INSURANCE
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Proposed Readoption with Amendments: N.J.A.C. 11:21-1 through 7, 8, 10, 17, 18, 23 and Appendix Exhibits A, F, G, H, N, O, T, V, W, Y, BB Parts 1 and 2, CC, DD, II and KK.

Proposed Repeals: N.J.A.C. 11:21 5.1, 6.3, 17.4 and Appendix Exhibits I, K, L, M, Q, JJ and Z, Part4

Proposed New Rules: N.J.A.C. 11:21-1.6, 7.15, 23, and Appendix Exhibit K

Authorized By: New Jersey Small Employer Health Benefits Program Board, Wardell Sanders, Executive Director

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

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

Proposal number: PRN-2003-439

Interested persons may testify with respect to the standard health benefits plans, set forth in Appendix Exhibits A, F, G, H, N, O, T, V, W, Y, DD, HH and II to N.J.A.C. 11:21 at a public hearing to be held on December 3, 2003 at 1:00 P.M. at the New Jersey Department of Banking and Insurance, Room 218, 20 West State Street, Trenton, New Jersey.

Submit comments by January 2, 2004 to:

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The agency proposal follows:

Summary

Overview and Rulemaking Procedures

Pursuant to N.J.S.A. 52:14B-5.1c, N.J.A.C. 11:21 expires on March 23, 2004. Some of the subchapters contained within this chapter were promulgated by the Small Employer Health

Benefits Program Board (SEH Board), the remainder were promulgated by the New Jersey Department of Banking and Insurance (Department). As required by the Executive Order and applicable law, the Board has reviewed those subchapters it promulgated and has determined that they are necessary, reasonable and proper for the purpose for which they were originally promulgated. Accordingly, the rules are being reproposed for adoption, with changes and new rules, noted herein.

The SEH Program Board was charged by the Legislature with implementing and regulating the reformed small employer health benefits coverage market pursuant to P.L. 1992, c.162 as amended, and codified at N.J.S.A. 17B:27A-17 et seq. (the "SEH Act"). The readoption of N.J.A.C. 11:21-1 is necessary because it implements the SEH Program.

Concurrent with the publication of this proposal, the amendments to the Plan of Operation are being submitted to the Commissioner for her approval pursuant to N.J.S.A. 17B:27A-30. Pursuant to N.J.S.A. 17B:27A-30, the Plan of Operation and any subsequent amendments thereto shall be submitted to the Commissioner who shall, after notice and hearing, approve the plan if she finds that it is reasonable and equitable and sufficiently carries out the provisions of the SEH Act. The Plan of Operation shall become effective unless disapproved in writing by the Commissioner within 90 days of receipt by the Commissioner, or earlier if the Commissioner approves the Plan of Operation in writing prior to the expiration of the 90-day period.

In a proposal in the February 4, 2002 New Jersey Register, at 34 N.J.R. 648(a), the SEH Board proposed substantial changes to the standard health benefits plans and a few of the subchapters that relate to the standard plans. The Board received substantial comments to the rule proposal, and did not act to adopt the entire proposal. It did act to adopt one small part, a

new standard Prescription Drug Rider at Appendix Exhibit H. The Board has chosen to repropose most of the proposed amendments contained in the earlier rule proposal. It has noted changes and additions to the prior proposal to the standard forms that are included in this rule proposal. Additionally, the Board has chosen to address each of the written comments to the prior proposal herein to provide a full rulemaking record. Also included is a report from the hearing officer to the hearing held for the proposed changes to the standard health benefits plans included in that prior rule proposal. As required by N.J.S.A. 17B:27A-51c, the SEH Board will hold a public hearing on the standard health benefits plans at the time and place set forth above. In addition, written comments to any portion of this proposed readoption with amendments, including comments to the standard health benefits plans, will be accepted until the date set forth above.

The Board's rule proposal provides for a comment period of 60 days, and therefore, pursuant to N.J.A.C.1:30-3.3(a)5, is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Readoption of the remaining subchapters in Chapter 21 was proposed separately by the Department and appeared in the October 6, 2003 New Jersey Register at 35 N.J.R. 4438(a), and completion of the readoption process will be coordinated between the agencies.

Discussion of Readopted Rules

The readoption of N.J.A.C. 11:21-1 is necessary because it sets forth the definitions of terms used in Chapter 21, identifies how the Board may be contacted, sets forth the penalties available under law, and provides a severability clause for the subchapter. The Board is also proposing amendments to this subchapter. First, the amendments delete references in N.J.A.C. 11:21-1.1 to amendments to the SEH Act. Since its initial enactment in 1992, the SEH Act has

been amended 28 times (which includes mandated benefit laws) and references to all pamphlet laws is not very helpful and, with the passage of additional laws, would require additional rulemaking to keep current. Second, the reproposal amends N.J.A.C. 11:21-1.4 to set forth the specific penalty provisions provided for under the SEH Act. Third, in this reproposal, the Board is replacing the coinsurance cap and coinsured charge limit features that have been part of the standard health benefit plans since inception, with a maximum out of pocket feature. The terms coinsurance cap and coinsured charge limit are being deleted from N.J.A.C. 11:21-1.2, and definitions of maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket are being added. Lastly, N.J.A.C. 1:30-2.9 requires agencies to provide a description of their organization, stating the general course and method of its operations. As a result, the Board is proposing new rule, N.J.A.C. 11:21-1.6, which states the Board's mission.

The readoption of N.J.A.C. 11:21-2, the Board's Plan of Operation, is necessary in general because it sets forth the purpose and structure of the SEH Program. Pursuant to N.J.S.A. 17B:27A-30, the Board is required to promulgate a Plan of Operation, which outlines the key elements of the Board's administration of the Program under the law. Included in the items in the Plan are the powers of the SEH Board, the Board's structure and how it meets to deliberate, the committee structures and duties, the Board's selection of the Executive Director and duties, the procedures for assessments for administrative and operating expenses, the reporting requirements for carriers, the financial administration of the program, identification of required record keeping for the Board, the requirements for the auditing of the Board's finances, penalties and adjustments of assessment disputes, indemnification for Board members and its staff, and procedures for amendment or the termination of the Plan of Operation.

The Board proposes to delete N.J.A.C. 11:21-2.3(a)6 to remove a reference to the Board's authority to create a standard claim form. While the SEH Act specifically provided the SEH Board with such authority, another act of the Legislature, P.L. 1999, c. 154, The Health Insurance Information Electronic Data Exchange Technology Act (HINT), addressed the electronic submission of claims and the requirement that paper claim forms be standardized. The Department adopted N.J.A.C. 11:22-3 to address these requirements. Carriers operating in the SEH market must be guided by that regulation, as adopted. Consequently, the Board proposes to delete the provision in its rules that authorized it to create a standard claim form. At N.J.A.C. 11:21-2.5(a)2vi, the Board proposes correcting the cross-reference to the Board's record retention rule which should be to N.J.A.C. 11:21-2.11, not N.J.A.C. 11:21-2.12. At N.J.A.C. 11:21-2.6(b)4ii, the Board proposes to eliminate the requirement that the SEH Policy Forms Committee review Exhibit BB, Part 1 and Part 6 filings, as that is a function that has been delegated to staff. Also, the Board proposes at N.J.A.C. 11:21-2.6(b)4iii elimination of the requirement that the Policy Forms Committee review alternative method of utilization review filings since the Board is proposing to delete the provision that allowed carriers to make such filings. The Board notes that the utilization review provisions include myriad areas of variability and thus carriers have been able to accomplish changes by means of the variable text. Thus, provisions allowing carriers to file an alternative section are not necessary.

The Board proposes amending N.J.A.C. 11:21-2.8(a)3 to set a *de minimus* amount for program assessments beginning in Fiscal Year 2005. In the past, because the administrative costs of the Program have been low, the Board has assessed carriers with small market share for as little as a few pennies. The Board also proposes an amendment to N.J.A.C. 11:21-2.8(c)1 to specifically identify the law which empowers the Board to assess a late fee for assessment

payments not made on time. The Board proposes amendments to N.J.A.C. 11:21-2.8(c)3 to remove the reference to an "escrow" account, since deferred funds are placed by the SEH Board in an interest bearing account in Treasury. A true escrow of money is a deposit of funds with a neutral third part to be held until the performance of a condition. The placement of funds in Treasury does not meet this definition.

The Board proposes to delete N.J.A.C. 11:21-2.11(d) which addresses the Board's mailing list, and to create a new subchapter 23 to more fully address mailing lists, their uses, and notice procedures.

The Board proposes amending N.J.A.C. 11:21-2.13(c) to delete the phrase that set forth the time period in which to file an appeal of an assessment as well as the direction to follow the procedures set forth in N.J.A.C. 11:21-2.13(d). The Board proposes amending N.J.A.C. 11:21-2.13(c) to provide direction to refer the appeals procedures as set forth in N.J.A.C. 11:21-2.17. The Board proposes deleting N.J.A.C. 11:21-2.13(d) in its entirety. The deleted section addressed procedures to follow in connection with the appeal of an assessment. The Board proposes a new section on appeals set forth at N.J.A.C. 11:21-17. The new section addresses appeals of assessments as well as to other matters that might give rise to disputes. The new section addresses the time period in which to file an appeal, the information to be provided when requesting a hearing, and the types of action the Board may take following a request for a hearing. The purpose of these changes is to create one standardized set of appeal procedures for appeals taken from Board actions.

The readoption of N.J.A.C. 11:21-3 is necessary because it sets forth the standardized health benefits plans which small employer market carriers are required to offer by law, and the deductible and copay options and ranges that may or must be offered. The subchapter also sets

forth a description of the standard riders, and procedures for filing optional, nonstandard benefit riders of increasing value with the SEH Board.

The Board is also proposing amendments to this subchapter to correct and clarify terminology. For the sake of consistency with terminology used in the standard policy forms, the Board proposes replacing all references in N.J.A.C. 11:21-3 to "in–network" with "network," and all references to "out-network" with "non-network."

The Board proposes significantly modifying N.J.A.C. 11:21-3.1(b)2 and 3 in a manner that affords carriers greater flexibility in the designation of the cash deductible as applicable on a per person and on a per family basis. The Board proposes deleting the specific per person deductible amounts, $250.00, $500.00, $1,000 and $2,500 as well as the corresponding family deductible amounts and replacing those specific dollar amounts with a range of per person deductible amounts. The Board proposes that the range of per person deductible amounts will be $250.00 to $5,000 where the family deductible amounts will be either two times or three times the per person deductible amount. The use of a range for deductible amounts will allow carriers to more easily respond to requests from employers for more deductible options, especially those with greater cost sharing than the standard options. With the prior specified deductible amounts, carriers could file optional benefit riders to accommodate requests for different deductible amounts, and as a result a number of carriers filed riders to provide for different deductible amounts. The use of a range of deductible eliminates the need to file a rider to change the dollar amount of the deductible and thus carriers will be able to more rapidly respond to employer requests. The Board notes that as the deductible amount increases the cost of coverage decreases. Thus, the availability of higher deductibles, up to $5,000, will result in lower premium costs than were associated with the prior deductible amounts which only allowed

amounts up to $2,500. The Board notes that carriers are not required to offer every deductible amount between $250.00 and $5,000, but rather that carriers will market the dollar amounts the carriers anticipate employers will purchase.

The proposed new section N.J.A.C. 11:21-3.1(b)3 replaces the prior coinsurance cap provision in Plans B, C, and D with a maximum out of pocket provision which is the maximum amount a person would be required to pay as a result of deductible and coinsurance and copayment, if any, during a calendar year. The Board believes that the maximum out of pocket concept will be more easily understood by consumers, brokers and carriers since the name "maximum out of pocket" clearly identifies the purpose of the provision. With the prior coinsurance cap provision, a consumer could calculate an out of pocket by adding the deductible to the coinsurance cap. The maximum out of pocket eliminates the need for that calculation. The Board proposes $2,000 to $10,000 as a range for the maximum out of pocket amount rather than the specific amounts that were used as coinsurance caps. The range will allow carriers to more easily respond to requests from employers for lower cost plans. As the maximum out of pocket increases the premium cost will decrease since the consumer assumes a greater responsibility for the cost of covered services as the maximum out of pocket increases.

The Board proposes amending N.J.A.C. 11:21-3.1(b)4i to replace the coinsurance cap provision in Plan E with a maximum out of pocket feature. Since Plan E is a plan that was originally designed to be comparable to an HMO plan with fairly low copayments, the Board is proposing that the maximum out of pocket for Plan E simply be the sum of the deductible plus the coinsurance cap.

The Board proposes replacing N.J.A.C. 11:21-3.1(c) with new N.J.A.C. 11:21-3.1(c). Similar changes are proposed at N.J.A.C. 11:21-3.1(h) for the standard HMO POS plan. The

new text addresses the possibility that an HMO may use deductible and coinsurance as well as copayment features. The physician visit copayments carriers may use have been expanded to include $40.00 and $50.00. The higher copayments will reduce the cost of coverage, and thus respond to requests from employers for lower cost alternatives. The emergency room copayment has been made variable. At the option of a carrier, the emergency room copayment may be $50.00, $75.00 or $100.00. Since the emergency room copayment is a penalty that applies when a person uses the emergency room but is not admitted within 24 hours, the Board believed that allowing a larger amount as the copayment might help deter inappropriate use of emergency room facilities. While a $50.00 copayment might have been a sufficient deterrent to inappropriate use of emergency room facilities in 1994 when the standard plans were first marketed, $50.00 may not have the same impact on consumers ten years later.

The pre-natal care copayment has been made variable. At the option of the carrier, the copayment may be either $25.00 or the same copayment as applicable to a primary care physician visit. The variability has been added to simplify administration for both carriers and consumers. If a carrier elects to use the same copayment as for a physician visit, the copayment for pre-natal care would be the same as shown for a physician visit on the identification card. The pre-natal care copayment continues to be a copayment paid only during the initial visit in order to encourage regular pre-natal care.

The Board proposes that all inpatient copayments associated with the $20.00 physician visit copayment be $200.00 per day. The replaced text provided for a $250.00 copayment for hospital inpatient care and a $200.00 copayment for the inpatient treatment of a non-biologically-based mental illness. The new text no longer includes that difference. The Board believes that

using $200 as the inpatient copayment regardless of why the patient was confined as an inpatient will be easier for consumers to understand and carriers to administer.

In N.J.A.C. 11:21-3.1(d), the Board proposes clarifying that the “arrangement” referred to is a "selective contracting arrangement," which is the term the Department uses in N.J.A.C. 11:4-37.

The Board proposes replacing N.J.A.C. 11:21-3.1(d)2, 3 and 4, with N.J.A.C. 11:21-3.1(d)2, 3, 4 and 5. The text the Board proposes to delete addressed the application of deductible and coinsured charge limit provisions in plans issued through or in conjunction with a selective contracting arrangement. The Board proposes use of a maximum out of pocket feature as opposed to the prior coinsured charge limit feature. The maximum out of pocket refers to the maximum amount a person would be required to pay as copayment, deductible and coinsurance during a calendar year. It differs from the prior coinsured charge limit feature which represented the maximum amount of covered charges a person had to incur in a calendar year, and thus included amounts paid by the person as well as paid by the carrier. The Board proposes affording greater flexibility to carriers in setting deductible amounts. Rather than limit carriers to discreet deductible amounts, the Board proposes allowing carriers to set the deductibles within specified ranges. As discussed in connection with N.J.A.C. 11:21-3.1(b)2, the use of a range of deductibles will allow carriers to more easily respond to employer requests for lower cost options. The use of a maximum out of pocket feature with plans issued through or in conjunction with a selective contracting arrangement will assist understanding of financial exposure by carriers, employers, employees and brokers since the term is self-explanatory. The upper end of the range of dollar amounts that could be used for a network maximum out of pocket and a non-network maximum out of pocket, or a common network maximum out of

pocket could result in greater financial exposure to employees than existed with the replaced coinsured charge limit. However, there would be a premium decrease associated with the increased amount of financial exposure.

The Board proposes amending N.J.A.C. 11:21-3.1(e) to add new sections 3 and 4 to address the network and non-network maximum out of pocket feature that would apply to Plan A, if Plan A were sold through or in conjunction with a selective contracting arrangement. Since Plan A, a limited benefits plan, is a unique plan in terms of benefit design, provisions addressing how Plan A would be offered through or in conjunction with a selective contracting arrangement are not combined with the provisions for the other standard plans.

In N.J.A.C. 11:21-3.2(d)6i and ii the Board proposes clarifying that only one copy of the forms must be submitted with an optional benefit rider filing. The Board proposes amendments to N.J.A.C. 11:21-3.2(d)7i to simplify the options for the Board's determination of an optional benefit rider filing. The existing regulation discusses both completeness and substantial compliance. The Board notes that optional benefit riders are filed on an informational basis. The Board's regulation, N.J.A.C. 11:21-3.2(d), provides specific direction as to the elements for an informational filing. Simply including the required elements in a filing will result in a finding of completeness; failure to submit the required elements will result in a finding of incompleteness. The Board therefore proposes eliminating the second category of "incomplete but in substantial compliance." The Board proposes explaining in N.J.A.C. 11:21-3.2(f) the period covered by the Certification of Compliance, Exhibit BB Part 6.

The readoption of N.J.A.C. 11:21-4 is necessary because it sets forth the standard policy forms that carriers are required to use in issuing the standard plans. The subchapter references the Appendix Exhibits which set forth the policy forms, riders, and explanation of brackets in the

standard forms. This subchapter also sets forth the rules for certification or filing of forms with the SEH Board, the Board's standard of review, and guidance for a carrier's use of a compliance and variability rider.

The Board is also proposing amendments to this subchapter to consistently reference the new Explanation of Brackets for all forms which is set forth at Exhibit K. The Board proposes amending N.J.A.C. 11:21-4.1(a), (b), (c), (d) and (f). The Board proposes deleting N.J.A.C. 11:21-4.1(a)1, N.J.A.C. 11:21-4.1(b)1, N.J.A.C. 11:21-4.1(c)1 which are sections that addressed the filing of an alternative method of utilization review for use with the standard plans. Since the standard plans that contain utilization review provisions contain significant areas of variability, the Board notes that the opportunity to file an alternative method is not necessary. The Board proposes amending N.J.A.C. 11:21-4.1(j) to correctly identify the prescription drug rider as Exhibit H; the Board notes that it failed to amend N.J.A.C. 11:21-4.1(j) when it adopted Exhibit H in a previous rulemaking. See 35 NJR 442(a).

The Board proposes amending N.J.A.C. 11:21-4.2(a)1 to add a requirement that carriers file a Certification of Compliance, Exhibit BB Part 1, within 45 days after the effective date of amendments to the standard plans and to specify the period covered by the Certification of Compliance, Exhibit BB Parts 1 and 6. In light of the significant deductible, copayment and coinsurance amendments being proposed to the standard plans, the Board is proposing significant revisions to Exhibit BB Part 1. This certificate, Exhibit BB Part 1, is in lieu of carriers filing the standard forms with the Board. These amendments are necessary to capture adequate information regarding the options carriers are electing to use in the standard plans. The Board is proposing a minor change to Exhibit BB Part 2 to capture additional information regarding the respondent. The Board is reproposing Exhibit BB Part 6 without amendments.

The Board proposes deleting N.J.A.C. 11:21-4.2(b), (c), (d) and (f) since those sections address the filings of alternative methods of utilization review. As discussed earlier, the Board is proposing deleting the opportunity for carriers to file an alternative method of utilization review in light of the fact that the utilization review provisions in the standard plans contains permitted areas of variability. The Board proposes deleting the last sentence of N.J.A.C. 11:21-4.2(c) which addressed the possibility of carriers using combined forms to create the standard plans since that text was misplaced in a provision that addressed the filing of alternative utilization review provisions.

The Board proposes amending N.J.A.C. 11:21-4.3 to delete all references to an alternative method of utilization review since this proposal eliminates the possibility for carriers to file an alternative method of utilization review. The Board proposes deleting N.J.A.C. 11:21-4.3(a)4 to delete a provision that erroneously indicated a carrier could deviate from the standard plan text with regard to effective date, renewal and termination provisions. Although carriers may use the variable areas within those provisions, the Board has never permitted carriers to modify the text of those provisions other than as permitted by the variable text.

The readoption of N.J.A.C. 11:21-5.1, describing the standard claim form, is no longer necessary. Pursuant to N.J.S.A. 17B:30-23b, the Department has promulgated a regulation at N.J.A.C. 11:22-3.3 governing all claim forms, including those used in the small group market. As a result the Board proposes to repeal N.J.A.C. 11:21-5.1 and Appendix Exhibits L and M.

The readoption of N.J.A.C. 11:21-6 is necessary because it sets forth the standard application form, small employer certification form, and waiver form. These standardized forms are necessary to effectuate the intent of the Legislature in having a standardized market that promotes access to coverage, and to help ensure that carriers administer their business in a fair

and equitable manner. The Board is proposing minor clarification changes to the employer application set forth at Exhibit N. The Board is reproposing the certification form, Exhibit O, and the waiver form, Exhibit T, without amendments.

The Board is also proposing amendments to N.J.A.C. 11:21-6.2(b) to provide that the standard small employer certification form shall be sent to the small employer for completion no earlier than 150 days prior to the renewal of the small employer's health benefits plan. The existing rule provides that such forms must be sent no earlier than 120 days. With the passage of P.L. 2003, c. 27, a law which requires the Board to increase the notice of rate change provision in the contracts from 30 days to 60 days, the Board determined that carriers may need an additional 30 days to receive completed small employer certifications from employers.

The Board is proposing to repeal N.J.A.C. 11:21-6.3 regarding the standard enrollment form and Appendix Exhibit Q. Pursuant to N.J.S.A. 17B:30-23b, the Department promulgated a new enrollment form to be used by carriers in all markets, including the small employer market, which is currently set forth at N.J.A.C. 11:22-3, Appendix Exhibit 1. The Department's regulation was effective on October 1, 2001.

The readoption of N.J.A.C. 11:21-7 is necessary because it sets forth the key elements of Program compliance for carriers. Included in the requirements are standards for carriers with respect to eligibility and issuance; restrictions on changing plans; minimum employee participation requirements; minimum employer contribution requirements; preexisting condition standards; effective date of coverage; price quotes and disclosures; tie-in sales; guaranteed renewability of coverage; enrollment reporting requirements; paying benefits; and permissible rate classification factors.

The Board is proposing an amendment to N.J.A.C. 11:21-7.1 to delete the effective date for Subchapter 7 since it is the same as the effective date for the entire chapter. The Board is proposing an amendment to N.J.A.C. 11:21-7.2 to the definition of "late enrollee" to conform to the definition in the law by replacing an erroneous reference to “small employer” with “individual,” and by adding termination of an employer’s contribution toward coverage as one of the reasons a person may have previously declined coverage. The Board proposes deleting N.J.A.C. 11:21-7.3(a)1 regarding the circumstances under which an HMO may refuse to issue coverage since that provision was inconsistent with the small employer law which requires that the majority of employees work at a New Jersey location and does not require that the small employer be headquartered in a service area. N.J.S.A. 17B:27A-26 states that an HMO is not required to issue coverage if the small employer does not have eligible employees who "live, work or reside" in the HMO's service area. The proposed change is to make the exception to guaranteed issuance in the rule conform to the statute.

The Board proposes amending N.J.A.C. 11:21-7.3(a)5iii to state that there must be at least two employees on the first day of the plan year, as required by the definition of a "small employer" in N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.2.

The Board proposes amending the heading of N.J.A.C. 11:21-7.4 to use the same caption as that contained in N.J.S.A. 17B:27A-50, the statutory authority for the Board's rule. The Board proposes deleting N.J.A.C. 11:21-7.4(d), as such an exception to guaranteed issuance does not appear in N.J.S.A. 17B:27A-50 or anywhere else in the SEH Act or the federal Health Insurance Portability and Accountability Act (HIPAA). The Board proposes moving N.J.A.C. 11:21-7.4(d)2, which permits a carrier to require an employer to pay six months advance premium if its previous plan was canceled for nonpayment or fraud, to a new rule at N.J.A.C. 11:21-7.3(h).

The Board is proposing an amendment to the minimum participation requirement set forth at N.J.A.C. 11:21-7.5(a) to provide participation satisfaction credit for employees covered under Medicare and another group health plan. These changes are to conform the regulation to the changes in participation provision in the law N.J.S.A. 17B:27A-24, as amended by P.L.2001, c.346.

The Board is proposing an amendment to N.J.A.C. 11:21-7.9 regarding price quotes to change the reference from a "producer" to "third party" in recognition of the use by some carriers of other persons or entities that may be providing quotes on behalf of the carrier.

The Board is proposing to delete N.J.A.C. 11:21-7.12(a), the requirement that carriers file an annual report. A number of carriers have been unable to report much of the data contained on the annual report, such as SIC codes, voluntary cancellation versus other types of cancellation, and how many persons were previously uninsured. The Board prefers to focus attention on accurate reporting of information on the number of employers, employees and dependents as well as plan type data. Such information is collected on a quarterly basis.

The Board is proposing an amendment to N.J.A.C. 11:21-7.13 to update both the owner and the address of the Prevailing Health Care Systems (PHCS) fee profile. The PHCS fee profile was sold by the Health Insurance Association of America (HIAA) to Ingenix.

The Board proposes amending N.J.A.C. 11:21-7.14(b) to include a reference to the standard HMO-POS plan.

The Board proposes a new rule at N.J.A.C. 11:21-7.15 to provide that a small employer carrier shall not be required to modify the waiting period provision of a health benefits plan except as of an anniversary date of the plan when requested by a small employer. Permitting a

change at any time during the plan year subjects the market to adverse selection and adds to a carrier's administrative costs, thus leading to increases in premiums for small employers.

The readoption of N.J.A.C. 11:21-8 is necessary because it establishes which carriers are not members of the SEH Program and how those carriers may be certified as non- members. The Board proposes amending N.J.A.C. 11:21-8.6 to delete the references to an appeals procedure and cross-reference the general appeals procedures proposed as N.J.A.C. 11:21-2.17.

The readoption of N.J.A.C. 11:21-10 is necessary because it sets forth annual reporting requirements of market share data for the assessment of operational and administrative expenses of the SEH Program. The Board proposes amending N.J.A.C. 11:21-10.4(a)1, to make clear that a carrier may deduct from its net earned premium refunds paid by the carrier during that calendar year as a result of the application of the minimum loss ratio requirement. The Board proposes an amendment to N.J.A.C. 11:21-10.4(a)2 to clarify that in reporting net earned premium, the reported amount should correspond to the carrier's annual NAIC statement blank.

The readoption of N.J.A.C. 11:21-17 is necessary because it sets forth the standards for carriers for plan identification and marketing, retention of marketing and promotional material, provides for a certification of the marketing material using the certification set forth at Appendix Exhibit BB, Part 2, and outlines prohibited practices by carriers with respect to contracting with producers.

The Board is proposing an amendment to N.J.A.C. 11:21-17.1(b) to provide that a carrier must describe eligibility, coverage and exclusions in their marketing material consistent with the SEH Act. The regulation had referred to "terms, definitions, and text" used in marketing material. The Board is also proposing to repeal N.J.A.C. 11:21-17.4 to delete the requirement that carriers provide copies of the Board’s publication, “Get the Facts.” While the Board

anticipates that it will continue to publish materials for consumers, there appears to be no material benefit associated with requiring carriers to distribute materials which outline the key elements of the 1992 reforms.

In addition, the Board proposes amendments to N.J.A.C. 11:21-17.5(a) regarding producer contracts and compensation. The amendments provide that a carrier may not use the average number of eligible employees or the average number of employees enrolled in small employer plans placed by the producer with the carrier as a basis of determining whether it will contract or continue to contract with a producer. As with the other items in this list, the Board proposes this amendment to make clear that it does not believe it appropriate for carriers to use a producer compensation arrangement as a vehicle to directly or indirectly select risk in the market.

The readoption of N.J.A.C. 11:21-18 is necessary because it sets forth the procedures for interested parties to submit petitions for rulemaking. Under the Administrative Procedure Act (APA), N.J.S.A. 52:14B-1 et seq., all State agencies are required to promulgate regulations for such petitions. The APA provides for a uniform application and administration of the rulemaking process. The Board proposes amendments to clarify the submission requirements. Additionally, at N.J.A.C 11:21-18.3(b) the Board proposes to amend the timeframe from 30 to 60 days in which the Board shall respond to a petition for rulemaking. This change is consistent with the timeframe set forth in the APA.

The Board is proposing new rules at N.J.A.C. 11:21-23. The purpose of this new subchapter is to establish the procedures that the Board uses in providing notice of proposed rulemaking, receiving public comments regarding existing rules and proposed rulemaking, extending the public comment period, conducting a public hearing, and providing notice of

public meetings. Many of the provisions in this new subchapter are to comply with the APA, N.J.S.A. 52:14B-1 et seq., as amended by P.L. 2001, c.5. This law governs the rulemaking activities of all State agencies, including the Board. The new requirements of the APA codified at N.J.A.C. 1:30 address public participation in an agency's rulemaking process. N.J.A.C. 1:30 requires each State agency to publish a rulemaking calendar in the New Jersey Register announcing its schedule of rule proposals. An exception to this requirement permits agencies to choose to publish their proposals with a 60-day comment period. The Board has chosen to provide a 60-day comment period for all of its proposals. The Board's proposed new rule provides that the Board will provide notice of its rules via its website and establishes the requirements for determining if sufficient public interest exists for the purposes of extending the comment period or holding a public hearing on a rule proposal.

Discussion of Reproposal

As was noted above, the SEH Board had previously proposed amendments to its standard contracts and to the rules that refer to the standard contracts. That prior proposal appeared at 34 N.J.R. 648(a). The Board did not adopt that entire proposal. It did adopt one discrete item, a new Rider for Prescription Drugs set forth at Appendix Exhibit H, to provide for a 90-day supply of drugs as required by P.L. 1999, c.395, and to expand the options available for prescription drug coverage. That adoption appears at 35 N.J.R. 442(a). This proposed readoption incorporates many of the proposed changes that were included in that proposal. The summary discussion that follows is largely the same as that published in the earlier proposal, with some modifications for clarity and some to delete changes that the Board is no longer pursuing, and is included here to assist readers. Following the summary is an identification of comments made to the earlier proposal and the Board's responses.

Changes to Comply with New Jersey Law

To comply with the requirements of P.L. 1999, c. 341, the coverage for mammography contained in Plans A through E and the non-network component of the HMO-POS plan has been amended to provide for coverage for one mammogram examination every year for female covered persons age 40 and older.

To comply with the requirements of P.L. 2000, c.121, Plans B through E, HMO and HMO-POS have been amended to specifically provide coverage for the treatment of hemophilia.

To comply with the requirements of N.J.A.C. 8:38, the rules that address the Health Care Quality Act, Plans A through E, HMO and HMO-POS have been amended to include definitions of terms consistent with those contained in N.J.A.C. 8:38 and to provide the notices and disclosures required by N.J.A.C. 8:38.

To comply with the requirements of P.L. 1999, c.383, the exclusion regarding work-related injuries or illnesses contained in Plans A though E, HMO, HMO-POS and in the prescription drug rider has been amended to state that the standard plan will provide coverage for a work-related injury or illness when the self-employed persons described in the law elect not to purchase Worker's Compensation coverage.

To comply with the requirements of N.J.A.C. 11:4-42.8(a)3, the penalty for failure to secure pre-approval as contained in plans A through E and HMO-POS has been amended to provide for a 50 percent reduction in benefits.

To comply with the Supreme Court opinion in the case of *Maria Perreira and Luciano Perreira v. Michael C. Rediger et als*, 169 N.J. 399 (2001), and the Department Bulletin No. 01-11, the Right to Recovery-Third Party Liability provision contained in Plans A through E, HMO and HMO-POS has been deleted.

Changes to Address Federal Law

The benefits for reconstructive breast surgery in Plans A through E, HMO and HMO-POS have been clarified to specifically include text from the Federal Women's Health and Cancer Rights Act. Specifically, the reconstructive breast surgery provision has been amended to state that coverage is provided for the treatment of physical complications of mastectomy, including lymphedemas. This change does not affect the benefits under the standard plans and was designed to include language found in federal law.

The Appeals Procedure in Plans A through E, HMO and HMO-POS include direction to carriers to include text that addresses the claims procedure requirements under Federal law set forth in 65 Fed. Reg. 70246, pages 70268, page 70243 (2000), to be codified at 29 C.F.R. section 2560.

The ERISA text included in Plans A through E, HMO and HMO-POS has been revised to conform to the specimen text set forth in 65 Fed. Reg. 70226, page 70243 (2000), to be codified at 29 C.F.R. section 2520.

The description of network providers in Plans A through E, HMO and HMO-POS has been expanded to advise covered persons that provider lists are furnished automatically, and provided without charge, as required by 65 Fed. Reg.70226, page 70241, (2000) to be codified at 29 C.F.R. section 2520.

The Continuation Rights provision in Plans A through E, HMO and HMO-POS has been amended to comply with recent amendments to the Consolidated Omnibus Reconciliation Act (COBRA) regulations at 26 C.F.R. Part 54, published January 10, 2001 in Volume 6, No.7 of the Federal Register.

Change to Accommodate the Coverage Described in the Consensus Document

In December 1999, a number of carriers participating in the New Jersey Working Group to Improve Outcomes in Cancer Patients voluntarily agreed to provide coverage to patients participating in scientifically valid cancer clinical trials. In order to accommodate those carriers that are participating in the Consensus Document, Plans B through E, HMO and HMO-POS include variable language that a carrier that signed the Consensus Document may include in the standard plans to specify the nature of the coverage.

Other Modifications to the Standard Plans

- *Schedule Page Text*

The Coinsurance text provision of the Schedule in Plans A through E has been amended to clarify that coinsurance does not include either Cash Deductibles or Copayments.

The Coinsurance provision detailing coverage for Network and Non-Network coverage as applicable in PPO and POS plans issued using plans B through E and HMO-POS has been amended to state that coverage for prescription drugs is always covered subject to the Non-Network level of benefits. This change will eliminate confusion regarding whether the benefit is paid at the Network or Non-Network level based on the pharmacy where the prescription is filled or based on the provider who prescribed the prescription drug.

Text regarding referrals as found in POS plans issued using plans C through E and HMO-POS has been revised to clarify that Non-Network benefits are payable if a person fails to secure a referral regardless of whether the provider who provided the services is a Network or a Non-Network provider.

The list of services and supplies in Plans B through E for which pre-approval may be required has been expanded to include speech, cognitive rehabilitation, occupational and

physical therapies and certain prescription drugs. Carriers that elect to require pre-approval in connection with these services would add such services to the list on the schedule page.

The $1,000,000 lifetime benefit that was included for Plan B has been deleted and replaced with an unlimited lifetime benefit.

The premium rates provision of the schedules in plans A through E, HMO and HMO-POS has been amended to clarify that rate changes can only be made prospectively.

- *General Provisions*

The Statements provision in Plans A through E, HMO and HMO-POS has been revised to delete the reference to the beneficiary. Since health plans do not allow the designation of a beneficiary, the reference to a beneficiary was not necessary.

The Premium Amounts provision in Plans A through E, HMO and HMO-POS has been revised to delete the possibility of alternative methods for the calculation of premium payments.

An optional Reinstatement provision that addresses the acceptance of premium beyond the grace period and the impact on continued coverage has been added to Plans A through E, HMO and HMO-POS.

The Clerical Error-Misstatements provision in Plans A through E, HMO and HMO-POS has been has been modified to delete the references to an amount of coverage. References to an amount of coverage would be appropriate in a life or disability plan, for example, but do not have significance in a health plan.

The Termination of the Policy/Contract Renewal Privilege provision in Plans A through E, HMO and HMO-POS has been re-named as Term of the Policy/Contract – Renewal Privilege – Termination. The text of the provision has been re-organized for clarity.

The Conformity with Law provision in Plans A through E, HMO and HMO-POS has been revised to clarify that the provision addresses both New Jersey law and Federal law.

- *Claims Provisions*

The Limitations of Actions provision in plans A through E has been deleted from the Claims Provisions since it appeared also in the General Provisions.

- *Definitions*

The following terms have been newly defined in Plans A through E, HMO and HMO-POS: Accredited School; Approved Cancer Clinical Trial (a definition a carrier would only include if the carrier elects to include the optional benefit description); Emergency; Private Duty Nursing; Referral; and Urgent Care.

The definitions of the following terms in Plans A through E, HMO and HMO-POS were revised for clarity: Actively at Work; Affiliated Company; Alcohol Abuse; Creditable Coverage; Custodial Care; Dependent; Diagnostic Services; Experimental or Investigational; Facility; Illness; Injury; Nurse; Pre-Approval; Skilled Nursing Care; Skilled Nursing Facility (changed from Skilled Nursing Center); and Surgery.

The definitions of the following terms in Plans A through E, HMO and HMO-POS were deleted as the terms were not used: Generic Drug; and Medical Emergency.

- *Employee Coverage*

The following clarifications were made in Plans A through E, HMO and HMO-POS:
The Multiple Employment provision was amended to address earnings and the number of hours worked for affiliated companies; the When Employee Coverage Starts provision was amended to address the effective date of coverage for a late enrollee.

- *Dependent Coverage*

The following clarifications were made in Plans A through E, HMO and HMO-POS:

The Incapacitated Children provision was expanded to include the term developmentally disabled; the Enrollment requirement provision was amended to address the termination of the employer's contribution toward dependent coverage; the When Dependent Coverage Starts provision was clarified to address the effective date of coverage for a late enrollee; the Newborn Children provision was clarified to specify that coverage for the first 31 days is without additional premium and addresses the notice requirements; and the When Dependent Coverage Ends provision was expanded to include variable text to allow an end of the month termination of coverage.

- *Benefit and Coverage Provisions*

The "If This Plan Replaces Another Plan" provision of Plans A through E was amended to clarify that although deductible credit is given, no coinsurance credit is given. Thus, if a covered person had already satisfied the deductible and reached the coinsurance cap or coinsured charge limit, as applicable, the person is entitled to credit under the replacement plan for already having satisfied the deductible, but must resume coinsurance liability anew.

The Anesthetics and Other Services and Supplies provision of Plans B through E and HMO-POS has been amended to add coverage for medically necessary replacements of various supplies.

The Prescription Drugs provision of Plans B through E, HMO and HMO-POS has been amended to include variable text that carriers could include to impose a pre-approval requirement for certain drugs.

The prescription drug coverage in Plans B through E, HMO and HMO-POS has been amended to include text to state that coverage is provided for supplies which require a prescription that are essential to the administration of the prescription drug.

The Therapy Services provision in Plan B through E and the non-network therapy services benefit in the HMO-POS Plan has been amended to include coverage for certain therapies as might be used for the treatment of a biologically-based mental illness. As is discussed more fully in the comment and response section that follows, the Board views this change as a benefit increase. It is the Board's understanding that some carriers have provided no benefits for therapy services where such services are not restorative. This proposed change represents a benefit increase, as compared to a declination of benefits. In addition, variable text allows a carrier to include a pre-approval requirement in connection with physical, occupational, speech and cognitive rehabilitation therapy services. The Therapy Services provision of the HMO plan and the network portion of the HMO-POS plan has been amended to replace the 60-day per incident of illness or injury limitation on services with a 30-visit benefit per calendar year and to mirror the amended benefit in the B through E plans.

The fertility benefits provision in Plans B through E, HMO and HMO-POS has been amended to specifically list the services and supplies the plans cover. Services and supplies that are not listed are not covered.

The Preventive Care provision of Plans B though E, and the non-network section of the HMO-POS Plan have been amended to include bone density testing as a service a person could select to use under the preventive care benefit. In response to a comment, the dollar amount of benefit available as a preventive care benefit has been increased to $750.00 for children through the age of one and $500.00 for all other covered persons.

The Vision Screening provision of Plans B though E, HMO and HMO-POS has been revised to clarify the limited nature of this coverage.

The Transplant Benefits provision of Plans B though E, HMO and HMO-POS has been amended to include coverage for intestine transplants. In addition, the provision has been amended to state that costs for the donor associated with donations for all covered transplants are covered if the donor is not covered under a plan that will provide coverage for the donation. The costs that will be covered do not include travel, accommodations or comfort items.

The Alternate Treatment Features provision of Plans A though E and the non-network section of the HMO-POS Plan has been re-named as Specialty Case Management. In addition, the re-named provision was clarified to explain that it is solely up to the carrier to determine whether Specialty Case Management should be considered.

The dental care exclusion of Plans A through E, HMO and HMO-POS has been amended to state that dental implants are not covered under the plan.

The eye surgery exclusion of Plans A through E, HMO and HMO-POS has been amended to state that lasik surgery is not covered under the plan.

The fertility exclusion of Plans A through E, HMO and HMO-POS has been clarified to specifically state that donor sperm and surrogate motherhood are not covered.

The exclusion for methadone maintenance in Plans A through E, HMO and HMO-POS has been deleted.

The Continuation Rights and Medicare as Secondary Payor provisions which are based on Federal law, as contained in Plans A through E, HMO and HMO-POS have been amended to include parenthetical statements giving very general guidance as to which size groups are subject to the various sections of these provisions.

Changes to Ancillary Forms

- *Employer Application*

The form has been revised to specifically allow for electronic signatures, to ask a question about the application of the Medicare as Secondary Payor regulation to the group, and to ask about participation of a professional employer organization. These changes were made to assist carriers with underwriting and administering the small employer plans.

- *Employer Certification*

The text of the form has been reorganized and re-formatted to make it easier to complete.

- *Mental or Nervous Condition Rider*

The rider, found at Appendix Exhibits J and part 4 of Exhibit Z, was developed in 1993 before managed mental health programs were widely used. Carriers did not find the rider, as developed, to meet their needs in terms of a managed mental health benefit. As a result no carriers elected to use the rider. Carriers can accomplish managed mental health coverage for network coverage using the managed care provisions included in the standard forms. Thus, the rider is unnecessary. The Board proposes the elimination of this standard rider.

- *Certification of Compliance*

Changes were made to the Certification of Compliance set forth at Exhibit BB, Part 1 to address the plan options proposed herein.

- *Explanation of Brackets*

The new form, as proposed as Appendix Exhibit K, will consolidate all information concerning variable areas contained in all the standard plans.

Comments Received to Prior Proposal

Comments to the proposal published at 34 N.J.R. 648(a) were received from the following Legislative Offices, carriers, organizations and persons: Assemblyman Anthony Impreveduto; Assemblyman Peter Biondi; Assemblyman John S. Wisniewski; Former Assemblyman Nicholas Felice; Assemblywoman Charlotte Vandervalk; Assemblyman Paul DiGaetano; Assemblyman Neil M. Cohen; Former Assemblyman John V. Kelly; Assemblywoman Loretta Weinberg; Former Assemblyman Gerald H. Zecker; AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey; Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare of New Jersey; Oxford Health Insurance, Inc.; The ARC of New Jersey New Brunswick; The ARC of New Jersey North Brunswick; The Arc of Union County; The ARC of Bergen and Passaic Counties; The ARC of Essex County; The ARC of Salem County; The ARC of Monmouth; The New Jersey Center for Outreach and Services for the Autism Community, Inc. (COSAC); National Family Caregivers Association – NJ; American Physical Therapy Association; New Jersey Speech – Language – Hearing Association; New Jersey Protection and Advocacy, Inc.; Home Health Assembly of New Jersey, Inc.; Resolve of New Jersey; Lani M. Walvick, LSW; Carolyn Hayer; Theresa C. Gudin; Debra Werner; Caroline A. Kornutik; Deanna Tatusko; Stacey Green; Felicia N. Parks; Lisa Brumme; Jim Altobelli; Sherri Rohl.

COMMENT 1: One organization, one legislative office and eight individuals requested that the standard small employer health benefit plans be amended to include, as either a standard benefit or as an optional benefit, coverage for in vitro fertilization.

RESPONSE: The SEH Board has carefully considered all of the letters and supporting materials that were provided regarding the inclusion of either a mandated benefit or an optional benefit for in vitro fertilization. Although the request to add coverage, either as a mandate or as

an option, was outside the scope of the proposal and thus does not require a response, the SEH Board recognizes the significance of the requests to those persons who took time to comment during the comment period as well as the many persons who have continued to write even after the close of the comment period.

The SEH Board notes that rates in the New Jersey small employer market have significantly increased over the past several years. For example, based the annual premium comparison survey complied by the Department for a sample six-employee group, on January 1, 1999 the least expensive HMO $20.00 copay plan on the market up would have been $1,384 per month. By January 1, 2003, the same plan by the least expensive carrier in the market would have cost the same group $2,795. According to published reports, rate increases over the past several years for health care are not unique to the New Jersey small employer market. There is a cost associated with the inclusion of any benefit to a health benefits plan. To cope with rising rates small employers make plan changes so that they offer less rich benefit plans, or they shift more of the cost to the employees, and sometimes they elect to forego the offering of a health plan to employees. In fact, in New Jersey enrollment in the small employer market has decreased from its peak of about 930,000 covered lives as of January 1, 2000 to about 875,000 covered lives today.

The Board estimates the cost impact of adding a benefit for in vitro fertilization to be between 1.5 percent and five percent of premium for a New Jersey small employer. While advocates have argued that the cost of adding a benefit for in vitro fertilization are minimal, such estimates may not have taken into account a number of items that would affect a cost impact analysis. In effect, the cost of adding a benefit for in vitro fertilization to a large employer in Connecticut may not be the cost impact to a small employer in New Jersey. First, New Jersey's

small employer market is a guarantee issue market in which health underwriting is not permitted, and rates are limited to a 2:1 ratio. While such rules are effective in protecting consumer with health conditions, such rules also increase the danger of adverse selection. Further, while the small employer market includes employers with two to 50 employees, the average number of employees covered under a contract is between three and four employees. While larger sized employers tend to make benefit decisions irrespective of the health status or coverage needs of specific employees, that is less true for smaller sized employers. For example, it is unlikely that a large employer without health coverage would make a decision to purchase coverage based on coverage of a specific benefit like in vitro fertilization. The chance of that happening for an employer with two employees who are husband and wife is dramatically higher; especially where the cost of the benefit would be in excess of the annual premium. This distinction between the large and small employer markets is significant and helps to explain why small employer group health coverage tends to be more expensive than large employer group coverage. In today's climate of alarming cost increases and decreasing enrollment in the small employer market, , and because of the anticipated cost impact on the market, the SEH Board cannot support the mandatory inclusion of coverage for in vitro fertilization in the standard plans. The SEH Board notes that this result does not conflict with P.L.2001, c.236, a law which mandates coverage for in vitro fertilization, but which did not amend the SEH Act.

The SEH Board notes that carriers in the small employer market are permitted to file optional benefit riders of increasing value. Adding coverage for in vitro fertilization would represent a benefit increase. The Board further notes that although no carrier has filed a rider to add the coverage, there is not regulatory prohibition to such a filing. No change is being made in response to the comment.

COMMENT 2: One organization commented that the proposed changes to Plan A eliminated coverage for fertility services and requested that the benefit be retained.

RESPONSE: The Board notes that Plan A is a basic plan that covers 30 days of hospitalization along with some very limited outpatient benefits. It was designed by the Legislature to be a limited benefit plan for those that could not afford or did not wish to purchase more comprehensive coverage. Since the services to treat infertility that were included in Plan A would be provided on an outpatient basis, the SEH Board recognized that it had erroneously included these limited benefits to treat infertility in Plan A when it included the coverage in the other standard plans during a prior rule amendment. The Board further notes that Plan A does not cover outpatient drugs for any conditions, and therefore the SEH Board believes drugs should not be covered in connection with the treatment of infertility. Lastly, the Board notes that small employers have not found Plan A to be an attractive plan option; of the approximately 113,000 contracts in the market, approximately three are Plan A contracts. No change is being made in response to the comment.

COMMENT 3: The commenter noted that the standard plans other than Plan A include text relative to prescription drugs that addresses situations in which off-label use of a prescription drug would be covered under the plans. The commenter observed that coverage for drugs for the treatment of infertility excludes off-label use. The commenter asked that prescriptions for the treatment of infertility also include off-label use.

RESPONSE: The Board agrees with the commenter and has amended the standard plans, other than Plan A, to address off-label use of drugs for the treatment of infertility.

COMMENT 4: Eleven organizations and one consumer opposed the proposed reductions in coverage for home health care and private duty nursing. The commenters noted that the needs

of persons who have been receiving home health care and private duty nursing care are enormous and the level of benefits as proposed would be insufficient for many, leaving some families with no choice regarding care for serious, chronic health issues. Some commenters noted that the alternative to continued care in the home would be placement in a residential facility. The commenters asked that the standard plans not be amended to eliminate the unlimited benefits that have been provided in the past.

RESPONSE: The Board has carefully considered the comments that were provided and recognizes that there are persons whose medical condition may require that they receive a greater number of nursing visits under home health care or private duty nursing hours than the proposed changes to the standard plans would have allowed. The Board notes that the unlimited benefits for nursing care under home health care that have been included in the standard plans since their creation in 1994 far exceed the level of benefits required by New Jersey law (N.J.S.A. 17B:27-51.5) and exceed the level of benefits typically found in large group plans. Nevertheless, in light of the fact that an unlimited home health care benefit has been provided since 1994 and consumers have come to rely on the unusually rich coverage provided in the standard small employer plans, and because the cost savings of limiting the benefits at this time appears to be minimal, the Board will not implement the reduction in coverage, as proposed.

COMMENT 5: One commenter noted that the proposed provision for private duty nursing affords only 360 hours per year, subject to carrier pre-approval, a decrease from an unlimited benefit. The commenter believes the proposed limited hours are insufficient and offered calculations of how quickly the benefit would be exhausted by a patient who requires private duty nursing for eight hours per day, seven days per week and by a person who requires four hours per day, seven days per week.

RESPONSE: The Board recognizes that the prior proposal's provision for 360 hours of private duty nursing care represents a benefit decrease as compared to the prior unlimited benefit. The Board also recognizes that patients who require care for eight hours or even four hours a day may exhaust the 360-hour benefit before the need for nursing services has been fulfilled. The Board notes that while there is no law that requires coverage for private duty nursing, since inception, the standard plans have allowed for unlimited coverage for private duty nursing when provided as part of an approved home health care plan. It was clear from the comments that the Board received that many persons have come to rely on the private duty nursing services that the standard plans have covered under home health care. Further, the Board believes that the cost savings to employers of limiting coverage for home health care at the present time appears to be minimal. Therefore, the Board has determined that it will not proceed with the proposed change in coverage for private duty nursing it had proposed in its prior proposal.

COMMENT 6: One organization objected to the proposed reductions in benefits for home health care and private duty nursing and noted that the cuts will impact other portions of the State budget, specifically the New Jersey Health Department's Catastrophic Care Fund and the commenter stated that many patients will likely require Medicaid funding in an institution. The commenter stated that the "Economic Impact statement seems sadly cavalier in its treatment of these families." The commenter noted that the statement explained that some of the increases "may be mitigated by some of the cost containment features included." The commenter stated that, "[t]hose limits may mitigate the issue for employers, but their employees and the State of New Jersey will, frankly, be left 'holding the bag.'"

RESPONSE: As noted in the Responses to Comments 4 and 5, the Board is not going to proceed with the proposed modifications to coverage for home health care and private duty nursing.

COMMENT 7: The commenter also objected to "limited information in the public domain about these changes." The commenter stated that two calls were made to the Commissioner's Office to seek information on the Board's pending proposal and the public hearing. The commenter said she was erroneously advised that no hearings were scheduled for the date of the Board's hearing.

RESPONSE: The Board notes that notice of the proposed changes was published in three New Jersey newspapers, information was provided to the press corps, information on the proposed changes was mailed to every person on the Board's interested parties mailing list, and the proposed changes were posted on the web page of the Department. Given the number of persons and organizations who commented in writing as well as testified during the public hearing, it seems that notice of the proposed changes was properly disseminated. The Board invites the commenter and any others who are interested in being added to the interested parties mailing list to contact the Board to request inclusion on the list.

COMMENT 8: One commenter objected to the proposed changes regarding home health care and private duty nursing. The commenter stated that the proposed reductions in coverage "diminish the coverage, which is required by Statute." The commenter stated that "this is in direct contravention of the legislative intent."

RESPONSE: The Board notes that N.J.S.A. 17B:27-51.5 and the corresponding rule, N.J.A.C. 11:4-14, establish the level of benefits that a health plan must provide. The statute requires that plans cover 60 home health visits. The Board disagrees with the commenter that

the proposed benefit which imposes the 60-visit limit on only one component of the home health care benefit as opposed to a 60-visit limit on the entire benefit, as is permitted by statute, is in conflict with the statute. In fact, the change, as originally proposed would have provided greater benefits than that required under the statute. The Board is not aware of any statement of legislative intent that would indicate an unlimited benefit is required to be provided. Nevertheless, as explained in the responses to Comments 4 and 5 above, the Board has chosen not to reduce the unlimited benefits for home health care and private duty nursing.

COMMENT 9: One commenter challenged the distinction made between nursing care as part of home health care and private duty nursing, stating that the "proposal does not provide any indication what the practical difference is between the two. Nowhere in the proposal does the Board specify criteria under which one provision or the other would be operative." The commenter stated that the Board was attempting to "circumvent the Legislative intent of the Statute through semantics."

RESPONSE: The Board notes that the proposed changes to the forms defined Private Duty Nursing as skilled nursing care for covered persons who require individualized continuous nursing care provided by a registered nurse or a licensed practical nurse. The Board believes that the continuous nature of the care distinguishes private duty nursing care from the nursing care provided under home health care which the Board understands to be directed toward a specific task during a visit and intermittent rather than continuous in nature. However, as stated in the Responses to Comments 4 and 5, the Board is not proceeding with the proposed changes to home health care and private duty nursing. Therefore, there is no longer any distinction being made between private duty nursing and skilled nursing care.

COMMENT 10: One commenter stated that the 60 home health care visits specified in N.J.A.C. 11:4-14.2 would be the level "a Policy must minimally provide" and would not mean the maximum number of visits.

RESPONSE: The Board agrees that the 60 visits is the minimum number of visits that must be covered. However, the law does not require that more than the minimum number of visits be provided. As noted in the Response to Comment 4 above, the Board is not proposing to limit the nursing benefits to 60 visits, as was previously proposed.

COMMENT 11: The commenter objected to the use of a 50 percent penalty in the event a consumer fails to secure pre-approval for home health care. Since the nursing benefits also require pre-approval the commenter indicated that the pre-approval process was duplicative.

RESPONSE: Since the Board is not proposing a change to the home health care and private duty nursing coverages (which means the current proposal does not include a separate private duty nursing benefit) there is not a separate pre-approval requirement associated with private duty nursing.

COMMENT 12: One commenter objected to provisions in the text that provide for "non-payment of services that could be considered custodial in nature, both for hospitalizations and for Home Health Care." The commenter noted that some tasks associated with treatment of a specific illness "could also be considered custodial." The commenter believes that carriers could "disallow payment and force the Insured to pay rates far in excess of their stated copays" and stated that such a result would be "inconsistent with the general coverage provisions of the policy and with the legislative intent of the Statute."

RESPONSE: The Board refers the commenter to the definition of custodial care as it appears in the standard plans and as set forth below.

"Custodial Care means any service or supply, including room and Board, which:

a) is furnished mainly to help a person meet his or her routine daily needs; or

b) can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for that part of the care which is mainly custodial."

The Board recognizes that it is possible that a patient may receive care and treatment that is medically necessary and appropriate and may also receive some care that is custodial. Based on the definition of custodial care, carriers would cover the charges that are considered to be medically necessary and appropriate and not cover charges for those services that are custodial. The Board notes that medical necessity is a prerequisite for all services and supplies under the standard plans and disagrees with the commenter that covering only medically necessary and appropriate services is "inconsistent with the general coverage provisions of the policy." The Board cannot comment on the commenter's contention that not covering custodial care is inconsistent "with the Legislative intent of the Statute" since the commenter did not specify which Statute nor what provision in the Statute leads the commenter to believe that the Legislature intended that custodial care be covered. No change is being made in response to the comment.

COMMENT 13: One commenter objected to the renaming of the Alternate Treatment Features provision to Specialty Case Management. The commenter stated that the "reclassification of this feature allows the insurer, in their [sic] sole discretion, to determine whether a member can be considered for 'Specialty Case Management.'" The commenter stated that the Alternate Treatment Features provision included a bilateral agreement for treatment which was necessary to protect members "from preclusion of medically necessary care." The

commenter stated "[i]nasmuch as the Legislature sought to create this exception for persons suffering from 'Catastrophic Illnesses,' it is in direct contravention of the Statute that the Board take away any force this provision may have by creating a unilateral option favoring the Insurer."

RESPONSE: The Board chose to rename the provision in response to some confusion between the terms "alternate treatment" and "alternative treatment." For example, one carrier has used the term "alternative treatment" to refer to treatments for non-traditional care (for example, homeopathic care) resulting in some people thinking the alternate treatment features provision only addresses non-traditional medical care. The Board believed that Specialty Case Management more accurately reflected the nature of the provision and would eliminate any confusion that the plans would cover alternative treatments. The new name in no way changed the nature of the provision of the benefits under the terms of the contract. The provision called Alternate Treatment Features gave discretion to the carrier, or the carrier's case manager, to identify which cases should be considered for alternate treatment. The physician and patient are consulted in the Specialty Case Management provision to the same extent as they were consulted in the Alternate Treatment Features provision. Whether named Alternate Treatment Features or Specialty Case Management, the carrier initiates the consideration, and the coverage the carrier suggests is only provided if both the physician and patient agree.

The Board voluntarily included the Alternate Treatment Features provision in the standard plans when they were created in 1993. It was not a provision required by the Legislature. The Board is not aware of any Statute governing such a provision. Since the commenter did not state which Statute the commenter believed the Board was contravening by renaming the provision, the Board cannot offer a more specific response.

The Board takes this opportunity to explain, for the benefit of the commenter, and any other persons who may benefit from an explanation, what Specialty Case Management is intended to accomplish. It is the same goal Alternate Treatment Features was intended to accomplish. First, Specialty Case Management is a name crafted by the Board, as was the prior name, Alternate Treatment Features. It is a process that is often handled administratively by a carrier, but the Board chose to include it in the standard plans both to inform consumers and to ensure consistency among carriers that sell standard plans. In all instances it will be the carrier, or the carrier's case manager, that would identify those cases that are catastrophic illness or injuries. The provision will only be considered if there are treatments for the illness or injury that the plan would cover. However, the carrier may be aware of another treatment that has been successful in treating the illness or injury, but which is not covered by the plan. The carrier would contact the physician and the patient to discuss the other treatment and, if all parties agree, would provide coverage for the treatment, even though the service or supply would not otherwise be covered under the plan. For example, suppose a patient suffered a spinal cord injury. One treatment option would be surgery which would require hospitalization. Both the surgery and hospital stay are covered under the plan. The patient may have been getting physical or occupational therapies and already exhausted the available physical and occupational therapy benefits under the plan. The carrier could offer to cover further therapy services, perhaps in an intensive rehabilitation setting. If the physician and patient agree that further therapies would be beneficial, the carrier would cover the additional therapies, even though the therapy coverage specified in the plan had been exhausted. If the additional therapies are successful, the patient might not need to undergo surgery. If the therapies are not successful, the coverage for surgery

and hospitalization would still be available. No change is being made in response to the comment.

COMMENT 14: One commenter expressed concern that the proposed rules would require carriers to identify persons who were currently receiving unlimited home health care benefits and continue to provide unlimited coverage for such patients. The commenter noted that the continued coverage would cease if the employer were to change plans. Additionally, coverage would not be available for other family members who might first require coverage after the plans have been amended to include the limited benefits for nursing services.

RESPONSE: The Board believed that maintaining the current level of coverage for those persons who were already receiving greater benefits than the proposed forms would provide was necessary since those families already had the expectation of coverage. However, as discussed in the Responses to Comments 4 and 5 above, the Board is not revising the home health care and private duty nursing coverage and thus all persons who require home health care will receive the same unlimited coverage as has existed since 1994.

COMMENT 15: One commenter stated that "limiting Home Health Care benefits as proposed will unduly burden State programs which grant assistance for Private Duty Nursing." Families "may be forced to institutionalize their dependents out of sheer exhaustion of resources."

RESPONSE: Since the Board has decided not to proceed with the limitation on coverage for home health care and private duty nursing persons covered under small employer plans will continue to receive the unusually rich unlimited coverage. The Board notes, however, that persons covered under small employer plans have the same access to Medicaid as persons covered under other types of plans as required by N.J.S.A. 17B:27A-21.1.

COMMENT 16: Two commenters expressed concern with the proposed replacement of therapy services for up to 60 days per incident of illness or injury with 30 visits per calendar year, believing the change to be a reduction in benefits. One commenter requested clarification of how this change affects out of network benefits that provided up to 30 visits per year. One commenter noted that the proposed change "fails to take into account situations where patients have multiple impairments requiring greater than 30 therapy sessions total per year."

RESPONSE: The Board believes that the replacement of a 60**-day** limit per incident of illness or injury with a 30**-visit** limit per year represents an increase in coverage in all but some very limited instances. First, the 60-day per incident of illness or injury benefit provided benefits for up to 60 calendar days, and did not provide up to 60 visits unless, of course, a patient had 60 therapy visits during 60 calendar days. It is the Board's understanding that a patient might receive two or even three visits per week but that it would be unlikely many patients would have visits seven days a week. Using the 60-day limit, a patient who required two visits per week would be covered for up to eight weeks, giving only 16 or maybe 17 visits during a 60-day period; clearly less than the 30 visits as proposed by the Board. And if the person did not require extensive therapy immediately after the onset of injury or illness, some of the 60-day period might be exhausted before the patient was ready for intensive therapy. And, once the 60 days for an illness or injury has been exhausted, no further visits for that illness or injury are covered under the plan for as long as the person remains covered under the plan. That is, the 60-day period was not replenished every year.

With a 30-visit limit per calendar year benefit, the patient can space the visits at whatever intervals are appropriate. Further, the 30 visits are replenished each calendar year.

With respect to plans that provide an out of network benefit of 30 visits and will now provide a 30-visit limit for network services as well, the plans will continue to offset services received as network services with non-network services and vice versa. With the existing structure, the 60-day period for network benefits may have been exhausted forcing the person to use non-network services for the balance of the 30 visits.

Regarding those patients who have multiple impairments, the Board agrees that it is true that the 60-day per incident of illness or injury limit might serve some patients better than a 30-visit per year limit. The standard plans are intended to address the healthcare needs of the broadest base of persons. The commenter did not provide any information to demonstrate or even to suggest that the population with multiple impairments is the majority. No change is being made in response to these comments.

COMMENT 17: One commenter expressed support for replacing the 60-days per incident of illness or injury limit for therapy services with a 30-visit per calendar year limit. The commenter noted that for some patients, the 60-day period may have passed before they are best able to respond to therapy. Additionally for some patients, therapy services are required at different points as a disease progresses.

RESPONSE: The Board thanks the commenter for supporting the change and further confirming information the Board considered when deciding to propose the change.

COMMENT 18: One commenter applauded the Board for including the term "developmentally disabled" in the Incapacitated Children provision and the clarification that newborn coverage is without charge for the first 31 days.

RESPONSE: The Board thanks the commenter for the comment. The Board notes that the Incapacitated Children provision had previously referred to developmental disability in

another paragraph, and that the term developmentally disabled was inserted to make the text parallel. The standard plans previously considered developmental disability for determining whether a child qualified for the Incapacitated Children extension of coverage.

COMMENT 19: One commenter recommended that the 30-visit limit for therapy services be expanded to 60 visits, as 30 visits would be insufficient for many individuals.

RESPONSE: The Board recognizes that there are some persons whose conditions would require greater than 30 therapy visits per year. However, the Board is conscious of increased costs associated with increased benefits. The Board also considered the level of coverage large group plans provide for therapy services and noted that a 30-visit limit was in line with benefits a person might receive under large group coverage. No change is being made in response to this comment.

COMMENT 20: One commenter also asked that the 60 therapy services visits be for outpatient visits, and be distinct from therapy services received in an inpatient acute program or rehabilitation program.

RESPONSE: The specific therapy services specified as being covered under the standard plans are outpatient services. If a patient received a therapy while confined in a hospital the visit would not be considered as one of the available therapies under the plan. Although the Board is not aware of any carrier having applied inpatient therapies against the limits, the Board is amending the plan to specifically state that the therapy section applies to outpatient therapy services only.

COMMENT 21: One commenter asked the Board to "clarify this section [therapy services] by indicating that this would be for 60 visits per calendar year per discipline."

RESPONSE: The Board notes that the commenter has not requested a clarification but rather an increase in coverage. The standard plans provide for a combined benefit for speech and cognitive rehabilitation therapy of 30 visits per year and a combined benefit for physical and occupational therapy of 30 visits per year. The Board has considered the request to increase coverage and has determined not to do so given the increased costs associated with increasing the level of coverage. No change is being made in response to this comment.

COMMENT 22: One commenter questioned the criteria for pre-approval of speech, cognitive, occupational and physical therapies. The commenter asked that the criteria be included in the proposal.

RESPONSE: The Board points out that the pre-approval provisions included in the proposal are variable, meaning a carrier may choose to impose a pre-approval requirement or may opt not to impose pre-approval. As with all services and supplies for which pre-approval is required, the determination is made by the carrier. Each carrier is required to make this determination based on whether the service or supply is "medically necessary and appropriate." It is not possible to include all of the factors a carrier might consider in the policy provision. Further the Board believes any attempt to include some of the criteria would be a disservice since the information would be incomplete and subject to change over time as diagnostic tests and medical standards are not static. No change is being made in response to this comment.

COMMENT 23: Nine commenters opposed the limitations on benefits for home health care and private duty nursing. Some of these commenters noted that families of persons with severe health problems will not be able to survive without the current level of home health care and private duty nursing service. The proposed level of care is not sufficient and many of the commenters said the person's health would deteriorate without adequate care and some may not

be able to remain in a home setting. One commenter noted that "the number of individuals with developmental disabilities who need ongoing skilled nursing care is relatively small but their needs are enormous."

RESPONSE: The Board understands that the proposed level of home health care and private duty nursing care would not be sufficient for all persons and that the families most affected by the reduction in benefits would have been those with family members with a severe illness or injury who require extensive nursing care. As stated in the Responses to Comments 4 and 5 above, the Board is not proceeding with the proposed limitations on coverage for home health care and private duty nursing.

COMMENT 24: Eight commenters opposed the use of a 30-visit limit for therapy services. Some noted that the need for therapy service by a person with a developmental disability differs significantly from the needs of a person who sustained injury in an accident. Two of these commenters also objected to the use of a combined limit for physical therapy and occupational therapy. One commenter objected to the requirement that treatment be restorative.

RESPONSE: The change the Board proposed was to replace the 60 days per incident of illness or injury limit with a 30-visit limit. As discussed in the Response to Comment 16, the Board does not view this change as being a cutback, except in some limited circumstances. The Board recognizes that the 30-visit limit for therapy services does not afford sufficient coverage for all persons. However, as stated in other responses, the Board is conscious of adding benefits to the standard plans, and as a result, increasing the cost of coverage. Thus, increasing the limit beyond 30 visits or providing 30 visits per each type of therapy as opposed to combined, are not changes the Board is prepared to make. Regarding the fact that the plans define the therapy services as being for restorative purposes, the Board notes that therapy services to treat a

biologically-based mental illness such as autism and pervasive developmental disorder, are not limited to services that are restorative. The Board made that change to comply with the Department's interpretation of P.L. 1999, c. 106, as set forth in its proposed regulation at 35 N.J.R. 2158(a). No change is being made in response to this comment.

COMMENT 25: Two commenters opposed changes made to the therapy services section to address the treatment of biologically-based mental illness. The commenters characterized the changes as limitations and decreases. The commenters noted the nature of the therapy service needs of a child with autism or pervasive developmental disorder, both of which are included in the definition of biologically-based mental illness.

RESPONSE: The Board notes that prior to the proposed change, the therapy services benefits did not specify any coverage for the treatment of autism or pervasive developmental disorder since treatment of those conditions would not have met the requirement under the contracts that treatment be restorative, and thus such benefits were not being covered under the contracts. The proposed changes removed the restorative restriction with respect to the treatment of autism and pervasive developmental disorder. Thus, the forms, as proposed, actually added a benefit for the treatment of autism and pervasive developmental disorder. The Board further notes that the level of therapy services a child with autism or pervasive developmental disorder would receive is identical to the level of services a patient receiving therapy for any other diagnosis would receive. No change is being made in response to this comment.

COMMENT 26: One commenter expressed pleasure that the Board visited the issue of autism but objected to the limited benefits the Board proposed. The commenter asked that the proposed limited benefits be replaced with unlimited coverage for the treatment of autism since limited benefits do not “truly meet the needs of this special population.” The commenter noted

that use of treatment options and therapies "can do much to ameliorate the condition of autism, leading to a reduction in special therapies and programs in the future."

RESPONSE: The Board does not disagree with the commenter that the limited benefits for therapy services as contained in the proposal may be inadequate for patients with autism. The Board's proposal recognized the fact that patients with autism should be able to access the same level of coverage as patients with other conditions that require various therapy services. The Board does not agree with the commenter that insurance plans should provide unlimited coverage for the condition of autism, thus treating autism better than other conditions for which therapy services are required. As summarized in comments from other commenters, the 30-visit limit may provide insufficient coverage for some patients, not just those with autism. While the Board is sympathetic to the therapy needs of patients with autism and other conditions that require therapy services, the Board is concerned that increasing benefits would lead to increased costs to employers and their employees. No change is being made in response to this comment.

COMMENT 27: One commenter stated that the proposal summary inaccurately described the changes the Board proposed regarding treatment of biologically-based mental illness, and specifically autism and pervasive developmental disorder, since the summary indicated that coverage was being included. See 34 N.J.R. 650 The commenter stated "[t]hat upon reference to the Board's actual proposed changes, one finds that the Board is not amending the standard policy forms to include coverage; the Board's amendments limit coverage that already exists in the policies." The commenter stated that the law, P.L. 1999, c. 106 requires that coverage for biologically-based mental illness be provided "Under the same terms and conditions as provided for any other sickness." The commenter stated that unless a "benefit limit that is placed on autism is one that is applied generally to all illnesses, then autism is not being covered

'under the same terms and conditions as provided for any sickness.'" The commenter noted that the Board had previously amended the standard plans to cover biologically-based mental illness the same as any other illness. The commenter stated that "what the Board now proposes is to reduce the coverage that it has already provided, by amending the definition of the treatments that are most often utilized with the treatment of autism: physical therapy, occupational therapy, speech therapy and cognitive therapy." The commenter further stated that the limited treatment the Board proposed is "too little to be of any benefit." Seven other commenters made similar comments.

RESPONSE: The Board respectfully disagrees with the commenter that the Board misstated the change to the therapy services benefit as an increase. While it is true that the Board previously amended the plans to cover biologically-based mental illness as any other illness, that amendment did not have the effect of providing unlimited benefits for all treatments a person with a biologically-based mental illness might require. The law required that the plans cover a diagnosis of biologically-based mental illness the same way the plan would cover any other diagnosis. The Board encourages the commenter to review the therapy services provision as it existed prior to the proposed changes. Physical and occupational therapy were covered only to the extent treatment was restorative. Speech therapy was to correct a speech impairment. The Board understood that as a result of the manner in which therapy services were defined, some carriers were not covering any therapies a child with autism might seek. Yet, the same limitations on services were applied to all other illnesses under the plan. Thus, the statement that biologically-based mental illness is covered the same as any other illness was technically true. However, the Board believed that patients with a biologically-based mental illness should be afforded the same level of benefits available to someone whose therapy was restorative. Thus

the Board proposed amending the therapy services provision to include coverage for biologically-based mental illness, coverage that was previously excluded by virtue of the manner in which various therapies were defined.

The Board understands that the standard plans in the small employer market were not the only plans that provided coverage for biologically-based mental illness yet, by virtue of the definitions of therapy services, the standard plans provided no coverage for certain therapies a patient with a biologically-based mental illness such as autism or pervasive developmental disorder might use. The Board refers to proposed new rules N.J.A.C. 11:4-57, at 35 N.J.R 2158(a). In this proposal, the Department created a new regulation to address coverage for biologically-based mental illness. The summary to the proposal states that "[t]he Department believes the use of these exclusions [that is, nonrestorative exclusions and chronic condition exclusions] to deny treatment for persons with biologically-based mental disorders (BBMI) undermines the intent and purpose of the Act."

Therefore, the Board believes that the therapy services benefits, as proposed, comply with the requirements of P.L. 1999, c. 106 in providing benefits for biologically-based mental illness to the same extent as for any illness and are consistent with the Department interpretation of that law. No change is being made in response to this comment.

COMMENT 28: The commenter stated that members of the Board are to "serve the public good" which means being "straight with the public." The commenter stated that the Board tried "to limit coverage for the treatment of autism in such a way that the actual facts are buried from sight and the public has no idea what is really going on." The commenter said that in his view, failure to be straight with the public "invalidates the Board's proposal under the Administrative Procedures Act and the act creating and imposing various duties of the Board."

The commenter stated that "the proposal cannot be validly adopted, because it both violates the statute and fails accurately to inform the public of what the Board actually proposes to do." Two other commenters made similar comments.

RESPONSE: As explained in the Response to Comment 27, the amendments the Board proposed are increases in coverage, as was stated in the proposal. The Board has acted in good faith attempting to act in a manner that is good for the small employer market, a market which encompasses carriers, small employers and persons covered under small employer plans. In proposing amendments to the standard plan designs the Board has carefully considered the requirements of applicable laws and has proposed amendments in keeping with the requirements of the laws. As explained in the Response to Comment 27 above, the Board believes the proposed text complies with the requirements of P.L. 1999, c. 106 and the Department's proposed regulations. Also, this reproposal, which provides additional discussion on the Board's proposed changes relating to benefits for biologically-based mental illness and the comments and responses to this issue published herein should further address the concern raised by the commenters.

COMMENT 29: The commenter stated that the limits the Board imposed on the coverage for autism "shows a great lack of understanding about autism." The commenter explained that a general physical or speech or occupational therapist cannot apply the techniques required for a patient with autism. For example, the commenter stated that it is not correct to state that speech therapy is to treat a speech impediment. The commenter stated that "the Board's definition of those therapies does not describe the treatment for autism, and the Board's attempt to limit therapy for autism actually fails on pure medical grounds."

RESPONSE: The Board understood the nature of the specialized treatments a patient with autism requires and for that reason proposed benefit provisions for speech, physical and occupational therapies that do not specify techniques nor do they provide detail as to the nature of the condition for which the therapy is required other than to state that the treatment is for a biologically-based mental illness. The commenter used speech therapy as an example. The Board notes that while a patient with autism may not have a speech impediment such as a lisp, the patient nevertheless has a condition that impedes speech. The Board believes that the benefit provisions, as proposed, encompass the therapies patients with autism require. No change is being made in response to the comment.

COMMENT 30: The commenter noted the interest of the Legislature in "providing full coverage for the treatments we already have in hand." The commenter stated that the legislature "can be counted on to see to it that the laws it has passed are fully implemented." Three other commenters made similar comments.

RESPONSE: The Board appreciates that the Legislature expects that the laws it enacts are fully implemented. As explained in the Response to Comment 27 above, the Board believes that the proposed text complies with the requirements of P.L. 1999, c. 106, in that these benefits for biologically-based mental illness are being provided under the same terms and conditions as for other illnesses, and further notes that the proposal is consistent with a recent Department proposed N.J.A.C. 11:4-57 published at 35 N.J.R. 2158(a).

COMMENT 31: One commenter objected, in the context of treatments for autism, to the use of "an arbitrary number of treatments" or not providing "treatment at all because there is a chance there will be limited improvement." The commenter asked that the plans "allow the

physician and the parent or the patient more input into the decision-making process on a case-by-case basis."

RESPONSE: The Board notes that the standard plans do not require a patient to use one treatment as opposed to another. It is true that some services are subject to benefit limits. The therapies often used in the treatment of autism are examples of benefits subject to benefit limits. The Board believes either a 30-visit limit or a 60 days per incident of illness or injury limit are fairly typical in the group market. While the patient and physician will discuss treatment options and may determine that a certain treatment plan is best for the patient, everything a patient may need may not be covered in full under the small employer plans and is likely not covered in full under most other plans. The limit ensures consistency of coverage and also allows the carriers to consider potential utilization for purposes of pricing. No change is being made in response to this comment.

COMMENT 32: Two commenters noted the commitment of the Legislature to champion for the treatment of autism. Specifically related to autism, the commenter noted that P.L. 1999, c. 105 contains an "unusually detailed description of and commitment to the treatment of these illnesses." P.L. 1999, c. 106 "was companion legislation to that requiring full coverage."

RESPONSE: Based on the volume of comments provided by Legislative offices the Board is aware of the commitment of many legislators to addressing the needs of persons with autism. As stated in the response to Comment 27, the Board believes it implemented the requirements of P.L. 1999, c. 106. The law does not appear to require that coverage of autism be greater than coverage for other illnesses. Rather, the law states coverage must be the same as for other illnesses. The Board's proposal is consistent with the requirement that coverage be the same as coverage for other illnesses. No change is being made in response to this comment.

COMMENT 33: One commenter, in addressing the 30-visit benefit per calendar year for therapy services, stated that "the clear intent of the 'Mental Health Parity Act' was to remove such limitations from the coverage for biologically-based mental illnesses. Do we limit cancer patients to a set number of chemotherapy treatments per calendar year?" The commenter further stated that she would "introduce further legislation to reinforce the original intent of the law."

RESPONSE: The Board believes it implemented the requirements of P.L. 1999, c. 106, as enacted. Health insurance contracts are generally not crafted by listing all illnesses and injuries covered under the terms of the contract. Rather, they are generally crafted by identifying the scope of coverage for certain services and supplies to which a covered person is specifically covered, regardless of the nature of the illness or injury which gives rise to the need for such services or supplies. Occasionally, a specific injury or illness may be excluded from coverage or severely restricted, as was many times the case with coverage for the treatment of mental illness. This background may be helpful in understanding how the Board has interpreted the law which requires that services be provided for mental illness "the same as any other illness."

In effect, the standard plans and health plans in general provide for different treatment for specific services or supplies, not to the underlying illness or injuries. For example, under the standard plans, a patient with thoracic cancer who needs speech therapy would be subject to the same limitation on coverage for speech therapy as a child with autism would have. The Board did not interpret P.L. 1999, c. 106 to require that the standard plans treat biologically-based mental illness more favorably than any other illnesses by creating an unlimited benefit for all services and supplies. As explained in the Response to Comment 27, the law requires that coverage be the same as for other illnesses, not better than other illnesses. Therapy services for other illnesses are subject to visit limits and therefore the Board believed that therapy services

for biologically-based mental illnesses could be subject to the same limitations. The Board agrees that plans do not typically limit the number of chemotherapy treatments a cancer patient receives. However, if a cancer patient were to require occupational therapy, the cancer patient would receive coverage only for a maximum of 30 visits per year, just the same as a patient with autism would be eligible for a maximum of 30 visits per year. If further legislation is introduced and enacted the Board will be guided accordingly. No changes are being made in response to this comment.

COMMENT 34: One commenter expressed "support for the Board's efforts to make the policy forms and related documents more precise and consistent with current legal requirements."

RESPONSE: The Board appreciates the comment.

COMMENT 35: One commenter suggested that the payment limit as it appears in the Schedule and the text as it is described in the home health care provision applicable to charges for home health care should specify that the covered charges would "Not exceed what [Carrier] would have paid if the Covered person had remained in a Facility appropriate to the level of care required."

RESPONSE: The Board crafted the payment limit, as proposed, based on the limits permitted in N.J.A.C. 11:4-14.3(b)1, which refers to the daily hospital room and board benefit. The regulation does not allow a comparison to be made to other types of facility charges. In light of the fact that the Board is not proceeding with imposing limits on home health care and private duty nursing, the payment limit text is not included in the current proposal.

COMMENT 36: One commenter suggested that the Reinstatement Provision should not require a written request so that carriers could accept oral requests. In addition, the commenter

requested that the provision allow for a flat reinstatement fee since the commenter believed the cost for reinstatement would be a fixed cost rather than a function of premium.

RESPONSE: While the group health statutes do not include a general provision regarding reinstatement, there is a reinstatement provision applicable to individual health coverage. The Board notes that N.J.S.A. 17B:26-7 refers to an application for reinstatement. Thus, the Board believes it is appropriate for a reinstatement request to be in writing. Regarding the cost associated with reinstatement, the Board has added variable text to the reinstatement provision such that a carrier could use a flat fee rather than a percentage.

COMMENT 37: The commenter suggested revisions to the Participation provision and the waiver form and the annual certification form to comply with the requirements of P.L. 2001, c. 346.

RESPONSE: The Board is aware of a number of bills that were signed after the forms changes were proposed. The current reproposal addresses the requirements of all such bills, including P.L. 2001, c. 346.

COMMENT 38: The commenter expressed concern with the proposed reorganization and clarification of the Renewal privilege provision. The commenter identified a number of circumstances for when he believed non-renewal could occur as of any premium due date as opposed to the anniversary date, as proposed.

RESPONSE: The Board refers the commenter to N.J.S.A. 17B:27A-23a which specifies the circumstances that would permit a carrier to discontinue coverage as of a premium due date rather than discontinuance at anniversary. All other reasons for discontinuing coverage would result in non-renewal which must occur as of an anniversary date. Since the requested change is inconsistent with the law, the Board is not making the requested change.

COMMENT 39: The commenter questioned the deletion of the Limitations of Actions Provision as it appeared in the Claims provisions.

RESPONSE: The Board refers the commenter to the General Provisions of the standard plans. The Board recognized that the provision appeared in both the General Provisions and the Claims Provisions sections and eliminated the duplication.

COMMENT 40: One commenter suggested that the definition of Accredited School be revised to refer to a "school accredited by a nationally recognized accrediting association…" instead of a school "approved" by a nationally recognized accrediting association.

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

COMMENT 41: One commenter suggested that the definition of pre-approval be clarified to specifically state that the 50 percent reduction will apply only in the event services or supplies which require pre-approval have not been pre-approved.

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

COMMENT 42: One commenter suggested including the term Pre-existing Condition in the Definitions section. Although the term is defined in the Covered Charges with Special Limitations section, the commenter suggested that including it among the definitions might help avoid confusion between a Pre-existing Condition and a Pre-existing Conditions Limitation.

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

COMMENT 43: One commenter suggested that the definition of Small Employer as found in the forms be revised to state that only eligible employees are considered in determining the size of the group.

RESPONSE: The Board notes that the definition of small employer already refers to eligible employees, as required by N.J.SA. 17B:27A-17. For further clarity the Board is adding

the adjective “eligible” to some subsequent references to Employee as the term is used in the definition.

COMMENT 44: One commenter stated that the proposed change in item f of the Employee Coverage-Enrollment Requirement section of the policy forms is inconsistent with the requirements of the Health Insurance Portability and Accountability Act. The commenter stated that the forms should address termination of an employer’s contribution, rather than the policyholder’s contribution.

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

COMMENT 45: One commenter stated that the proposed change to item f of the Dependent Coverage–Enrollment Requirement provision is inconsistent with the requirements of the Health Insurance Portability and Accountability Act. The commenter suggested referring to termination of any employer’s contribution toward coverage.

RESPONSE: Although the Board agrees that item f should be revised to make it clearer, the Board disagrees with the commenter’s suggested modification. The Board is instead referring to termination of the contribution toward coverage that was being made by the employer that offered the group coverage under which the Dependent was covered.

COMMENT 46: One commenter suggested that the Newborn Children provision be amended to explain that a child who is enrolled after the first 31 days is a Late Enrollee and that Late Enrollees are subject to the Pre-existing Conditions Limitation.

RESPONSE: The Board notes that the Newborn provision already identifies children who enroll more than 31 days after birth as Late Enrollees. Since Late Enrollee is a defined term and the consequences of being a Late Enrollee are clearly specified in the plan, the Board does not agree that it is necessary to add the text the commenter suggested. The Board further notes

that there are other enrollment provisions in the plan that identify persons who fail to enroll during the first 31 day as Late Enrollees. Those provisions do not state the consequence of being a Late Enrollee but rather rely on the Enrollment Requirement provision that explains the consequence of being a Late Enrollee. No change is being made in response to this comment.

COMMENT 47: One commenter asked that Coinsured Charge Limit be redefined to include only those services for which the member has a coinsurance obligation. The commenter believes it would be difficult to apply the Coinsured Charge Limit to charges where a copayment is applicable.

RESPONSE: The Board has subsequently determined that it would eliminate the Coinsured Charge Limit feature and instead use a maximum out of pocket feature, as described elsewhere in this proposal. However, the Board notes that the prior proposal in no way amended the calculation of the Coinsured Charge Limit. The Coinsured Charge Limit, since inception in the standard plans, has always included everything that the member pays plus everything the carrier pays. That is, if the charge was considered as a covered charge, all amounts related to the covered charge have been used in the calculation. The language the Board included in the proposal was included in response to questions by producers who requested that the text spell out everything that was included in the calculation so it would be easier for them to explain to clients.

COMMENT 48: Two commenters suggested that Private Duty Nursing coverage not be provided if the person is confined in an inpatient Facility. The provisions as proposed only exclude private duty nursing coverage if the person is confined in a Hospital.

RESPONSE: The Board notes that the commenter was suggesting making the provision, as it was proposed, more restrictive. Since the Board is not amending the home health care and

private duty nursing provisions, private duty nursing will continue to be covered only when part of an approved home health care plan.

COMMENT 49: One commenter questioned the intent of the proposed changes in the therapy services provision that address therapy services without limiting the services to those that are listed. The commenter stated that every therapy that is covered should be listed and appropriate limits included.

RESPONSE: The Board understands that unless a service or supply is excluded, the service or supply is covered. The standard plans do not enumerate every type of therapy service but rather identify those that are most commonly used. To the extent the Board believed it was important to impose an internal limit with respect to a certain therapy service, such an internal limit is included. Thus, using the Therapy services as it existed prior to the proposed change, the Board believes carriers would have covered another type of therapy, assuming, of course it was medically necessary. For example, coverage has been provided for feeding therapy. There is no exclusion for feeding therapy, yet the fact it was not listed as a covered therapy did not, nor should it have served as a basis to deny coverage for the service.

COMMENT 50: One commenter objected to the deletion of the Third Party Liability provision from the standard plans. The commenter believes third party recovery is allowed in circumstances under which New Jersey's collateral source rule does not apply. The commenter further noted a pending Federal court case, and suggested using language as is found in the standard individual health benefits plans.

RESPONSE: The Board consulted with the Department regarding the Department's expectations and what the Department has allowed carriers to include in other plans. Since the Department is not allowing a provision such as the commenter requested to be included in any

form the Department reviews, the Board is not including such provision in the standard plans. Further, the standard SEH contracts must be approved by the Department pursuant to N.J.S.A. 17B:27A-33.

COMMENT 51: One commenter suggested deleting the Statement of ERISA Rights text from the policy and contract documents and including it only in the certificate and evidence of coverage documents since the statement addresses the relationship of the employee to the plan not that of the employer.

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

COMMENT 52: One commenter asked that the timeframes in the Claims Procedure section of the ERISA statement be made variable to accommodate recently promulgated Department of Labor regulations.

RESPONSE: The Board notes that under 65 Fed. Reg. 70246, page 70267, (2000) to be codified at 29 C.F.R. § 2560, a plan administrator must notify the claimant of an adverse benefit determination within 90 days after receipt of the claim. The Board has determined that rather than specify standard language to address the requirements of Federal law as regards claims procedures, the standard plans will direct carriers to insert their own provisions to address claims procedures.

COMMENT 53: One commenter noted that the proposed changes to the HMO contract deleted the Independent Contractor Relationship provision. The commenter urged that the provision be retained to disclose the relationship between the carrier and providers.

RESPONSE: The Board deleted the provision upon direction from the Department. It is the Board's understanding that the Department does not allow such a provision in any form it

reviews. Further, the standard contracts must be approved by the Department pursuant to N.J.S.A. 17B:27A-33.

COMMENT 54: One commenter noted that the proposed changes to the HMO contract deleted the Contract Interpretation provision. The commenter urged that the provision be retained so the ability of carriers to make determinations as to the administration of the plan will not be undermined.

RESPONSE: The Board deleted the provision upon direction from the Department. It is the Board's understanding that the Department does not allow such a provision in any form it reviews. Further, the standard contracts must be approved by the Department pursuant to N.J.S.A. 17B:27A-33.

COMMENT 55: One commenter asked that the Statement of ERISA rights include text regarding procedures for a Qualified Medical Child Support Order as discussed at 29 CFR §2520.102-3.

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

COMMENT 56: One commenter noted that a number of mandates were enacted after the forms were proposed. The commenter asked that they be addressed in any adoption.

RESPONSE: The Board has addressed recent mandated benefits in this current proposal and they are described in the summary of changes section of the proposal.

COMMENT 57: One commenter requested a clarification of the interaction of state continuation rights and total disability. The commenter noted that under the COBRA text there is a specific mention of the additional 11 months allowed under COBRA for certain disabled persons.

RESPONSE: The Board notes that all standard health benefits plans include a provision that addresses the requirements of N.J.S.A. 17B:51.12. Said statute is not unique to the small employer market and has application to groups subject to COBRA as well as those not subject to COBRA. If the reason a person would lose coverage is due to disability, and the person had been covered for at least three months, the law allows coverage to continue for as long as disability continues, assuming the employer continues to maintain a group health plan and premiums are paid. The standard plans address the disability extension as a separate provision because it need not be tied to any particular continuation. In fact, it can be triggered absent any continuation. Therefore, the Board does not believe it appropriate to include language that specifically addresses the operation of the provision in the state continuation section.

COMMENT 58: One commenter asked that the Coinsured Charge Limit definition as included on the schedule page be expanded to say it includes what a carrier pays as well as what the member pays.

RESPONSE: The Board is replacing Coinsured Charge Limit and Coinsurance Cap with a maximum out of pocket feature. The Board agrees with the commenter that the explanation of the feature, formerly known as coinsured charge limit, now a maximum out of pocket, should be included on the schedule page.

COMMENT 59: One commenter asked for clarification of the Home Health Care provision. How is "visit" to be defined? Is cost share applied to each visit?

RESPONSE: The Board notes that the law requiring coverage for home health care does not define the term "visit." The Board expects that carriers consider a visit to be measured as the time the nurse arrives at the home until the nurse leaves the home. There is no time limit for a visit specified in the law or in the policy provision and thus the Board expects that no carrier will

attempt to impose a duration limit on a visit. Regarding cost shares for home health care, while deductible and coinsurance could easily be applied to a total bill, if the plan is a managed care plan with a copayment cost sharing feature, the copayment would not apply since the schedule does not include a copayment applicable to home health care.

COMMENT 60: One commenter asked that the non-biologically-based mental illness provision that allows an exchange of unused hospital days for additional outpatient visits be made subject to pre-approval so the exchange is requested prior to use of the service.

RESPONSE: The Board expects that a request for an exchange is taking place before additional outpatient visits are used. The Board is adding pre-approval text to the provision for non-biologically-based mental illness to clarify that the request must be made and approval received before services are used. The Schedule page text is also being revised to list the service among those requiring pre-approval.

COMMENT 61: One commenter asked that a modality limit be added to the physical therapy provision similar to the modality limit the plans include for therapeutic manipulation. The commenter requested that physical therapy that uses more than three modalities require pre-approval.

RESPONSE: The Comment is beyond the scope of the proposal. Nevertheless, the Board notes that pre-approval was already added to the physical therapy provision.

COMMENT 62: One commenter opposed the grandfathering of persons who are currently receiving unlimited nursing services under the home health care provision. The commenter noted the difficulty for rate setting and questioned how grandfathered persons would receive information regarding the continued benefit.

RESPONSE: The Board is not proceeding with the limitation on coverage for home health care and thus there is no longer a need to identify persons who were receiving an unlimited level of coverage.

COMMENT 63: One commenter asked that the therapeutic manipulation benefit be amended to include a standard of continued substantive improvement and that the condition must be acute or an acute exacerbation of a chronic condition.

RESPONSE: The Board notes that this comment is beyond the scope of the proposal. Nevertheless, the Board considered the comment and has determined not to make the requested change. The Board notes that benefits are payable if the care is medically necessary and appropriate. The suggested "substantive improvement" requirement is a subjective standard and would generate confusion among employers and employees as to when benefits are available. Limiting treatment only to acute conditions or acute exacerbation of a chronic condition would preclude coverage for chronic condition and as a result the person may subsequently experience an acute exacerbation of a chronic condition. The Board believes it would be prudent to allow a person to proceed with care for a chronic condition to potentially avoid an exacerbation of the condition. The Board notes that coverage for therapeutic manipulation is subject to a 30-visit limit, so the carrier's exposure, whether treatment deals with an acute condition or a chronic condition, is limited.

COMMENT 64: One commenter opposed the proposed inclusion of coverage for methodone maintenance. The commenter contrasted this treatment to detoxification and further noted that adding this coverage will increase the cost of coverage.

RESPONSE: The Board believes that as a matter of public policy, inclusion of methadone maintenance is an important benefit. Further, the Board notes that increased cost

associated with coverage for such treatment may be offset by reduced medical expenditures for a person receiving such treatment as compared to a person not seeking treatment for drug addiction. No change is being made in response to this comment.

COMMENT 65: One commenter suggested that the wellness allowances be increased from $300.00/$500.00 to $750.00/$1000.00 since the current amounts are inadequate under current guidelines.

RESPONSE: The Board recognizes that the $300.00 allowance for preventive care that was established in 1994 may no longer be adequate. The Board is increasing the preventive care benefit for Plans B through E to $500.00 and $750.50 for children through age one. The Board believes that these dollar amounts are more in keeping with current costs of medical care.

COMMENT 66: One commenter asked that "developmentally disabled" as the term is used in the provision for incapacitated children be defined.

RESPONSE: A definition has been added. The new definition is based on the definition of developmental disability as found in the state Developmental Disabilities Act, N.J.S.A. 30:6D-25(b) and the Federal Developmental Disabilities Act.

Hearing Officer Recommendations

As noted above, the SEH Board held a public hearing on March 20, 2002 in order to receive testimony regarding its amendments to the standard health benefits plans contained in its notice of proposal published in the February 4, 2002 New Jersey Register. Testimony was taken from six persons. Ellen DeRosa, SEH Board Deputy Executive Director, who acted as hearing officer, conducted the SEH Board hearing. While the Board did not act on that proposal, many of the same proposed changes are set forth in this adoption. As a result, as required by N.J.A.C.

1:30-5.5(a), set forth below is a summary of the comments and agency responses and the hearing officer's recommendations and agency responses.

COMMENT 1: Six people commented to object to the Board's proposed changes to limit coverage for skilled nursing services and private duty nursing. One of the commenters was a representative of a home health care agency, one was a Legislator, and the rest were parents of children with a need for unlimited nursing care who would prefer to have such services in their home. Each of the commenters noted that a limitation in such services would have a devastating impact on their lives, and the lives of other families that needed such services.

BOARD RESPONSE: The Board agrees that a limitation of coverage for skilled nursing services and private duty nursing would have had a significant impact on the lives of patients, particularly those with limited incomes. As noted in the response to a number of the written comments above, the Board has chosen not to proceed at this time to reduce the benefits under the standard plans by imposing limitations on coverage for skilled nursing services and private duty nursing.

RECOMMENDATION: Do not modify the forms to limit coverage for skilled nursing services or private duty nursing in the context of home health care. Clearly, for the patients that require unlimited home health care, a reduction in benefits would significantly affect their quality of life. Moreover, since the Board had chosen to provide such a rich benefit for home health care since the inception of the Program in 1994, insureds have grown accustomed to the benefit. The proposed grandfathering provision which would require carriers to continue unlimited benefits for those currently receiving such benefits would not fully protect the consumer, since it would not apply if the employer changed plan options. Absent a compelling

harm to the market of retaining home health care as an unlimited benefit, the benefit should not be changed.

BOARD RESPONSE TO RECOMMENDATION: Accept the hearing officer's recommendation.

COMMENT 2: One commenter argued that the legislative intent behind P.L.1999, c.106, was to provide for an unlimited benefit for biologically-based mental illnesses such as autism. Specifically, the commenter argued that limitation in therapy services intentionally or unintentionally reduces coverage for people with biologically-based mental illnesses. Such limitations would have a devastating impact on many residents in the State.

BOARD RESPONSE: The Board does not believe that the language in P.L.1999, c.106 supports the position that health benefits plans must provide an unlimited benefit for biologically-based mental illness. As noted above in response to the written comments about the benefits for biologically-based mental illnesses, the Board's proposal recognized the fact that patients with autism should be able to access the same level of coverage as patients with other conditions that require various therapy services. The Board does not agree with the commenter that insurance plans should provide unlimited coverage for the condition of autism, thus treating autism better than other conditions for which therapy services are required. While the Board is sympathetic to the therapy needs of patients with autism and other conditions that require therapy services in excess of that required under the contract, the Board is concerned that providing unlimited benefits for therapy services would lead to increased costs to employers and their employees.

RECOMMENDATION: While the commenter offered compelling arguments in favor of providing an unlimited benefit for biologically-based mental illnesses such as autism, the

recommendation is that the limited benefits, as contained in the proposal should be retained. Although the language contained in P.L. 1999, c. 106 clearly supports providing coverage for the treatment of biologically-based mental illness to the same extent as coverage is provided for other illnesses, the law does not require providing a richer benefit than is provided for other illnesses**.** This interpretation appears to be consistent with Department proposed new rules N.J.A.C. 11:4-57, at 35 N.J.R 2158(a).

BOARD RESPONSE TO RECOMMENDATION: Accept recommendation.

Forms Changes Not Contained in Prior Proposal

Changes to comply with law.

To comply with the Department's rules at N.J.A.C. 11:4-28, The Coordination of Benefits provision in every policy, certificate, contract and evidence of coverage form has been deleted in its entirety and replaced with a provision that is consistent with the requirements of the newly adopted rules.

To comply with P.L. 2003, c. 27, the Premium Rate Changes provision in every policy and contract form has been amended to provide for a 60-day period for notice of a rate change. Although the law only requires such 60-day notice in cases of a rate increase, the proposed change requires 60 days notice in the event of any rate change.

To comply with the requirements of P.L. 2001, c. 367, the sample Schedule page text in POS plans, both indemnity POS and HMO-POS has been amended to provide for network level benefits to be paid to network hospitals and facilities regardless of whether the admitting physician is a network provider. Text describing coverage for non-network services has been revised to specify payment at the network level regardless of whether a network provider admits the patient.

To comply with the requirements of P.L. 2001, c. 346, the Participation Requirements provisions in all of the policy and contract forms have been amended to include participation credit for persons who waive coverage due to coverage under Medicare or another group health benefits plan. While not specifically required by the passage of this law, the Board has used this opportunity to clarify the participation requirement to state that only fully insured plans sponsored by the employer count toward participation satisfaction; coverage under a self-funded plan sponsored by the small employer does not count toward participation satisfaction.

To comply with the requirements of P.L. 2001, c. 361, coverage for certain infant formulas has been added to the covered charges and covered services and supplies provisions of all plans except Plan A.

To comply with the requirements of P.L. 2001, c. 295, coverage for colorectal cancer screening has been added to the covered charges and covered services and supplies provisions of all plans except Plan A. In addition, colorectal cancer screening has been added to the list of services that would be considered under the preventive care benefit.

To comply with the requirements of P.L. 2001, c. 373, coverage for newborn hearing screening has been added to the covered charges and covered services and supplies provisions of all plans except Plan A.

To comply with 32 CFR Part 220, and specifically §220.12(b), the exclusion for services or supplies provided by a government hospital or VA hospital as contained in all of the standard plans has been amended such that the exclusion does not apply to a uniformed services beneficiary.

To comply with a recent change to the Consolidated Omnibus Budget Reconciliation Act, the period specified for notice to the qualified beneficiary has been expanded from 14 days to 44 days.

Board Initiated Changes, Not Required by Law

The Board proposes replacing the coinsurance cap and coinsured charge limit features of the standard plans with a maximum out of pocket feature. The purpose of the change is to make the plans easier to understand for consumers and easier for carriers to administer. To accomplish this change, the definitions of coinsurance cap and coinsured charge limit are being deleted from N.J.A.C. 11:21-1.2, and definitions for maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket have been added. N.J.A.C. 11:21-3.1(b), (c) and (d) are being amended to delete coinsurance cap and coinsured charge limit features. The Board proposes including maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket text to N.J.A.C. 11:21-3.1(b), (c) and (d). These changes are reflected in the schedule page and benefit provision sections of Plans A though E and the HMO-POS plan The Board reviewed the Department of Banking Insurance rule proposal published at 34 N.J.R. 3485(a) regarding the rules for in-network and out-network benefits and believes that the Board's proposed provisions, comply with the Department's proposed rule.

The Board proposes amending the HMO and HMO-POS plans to allow for use of deductible and coinsurance features with respect to network services and supplies. Variable text has been added to the schedule page sections of the forms providing samples of the structure carriers would use to craft an HMO or an HMO-POS plan that uses deductible and coinsurance for network benefits. The HMO and HMO-POS plans are being amended to include a definition of deductible, to revise the coinsurance and copayment definitions, and to add a provision to

address deductible credit in the instance of a group transfer, as required by N.J.A.C. 11:2-13. Coverage provisions have been included in the plans to address deductible, coinsurance and maximum out of pocket. The maximum out of pocket feature added to the HMO and HMO-POS plans is consistent with that added to the Plans A-E and the Department's proposed regulation.

The Board proposes amending the definition of reasonable and customary as contained in all plans except the HMO plan to note that a provider may bill a covered person for difference between the billed charge and the amount the carrier determines is the reasonable and customary allowance for the charge. Such billing could only occur in an instance in which the charges are not subject to a negotiated fee arrangement.

Clarifications

In the Continuation rights section of the standard plans, the provision addressing stacking of continuation rights has been clarified to note that it applies only to COBRA and New Jersey continuation rights. It would not apply to a disability extension right.

The list of services for which pre-approval is required has been expanded to include the exchange of unused inpatient days for additional outpatient visits for the treatment of a non-biologically-based mental illness. The coverage section already noted the pre-approval requirement. The exchange is being added to this list that appears on the schedule for consistency.

The Board proposes clarifying the home health care coverage in the standard plans to better specify the circumstances under which the benefit is available. The text of the provision as contained in the HMO plan was not as detailed as that contained in Plans B-E. The Board proposes replacing the text found in the HMO plan with the same text found in Plans B-E.

The Board proposes adding text to the schedule page of all the plans to clarify that the Emergency Room Copayment must be paid in addition to the applicable copayment, deductible and coinsurance.

The Board proposes amending the schedule page for Plan B to clarify that the hospital confinement copayment must be paid in addition to the applicable copayment, deductible and coinsurance.

The Board proposes further clarifications to the coverage for newborn children contained in all of the standard plans to explain why it is important for the carrier to be notified of the birth of the child.

The Board proposes a clarification to the Prescription Drug Rider, Exhibit H, to specify the quantity of drugs that can be obtained per copayment with respect to drugs that are not obtained through a mail order program.

Social Impact

The proposed readoption of these subchapters of N.J.A.C. 11:21, which established the SEH Program under which all small employer carriers in New Jersey must offer standard health benefits plans, will continue to have a favorable impact on New Jersey small employers and their employees. Small employers will continue to have access to a variety of carriers offering small employer health benefits in the State, and the requirement that carriers offer only the health benefits plans designed by the SEH Program Board will enable small employers to understand benefits more easily. Further, carriers will continue to be obligated to provide small employer health benefit plans on a guaranteed issue basis, with plans subject to guaranteed renewability, modified community rating and limitations as to the imposition of a pre-existing conditions

exclusion. These strong consumer protections will have a positive impact on residents covered under small employer plans, especially those with health conditions.

In general, the addition of benefits to the standard plans will be good for covered persons that need the benefits and services that are currently not covered under the standard plans. However, the addition of benefits may result in rate increases. To the extent that rates increase, some employers or employees may choose to drop coverage if they believe that they can no longer afford coverage.

The proposed change to the standard forms to require 60 days advance notice of a rate change, as required by P.L.2003, c.27, will provide employers with additional time to evaluate and consider alternative coverage. The amendments to N.J.A.C. 11:21-7.5 to provide participation satisfaction credit for employees covered under Medicare and another group health plan, as required by P.L. 2001, c.346, will have a positive impact on small employers as the change will make it easier for them to meet the minimum participation requirement in order to obtain coverage. This amendment will be especially significant for smaller sized groups, since the impact of participation credit for each employee becomes more significant.

The proposed amendment to N.J.A.C. 11:21-7.15 to provide that a carrier need not honor an employer's request to modify the employee waiting period off anniversary will adversely affect small employers wishing to change waiting periods off-anniversary. However, small employers will be able to change employee waiting periods as of the next anniversary date.

The amendments to the standard plans to provide for coverage for one mammogram examination every year, as required by P.L. 1999, c. 341, will have a positive impact on some women covered under standard small employer plans.

The Board's proposed amendment to increase the dollar amount of benefit available as a preventive care benefit to $750.00 for children through the age of one and $500.00 may induce some people to take advantage or take greater advantage of preventive care.

The proposed amendments and new rules will have the positive effect of providing the public with a greater opportunity to participate in the rulemaking process of the Board.

Economic Impact

The rules proposed for readoption will continue to have a substantial economic impact on carriers offering small employer health benefits plans in this State. Member carriers will continue to be required to bear the costs associated with complying with the requirements of these rules. These carrier costs will include costs associated with the payment of assessments for the administrative and operating expenses of running the Small Employer Health Benefits Program, providing the SEH Board with filings required under the rules, training appropriate personnel in the rules relating to the SEH Program, and developing and disseminating promotional or marketing materials that conforms to the law. All of these costs, however, are attendant to the continued implementation of the comprehensive reforms of the Small Employer Health Benefits Act, and are far outweighed by the long-term benefits to carriers, small employers and their employees covered by one of the standard SEH plans.

Carriers will be significantly economically affected by the proposed amendments to the standard policy forms set forth in N.J.A.C. 11:21-3.1 and in the Appendix Exhibits for the standard policy forms. Carriers will be required to use these new forms for new issues and renewals. While the cost of this may be significant for carriers, many carriers have noted that the cost sharing features of the standard plans described in proposed N.J.A.C. 112:21-3.1 are similar

to products in other markets. As a result, the administration of the revised forms may produce some cost savings.

The elimination of the standard enrollment form will have a positive economic impact on carriers. Pursuant to N.J.S.A. 17B:30-23b, the DOBI published a standard enrollment form to be used by carriers in all markets. Administration of a single form across all markets may reduce administrative costs for carriers.

Carriers will be impacted directly by the elimination of the requirement under N.J.A.C. 11:21-17.4 that carriers distribute copies to small employers of the "Get the Facts" brochure published by the SEH Board. They will not have the expense of having to distribute the brochure.

The amendments to the standard forms and to N.J.A.C. 11:21-3.1 to allow greater flexibility in cost sharing features may result in some less expensive products for small employers. However, the greater cost sharing under the plans will be borne by the employees and dependents of small employers covered under such plans. Covered persons that do not access coverage would not be affected economically by the changes, but covered persons that do access coverage may find that they have a much greater out-of-pocket cost when using services.

A number of the proposed amendments to the standard forms will have an economic impact on small employers. The amendment to require carriers to provide 60 days advance notice of a rate change, as required by P.L.2003, c.27, may modestly increase the cost of coverage as carriers will be asked to provide rate quotes further in advance from the time of renewal, thus making it more difficult to accurately predict rates that would meet a minimum 75 percent loss ratio.

The Board's deletion of the $1,000,000 lifetime benefit that was included in Plan B will have a significant positive financial impact on those persons covered under that plan that would have hit that lifetime maximum; the Board believes that the change will not have a significant impact on the cost of coverage.

The Board's proposed amendment to include coverage for intestine transplants in the Transplant Benefits provision of Plans B though E, HMO and HMO-POS will have a positive economic impact on covered persons needing such transplants.

Board's proposed deletion of the exclusion for methadone maintenance in the standard plans will have a positive economic impact on covered persons needing such treatment.

The Board will continue to be required to bear the costs of reviewing filings submitted by carriers in complying with this chapter and with working with the Department to enforce the rules in the market. The changes to the standard plans and some changes in the law will require the Board to write, layout, print and disseminate new marketing materials such as the Buyer's Guide. The additional costs of the production and distribution of new marketing materials will be an operating cost that will be paid for by the SEH Program member carriers in the form of assessments.

Insurance producers may be modestly affected by the rules proposed for readoption with amendments. They will be required to learn and understand the changes in the law and the changes in the standard contracts in order to serve their clients.

Federal Standards Statement

The rules proposed for readoption comply with the following federal laws: the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), 29 U.S.C. §§1161 et seq.; the

Employee Retirement Security Act of 1974 (ERISA), 29 U.S.C. §§1001 et seq. and implementing regulations at 26 C.F.R. Part 54, 29 CFR Parts 2520 and 2560, and 32 C.F.R. Part 220; Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. §1395y(b)(1994) and implementing regulations at 45 C.F.R. Part 411; the Public Health Service Act 42 U.S.C.A. §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 C.F.R. Parts 145 and 146.

The rules do not expand upon the requirements set forth in these Federal laws. There are no other Federal laws that apply to these regulations.

Jobs Impact

The Board does not anticipate the creation or loss of any jobs as a result of rules proposed for readoption with amendments and new rules.

Agriculture Industry Impact

The Board does not believe that the rules proposed for readoption with amendments and new ruleswill have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The Board believes that all carriers subject to these rules have in excess of 100 employees or are located outside of the State of New Jersey. Therefore, a regulatory flexibility analysis is not required. However, to the extent that any carrier might be considered a small

business under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the following analysis would apply.

All carriers to whom these rules apply are required to bear any costs associated with complying with the requirements of the rules. The requirements and costs are discussed under the Summary and Economic Impact above. To the extent that these rules apply to small businesses, they may have a greater impact in that small businesses may be required to devote proportionately more staff and financial resources to achieve compliance. The Board believes, however, that any additional costs would not pose an undue burden because the information required is readily available to carriers.

The Small Employer Health Benefits Act provides no different compliance requirements based on business size. The rules at N.J.A.C. 11:21 establish procedures and standards for carriers to meet their obligations pursuant to the Act, and the fair, reasonable and equitable administration of the SEH Program pursuant to N.J.S.A. 17B:27A-17 et seq. All of the required changes to a carrier's business fall within the normal functions a carrier performs in complying with any State insurance law or regulations. An exemption from the policy form changes for certain carriers that are small businesses would be inappropriate because such and exemption would permit the sale of non-conforming forms in an otherwise standardized market. Accordingly, these reproposed rules provide no differentiation in compliance requirements based on business size.

Smart Growth Impact

The rules proposed for readoption with amendments and new ruleshave no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:21.

Full Text of the proposed repeals may be found in the New jersey Administrative Code at N.J.A.C. 11:21-5.1, 6.3, 17.4 and Appendix Exhibits I, K, L, M, Q, JJ and Z.

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

SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended **[by P.L. 1993, c.162, P.L. 1994, c.11, P.L. 1994, c.97, P.L. 1995, c.50, P.L. 1995, c.298, and P.L. 1995, c.340]** (N.J.S.A. 17B:27A-17 et seq.), herein referred to as the Small Employer Health Benefits Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-17 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Small Employer Health Benefits Program pursuant to N.J.S.A. 17B:27A- 17 et seq.

– (c) (No change.)

11:21-1.2 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.

. . .

["Coinsurance cap" means the maximum amount a covered person is required to pay as a result of the application of the coinsurance under the standard plans, as set forth in the Appendix Exhibits to this chapter. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsurance cap.

"Coinsured charge limit" means, with respect to a preferred provider organization (PPO) plan, or a point of service (POS) plan, developed based on the standard health benefit plans set forth in the Appendix Exhibits to this chapter, the amount of covered charges a covered

person must incur before no coinsurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsured charge limit.]

. . .

"Maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all covered services and supplies in a calendar year. All amounts paid as copayment, deductible and coinsurance shall count toward the maximum out of pocket. Once the maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for covered services and supplies for the remainder of the calendar year.

. . .

"Network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all services and supplies provided by network providers in a calendar year. All amounts paid as copayment, deductible and coinsurance shall count toward the network maximum out of pocket. Once the network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by network providers for the remainder of the calendar year. If a carrier wishes to use a common maximum out of pocket provision in a plan that has both network and non-network benefits, the network maximum out of pocket shall mean the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all services and supplies provided by network providers

and non-network providers in a calendar year. All amounts paid as copayment, deductible and coinsurance for both network and non-network services and supplies. shall count toward the network maximum out of pocket. Once the network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by network or non-network providers for the remainder of the calendar year.

"Non-network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as deductible and coinsurance for all services and supplies provided by non-network providers in a calendar year. All amounts paid as deductible and coinsurance shall count toward the non-network maximum out of pocket. Once the non-network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by non-network providers for the remainder of the calendar year.

. . .

11:21-1.4 Penalties

Failure of a carrier to comply with any provision of this chapter **[may]** **shall** result in the **[carrier losing its authority to write health benefits in New Jersey and imposition of any and all penalties and action available under law]** **imposition of penalties as authorized by law, including, but not limited to, penalties set forth at N.J.S.A. 17B:27A-41 and 17B:27A-43.**

11:21-1.6 Mission statement

The mission of the New Jersey Small Employer Health Benefits Program Board is to administer the New Jersey Small Employer Health Benefits Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders in the marketplace and other interested parties, and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to small employers and establishing and administering assessment mechanisms. It also includes the regulation of small employer 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. NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM PLAN OF OPERATION

11:21-2.3 Powers of the Board

(a) The Board has the specific authority pursuant to the Act to:

1. – 5. (No change.)

[6. Promulgate one standard claim form. In order to provide a standard system of payment for medical services, all claim forms for any claimant's use under a group health insurance policy delivered or issued for delivery in this State shall conform to the form adopted by the Board and promulgated in conjunction with the Individual Health Coverage Program pursuant to P.L. 1993, c.162, Section 20;]

Recodify existing 7.-15 as 6.-14 (No change in text.)

11:21-2.5 Board structure and meetings

(a) The Program shall exercise its powers through a Board.

1. (No change.)

2. Initially, three of the elected public members shall serve for a term of three years; three shall serve for a term of two years; and three shall serve for a term of one year. The tenth elected public member, added by P.L. 1994, c.94 shall be elected for a three year term. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Thereafter, all public members shall serve for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. The public directors shall serve their terms of office until their replacements are duly elected or pursuant to the terms of their appointments as applicable.

i. – v. (No change.)

vi. The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at **N.J.A.C. 11:21-[2.12] 2.11**.

3. (No change.)

(b) The votes of the Board shall be **on** a one person, one vote basis. An elected public member, other than the three small employer representatives provided for in Section 13 of the Act (N.J.S.A. 17B:27A-29) as amended by P.L. 1994, c.97, and the Commissioners of Health and Senior Services and Banking and Insurance or their designees, may designate a voting alternate employed by the same carrier or same State agency, as appropriate. Appointed public members and the three small employer representatives, all of whom are appointed or elected as individuals, may not designate a voting alternate.

(c) -(m) No Change.)

11:21-2.6 Committees

(a) (No change.)

(b) Standing Committees shall include the following:

1. – 3 (No change.)

4. A Policy Forms Committee which shall make recommendations to the Board with respect to:

i. (No change.)

[ii. **Exhibit BB, Part 1 filings received pursuant to N.J.A.C. 11:21- 4.2(a), and Exhibit BB, Part 6 filings received pursuant to N.J.A.C. 11:21-3.2(f);**

iii. Alternative method of utilization review filings received pursuant to N.J.A.C. 11:21-4.2;]

Recodify existing iv. – viii as ii. – v. (No change in text.)

(c) – (d) (No change.)

11:21-2.8 Assessments for administrative and operating expenses

(a) Within 45 days after approving a final audited Program statement, the Board shall determine the final administrative expense total for the fiscal year, if any.

1. – 2. (No change.)

3. Members shall be assessed for a proportionate share of the final administrative expenses for the fiscal year on the basis of health benefits plan earned premiums for the calendar year that includes the first six months of the fiscal year. The administrative expense assessment for each member shall be equal to the total of all administrative expenses for the fiscal year multiplied by the ratio of that member's earned premium for health benefits plans to the earned premium for health benefits plans of all members of the calendar year that includes the first six months of the fiscal year.

i. Beginning in Fiscal Year 2005, if a member's proportionate share of the interim assessment or final administrative assessment is less than $5.00, the carrier shall not be assessed and the amounts uncollected will be reapportioned proportionally, based on market share, among the member carriers.

(b) (No change.)

(c) Assessment amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer--State of New Jersey, SEH Program, and mailed to the Executive Director at the address in N.J.A.C. 11:21-1.3.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 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 **as permitted by N.J.S.A. 17B:27A-32c**.

i. – ii. (No change.)

2. (No change.)

3. A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:21-15.

i. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice to be held in an interest bearing **[escrow]** account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

ii. (No change.)

4. (No change.)

(d) – (f) (No change.)

11:21-2.11 Records

(a) – (c) (No change.)

[(d) For the purpose of disseminating information about the Program, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of member carriers initially shall be based upon the member carriers' addresses filed with the Department pursuant to N.J.A.C. 11:1-25. The Board may proceed to develop its own list of member carriers.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name

and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.]

11:21-2.13 Penalties/adjustments and dispute resolution

(a) – (b) (No change.)

(c) A carrier which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the Board **consistent with the appeals procedures set forth at N.J.A.C. 11:21-2.17. [no later than 20 days after receiving the notice of assessment following the procedures in (d) below.**

(d) Concurrent with its challenge to the assessment, a carrier shall advise the Board in detail of the reasons why the assessment is inaccurate or not appropriate and shall submit all documentation that supports or tends to support the carrier's position. The carrier shall also advise at this time whether a hearing is requested.

(e) If a hearing is requested, within 45 days of its receipt thereof, the Board shall determine whether the matter constitutes a contested case. If the matter is determined to be a contested case, the Board shall determine whether to hear the matter or refer it to the Office of Administrative Law for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. If the matter does not constitute a contested case, the Board shall review the challenge itself or delegate this review to an appropriate committee to make a recommendation to the Board.]

11:21-2.17 Appeals

(a) If the Board denies a member's request for relief made pursuant to this chapter, or if the member objects to the terms of the relief granted, the member may request a hearing on the Board's determination within 20 days from the date of receipt of such determination as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, daytime telephone number, and fax number of a contact person familiar with the matter;

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the material facts in dispute and describing the basis for which the member believes that the Board's findings of fact are erroneous.

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are material issues of fact in dispute.

3. The Board shall, within 45 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. If the Board finds that the matter constitutes a contested case, it shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. In a matter which has been determined to be a contested case, if the Board finds that there are no good-faith disputed issues of

material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

ii. If the Board finds that the matter does not constitute a contested case, it may, with the approval of the Director of the Office of Administrative Law, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21. If the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

11:21-3.1 Benefits provided

(a) (No change.)

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall offer all of the health benefits Plans A, B, C, D and E as set forth in Exhibits A and F, V and W, in the Appendix, except as set forth in (c) below.

1. Plan A shall contain a deductible of $250.00 per covered person and:

i. $500.00 per covered family, to be satisfied by two separate covered persons and a per person **[coinsurance cap]** **maximum out of pocket** of **[$5,000]** **$7,750**; or

ii. $750.00 per covered family, to be satisfied on an aggregate basis and a **per** person **[coinsurance cap]** **maximum out of pocket** of **[$5,000]** **$7,750**.

2. Plans B, C, and D shall contain **[the following]** **annual deductible provisions consistent with the following specifications:** **[options to the small employer for each plan**

i. $250.00 per covered person and $500.00 per covered family; $500.00 per covered person and $1,000 per covered family; and $1,000 per covered person and $2,000 per covered family. For all three deductible options, the family deductible limit must be satisfied by two separate covered persons. The per person coinsurance caps for Plans B, C, and D are $3,000, $2,500, and $2,000 respectively. The family coinsurance caps for Plans B, C, and D are $6,000, $5,000, and $4,000 respectively, which must be satisfied by two separate covered persons; or

ii. $250.00 per covered person and $750.00 per covered family; $500.00 per covered person and $1,500 per covered family; and $1,000 per covered person and $3,000 per covered family. For all three deductible options, the family deductible limit must be satisfied on an aggregate basis. The per person coinsurance caps for Plans B, C, and D are $3,000, $2,500 and $2,000 respectively. The family coinsurance caps for Plan B, C, and D, are $9,000, $7,500, and $6,000 respectively, which must be satisfied on an aggregate basis.

3. Member carriers may offer Plans B, C and D with the following deductible option, provided that all options offered by the member carrier shall be offered to each small employer:

i. $2,500 per covered person annual deductible option with $5,000 annual deductible per covered family where the family deductible limit must be satisfied by two separate covered persons; or

ii. $2,500 per covered person annual deductible option with $7,500 annual deductible per covered family where the family deductible limit must be satisfied on an aggregate basis.]

i. The per covered person annual deductible shall be an amount not less than $250.00 and not greater than $5,000.

ii. The per covered family annual deductible shall be, at the option of the carrier, either:

(1) Two times the per covered person annual deductible, and may either be satisfied by two separate covered persons or on an aggregate basis; or

(2) Three times the per covered person annual deductible and must be satisfied on an aggregate basis.

3. Plans B, C, and D shall contain maximum out of pocket provisions consistent with the following specifications:

i. The per covered person maximum out of pocket for Plan B shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

ii. The per covered person maximum out of pocket for Plan C shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

iii. The per covered person maximum out of pocket for Plan D shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

iv. The per covered family maximum out of pocket shall be at the option of the carrier, either:

(1) Two times the per covered person maximum out of pocket, and may either be satisfied by two separate covered persons or on an aggregate basis; or

(2) (b) Three times the per covered person maximum out of pocket and must be satisfied on an aggregate basis.

4. Plan E shall contain a deductible of $150.00 per covered person and:

i. $300.00 per covered family, to be satisfied by two separate covered persons, with a per person **[coinsurance cap]** **maximum out of pocket** of **[$1,500]** **$1,650**, and a family **[coinsurance cap]** **maximum out of pocket** of **[$3,000]** **$3,300** to be satisfied by two separate covered persons; or

ii. $450.00 per covered family, to be satisfied on an aggregate basis, with a per person **[coinsurance cap]** **maximum out of pocket** of **[$1,500]** **$1,650,** and a family **[coinsurance cap]** **maximum out of pocket** of **[$4,500]** **$4,950** to be satisfied on an aggregate basis.

(c) State approved and Federally qualified HMO members may offer the HMO Plan, as set forth in Exhibit G of the Appendix, in lieu of Plans A through E in (a) above. HMO members offering the HMO Plan shall offer **one or more of** the following **[arrangements] plan designs using copayments and may, at the option of the HMO members, also offer HMO plans using deductible and coinsurance provisions. All options offered by the HMO member shall be made available to every small employer seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (C)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (c)3 below**

1. Copayment Design

i. The hospital inpatient copayment shall be: $75.00; $100.00; $150.00; $200.00; $300.00; $400.00; or $500.00.

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, pre-natal care and prescription drugs shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00, respectively.

2. Deductible and Coinsurance Design

i. The copayment for primary care physician services shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $250.00 and not greater than $2,500 per person. The covered family deductible shall be two times the per person deductible and may, at the option of the HMO, either be satisfied by two separate covered persons or may be satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies or prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in five percent increments.

iv. The maximum out of pocket shall be a dollar amount not to exceed $5,000, and for a covered family shall not exceed two times the per person maximum out of pocket.

3. Common Features

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall be, at the option of the carrier, $50.00, $75.00 or $100.00

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

iii. Prescription drugs covered under the HMO plan, as opposed to under a separate prescription drug rider, shall be subject to 50 percent coinsurance, or a $15.00 copayment, at the option of the HMO.

[$150.00 hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only) and $15.00 copayment for all other

copayments. Prescription drugs may be subject to 50 percent coinsurance or $15.00 copayment at HMO member's option. HMO members choosing to offer optional health benefits plans may offer one or more of the following copayment options, provided that all options offered by the HMO member shall be offered to each small employer:

1. $75.00 hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only) and $5.00 copayment for all other copayments;

2. $100.00 hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only) and $10.00 copayment for all other copayments;

3. $250.00 hospital inpatient copayment excluding mental/nervous non-biologically based mental illness and substance abuse, $200.00 mental/nervous non-biologically based mental illness and substance abuse hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only) and $20.00 copayment for all other copayments;

4. $300.00 hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only) and a $30.00 copayment for all other copayments.]

(d) The standard health benefits Plans B, C, D and E and optional riders may be offered through or in conjunction with a **selective** contracting arrangement approved pursuant to P.L. 1993, c.162, section 22. The standard health benefits Plans B, C, D and E and optional riders may be offered with the same selective contracting **arrangement** by a carrier that is exempt from the requirements of P.L. 1993, c.162, section 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is

permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through an approved selective contracting arrangement and plans with selective contracting **arrangement** features issued by an entity exempt from the requirements shall be subject to the following:

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

2. The network annual deductible shall be an amount not less than $250.00 and not greater than $2,500 per covered person, and for a covered family shall not exceed two times the per covered person annual deductible, satisfied on either an individual basis or on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies.

3. The network maximum out of pocket shall not exceed $5,000 per covered person, and for a covered family shall not exceed two times the per covered person maximum out of pocket. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies.

4. The non-network annual deductible shall be no more than three times the network annual deductible per covered person, and for a covered family shall equal two times the per covered person annual deductible.

5. The non-network maximum out of pocket shall be no more than three times the network maximum out of pocket per covered person, and for a covered family shall equal two times the per covered person maximum out of pocket.

[2. The coinsured charge limit and deductibles specified for the standard health benefits plan being offered through or in conjunction with a managed care arrangement, as set forth in Exhibits F and G in the Appendix, shall be the coinsured charge limit and deductibles for the in-network and out-network benefits combined;]

[3.] 6. The HMO Plan standard copayment levels for practitioner visits, emergency room and hospital confinements may be substituted for deductibles applicable to [in-]network benefits. **[Where such copayments are utilized, the applicable deductible and coinsured charge limit shall be applicable only to out-network benefits; and**

4. Where in-network services are directed through a primary care physician under Plans B, C, D and E and HMO Plan, in-network services must conform to one of the options provided in (c) above, and out-network services must conform to one of the options provided in (b) above.]

(e) The standard health benefits Plan A may be offered through or in conjunction with a managed care arrangement, and shall be subject to the following:

1. For those services which are subject to 20 percent coinsurance, the **[in-]**network benefit shall not be subject to coinsurance; **[and]**

2. For those services which are subject to 50 percent coinsurance, the **[in-]**network coinsurance shall be 30 percent**[.];**

3. The network maximum out of pocket shall not exceed $5,000 per covered person. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies; and

4. The non-network maximum out of pocket shall be no more than three times the network maximum out of pocket per covered person.

(f) An insurer with an approved selective contracting agreement, like all other carriers, shall offer the standard health benefits plans, whether as indemnity plans or through or in conjunction with a selective contracting arrangement, in all geographic areas in the State.

1. (No change.).

2. If an insurer's approved service area for its selective contracting arrangement does not include all geographic areas in the State, the insurer shall offer:

i. (No change.)

ii. The standard health benefit plans as either indemnity plans or in conjunction with a selective contracting arrangement, or both**,** in all geographic areas within its approved service area.

3. (No change.)

(g) (No change.)

(h) State approved and Federally qualified HMO members may offer the HMO POS plan, as set forth in Exhibit HH of the Appendix, so long as the member is in compliance with N.J.A.C. 8:38-14, which regulations set forth requirements for HMOs offering indemnity benefits. HMO members offering the HMO POS plan may offer the following arrangements **set forth in (h)1, 2 and 3 below** with respect to their **[in-]**network services and supplies**. The non-network deductible, coinsurance and maximum out of pocket must comply with N.J.A.C. 11:21-3.1(d).**

1. Copayment Design

i. The hospital inpatient copayment shall be: $75.00; $100.00; $150.00; $200.00; $300.00; $400.00; or $500.00.

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, pre-natal care and prescription drugs shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00, respectively

2. Deductible and Coinsurance Design

i. The copayment for primary care physician services shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $250.00 and not greater than $2,500 per person. The covered family deductible shall be two times the per person deductible and may, at the option of the HMO, either be satisfied by two separate covered persons or may be satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies or prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in five percent increments.

iv. The maximum out of pocket shall be a dollar amount not to exceed $5,000 and for a covered family shall not exceed two times the per person maximum out of pocket.

3. Common Features

iv. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall be, at the option of the carrier, $50.00, $75.00 or $100.00

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

vi. Prescription drugs covered under the HMO-POS plan, as opposed to under a separate prescription drug rider, shall be subject to the non-network deductible and coinsurance.

[1. $75.00 hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only), $5.00 copayment for all other copayments, and prescription drugs at either a $5.00 copayment or at the non-network coinsurance level;

2. $100.00 hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only), $10.00 copayment for all other copayment, and prescription drugs at either a $10.00 copayment or at the non-network coinsurance level;

3. $150.00 hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only), $15.00 copayment for all other copayments, and prescription drugs at either a $15.00 copayment or at the non-network coinsurance level.

4. $250.00 hospital inpatient copayment excluding mental/nervous and substance abuse, $200.00 non-biologically based mental illness hospital inpatient copayment $50.00, separate emergency room copayment, $25.00 pre- natal care office visit copayment (initial visit only), $20.00 copayment for all other copayments, and prescription drugs at either a $20.00

copayment or at the non-network coinsurance level;

5. $300.00 hospital inpatient copayment, $50.00 separate emergency room copayment, $25.00 pre-natal care office visit copayment (initial visit only), prescription drugs at either a $30.00 copayment or at the non-network coinsurance level and a $30.00 copayment for all other copayments.]

11:21-3.2 Optional benefit riders to standard plans and administrative functions

(a) Members that offer health benefits Plans B, C, D and E may offer one or more of the standard optional benefit riders set forth in (c)1 and 2 below. Members that offer the HMO health benefits plan may offer the prescription drug riders set forth in (c)3 below. All riders shall contain the benefits, limitations and exclusions set forth in the Appendix which is incorporated herein by reference and shall be issued in the standard form set forth in the Appendix which is incorporated herein by reference. A member electing to offer an optional benefits rider with a standard health benefits plan (Plan B, C, D, E, **[or]** HMO plan**, or HMO POS plan** as applicable) must offer the rider to any employer seeking to purchase that health benefits plan.

(b) –(c) (No change.)

(d) In addition to the standard optional benefit riders listed in (c) above, members may offer riders that revise in any way the coverage offered by Plans A, B, C, D, E, HMO, and HMO POS plan subject to the provisions set forth in (d)1 through 8 below.

1. – 2. (No change.)

3. "Coverage" offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above includes, but is not limited to:

i. (No change.)

ii. Deductibles, Coinsurance, Copayments, **maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket** **[Coinsured Charge Limits, and Coinsurance Caps]**of Plans A, B, C, D, E, HMO, and HMO POS as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident; and

iii. (No change.)

4. - 5. (No change.)

6. A member making an informational filing to the Board pursuant to (d)2 above shall:

i. Submit **[an original]** one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:21-1.3;

ii. Submit **[copies]** **one copy** of the rider or riders which amend the standard group policy and certificate forms, which rider or riders shall include cross- references to the standard group policy and certificate provisions or sections and/or pages which are being modified;

iii. – vi. (No change.)

7. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in **[substantial]** compliance with this subsection, within 45 days of the Board's receipt of the member's submission of a rider or amendment thereof. If the Board does not notify a member of its determination with respect to an informational filing within 45 days of the Board's receipt of the submission, the informational filing shall be deemed complete.

[i. If an informational filing is incomplete, but in substantial compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing.]

[ii.] i. If an informational filing is incomplete and not in **[substantial]** compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing. Upon receipt of notice from the Board that a filing is incomplete and not in substantial compliance with the requirements of this subchapter, the member shall not sell the rider or amendment thereof until the member has received written notice from the Board that the informational filing is **[in substantial compliance or]** complete.

[iii.]ii. If the Board takes no action within 45 days of receipt by the Board of a member's submission of information requested by the Board to complete an informational filing, the filing shall be deemed to be **[in substantial compliance**] **complete**.

(e) (No change.)

(f) All carriers shall file, by March 1 of each year, Exhibit BB Part 6, on which all optional benefit riders are identified, regardless of whether or not the carrier has filed optional benefit riders. **Carriers shall include in such filing information that is current through December 31 of the prior year.**

SUBCHAPTER 4. POLICY FORMS

11:21-4.1 Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D, and E which are set forth in the Appendix to this chapter as Exhibits A, F, V, and W subject to the "Explanation of Brackets" set forth in Exhibit K**[, Part 1]** of the Appendix, incorporated herein by reference.

Members shall not make any changes to the text of the standard policy forms, except as permitted consistent with the explanation of brackets set forth as Exhibit**[s]** K **[and JJ].**

[1. Notwithstanding (a) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.]

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G and Y, subject to the "Explanation of Brackets" set forth in Exhibit K**[, Part 2]** of the Appendix, incorporated herein by reference.

[1. Notwithstanding (b) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier

pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.]

(c) Members shall use the standard policy form for HMO-POS plan which is set forth in the Appendix to this chapter as Exhibit HH and II, subject to the "Explanation of Brackets" set forth in Exhibit **[JJ]**K of the Appendix, incorporated herein by reference.

[1. Notwithstanding (c) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review

uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.]

(d) In issuing standard optional benefit riders pursuant to N.J.A.C. 11:21- 3.2(c), members shall use the standard rider form**[s]** which **[are] is** set forth in the Appendix to this chapter as Exhibit**[s]** H**[, I, and J, as applicable]**.

(e) (No change.)

(f) Members shall use the standard small group health benefits certificate for Plan A which is set forth in the Appendix to this chapter as Exhibit V, subject to the "Explanation of Brackets **[--Certificate Forms]**" set forth in Exhibit **[X, Part 1]K** of the Appendix, incorporated herein by reference.

(g) Members shall use the standard small group health benefits certificate for Plans B, C, D and E which is set forth in the Appendix to this chapter as Exhibit W, subject to the "Explanation of Brackets **[--Certificate Forms]**" set forth in Exhibit **[X, Part 1]K** of the Appendix, incorporated herein by reference.

(h) Members shall use the standard employee evidence of coverage for HMO Plan which is set forth in the Appendix to this chapter as Exhibit Y, subject to "Explanation of Brackets **[(HMO Plan)]**" set forth in Exhibit **[X, Part 2]K** of the Appendix, incorporated herein by reference.

(i) Members shall use the standard employee evidence of coverage for the HMO POS plan which

is set forth in the Appendix to this chapter as Exhibit II, subject to "Explanation of Brackets **[(HMO/POS Plan)]**" set forth in Exhibit **[JJ]**__**K**__ of the Appendix, incorporated herein by reference.

(j) Members **[shall]**__**that wish to**__ use the __**standard Prescription Drug**__ Rider __**shall use the form**__**[--Certificate Forms for Plans B, C, D and E as set forth in the Appendix to this chapter as Exhibit Z, Part 1, "Card/Mail"; Part 2, "Card"; Part 3, "Mail"; and Part 4 "Mental and Nervous Conditions and Substance Abuse Benefits."**

(k) Members shall use the Riders--Employee evidence of coverage for HMO Plan as] set forth in the Appendix to this chapter as Exhibit **[AA, Part 1, "Card/Mail"; Part 2, "Card"; and Part 3, "Mail."]** __**H.**__

[(l)]__**(k)**__ (No change in text.)

11:21-4.2 Certification or filing of forms

(a) No carrier shall issue any health benefits plan certificate or evidence of coverage to a small employer or the employees of a small employer or use any application form, employer or employee certification, waiver or enrollment form or make any amendments thereto until the carrier has certified that its health benefits plans and forms are in compliance with the small employer health benefits plans and all provisions of N.J.A.C. 11:21-4 and 6.

1. A carrier shall submit completed Certification of Compliance forms, set forth in Parts 1__**, 2**__ and 6 of Exhibit BB of the Appendix to this chapter and incorporated herein by reference upon entering the small employer market__**, on or before 45 days of the date amendments to the standard policy forms are effective, and**__ on or before March 1 of each year thereafter. __**The market entry filing and the filing upon amendments being made to the standard policy forms shall address the plans the carrier will be marketing and issuing. The March 1 filing**__

shall address the plans the carrier issued or renewed at anytime during the prior calendar year.

2. – 3. (No change.)

[(b) A carrier that elects to include in its health benefits plans an alternative method of utilization review shall submit, in addition to the required Certification of Compliance, its alternative method of utilization review to the Board as specified at N.J.A.C. 11:21-4.1.

(c) As a condition of approval, all alternate methods of utilization review provisions shall contain the statement that the utilization review modifies the small employer health benefits policy form language and has been approved for use by the carrier pursuant to N.J.A.C. 11:21-4.3. As a condition of approval, all combined form policies shall contain a statement that together, the two policies provide coverage as specified in N.J.A.C. 11:21-3.1, and have been approved pursuant to the requirements of N.J.A.C. 11:21-4.3.

(d) Any amendment to an approved alternative method of utilization review shall be submitted to the Board and simultaneously to the Commissioner for review and approval as set forth in (b) above.]

[(e)] b. (No change in text.)

[(f) Notwithstanding (e) above, a carrier shall neither issue nor make effective any health benefits plan to which an alternative method of utilization review or amendment thereto will apply until approved by the Board in consultation with the Commissioner.]

Recodify existing (g) and (h) as (c) and (d). (No change in text.)

11:21-4.3 Standards for review

(a) In determining whether to approve **[an alternative method of utilization review or**] combined forms (of a hospital service corporation and another small employer carrier), a carrier

shall consider in submitting in its **[Certification of Compliance (with respect to an alternative method of utilization review), and its] certification** of substantial compliance (with respect to combined forms), and the Board and Commissioner shall consider in their review whether:

1. (No change.)

2. The **[alternative method of utilization review or]** combined forms contain all provisions required by New Jersey law and the small employer health benefits plans forms which, if not the same as that required by law or in the small employer health benefits plans forms, is at least as favorable to the covered person;

3. The **[alternative method of utilization review or]** combined forms contain all coverages, coverage limits and exclusions set forth in the small employer health benefits plans forms; **and**

[4. There is any deviation from the effective date of coverage, renewal or termination provisions in the small employer health benefits plans forms; and]

[5.] 4. (No change in text.)

Easy comparison with the appropriate small employer health benefits plans forms by the consumer, the Board or the Commissioner is impeded.

(b) In addition to (a) above, the Board, in consultation with the Commissioner, may disapprove **[an alternative method of utilization review or]** combined forms on the grounds that its provisions are unjust, unfair, inequitable, misleading, contrary to law or to the public policy of this State.

11:21-4.4 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO and HMO

POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board, through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix, incorporated herein by reference, subject to the following:

1. If expressly permitted by the Board, the Compliance and Variability Rider may be issued by Members to incorporate changes to the standard policy forms Plans A-E, HMO and HMO POS contracts, certificates, evidences of coverage, or standard riders promulgated by the Board. Nothing contained herein shall prevent a Member from issuing a standard policy form Plans A-E, HMO or HMO POS contract, certificate, evidence of coverage or standard rider which has incorporated **[board] Board** promulgated changes.

(b) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, members may make any changes to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board consistent with the variability as explained in Exhibit K **[and JJ]** to this Appendix through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix.

(c) (No change.)

SUBCHAPTER 5. [STANDARD CLAIM FORM] (RESERVED)

[11:21-5.1 Standard claim form

(a) All members offering health benefits plans to small employers, to the extent that the member uses claims forms in its transaction of business (rather than an electronic billing

system), shall require as a condition of payment, the standard claim forms approved by the Board and set forth in Exhibit L in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions, set forth in Exhibit L, Part 1, shall be the standard claim form for all medical expenses incurred for services other than hospital inpatient services. The form UB-92 set forth as Exhibit L, Part 2, shall be the standard claim form for all hospital inpatient services.

(b) If a carrier determines that additional information is necessary of the claimant to process a claim, the carrier shall use the "Annual Family Profile and Claim Notice" form as set forth as Exhibit M and incorporated herein by reference. A carrier shall not use any other form to solicit family profile information of the claimant.]

SUBCHAPTER 6. STANDARD EMPLOYER AND EMPLOYEE APPLICATION AND SMALL EMPLOYER CERTIFICATION FORMS

11:21-6.2 Annual Small Employer Certification Form

Small employer carriers shall require each small employer covered by a small employer health benefits plan issued by the small employer carrier to that small employer to complete each year the New Jersey Small Employer Certification form approved by the Board and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference. This form shall be sent to the small employer for completion no earlier than [120]**150** days prior to the renewal of the small employer's health benefits plan.

11:21-6.3 [Enrollment] (RESERVED)

[(a) Small employer carriers shall require each eligible employee electing coverage under the small employer health benefits plan to complete the Enrollment form approved by the Board and specified in Exhibit Q of the Appendix to this chapter incorporated herein by reference, except that carriers can reformat the standard application in any manner necessary to simplify administration for the carrier without modification of the content of the form. At the end of the standard application in an additional section, a carrier may also require periodic updates of the following information: name changes, primary care physician change, health center change, additions or deletions to family coverage, address changes and State and Federal continuation election

(b) Small employer carriers offering the HMO plan and the HMO POS plan shall require each eligible employee electing coverage under the HMO plan to complete the enrollment form approved by the Board and specified in Exhibit Q of the Appendix to this chapter incorporated herein by reference, except that carriers can reformat the standard application in any manner necessary to simplify administration for the carrier without modification of the content of the form. At the end of the standard application in an additional section, a carrier may also require periodic updates of the following information: name changes, primary care physician change, health center change, additions or deletions to family coverage, address changes and State and Federal continuation election.

(c) A small employer carrier may require a report of an eligible employee's health status for the purpose of determining the applicability of the preexisting condition limitation in accordance with the Act. The carrier shall require eligible employees to complete the Health Status form approved by the Board and specified as optional text in Exhibit Q of

the Appendix to this chapter incorporated herein by reference.

1. Such report may be used only for the purpose of determining the applicability of a preexisting condition limitation in accordance with the Act.]

11:21-6.4 Waiver

Any eligible employee who declines coverage under the small employer health benefits plan shall complete the employee waiver form approved by the Board and specified in Exhibit T of the Appendix to this chapter incorporated herein by reference. **[The waiver form may be combined with Exhibit Q, into a single form, at the option of the carrier without modification of the content of either form, except to reformat in any manner necessary to simplify administration.]**

SUBCHAPTER 7. PROGRAM COMPLIANCE

11:21-7.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering, issuing and renewing all health benefits plans to any small employer, the small employer's eligible employees, and the dependents of those eligible employees **[on or after January 1, 1994]**.

11:21-7.2 Definitions

All words and terms used in this subchapter shall have the meanings as set forth in the Act, N.J.A.C. 11:21-1.2 or as further defined below, unless the context clearly indicates otherwise.

. . .

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the **[small employer]** **individual**: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such a statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, **termination of the employer's contribution toward coverage,** death of a spouse, or divorce or legal separation; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the small employer is employed by an employer which offers multiple health benefits plans and the small employer elects a different plan during an open enrollment period; the small employer had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order. An eligible employee and his or her dependent spouse, if any, will not be

considered late enrollees because the eligible employee initially waived coverage under the health benefits plan for himself or herself and any then existing dependents provided the eligible employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the plan within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.

. . .

11:21-7.3 Eligibility and issuance

(a) Except as may otherwise be provided in N.J.A.C. 11:21-3A with respect to non-standard health benefits plans, a small employer carrier shall issue a health benefits plan to any small employer which requests it, pays the premiums therefor and meets the contribution and participation requirements, if any, of the small employer carrier. All health benefits plans shall provide coverage for all eligible employees and their dependents who elect to participate regardless of health status-related factors and without exclusionary riders.

[1. A small employer carrier shall not refuse to issue coverage, or discriminate in the issuance of coverage, to a small employer based upon the geographic location of the small employer, except that small employer carriers that are HMOs may refuse to issue coverage to a small employer not physically located in the HMO's service area.]

[2.] **1.** A small employer carrier shall not refuse to issue coverage, or discriminate in the issuance of coverage, to a small employer based upon the geographical location of the employees of the small employer, except that:

i. (No change.)

ii. **[The small employer carrier may refuse to issue coverage if the participating employees**

are not physically located within the small employer carrier's service area, if the small employer carrier is an HMO.] **An HMO carrier may refuse to issue coverage to an employer to cover an employee that does not live, work, or reside in the small employer carrier's service area.**

Recodify existing 3. and 4. as 2. and 3. (No change in text.)

[5.] **4.** At the time of application, the determination of whether an employer is a small employer shall be based upon the small employer's completed New Jersey Small Employer Certification form.

i. – ii. (No change.)

iii. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. An employer that was not in existence during the preceding calendar year must have at least two eligible employees when completing the employer certification **and on the first day of the plan year** to be considered a small employer.

(b) – (g) (No change.)

(h) In the event that the previous health benefits plan of a small employer group was cancelled for nonpayment of premiums or fraud, a small employer carrier may require the small employer group to pay up to six months of premiums in advance of the issuance of a health benefits plan.

11:21-7.4 [Restrictions on replacement of health benefits plans]**Limitations on purchase by small employers of health benefits plans or riders with different actuarial value than**

existing plan

(a) – (c) (No change.)

[(d) In the event that the previous health benefits plan of a small employer group was cancelled for nonpayment of premiums or fraud, a small employer carrier may:

1. Refuse to issue a health benefits plan to the small employer group for one year from the last date of coverage of the previous plan; or

2. Require the small employer group to pay up to six months of premiums in advance of the issuance of a health benefits plan.]

11:21-7.5 Participation requirements

(a) A small employer carrier shall require a minimum participation under the small employer's health benefits plan of 75 percent of eligible employees who are not serving under a waiting period as permitted under N.J.A.C. 11:21- 7.8(c), except as set forth in (b) below. This participation requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers. A carrier shall count as covered under the small employer's health benefits plan, for the purpose of satisfying employee participation requirements, an eligible employee who [either]:

1. Is covered as an employee or dependent under any **fully insured** health benefits plan offered by the small employer; **[or**

2. Is not covered under the small employer's health benefits plan because the employee is covered as a dependent under a spouse's health benefits policy or contract, as long as the spouse's plan is not an individual health insurance policy or contract but is otherwise included in the definition of creditable coverage.]

2. **Is covered under Medicare;**

3. **Is covered under another group health benefits plan; or**

4. **Is covered under a spouse's health benefits plan.**

(b) – (d) (No change.)

11:21-7.9 Price quotes; disclosures

(a) A small employer carrier shall provide a price quote to a small employer, directly or through an authorized **[producer] third party**, within 10 working days of receiving a request for a quote and such information as is reasonable and necessary to provide the quote. A small employer carrier shall notify a small employer, directly or through an authorized producer, within five working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

(b) (No change.)

11:21-7.12 Reporting requirements

[(a) Effective January 1, 1995, a small employer carrier shall file with the Board, annually no later than March 15, the following information reported separately with respect to standard and non-standard health benefits plans:

1. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar year, separately as to newly issued plans and renewals, and separately for standard health benefits plans A,

B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

2. The number of health benefits plans in force by geographic territory, labeled A though F, as set forth in N.J.A.C. 11:21-7.14, and by two digit Major Group of the Standard Industrial Classification as of December 31 of the previous calendar year;

3. The number of health benefits plans that were voluntarily cancelled by small employers in the previous calendar year;

4. The number of health benefits plans that were cancelled or nonrenewed by the carrier in the previous calendar year, and the reason for such cancellation or nonrenewal; and

5. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar year that were uninsured for at least the three months prior to issue.]

[(b)] (a.)(No change in text.)

[(c)] (b.)[Annual and quarterly] Quarterly reports shall be filed at the address listed in N.J.A.C. 11:21-1.3.

[(d)] (c.)(No change in text.)

11:21-7.13 Paying benefits

(a) In paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services, on a reasonable and

customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, incorporated herein by reference published and available from the **[Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004-1109] Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.**

1. – 2. (No change.)

11:21-7.14 Permissible rate classification factors

(a) (No change.)

(b) Notwithstanding (a) above, a carrier may differentiate premium rates charged to different small employers for the same standard health benefits plan, whether it be A, B, C, D, E **[or],** HMO, **or HMO-POS,** on the basis of family structure according to only the following four rating tiers:

1. – 4. (No change.)

11:21-7.15 [(Reserved)] Employer waiting period

A small employer carrier shall not be required to modify the waiting period provision of a health benefits plan except as of an anniversary date of the plan, and upon the request of a small employer.

SUBCHAPTER 8. CARRIER CERTIFICATION OF NON-MEMBER STATUS

11:21-8.6 Review

(a) A carrier which has been denied non-member certification may contest that determination by filing an appeal with the Board **[no later than 20 calendar days after receiving the written determination from the Board.] pursuant to procedures set forth in N.J.A.C. 11:21-2.17.**

[(b) The appeal shall specify the reasons why the Board's determination is inaccurate and shall include all documentation that supports or tends to support the carrier's or entity's position. The carrier or entity also shall specify whether a hearing is requested.

(c) Within 45 days of its receipt of a request for a hearing, the Board shall determine whether bona fide issues of material fact exist such that a hearing shall be conducted. If bona fide factual issues do not exist, the Board shall review the challenge itself and may delegate this review to an appropriate Board committee to make a recommendation to the Board. If a hearing is appropriate, the Board shall determine whether to hear the matter itself or refer it to the Office of Administrative Law for a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.]

SUBCHAPTER 10. THE MARKET SHARE REPORT

11:21-10.4 Net earned premium

(a) Every member's net earned premium for the preceding calendar year ending December 31 shall be set forth in Part C of the Market Share Report.

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers**, less any refunds paid by the carrier during**

that calendar year as a result of the application of the minimum loss ratio requirement.

2. Net earned premium reported in Part C of the Market Share Report shall be based upon, if not the same as, the data set forth in the member's annual **[reports] NAIC statement blank**, adjusted to meet the definition of group health benefits plan **and exclude refunds as described in (a)1 above**, as necessary.

SUBCHAPTER 17. FAIR MARKETING STANDARDS

11:21-17.1 Plan identification and marketing materials

(a) (No change.)

(b) All **[terms, definitions, and text used]** **eligibility, coverage and exclusions described** in the small employer carrier's marketing and/or promotional material shall be consistent with the Act and this chapter.

[11:21-17.4 "Get the Facts" brochure

Small employer carriers shall set forth in their promotional and/or marketing materials that a Small Employer Health Benefits "Get the Facts" brochure about small employer health benefits coverage is available and can be obtained upon request, free of charge, by a small employer from the small employer carrier. Small employer carriers shall provide or mail the "Get the Facts" brochure to small employers within three business days of request. A small employer carrier may arrange for delivery or distribution of the "Get the Facts" brochure through its licensed agents or brokers.]

11:21-17.5 Producer contracts

(a) A small employer carrier may select those insurance producers, as defined by N.J.S.A. 17:22A-2j, with whom it chooses to contract. No small employer carrier shall terminate or refuse to renew the contract of its insurance producers because of health status-related factors of eligible employees or dependents**, the average number of eligible employees or the average number of employees enrolled in small employer plans placed by the producer with the carrier,** or the occupation or geographic location of the small employer groups placed by the insurance producer with the small employer carrier.

(b) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an insurance producer that provides for or results in any consideration provided to an insurance producer for the issuance or renewal of a small employer health benefits plan that varies on account of health status-related factors of eligible employees or dependents, the number of eligible employees or the number of **[enrollees] employees enrolled**, or the industry, occupation or geographic location of a small employer covered by a small employer health benefits plan.

SUBCHAPTER 18. PETITIONS FOR RULES

11:21-18.2 Procedure for petitioner

(a) Any person who wishes to petition the Board to promulgate, amend or repeal a rule shall submit to the Board, in writing, the following information:

1. Name and address of the petitioner;

2. The substance or nature of the rulemaking which is requested;

3. The reasons for the request and the petitioner's interest in the request; **[and]**

4. References to the **statutory** authority of the Board to take the requested action**[.]; and**

5. A caption at the top of the document identifying it as a petition for rulemaking pursuant to N.J.S.A. 52:14B-4(f) and this subchapter.

(b) The petition shall be sent to the Executive Director at the address in N.J.A.C. 11:21-1.3.

Recodify existing (b) and (c) as (c) and (d) (No change in text.)

11:21-18.3 Procedure of the Board

(a) (No change.)

(b) Within **[30] 60** days of receiving a petition in compliance with N.J.A.C. 11:21-18.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. – 5. (No change.)

(c) (No change.)

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

11:21-23.1 Purpose and scope

(a) The purpose of this subchapter is to establish the procedures that the Board uses in providing notice of proposed rulemaking, receiving public comments regarding existing rules and proposed rulemaking, extending the public comment period, conducting a public hearing, and providing notice of public meetings.

(b) This subchapter shall apply to all rulemaking of the Board.

11:21-23.2 Public notice regarding proposed rulemaking

(a) Unless the Board proposes a rule pursuant to the special procedures set forth at N.J.S.A. 17B:27A-51, the Board shall provide for the following four types of public notice for rule proposals in accord with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30:

1. The rule proposal shall be filed with the Office of Administrative Law for publication in the New Jersey Register;

2. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be posted and made available electronically on the Department of Banking and Insurance web site at: Http://www.njdobi.org;

3. The news media maintaining a press office in the State House Complex shall be provided notice of the rule proposal, as posted and made available electronically on the New Jersey Department of Banking and Insurance web site; and

4. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be made available to the Board's list of "interested persons" by e-mail or hard copy. Interested persons are those who have informed the Board in writing that they wish to receive notice of the Board's proposed regulations, as well as those people or entities that the Board determines are the subject of or significantly related to the rulemaking so that the persons most likely to be affected by or interested in the intended action receive notice.

11:21-23.3 Extension of the public comment period

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may extend the time for submission of public comments on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall extend the time for submission of public comments for an additional 30-day period, if, within 30 days of the publication of a notice of proposal, sufficient public interest is demonstrated in an extension of time to submit comments.

(c) The Board shall determine that a sufficient public interest for the purpose of extending the public comment period has been demonstrated if any of the following has occurred:

1. Comments received indicated a previously unrecognized impact on a regulated entity or persons; or

2. Comments received raise unanticipated issues related to the notice of proposal.

11:21-23.4 Conducting a public hearing

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may conduct a public hearing on a proposed rulemaking, at its

discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall conduct a public hearing if sufficient public interest has been demonstrated.

(c) A person interested in having a public hearing held on a notice of proposal shall submit an application within 30 days following the publication of the notice of proposal in the New Jersey Register in a form prescribed by the Board, to the Executive Director at the address listed in N.J.A.C. 11:21-1.3. The application shall contain the following information:

1. The person's name, address, telephone number, agency or association (if applicable;

2. The citation and title of the proposed rule and the date the notice of proposal was published in the New Jersey Register; and

3. The reasons a public hearing regarding the notice of proposal is considered necessary pursuant to (d) below.

(d) The Board shall determine that a sufficient public interest has been demonstrated for the purpose of holding a public hearing if the application demonstrates that additional data, findings and/or analysis regarding the notice of proposal are necessary for the Board to review prior to adoption of the proposal in order to ensure that the notice of proposal does not violate the intent of the statutory law.

11:21-23.5 Public notice regarding board meetings

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

(b) The Board may schedule meetings in addition to those set forth in the annual schedule.

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

1. Posting of a notice at the office of the Secretary of State;

2. Posting of a notice at the office of the Board at the address set forth at N.J.A.C. 11:21-1.3;

3. Posting of a notice on the Department of Banking and Insurance web site at: Http://www.njdobi.org;

4. Posting of the notice in two newspapers of general circulation designated by the Board; and

5. Mailing, either by hard copy or electronically, of the notice to a distribution list of those persons who have requested in writing to be informed of the Board's meeting schedule.

11:21-23.6 Board mailing list of interested parties

(a) For the purpose of disseminating information about the SEH Program, including information about rulemaking and meeting dates, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of members shall be based upon the member carriers' addresses filed with its most recently filed Exhibit CC Market Share Report.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and mailing address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications, other than copies of proposals, from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

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Date Wardell Sanders, Executive Director