INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Adopted Amendments: N.J.A.C. 11:20-1.2, 2, 3, 8.4, 8.5, 9, 12, 17.4, 22.5, 24 and 11:20 Appendix Exhibits A, B, C, F, G, K and L.

Adopted New Rules: N.J.A.C. 11:20-3.6, 3.7, 24.6 and 24.7 and Appendix Exhibit H

Adopted Repeals: N.J.A.C. 11:20-3.2, 6, 7, 18, 22.4 and 11:20 Appendix Exhibits E and J.

Proposed: December 15, 2008 (see 40 N.J.R 6904(a))

Adopted: December 19, 2008 by the New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director.

Filed: _____ as R. 2008 d. ___ with nonsubstantive changes not requiring reproposal

Authority: N.J.S.A. 17B:27A-2 et seq., P.L. 2007, c. 345 and P.L. 2008, c. 38.

Effective Date: December 19, 2008

Operative Date: The adopted repeals will have an Operative Date coinciding with the effective date of rules proposed by the Department of Banking and Insurance that will replace the repealed rules. Such proposed rules are expected to appear in the January 5, 2009 New Jersey Register. The adopted amendments and adopted new rules will have an immediate operative date.

Expiration Date: December 7, 2010.

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Individual Health Coverage (IHC) Program Board held a hearing on Tuesday, December 9, 2008 at 9:30 A.M. at the Department of Banking and

Insurance, Conference Room 219, 20 West State Street, Trenton, New Jersey to receive testimony with respect to the proposed amendments to the standard health benefits plan and basic and essential healthcare services plan set forth in N.J.A.C. 11:20 as Appendix Exhibits A, B, and F. Ellen DeRosa, Executive Director of the IHC Program Board, served as hearing officer. No testimony was provided during the hearing. The hearing officer made no recommendations regarding the proposed amendments. The hearing record may be reviewed by contacting Ellen DeRosa, Executive Director, New Jersey Individual Health Benefits Coverage Board, P.O. Box 325, Trenton, NJ 08625-0325.

Summary of Public Comments and Agency Responses:

Written comments were received from Akerman Senterfitt, LLP on behalf of Celtic Insurance Company.

COMMENT 1: One commenter contends that P.L. 2008, c. 38 and the Board's proposed regulations "clearly direct that the IHC Board provide for the immediate payment of all past reimbursement losses due, including interest, on any past, current or loss reimbursements that is owed under the program but has not to date been paid."

RESPONSE: The comment is beyond the scope of the proposal. No change is being made in response to the commenter's comment. Even if the comment were within the scope of the proposal, however, the IHC Board does not agree with the commenter's interpretation of either the statute or the proposed regulations. Upon receipt of the commenter's comment the Board contacted the commenter and requested that the commenter identify the specific section and language in P.L. 2008, c. 38 and in the proposed regulations that the commenter believes requires "immediate payment" of any past reimbursable losses due. The commenter has not responded to that inquiry.

Agency Initiated Changes

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1. Since the schedule pages in the text for Standard Plans A/50 – D as set forth in Appendix Exhibit A allow different cost sharing for services rendered by a specialist as opposed to a non-specialist, the Definition section is being amended on adoption to include definitions of Specialist Doctor and Specialist Services. The definitions being included are identical to those already included in the HMO plan as set forth in Appendix Exhibit B and which are included in the HMO plans in instances where the copayment for specialist services is not the same as the copayment applicable to non-specialist services. Carriers that elect to apply a different copayment to specialist services in Plans A/50-D should include these definitions of Specialist Doctor and Specialist Services so consumers will understand the difference between a specialist doctor and a doctor who is not a specialist doctor.

2. The definition of Copayment in the definition section and the Copayment provision in Benefit Deductibles, Copayments and Coinsurance section of the specimen Basic and Essential Healthcare Services plan set forth as Appendix Exhibit F is being amended to replace references to Reasonable and Customary with Allowed Charge, consistent with the replacement made in all other sections of the Basic and Essential specimen policy form.

Federal Standards Statement

State agencies that adopt, readopt or amend state rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. There are Federal standards, generally set forth at 45 CFR 148.101 through 148.170, applicable to individual health benefits plans. Additionally, 42 CFR 422.422 prohibits imposing a tax, fee or similar assessment with respect to Medicare Advantage premium regardless of whether the premium is paid by CMS, the Medicare beneficiary or a third party on the beneficiary's behalf. To comply with this requirement, Appendix Exhibit K has been amended to expressly except all Medicare Advantage premium. However, to the extent that the adopted amendments, new rules and repeals address the same subject matter as that set forth in the Federal regulations (specifically, with respect to guaranteed renewability of coverage, and the right of an individual to maintain his or her individual coverage even if he or she becomes eligible for coverage under a group health plan as well as taxing Medicare Advantage premium), the adopted amendments, new rules and repeals do not exceed the Federal standards. Accordingly, the IHC Board does not believe a Federal standards analysis is required.