INSURANCE

NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Proposed Readoption with Amendments: N.J.A.C. 11:20-1, 2, 3, 8, 12, 17, 19, 20, 23 and 24, and 11:20 Appendix Exhibits A through D and K

Proposed Repeals: N.J.A.C. 11:20-2.17, and 11:20 Appendix Exhibits F, G, H

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

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

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

Proposal Number: PRN 2018- .

Interested persons may testify with respect to the Plan of Operation, set forth at N.J.A.C. 11:20-2, and the health benefits plans, set forth in N.J.A.C. 11:20 Appendix Exhibits A and B, at a **public hearing** to be held on May 23, 2018 at 10:00 A.M. at the New Jersey Department of Banking and Insurance, in the 11th floor Conference Room 20 West State Street, Trenton, New Jersey.

Submit written comments by June 4, 2018 to:

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The agency proposal follows:

Summary

In accordance with the sunset provisions of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., the New Jersey Individual Health Coverage Program Board of Directors (IHC Board or Board) has evaluated its rules at N.J.A.C. 11:20 (except for N.J.A.C. 11:20-3A, 6, 7, 11 and 18, rules promulgated by the Department of Banking and Insurance (Department)), which are scheduled to expire on May 12, 2018, pursuant to N.J.S.A. 52:14B-5.1c. The readoption of N.J.A.C. 11:20 is necessary because it implements the IHC Program. The IHC Board has determined that the rules are necessary, reasonable and proper for the purpose for which they are currently promulgated, with the exception of the repeals and amendments which are noted herein.

The IHC Program Board was charged by the Legislature with implementing and regulating the reformed individual health benefits coverage market pursuant to the Individual Health Insurance Reform Act, P.L. 1992, c. 161 as amended, and codified at N.J.S.A. 17B:27A-2 et seq. (the IHC Act or the Act). This readoption with amendments and repeals removes provisions which are no longer necessary.

The IHC Board will hold a public hearing on the Plan of Operation and the standard health benefits plans at the time and place set forth above. Written comments to any portion of this proposed readoption with amendments and repeals, including comments on the Plan of Operation and the standard health benefits plans, will be accepted until the date set forth above for receiving written comments.

Subchapter 1 of these rules establishes procedures and standards applicable for the fair, reasonable and equitable administration of the IHC Program pursuant to the Act. This subchapter also sets forth definitions of terms that are used in Chapter 20.

The Board proposes deleting the definitions of "Community rated" and 'Enrollment date" because the terms are outdated and are nowhere used in the body of the regulations. The Board proposes deleting the definition of "Federally-qualified HMO" because the designation of an HMO as a Federally-qualified HMO no longer exists.

The Board proposes amending the definition of "Group health benefits plan" for consistency with the requirements for a group plan in the regulations implementing the Employee Retirement Income Security Act (ERISA) at 29 CFR 2510.3-3.

The Board proposes amending the definition of "Member" to refer to a reporting year rather than a two-year calculation period to align with the proposed amendments to N.J.A.C. 11:20-2.12 and N.J.A.C. 11:20-8. Refer to the explanation of the single reporting year in those sections of the proposal summary.

The Board proposes amending the definition of "Net earned premium" to clarify that Exhibit K is in the Appendix to N.J.A.C. 11:20.

The Board proposes amending the definition of "Standard health benefits plan with rider" to clarify that the inclusion of a rider does not create another standard health benefits plan.

The Board proposes amending the definition of "Two-year calculation period" to state that the final period ends on December 31, 2018. Refer to the explanation of the single reporting year in the later sections of this proposal summary addressing amendments to N.J.A.C. 11:20-2.12 and N.J.A.C. 11:20-8.

The Board proposes amendments to the Mission Statement at N.J.A.C. 11:20-1.6 to remove the reference to the marketplace to avoid any confusion with the Marketplace

as created by the Federal Patient Protection and Affordable Care Act, Pub. Law 111-148, as amended and supplemented by the Health Care and Reconciliation Act, Pub. Law 111-152 (collectively, the Affordable Care Act). The reference to the New Jersey Department of Health and Senior Services is also proposed to be deleted because the joint regulation with that Department no longer occurs.

Subchapter 2, Individual Health Coverage Program Plan of Operation, sets forth the fair, reasonable and equitable manner in which the Board will administer the IHC Program. Included in this subchapter are: the powers of the Board; guidelines on election and membership of the Board; the election, membership, and responsibilities of Committees; the financial administration of the Program; provisions regarding independent audits under the Program; the recordkeeping requirements of the Board; provisions regarding the standard health benefits plans; the assessment mechanism for administrative expenses of the IHC Program; notice requirements for carriers seeking a deferral from assessment; the consequences of a carrier's failure to pay an assessment; and provisions regarding penalties and disputes arising under the Program.

The Board proposes amending N.J.A.C. 11:20-2.1(a) to specify the finality of the loss assessment mechanism. Loss assessments were authorized by two different sections of the Act and the Board proposes using those two sections as the basis to structure the first two items of a list in N.J.A.C. 11:20-2.1(a)2. The third item in the list confirms the conclusion of all loss assessments with the 2007 – 2008 period.

The Board proposes amending the definition of "action" as it appears in N.J.A.C. 11:20-2.1(a) to exclude policy form filings and applications for exemptions. Since carriers must use the standard plans there are no policy form filings. Applications for exemptions were associated with the loss assessment which ended with the 2007 – 2008 period.

The Board proposes deleting the definition of "plan" as it appears in N.J.A.C. 11:20-2.1(a) since the term is already defined in N.J.A.C. 11:20-1.2

The Board proposes amending N.J.A.C. 11:20-2.3(b)2 to clarify that the Board establishes benefits, not benefit levels and that the Board does not establish copayments and deductibles. The Board notes that cost sharing levels such as deductibles and copayments are subject to N.J.A.C. 11:22-5 which is a Department regulation.

The Board proposes deleting N.J.A.C. 11:20-2.3(b)7. While N.J.S.A. 17B:27A-11 gives the Board discretion to establish a means test, the Board has not found it necessary or appropriate to establish a means test thus far and does not foresee any reason such test would be necessary or appropriate in the future. With the deletion of item 7 the Board proposes re-numbering the remaining items in N.J.A.C. 11:20-2.3(b).

The Board proposes amending N.J.A.C. 11:20-2.3(b)14 to delete the reference to N.J.S.A. 17B:27A-12 because that statute governs loss assessments and the only assessments the Board calculates and assesses are administrative assessments.

The Board proposes amending N.J.A.C. 11:20-2.3(b)16 to delete the reference to N.J.S.A. 17B:27A-10(f)(4) because that statute governs loss assessments. The Board notes that N.J.S.A. 17B:27A-11b gives the Board authority to establish rules, conditions and procedures for the administrative assessment and thus gives the Board authority to impose an interest penalty.

The Board proposes amending N.J.A.C. 11:20-2.4 to delete item (b) since there is no temporary plan of operation. With the deletion of item (b) the Board proposes to retain the text of item (a) and designate the text as N.J.A.C. 11:20-2.4.

The Board proposes amending N.J.A.C. 11:20-2.5(a)2ii to clarify the timing for the election of a Director.

The Board proposes amending N.J.A.C. 11:20-2.5(a)2ii(1), (3) and (5) to clearly explain the process for an election, the fact that the election does not occur during a meeting, and that ballots need not be cast in person.

The Board proposes amending N.J.A.C. 11:20-2.5(a)2iii to specify the timing for updates to the website to include updated information regarding Board members.

The Board proposes amending N.J.A.C. 11:20-2.5(i) to consolidate the text describing the taking of minutes set forth in (i) and (i)1 into a single item (i).

The Board proposes amending N.J.A.C. 11:20-2.7(a) to clarify the dates of the IHC Program's fiscal year.

The Board proposes deleting N.J.A.C. 11:20-2.7(c)ii and N.J.A.C. 11:20-2.7(e)4i because they are unnecessary as both address loss assessments which ended with the 2007 – 2008 period. The numbering of N.J.A.C. 11:20-2.7(e)4 is being adjusted with the deletion of i.

The Board proposes amending N.J.A.C. 11:20-2.10(a)1 to delete the term marketplace and in one place replace it with the term market and in another place re-structure the phrase because the Board seeks to avoid any confusion with the Marketplace as created pursuant to the Affordable Care Act.

The Board proposes amending N.J.A.C. 11:20-2.12(c) to clarify the timeframes used for administrative assessments by structuring the text with numbers. In new item N.J.A.C. 11:20-2.12(c)(3) the Board proposes a return to annual administrative assessments as occurred through fiscal year 1997. Beginning with fiscal years 1998 and 1999 the Board was required to calculate loss assessments on a two-year basis. The Board calculated administrative assessments on the same two-year basis. With the elimination of loss assessments, and the final reconciliation of all loss reimbursements now completed, there is no reason to continue administrative assessments on a two-year

basis and the Board proposes assessing for administrative expenses on an annual basis. The one-year basis will allow the Board to prepare an annual budget rather than project a two-year budget. The administrative assessment would fund one year of administrative expenses rather than two years and thus carriers will fund expenses for one year rather than two years at a time. The final assessment for each year which reconciles budgeted expenses to actual audited expenses, and uses net earned premium from the prior calendar year would occur sooner than has been possible using the two-year period. Because the current two-year period is in progress, the return to an annual assessment would occur with fiscal year 2020 which begins July 1, 2019 and ends June 30, 2020. Carriers would file the first assessment report using the annual basis by April 1, 2020, reporting premium for calendar year 2019. See also the summary for subchapter 8.

The Board proposes amending N.J.A.C. 11:20-2.12(d) which addresses interim assessments to specify the basis for such assessments beginning with fiscal year 2021.

The Board proposes amending N.J.A.C. 11:20-2.12(f) 1to delete the statutory reference that applies only to loss assessments and to extend the period for paying of an administrative assessment from 30 days to 45 days. The Board recognizes that the fiscal departments at some carriers would benefit from more time to process assessment invoices. Since the assessments fund administrative expenses for the coming fiscal year the Board's fiscal solvency would not be jeopardized by allowing 15 additional days for payment of invoices.

The Board proposes repealing N.J.A.C. 11:20-2.17 which addresses loss assessment funds as held by the Board prior to final disbursement of funds. At this time all loss audits have concluded, all reimbursable net paid losses have been paid and the Board is not holding any loss assessment funds and thus N.J.A.C. 11:20-2.17 is unnecessary.

Consistent with the elimination of provisions associated with loss assessments, the Board proposes amending N.J.A.C. 11:20-2.18, which addresses minimum assessments, to eliminate the reference to administrative assessment. Since the only assessments are administrative assessments it is not necessary to specify that the minimum applies only in case of an administrative assessment.

Subchapter 3 addresses benefits offered in the individual market. N.J.A.C. 11:20-3.1 and 3.2 provide a description of the standard health benefits plans that must be offered by carriers in the individual market, as well as various options that may be offered by carriers in the individual market. Examples of these options include the option to offer high deductible health plans which meet the deductible and out of pocket requirements under federal law for use with a health savings account, and the option for an HMO plan to include deductible and coinsurance provisions. N.J.A.C. 11:20-3.2(e) sets forth the requirements for carriers that choose to make the standard plans available through or in conjunction with a selective contracting arrangement. The Compliance and Variability Rider, set forth as N.J.A.C. 11:20 Appendix Exhibit D, is the form a carrier must use if the carrier desires to implement regulatory changes to a plan without having to reissue the entire policy or contract. This rider may only be used in a manner consistent with the directions set forth in N.J.A.C. 11:20-3.3. N.J.A.C. 11:20-3.6 addresses the opportunity for carriers to create and file optional benefit riders that increase the benefits or actuarial value of the standard plans. N.J.A.C. 11:20-3.7 sets forth the provisions governing a Board action to withdraw a standard plan or a plan option.

The Board proposes amendments to N.J.A.C. 11:20-3.1(b)3 to add a new item ii to specify the opportunity to use a deductible up to $3,000 if the standard plan is a

network-based bronze plan, which means a plan with a 60 percent actuarial value. The Board proposes moving current item ii to become item iv.

The Board proposes amendments to N.J.A.C. 11:20-3.1(c) to delete the reference to Federally qualified and state qualified HMOs. As stated earlier in this summary, Federal qualification of HMOs no longer exists and thus all HMOs are regulated in the same manner.

The Board proposes amending N.J.A.C. 11:20-3.1(e)2 and N.J.A.C. 11:20-3.1(f)1 and 2 to include the opportunity for a bronze plan to feature a $3,000 deductible.

The Board proposes amending N.J.A.C. 11:20-3.7 to replace the 90-day timeframe with a timeframe that would be included in any proposal that withdraws a standard plan or plan option. Since the standard plans are subject to the guaranteed availability requirements of State and federal law, any discontinuation of the issuance of plans must comply with such requirements.

Subchapter 8 sets forth reporting and certification requirements for premium data as required of carriers with reportable accident and health premium in New Jersey. The Assessment Report is the form for reporting under this subchapter and is set forth as Exhibit K in the Appendix to N.J.A.C. 11:20. As explained above, the Board proposes a return to annual administrative assessments as occurred through fiscal year 1997. Beginning with fiscal years 1998 and 1999 the Board was required to calculate loss assessments on a two-year basis. The Board calculated administrative assessments on the same two-year basis. With the elimination of loss assessments, and the final reconciliation of all loss reimbursements now completed, there is no reason to continue administrative assessments on a two-year basis and the Board proposes assessing for administrative expenses on an annual basis. The assessment report discussed in this subchapter 8 contains premium information that provides the basis for those

administrative assessments. Because the current two-year period is in progress, the return to an annual assessment based on a one-year Exhibit K would occur with fiscal year 2020 which begins July 1, 2019 and ends June 30, 2020. Carriers would file the first assessment report using the annual basis by April 1, 2020, reporting premium for calendar year 2019. The amendments to Subchapter 8 as discussed below are necessary to accommodate the current two- year period as well as the anticipated one-year period.

The Board proposes amending N.J.A.C. 11:20-8.1 to delete the reference to a two-year calculation period and instead refer to period. Through the 2017 to 2018 two-year calculation period, the term period would refer to that two-year period. Beginning with 2019, the period would be a one-year period.

The Board proposes amending N.J.A.C. 11:20-8.2(a) to explain the timing for filing of the Exhibit K whether the report covers two years or one year.

The Board proposes amending N.J.A.C. 11:20-8.2(b)1 to include the one-year period, as applicable.

The Board proposes amending N.J.A.C. 11:20-8.3(a) to explain the conclusion of the two-year period and the commencement of the one-year period.

The Board proposes amending N.J.A.C. 11:20-8.3(b) to refer to the preceding year, as appropriate. This text accommodates the one-year period.

The Board proposes amending the introductory text to N.J.A.C. 11:20-8.3(c) to explain that item (c) is specific to the two-year calculation period.

The Board proposes a new N.J.A.C. 11:20-8.3(d) which details the filing requirements for the one-year period.

Subchapter 12 establishes the standards for determining who is eligible to be covered under standard individual health benefits plans, the standards for obtaining a standard health benefits plan by persons covered by a group health benefits plan and by

persons already covered under another individual health benefits plan. This subchapter sets forth rules applicable to an annual open enrollment period as well as a special enrollment period.

The Board proposes amending N.J.A.C. 11:20-12.4(a) to replace the verb received with the verb submitted. The open enrollment period is the time during which applicants may submit an application. The carrier need not receive the application during this period.

The Board proposes amending N.J.A.C. 11:20-12.4(b) to state that the effective date of an open enrollment period application is January 1. Since the open enrollment period established by Federal law no longer extends beyond the end of the calendar year, it is no longer necessary to address effective dates for applications that are made January 1 or later and the Board proposes deleting the text that addressed such applications.

The Board proposes amending N.J.A.C. 11:20-12.5(b) to include the option for a later effective date to be requested by an applicant using a special enrollment period created by birth, adoption or placement for adoption or court order.

Subchapter 17 establishes quarterly submissions of enrollment status reports by all carriers issuing individual health benefits plans whether through the Marketplace or directly by the carrier. The subchapter specifies the information the reports must contain.

The Board proposes amending N.J.A.C. 11:20-17.4(a) to refer to enrollment through the Marketplace and enrollment directly to the carrier to conform to the manner in which enrollment is characterized in the reports submitted by the carriers.

The Board proposes deleting N.J.A.C. 11:20-17.4(a)2i because the factors to estimate the number of dependents are not necessary since carriers have dependent data and report the actual number of dependents.

The Board proposes amending N.J.A.C. 11:20-17.4(a)4 to explain how to report the PCP cost sharing in the event both deductible and copayment apply to PCP services and thus all carriers will consistently report PCP cost sharing.

Subchapter 19 sets forth the procedures for filing petitions for rulemaking with the Board.

Subchapter 20 provides the procedures for appealing an action of the Board.

Subchapter 23 addresses rulemaking notices, public notices, and the Board's interested parties mailing list. N.J.A.C. 11:20-23.2 sets forth the types of notices which the Board will provide when proposing rules pursuant to the Administrative Procedures Act (APA). N.J.A.C. 11:20-23.3 establishes the requirements for determining if "sufficient public interest" exists for the purposes of extending the public comment period for rulemaking. This rule is required by the APA. N.J.A.C. 11:20-23.4 sets forth the requirements for a public hearing on proposed rulemaking. N.J.A.C. 11:20-23.5 sets forth the requirements for the Board to provide notice of new rules, amendments, repeals or adoptions. N.J.A.C. 11:20-23.6 sets forth where the Board shall provide public notice of board meetings. N.J.A.C. 11:20-23.7 sets forth the requirements for inclusion on the Board's list of interested parties.

The Board proposes amending N.J.A.C. 11:20-23.6(c)3 to update the URL for its website and N.J.A.C. 11:20-23.6(c)4 to explain that notice is also provided to the State House Press Corps.

Subchapter 24 establishes certain standards that carriers issuing individual coverage must meet. N.J.A.C. 11:20-24.2 sets forth standards for eligibility and issuance. N.J.A.C. 11:20-24.2A sets forth standards for triggering events that result in a special enrollment period. N.J.A.C. 11:20-24.3 sets forth information about the payment of premium. N.J.A.C. 11:20-24.4 establishes standards for effective dates of coverage.

N.J.A.C. 11:20-24.6 establishes standards for the required good faith effort to market individual plans.

The Board proposes amending N.J.A.C. 11:20-24.2(c)2 to more clearly identify the notice a person seeking an exemption from the purchase of an individual plan will receive from the Marketplace.

The Board proposes amending N.J.A.C. 11:20-24.2(f) to explain that carriers issuing network-based plans, which includes HMO plans, but is not limited to HMO plans, are not obligated to issue coverage to persons living outside the service area. The Board proposes deleting the inapplicable reference to N.J.A.C. 11:20-12.

The Board proposes amending N.J.A.C. 11:20-24.2A(b) to refer to triggering events as defined in N.J.A.C. 11:20-1.2 and to delete the list of triggering events from this section.

The Board proposes amending N.J/A.C. 11:20-24.4(a)4 to more clearly identify the notice a person seeking an exemption from the purchase of an individual plan will receive from the Marketplace.

The Board proposes amending N.J.A.C. 11:20-24.4(c) to include the option for a later effective date to be requested by an applicant using a special enrollment period created by birth, adoption or placement for adoption or court order.

The Board proposes amending N.J.A.C. 11:20-24.6(a) and N.J.A.C. 11:20-24.6(c)1 to delete the specific treatment of a federally-qualified HMO since there are no Federally-qualified HMOs.

The Board proposes amending N.J.A.C. 11:20-24.6(c) to add a new item iii. Although this item iii sets forth new text, the text does not establish a new requirement. Rather, the text affirms the obvious fact that if a carrier is marketing in good faith the carrier must not negate the marketing by providing information stating the carriers does

not offer individual plans in New Jersey or does not misinform consumers of the eligibility requirements.

Throughout the Chapter the Board included necessary capitalization and grammatical amendments.

Standard Health Benefits Plans

As required by N.J.S.A. 17B:27A-7, the IHC Board established the contract forms and benefits to be made available by all carriers for the standard health benefit plans required to be issued. N.J.A.C. 11:20-3 identifies the standard health benefit plans, Plans A/50, B, C, D and HMO, which carriers offering coverage in the individual market must issue and renew. The text of the plans is set forth in Appendix Exhibits A and B, with variable text detailed in N.J.A.C. 11:20 Appendix Exhibit C.

The Board proposes the following amendments to Appendix Exhibits A and B:

- To comply with the requirements of P.L. 2017, c. 361, effective January 16, 2018, the Board proposes amending the duration of newborn coverage from 31 to 60 days.
- To comply with the requirements of P.L. 2017.c. 241, effective February 15, 2018, the Board proposes adding a new section to the standard plans to address coverage of contraceptives. Note that because the mandate requires coverage of devices in addition to drugs the reference to contraceptives in the prescription drugs section was removed.
- To comply with the requirements of P.L. 2017, c. 309, effective January 1, 2019, The Board proposes adding a new provision to address the coverage of donated human breast milk. The provision would be included in policies issued or renewed on or after January 1, 2019.

- To comply with the requirements of P.L. 2017, c. 305, effective August 1, 2018, the Board proposes adding a new provision to provide coverage for digital tomosynthesis.
- To provide text necessary to address the deductible and maximum out of pocket for a tiered plan that is a high deductible health plan the Board proposes adding variable text to the benefit Provision in Exhibit A.

The Board notes that although the effective date of two of these new laws has already occurred, the majority of individual health benefit plans will first be subject to the new mandates on January 1, 2019 which is the first renewal on or after the effective date of the new mandates. Policies issued as a result of a special enrollment period during 2018 would have an effective date that would trigger compliance with up to three of the new mandates. The standard plans include a compliance with law provision that would ensure compliance with the mandates even if the policy form is not yet updated to specify the mandates.

The Board proposes to readopt Appendix Exhibit C without change. The explanations set forth on this Exhibit are necessary to help carriers understand variable text as included in the standard plans.

The Board proposes to readopt Appendix Exhibit D without change. As explained in N.J.A.C. 11:20-3.3, Appendix Exhibit D is the form a carrier must use if the carrier desires to modify a plan without having to reissue the entire policy or contract. This form may only be used in a manner consistent with the directions set forth in N.J.A.C. 11:20-3.3.

The Board proposes to repeal Appendix Exhibits F, G and H for the reasons stated below. Appendix Exhibit F sets forth template text for the Basic and Essential Health Care Services Plan. Such plan does not satisfy the requirements of the Affordable Care

Act and could not be issued or renewed as of January 1, 2014. Appendix Exhibit G is a Plan Update Rider that was used in 2009 to address the replacement of individual plans that occurred in 2009. Since re-enrollments now occur in January of each year, the deductible and coinsurance credit described on the rider is no longer necessary. Appendix Exhibit H has been used to report which standard plans a carrier offers. The information contained on the report is no longer meaningful and the report is thus no longer necessary.

The Board proposes to amend Appendix Exhibit K to add pages appropriate to a one-year reporting period. The premium information required on these additional pages is consistent with the information reported for the two-year calculation period.

IHC Rulemaking Procedures

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

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

Please note that since this procedure allows a 20-day comment period it is likely the comment period will expire prior to publication of the proposal in the *New Jersey Register*.

Social Impact

The rules proposed for readoption with amendments and repeals at N.J.A.C. 11:20 (excluding N.J.A.C. 11:20-3A, 6, 7, 11 and 18) implementing the provisions of IHC Act will continue to affect the member carriers, producers, and individual consumers of health benefits coverage. Currently, there are approximately 67 individual health coverage program member carriers, of which approximately five carriers are currently

offering individual coverage. Member carriers are those carriers with accident and health premium in New Jersey, exclusive of those that are Medicaid only carriers. As of 4Q2017 approximately 309,521 persons are covered under individual health benefits plans.

The social impact of the rules proposed for readoption with amendments and repeals is the continued implementation of New Jersey's health insurance reforms in the individual market and continued compliance and consistency with the requirements of the Affordable Care Act.

The amendments proposed in this readoption with amendments and repeals delete text that is outdated, and conform with requirements in Federal law. The proposed amendment to revise the administrative assessment to a one-year process seeks to reduce the administrative burden that is associated with two-year reporting both for carriers and the Board.

The Board expects the expansion of benefits to include coverage for the newly enacted mandates will have a positive social impact on consumers who will benefit from coverage.

Economic Impact

The rules proposed for readoption with amendments and repeals at N.J.A.C. 11:20 are expected to have a modest economic impact on the IHC Program member carriers, brokers and consumers.

N.J.S.A. 17B:27A-2 et seq. sets forth criteria for a carrier being considered an IHC Program member carrier. As IHC Program member carriers encompass every carrier that has net earned health benefit premium in New Jersey during a two-year calculation period, or one-year period, as proposed herein, the rules will impact not just those carriers that elect to market individual health benefit plans to residents of New

Jersey, but also those carriers that elect not to market individual coverage. Carriers that elect to market individual coverage in New Jersey will have to bear the costs associated with selling individual plans which include creating and maintaining the provisions of the standard plans as well as rates for such plans, plan marketing, plan administration as well as reporting of enrollment, and various certifications. All member carriers must pay the administrative assessment described in the proposed readoption with amendments and repeals. The Board expects the use of a one-year period for the administrative assessment will have a positive impact on carriers in that they will not be assessed for a projected two- year budget. The reconciliation of a one-year assessment will occur closer in time to the assessment meaning carriers will be reimbursed for any monies not expended during the year more quickly than has been possible with the two-year calculation period.

With respect to the proposed amendments to the standard health benefit plans, Carriers will incur costs to update the plans to include the new mandated benefits. Carriers are unlikely to require any new or additional professional or technical services to accommodate these proposed amendments beyond those already at their disposal.

Brokers will be economically affected by the rules proposed for readoption with amendments and repeals due to the time they must take from selling to devote to reviewing and understanding the requirements set forth in the rules proposed for readoption with amendments and repeals. If a broker sells coverage offered by a carrier that pays a commission, the broker will be compensated for assisting consumers with the purchase of individual coverage.

Consumers will be economically affected by the amendments to the standard plans. The inclusion of additional benefits is expected to result in some increase to premium.

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Federal Standards Statement

The rules proposed for readoption with amendments and repeals comply with the following Federal laws: the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191; Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. § 1395y(b) (1994) and implementing regulations at 45 CFR Part 411; the Public Health Service Act, 42 U.S.C. §§ 300gg et seq., (incorporating the Federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191; the Newborns' and Mother's Health Care Protection Act of 1998, Pub.L. 104-204, 110 Stat. 2935 (1996); and the Women's Health and Cancer Rights Act of 1998, Pub.L. 105-277, Title IX, §903, 112 Stat.) and implementing regulations at 45 CFR Parts 145 and 146; and the Federal Patient Protection and Affordable Care Act, Pub. Law 111-148, as amended and supplemented by the Health Care and Reconciliation Act, Pub. Law 111-152. The rules do not expand upon the requirements set forth in the above Federal laws. There are no other Federal laws that apply to these rules.

Jobs Impact

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

Agriculture Industry Impact

The IHC Board does not believe the rules proposed for readoption with amendments and repeals will have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

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

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

Housing Affordability Impact Analysis

The IHC Board does not believe the rules proposed for readoption with amendments and repeals will have an impact on housing affordability in this State and

there is an extreme unlikelihood that the rules will evoke a change in the average costs associated with housing in that the rules proposed for readoption with amendments and repeals relate to the benefit levels and terms of standard health benefits plans offered in New Jersey for purchase by small employers.

Smart Growth Development Impact Analysis

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

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:20-1through 3, 8, 12, 17 through 20 and 22 through 24 and N.J.A.C. 11:20 Appendix Exhibits A, B, C, D, and K

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:20-2.17 and N.J.A.C. 11:20 Appendix Exhibits F, G and H.

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

TITLE 11. INSURANCE

CHAPTER 20. INDIVIDUAL HEALTH COVERAGE PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

§ 11:20-1.2 Definitions

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

. . .

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

. . .

["Enrollment date" means the effective date of coverage under the individual health benefit plan.]

. . .

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

. . .

"Group health benefits plan" means a health benefits [plan for groups of two or more persons] **covering at least one employee**.

. . .

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this chapter, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1)

of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan. The term "health benefits plan" specifically includes:

1. - 4. (No change)

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

6. – 7 (No change)

. . .

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

(1st day benefit - 2nd day benefit) / 5 + 2nd day benefit< $250.00

. . .

“Marketplace” means the Federally-facilitated [exchange] **Exchange** as defined in Federal regulations at 45 CFR 155.20, through which qualified individuals can purchase qualified health plans and obtain a determination of eligibility for a premium tax credit, cost-sharing reduction, or exemption from the requirement to purchase health insurance.

. . .

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

"Minimum essential coverage" means any of the following types of coverage:

1. – 5. (No change)

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

. . .

"Net earned premium" means the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Net earned premium shall include the aggregate premiums earned on the carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid or

NJ FamilyCare contracts with the State or federal government, but shall not include any premium associated with the benefits enumerated in Section 2 of Part C of the Premium Data Worksheet which is set forth [as] **in the Appendix to this** chapter **as Appendix** Exhibit K, incorporated herein by reference.

. . .

"Qualified health plan" or "QHP" means a health benefits plan certified to meet the requirements specified at 45 CFR 156.200 et seq. for participation on a [marketplace] **Marketplace** in accordance with 45 CFR 155.1000 et seq.

. . .

"Standard health benefits plan with rider" means a standard health benefits plan as amended with one or more optional benefit riders as permitted by N.J.A.C. 11:20-3.6**. Note that the inclusion of a rider with a standard health benefits plan results in a unique plan but does not create another standard health benefits plan.**

. . .

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

1. The date the eligible person loses eligibility for minimum essential coverage, or the eligible person's dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a QHP by the [marketplace] **Marketplace**;

2. - 3. (No change.)

4. The effective date of a [marketplace] **Marketplace** redetermination of an eligible person's subsidy, including a determination that an eligible person is newly eligible or no longer eligible for a subsidy with respect to **Marketplace** coverage; and for off [marketplace] **Marketplace** coverage the effective date of a [marketplace] **Marketplace** redetermination that an eligible person is no longer eligible for a subsidy;

5. – 9. (No change.)

10. The date of a [marketplace] **Marketplace** or carrier finding that it erroneously permitted or denied an eligible person enrollment in a QHP;

11**.** (No change.)

12. The date the eligible person demonstrates to the [marketplace] **Marketplace** or State regulatory agency that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

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

"Two-year calculation period" means a two calendar year period, the first of which shall begin January 1, 1997 and **the last shall** end December 31, [1998] **2018**.

§ 11:20-1.6. Mission statement

The mission of the New Jersey Individual Health Coverage Program Board is to administer the New Jersey Individual Health Coverage Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders [in the marketplace] and other interested persons, and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to

individuals and establishing and administering **the** assessment [mechanisms] **mechanisms**. It also includes the regulation of individual health coverage carriers in conjunction with the New Jersey Department of Banking and Insurance [and New Jersey Department of Health and Senior Services].

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

§ 11:20-2.1 Purpose and structure

(a) The "IHC Program" created pursuant to the N.J.S.A. 17B:27A-2 to 16, as amended, has as its members all insurance companies, health service corporations, hospital service corporations, medical service corporations, and health maintenance organizations that issue or have in force health benefits plans in this State. The IHC Program's purpose is:

1. (No change.)

2. To reimburse certain losses of member companies **as follows**:

i. for the calendar year ending December 31, 1992 pursuant to N.J.S.A. 17B:27A-13[,] **;**

ii. for each calendar year ending December 31, 1993 through December 31, 1996, and for each two-year calculation period through the 2007-2008 calculation period pursuant to N.J.S.A. 17B:27A-12, as amended[.]**; and**

iii. for all periods following the 2007 – 2008 two-year calculation period no loss assessments shall be calculated or collected and no losses shall be reimbursed.

(b) – (h) (No change.)

§ 11:20-2.2 Definitions

(a) (No change.)

(b) The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Action" means an action by the Board adopted, in the Board's discretion, in accordance with the procedures set forth either in the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., or in sections 7 and 8 of P.L. 1993, c.164. "Action" includes, but is not limited to: the establishment and modification of health benefits plans; procedures and standards for assessment of members and the apportionment thereof [and policy form filings]; and the promulgation or modification of policy forms. "Action" shall not include the hearing and resolution of contested cases, **or** personnel matters [or applications for exemptions].

["Plan" means the plan of operation of the IHC Program.]

§ 11:20-2.3 Powers of the IHC Program and Board

(a) (No change.)

(b) The Board shall have the authority to do the following:

1. (No change.)

2. Establish [benefit] **benefits** [levels, including any optional deductibles and copayments, and] exclusions and limitations for standard health benefits plans in accordance with law;

3. - 6. (No change.)

[7. Establish standards for a means test for standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended by P.L. 1993, c.164, section 3;]

[8.] **7**. (No change in text.)

[9.] **8**. (No change in text.)

[10.] **9**. (No change in text.)

[11.] **10**. (No change in text.)

[12.] **11**. (No change in text.)

[13.] **12**. (No change in text.)

[14.] **13.** Calculate assessments and assess member carriers their proportionate share of IHC administrative expenses in accordance with [N.J.S.A. 17B:27A-12 and] this Plan, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses;

i. – ii. (No change.)

[15.] **14.** (No change in text.)

[16.]**15.** Impose interest penalties upon members for late payment of assessments [as authorized by N.J.S.A. 17B:27A-10(f)(4];

[17.] **16.** (No change in text.)

[18.] **17.** (No change in text.)

[19.] **18.** (No change in text.)

[20.] **19**. (No change in text.)

i. (No change.)

[21.] **20.** (No change in text.)

§ 11:20-2.4. Plan of Operation

[(a)] The Plan of Operation and amendments thereto shall become effective upon approval by the Commissioner and submission of final action to the Office of Administrative Law for publication. The Commissioner may amend the Plan of Operation by providing written notice to the Board of amendments and their effective dates and upon adoption of amendments in accordance with applicable law.

[(b) Upon the submission of a Plan by the Board and approval of the Plan by the Commissioner pursuant to N.J.S.A. 17B:27A-10(d) and (e) as amended by P.L. 1993, c.164, section 6, the Commissioner shall rescind the Temporary Plan.]

§ 11:20-2.5 Board of Directors

(a) The Board shall consist of nine Directors, including the Commissioner or his or her designee, who shall sit ex officio.

1. (No change.)

2. (No change.)

i. (No change.)

(1) - (4) (No change.)

ii.[The Board shall hold a meeting, at least annually, of the members of the IHC Program for the purpose of electing Directors to fill any vacancies among the Directors who

represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office.] **The Board shall schedule and hold elections based upon the occurrence of an impending or actual vacancy of a Director.**

(1) On or about 60 days prior to the date of [the] **a scheduled** election [meeting], the Board shall send written notice to the IHC Program members setting forth the [time], date and [place] **closing time** of the election [meeting], stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

(2) (No change.)

(3) At least 30 calendar days prior to the date of [the] **a scheduled** election [meeting], the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election [meeting], along with a ballot by which the member carrier may vote [via absentee ballot on or before the date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting].

(4) (No change.)

(5) Elections shall be by the highest number of those votes properly cast [in person and absentee].

(6) (No change.)

iii. [Prior to the Board's annual meeting set forth at (c) below, or no] **No** later than 30 calendar days subsequent to the date of [the] **each** election [meeting, whichever date is later], the Board shall[send a] **update the Board's website to include an updated list**

of [written notice to IHC Program members of the names of] the Directors of the Board **and[**,] their respective designees, if any.

3. - 7. (No change.)

(b) - (h) (No change.)

[(i) The Board shall provide for the taking of written minutes of each Board meeting, including teleconferences and closed sessions, and distribute a copy of the minutes to the Directors. The Board shall retain the original of the minutes.]

[1.] **(i)**The staff of the Board shall take and maintain the written minutes of the proceedings of the Board meetings, including teleconferences and closed sessions **and distribute a copy of the minutes to the Directors. The staff of the Board shall retain the original of the minutes**. Board meeting minutes shall set forth as a minimum the following:

i. -vi. (No change.)

(j) (No change.)

§ 11:20-2.7 Financial administration

(a) The fiscal year of the IHC Program shall run from July 1 **of each year** to June 30 of [each] **the following** year.

(b) (No change.)

(c) Bank checking accounts shall be established separately in the name of the IHC Program and shall be approved by the Board.

1. (No change.)

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law.

i. (No change.)

[ii. All investment income earned on loss assessment funds shall be credited to the IHC Program and shall be applied to reduce assessments of members of the IHC Program, except as provided in N.J.A.C. 11:20-2.17(a).]

(d) (No change.)

(e) All financial records shall be kept in accordance with the State's prescribed policies and procedures. The Board shall maintain the books and records of the IHC Program at a location in New Jersey in a manner so that financial statements may be prepared to satisfy the Act and other requirements of New Jersey law.

1. – 3. (No change.)

4. The net balance due to or from the IHC Program shall be calculated for each carrier either when deemed appropriate by the Board or when requested by the carrier. The Board shall maintain records of each carrier's financial transactions with the IHC Program as necessary to ensure compliance with the Act and Plan of Operation, which records shall include at least the following:

[i. Net losses of the IHC Program based upon the assessments calculated in accordance with this Plan;]

[ii.]**i.** Any adjustments as set forth in this Plan;

[iii.]**ii.** Adjustments to the amount due to or from the IHC Program based upon corrections to carrier submissions;

[iv.]**iii.** Interest charges due from a carrier for late payment of amounts due to the IHC Program; and

[v.]**iv.** Other records required by the Board.

5. (No change.)

(f) (No change.)

§ 11:20-2.8 Audits

(a) The Board shall have an annual audit of its operations conducted by a qualified independent certified public accountant.

1. (No change.)

2. The annual audit shall include the following items:

i. -ii. (No change.)

iii. A review of the internal financial controls of the IHC Program; **and**

iv. A review of the annual financial report of the IHC Program[;]**.** [and]

[v. A review of the calculation by the IHC Program of any assessments of carriers for net losses.]

3. (No change.)

(b) (No change.)

§ 11:20-2.10 Standard health benefits plans

(a) The Board shall establish the policy and contract forms and benefit levels (standard health benefits plans) to be made available by members.

1. In designing and amending the standard health benefits plans, the Board shall give consideration to the types of coverage currently in force and/or available in the [marketplace]**market**, individuals' preferences and the evolution towards managed care.

2. – 6. (No change.)

§ 11:20-2.12 Assessments for administrative expenses and organizational and operating expenses

(a) – (b) (No change.)

(c) **Assessments shall be determined as follows:**

(1) Through fiscal year 1997 (that is, July 1, 1996 through June 30, 1997), all members shall be assessed for a proportionate share of final administrative expenses for the fiscal year on the basis of the ratio of the member's health benefits plans net earned premiums for the calendar year which includes the first six months of the fiscal year to the total of all members health benefits plans net earned premiums for that same calendar year.

(2) Beginning with fiscal years 1998 and 1999, all members shall be assessed for a proportionate share of final administrative expenses for two-year fiscal periods on the basis of the ratio of the member's health benefits plans net earned premiums for the two-year calculation period which begins six months prior to the beginning of the first fiscal year to the total of all members' health benefits plans net earned premiums for that same two-year calculation period. Thus, for example, for fiscal years 1998 and 1999, all members will be assessed based on 1997 and 1998 net earned premium.

(3) Starting with fiscal year 2020 (that is, July 1, 2019 through June 30, 2020), all members shall be assessed for a proportionate share of final administrative expenses for the fiscal year on the basis of the ratio of the member's health benefits plans net

earned premiums for the calendar year which includes the first six months of the fiscal year to the total of all members health benefits plans net earned premiums for that same calendar year.

(4) Net earned premiums **for items (1) through (3) above** shall be determined as reported by each member to the IHC Program Board in the Exhibit K Assessment Report as set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit an Exhibit K Assessment Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement or Statements, as appropriate, filed with the Department.

(d) Interim assessments beginning with fiscal years 1998 and 1999 **and ending with fiscal years 2018 and 2019 as well as 2020** shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding two-year calculation period. **Interim assessments beginning with fiscal year 2021 shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding calendar year.**

(e) (No change.)

(f) Assessment amounts are due and payable upon receipt by a member of an invoice for the assessment. Payment shall be by bank draft made payable to the Treasury-State of New Jersey, IHC Program, at the address set forth in N.J.A.C. 11:20-2.1(h).

1.[Pursuant to N.J.S.A. 17B:27A-10(f)(4), members] **Members** shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within [30] **45** days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. – iii. (No change.)

2. (No change.)

(g) – (h) (No change.)

§ 11:20-2.17 [Assessments for total reimbursable net paid losses for two-year calculation periods beginning with 1997 and 1998 and ending with 2007 and 2008

(a) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for assessments. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for two-year calculation periods through 2007/2008, when the net paid loss audit is complete. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of loss assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the applicable two-year calculation period, until such time as the dispute has been resolved against the disputing member, or the deferral denied, except that any portion of a loss assessment not in dispute or subject to a deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses for the applicable two-year calculation period year.

2. Upon receipt of notice that amounts of loss assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate the proportionate amount of interest, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held by the Board and provide notice to the member of the principal amount and interest amount. The Board shall calculate the amount to be returned to the member, which amount shall be paid within 30 days and shall include the payment of interest up until the date of the expected payment.]**Reserved**

§ 11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than $ 5.00 [in the case of an administrative assessment,] the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12. This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12.

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

§ 11:20-3.1 The standard health benefits plans

(a) (No change.)

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

is set forth as chapter Appendix Exhibit C, incorporated herein by reference, subject to the provisions set forth in (b)1 through 9 below and except as provided in (c) below.

1. – 2. (No change.)

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

i. For a network-based plan, the network per covered person annual deductible shall not exceed $ 2,500 **except as stated in items ii and iii below**.

[ii For a plan without a network, the per covered person annual deductible shall not exceed the maximum out of pocket as defined in (b)5 below.]

ii. **For a network-based bronze plan, meaning a plan with a 60% actuarial value, the network per covered person annual deductible shall not exceed $3,000.**

iii. (No change.)

iv. For a plan without a network, the per covered person annual deductible shall not exceed the maximum out of pocket as defined in (b)5 below.

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

4. -6. (No change.)

(c) Members which are [Federally-qualified] HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu of offering at least three of Plans A/50, B, C, and D in (a) above. [State qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in addition to at least two of Plans A/50, B, C, and D in (a)

above.] HMO carriers offering the HMO Plan may offer a copayment plan design set forth in (c)1 below and/or the HMO plan using deductible and coinsurance provisions set forth in (c)2 below. All options offered by the HMO member shall be made available to every eligible individual seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (c)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (d) below.

1. – 2. (No change.)

(d) (No change.)

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

1. (No change.)

2. The network annual deductible shall be no greater than $ 2,500 per covered person, **or $3,000 per covered person, as applicable, to bronze plans** and for a covered family shall equal two times the per covered person annual deductible, satisfied on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-

network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies;

3. – 7. (No change.)

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

1. If the deductibles for tier 1 and tier 2 are separately satisfied, the sum of the tier 1 deductible and the tier 2 deductible shall not exceed $ 2,500 **or $3,000 for a bronze plan.**

2. If the tier 1 deductible may be separately satisfied and is also applied toward the tier 2 deductible, the tier 2 deductible shall not exceed $ 2,500 **or $3,000 for a bronze plan.**

3. – 4. (No change.)

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

(a) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall cease issuing that plan, plan option, or deductible/copayment option within [90 days after the rules take effect]**the timeframe established by the IHC Board in regulation.**

(b) – (d) (No change.)

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

§ 11:20-8.1 Scope and applicability

(a) (No change.)

(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 and a copy of the Exhibit K Part C Premium Data Worksheet, which are set forth as Exhibit K in the Appendix to this chapter, incorporated herein by reference, on or before April 1 of the year immediately following every two-year calculation period **through the 2017 to 2018 calculation period Thereafter Exhibit K shall be filed on or before April 1 of the year immediately following each calendar year.**

(b) If a carrier with reportable accident and health premium in New Jersey is an affiliated carrier, the Exhibit K Assessment Report and the Part C Premium 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 **or one-year period, as applicable.**

2. – 3. (No change.)

(c) (No change.)

§ 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 **through the 2017 to 2018 calculation period. Thereafter, each member shall set forth its total net earned premium from plans issued, continued or renewed for all affiliated carriers during the preceding calendar year on Part C of the Exhibit K**. 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 **or preceding calendar year, as appropriate,** shall assert its status as a non-member by checking the box designated for non-members on the Exhibit K Assessment Report. Carriers either with 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 are non-members.

(c) **Through the 2017 and 2018 two-year calculation period** [Every] **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 Assessment Report.

1. -4. (No change.)

(d) Beginning with the Exhibit K filing due April 1, 2020 for the 2019 calendar year, 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 Assessment Report.

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 the calendar year.

2. In Section 2 of the Premium Data Worksheet, the carrier shall report the total net earned premium for the calendar year 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 net earned premium on Exhibit K Part C as calculated on the Exhibit K Part C Premium Data Worksheet.

SUBCHAPTER 12. PURCHASE OF A STANDARD HEALTH BENEFITS PLAN BY A PERSON COVERED UNDER AN INDIVIDUAL PLAN OR COVERED UNDER A GROUP PLAN

§ 11:20-12.4 Replacement during annual open enrollment period

(a) Except as stated in N.J.A.C. 11:20-12.5 with respect to the special enrollment period, a person who is covered under a standard health benefits plan, standard health benefits plan with rider, or group health benefits plan may only elect during the annual open enrollment period to replace the plan or coverage with a standard health benefits plan or a standard health benefits plan with rider. The application must be [received] **submitted** during the annual open enrollment period.

(b) The effective date of the replacement plan will be January 1 of the year following the annual open enrollment period if the application is submitted [prior to January 1] **during the annual open enrollment period**. [The effective date with respect to applications submitted later in the open enrollment period will be assigned based on N.J.A.C. 11:20-24.4(b).]

(c) (No change.)

§ 11:20-12.5 Replacement during special enrollment period

(a) (No change.)

(b) The effective date of the new standard health benefits plan or standard health benefits plan with a rider will be no later than the first of the month following the date the carrier receives the application. In addition to the first of the month effective date, carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption, or placement for adoption or the date of placement in foster care **unless the applicant requests a later effective date**. The effective date of coverage issued pursuant to a court order shall be the date stated in the court order **unless the applicant requests a later effective date**.

(c) (No change.)

SUBCHAPTER 17. ENROLLMENT STATUS REPORT

§ 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 separately for each of the standard health benefits plans, broken out into PPO or POS or EPO for Plans A/50, B, C and D, the HMO plans reported by copay or coinsurance, as well as catastrophic plans. Carriers shall separately report enrollment through the Marketplace and enrollment [outside the Marketplace] **directly by the carrier**.

1. (No change.)

2. Persons Insured shall be calculated and reported by adding the number of persons insured at the beginning of the period and the number of new insureds during the period, and subtracting the number of insureds lapsed during the period.

[i. The number of lives insured should be reported. For those carriers who do not maintain actual dependent data, the following factors shall be used to convert contracts to persons insured: single = 1; two adults = 2; adult and child(ren) = 2.8; family = 3.9.]

3. (No change.)

4. Inforce Contracts shall be reported separately by the PCP cost sharing, that is, deductible or copayment options applicable to PCP services. **Contracts that apply both deductible and copayment to PCP services shall be reported using the PCP deductible.** The sum of the contracts by PCP cost sharing shall equal the number of contracts inforce.

5. – 6. (No change.)

SUBCHAPTER 23. RULEMAKING; INTERESTED PARTIES; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

§ 11:20-23.6. Public notice regarding board meetings

(a) The Board shall adopt an annual schedule of regular meetings to be held [by it] **during** the following calendar year.

(b) (No change.)

(c) The Board shall provide public notice for all meetings by:

1. – 2. (No change.)

3. Posting of a notice on the Department of Banking and Insurance web site at: [http://www.njdobi.org]**www.dobi.nj.gov**; and

4. [Posting of] **Providing** the notice [in] **to** two newspapers of general circulation designated by the Board **and to the State House Press Corps**.

SUBCHAPTER 24. PROGRAM COMPLIANCE

§ 11:20-24.1 Purpose and scope

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

(b) (No change.)

§ 11:20-24.2 Eligibility, issuance, and continued coverage

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

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

1. (No change.)

2. The person has received a [certificate of exemption through the marketplace] **notice with an exemption certificate number (ECN) from the Marketplace that indicates that he or she qualifies for an exemption**.

(d) (No change).

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

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

§ 11:20-24.2A Triggering events that result in special enrollment periods

(a) (No change.)

(b) [The dates listed below are triggering] **Triggering [**events] **event is defined in N.J.A.C. 11:20-1.2**. A loss of coverage resulting from nonpayment of premium, fraud, or misrepresentation of material fact shall not be a triggering event.

[1. The date the eligible person loses eligibility for minimum essential coverage, or the eligible person's dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan (QHP) by the marketplace;

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

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

4. The effective date of a marketplace redetermination of an eligible person's subsidy, including a determination that an eligible person is newly eligible or no longer eligible for a subsidy with respect to marketplace coverage; and for off marketplace coverage the effective date of a marketplace redetermination that an eligible person is no longer eligible for a subsidy;

5. The date an eligible person gains or becomes a dependent due to birth, adoption, placement for adoption, or placement in foster care with respect to the eligible person and new dependent(s);

6. The date an eligible person gains or becomes a dependent due to marriage provided at least one spouse demonstrates having minimum essential coverage for one or more days during the 60 days preceding the date of marriage;

7. The date NJFamilyCare determines an applicant whose application was submitted during the open enrollment period or during a special enrollment period is ineligible if that determination is made after the open enrollment period or special enrollment period ends;

8. The date an eligible person and his or her dependent child(ren) who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment;

9. The date an eligible person gains access to plans in New Jersey as a result of a permanent move provided the eligible person demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move;

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

11. The date of the court order that requires coverage of a dependent; and

12. The date the eligible person demonstrates to the marketplace or State regulatory agency that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.]

(c) The carrier may require proof of the triggering [events listed in (b) above] **event**.

§ 11:20-24.4 Effective date of coverage

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

1. – 3. (No change).

4. If a person is applying for a catastrophic plan and is not under age 30, a copy of the [certificate of exemption from the marketplace] **notice with an exemption certification**

number (ECN) from the Marketplace indicating that the person qualifies for an exemption; and

5. (No change).

(b) (No change.)

(c) With respect to applications submitted during the special enrollment period, the effective date of coverage shall be the 1st of the month following the date the carrier receives the application. In addition to the 1st of the month effective date, carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption, or placement for adoption or the date of placement in foster care **unless the applicant requests a later effective date**. The effective date of coverage issued as a result of a court order shall be the date stated in the court order **unless the applicant requests a later effective date**.

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

(a) In order for the Board to determine whether a member that is a small employer carrier as defined in N.J.S.A. 17B:27A-17 has offered and made a good faith effort to market the standard health benefits plans pursuant to N.J.S.A. 17B:27A-19a, every small employer carrier shall submit to the Board, at the address specified at N.J.A.C. 11:20-2.1(h), on or before May 1 of each year, a report detailing the activities the small employer carrier undertook during the prior calendar year to market at least three of the standard health benefits plans, whether through the [marketplace] **Marketplace** or off the [marketplace] **Marketplace**, or in the case of [a Federally qualified] **an** HMO, the

standard individual HMO plan. If a member offers one or more standard health benefits plans with rider, the member may include information regarding efforts to market the standard health benefits plan with rider in the report.

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

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

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

i. The carrier provides evidence that it listed at least three standard individual health benefits plans, or in the case of [a Federally qualified] **an** HMO, the HMO plan, on the carrier's standard application for individual coverage in the prior calendar year and demonstrates how the individual application was made available to individual consumers during the prior calendar year; [and]

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

brochures, faxes, or other communications advising the producers of the availability of the plans; or information specific to the standard individual health benefits plans on the carrier's website. Carriers may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the standard individual health benefits plans provided such other method is an outbound consumer marketing approach**; and**

iii. The carrier did not provide information stating that the carrier did not offer individual health benefits plans in New Jersey or did not provide misinformation regarding eligibility for such plans.

2. (No change.)

(d) (No change.)