic and essential health care services ***__plan__*** policy form, a Certification, signed by a duly authorized officer of the company, stating that the Company is using the basic and essential health care services ***__plan specimen policy__*** form as included in Exhibit V, including the carrier name, and similar variable text, as appropriate. The Certification regarding use of the specimen *__policy__* form shall be submitted with the information set forth in N.J.A.C. 11:20-22.4(a).

2. Members that choose to use the ***specimen policy form*** as set forth in Exhibit V with some modifications to the text shall submit the form, redlined to show any differences between the submitted form and the form as contained in Exhibit V. The redlined text of the form shall be submitted with the information set forth in N.J.A.C. 11:20-22.4(a).

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

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.

(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. One 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; and

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.

(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.

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 g of P.L. 2001, c. 368, 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, ***with the first**

report due May 1, 2004,* 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 either an HMO plan or as an indemnity plan.

(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***[s]*** submitted by each member to determine whether the member has demonstrated that it made a good faith effort to market the basic and essential health care plan and provide written notice of its determination to the member within 45 days of a completed filing.

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

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

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the basic and essential health care services plan during the prior calendar year. Examples of marketing efforts may 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 web site. 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 certifies whether it used 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.

_____ Date: _____

Wardell Sanders, Executive Director