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INSURANCE

NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Proposed Readoption with Amendments: N.J.A.C. 11:20-1, 2, 3, 8, 12, 17, 19, 20, 22, 23 and 24, and 11:20 Appendix Exhibits A through D, F, G, H, K and L

Proposed Repeals: N.J.A.C. 11:20-2.13, 8.4, 8.5, 8.8 and 8.9

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

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

Calendar Reference: See Summary below for an explanation of the exception to the rulemaking calendar requirements of N.J.S.A. 52:14B-3 and N.J.A.C. 1:30-3.3.

Proposal Number: PRN 2011-009.

Interested persons may testify with respect to the Plan of Operation, set forth at N.J.A.C. 11:20-2, and the health benefits plans, set forth in N.J.A.C. 11:20 Appendix Exhibits A, B, C, D, F and G, at a **public hearing** to be held on Tuesday, March 8, 2011 at 9:00 A.M. at the New Jersey Department of Banking and Insurance, in the 11th floor Conference Room 20 West State Street, Trenton, New Jersey.

Submit written comments by March 19, 2011 to:

Ellen DeRosa

Executive Director

New Jersey Individual Health Coverage Program

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The agency proposal follows:

Summary

In accordance with the sunset provisions of Executive Order No. 66 (1978) and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., the New Jersey Individual Health Coverage Program Board of Directors (IHC Board or Board) has evaluated its rules at N.J.A.C. 11:20 (except for N.J.A.C. 11:20-3A, 6, 7, 11 and 18, rules promulgated by the Department of Banking and Insurance (Department)), which are scheduled to expire on June 5, 2011, pursuant to N.J.S.A. 52:14B-5.1c. The readoption of N.J.A.C. 11:20 is necessary because it implements the IHC Program. The IHC Board has determined that the rules are necessary, reasonable and proper for the purpose for which they are currently promulgated, with the exception of the repeals and amendments which are noted herein.

The IHC Program Board was charged by the Legislature with implementing and regulating the reformed individual health benefits coverage market pursuant to the Individual Health Insurance Reform Act, P.L. 1992, c. 161 as amended, and codified at N.J.S.A. 17B:27A-2 et seq. ("the IHC Act" or "the Act"). The IHC Board adopted a number of amendments to the rules governing the individual health benefits coverage market on December 19, 2008 to address the requirements of P.L. 2008, c. 38. The amended rules as of December 19, 2008 included provisions necessary to administer the final loss assessment for the 2007/2008 calculation period. Provisions necessary for the administration of the loss assessment mechanism are no longer necessary given that P.L.

2008, c. 38 established the 2007/2008 calculation period as the final period for which reimbursements could be sought. While there remain reconciliations and ultimately final assessments for calculation periods up to and including the 2007/2008 calculation period, the reconciliations and final assessments will be governed by the rules in effect for each particular calculation period. This readoption with amendments removes provisions which are no longer necessary.

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

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

The Board proposes amending the definitions of “family unit” and “pre-existing condition” to comply with the requirements of the Patient Protection and Affordable Care Act, Public Law 111-148 (PPACA). The amended definition of family unit removes the requirement that dependent children be in the same household. The amended definition of pre-existing condition states that the term applies only to covered persons age 19 or older.

Subchapter 2, Individual Health Coverage Program Plan of Operation, sets forth the fair, reasonable and equitable manner in which the Board will administer the IHC Program. Included in this subchapter are: the powers of the Board; guidelines on election and membership of the Board; the election, membership, and responsibilities of Committees; the financial administration of the Program; provisions regarding

independent audits under the Program; the recordkeeping requirements of the Board; provisions regarding the standard health benefits plans; the assessment mechanism for administrative expenses of the IHC Program; notice requirements for carriers seeking a deferral from assessment; the consequences of a carrier's failure to pay an assessment; and provisions regarding penalties and disputes arising under the Program.

The Board proposes amending N.J.A.C. 11:20-2.1(h) to update the phone contact information for the Executive Director.

The Board proposes amending the definition of "action" in N.J.A.C. 11:20-2.2 to exclude rate filings and loss ratio reports and associated refund plans from the list of Board actions. P.L. 2008, c. 38 delegates responsibility for these actions to the Department.

The Board proposes amending N.J.A.C. 11:20-2.3 to delete paragraph (b)8 in its entirety and the reference to losses from paragraphs (b)14 and 15. P.L. 2008, c. 38 established the 2007/2008 calculation period as the final period for loss assessments and loss reimbursement. Therefore, it is no longer necessary for the Board to establish rules governing performance standards for reimbursement of losses or the procedures for apportioning carrier losses among members of the IHC Program.

The Board proposes amending N.J.A.C. 11:20-2.6 to delete the committee responsibilities associated with the review of filings supporting loss reimbursement and loss assessments since P.L. 2008, c. 38 established the 2007/2008 calculation period as the final period for loss assessments and loss reimbursement. Proposed for deletion are N.J.A.C. 11:20-2.6(d)1iii and iv, which address performance standards and exemptions that the Technical Advisory Committee was charged with reviewing, and N.J.A.C. 11:20-2.6(d)4viii, which addresses performance standards that the Operations and Audit Committee was charged with reviewing.

The Board proposes amending N.J.A.C. 11:20-2.7(c)2ii to replace the reference to N.J.A.C. 11:20-2.17(h) with N.J.A.C. 11:20-2.17(a) and to remove references to future and subsequent loss assessments since there will be no new loss assessments.

The Board proposes deleting N.J.A.C. 11:20-2.8(c), which addresses audits of carriers filing for reimbursement of losses, since P.L. 2008, c. 38 eliminated the ability of carriers to seek reimbursement for losses.

The Board proposes eliminating the requirement set forth at N.J.A.C. 11:20-2.13 that a duplicate copy of the deferral filing that a carrier makes with the Department be made with the Board. The duplicate copy is not necessary given the facility with which the Department and the Board share filing information.

The Board proposes eliminating all but one subsection of N.J.A.C. 11:20-2.17, which governed net paid losses and loss assessments. P.L. 2008, c. 38 eliminated the loss assessment and therefore the opportunity for carriers to seek reimbursement of losses with the final period for loss reimbursement being 2007/2008. The retained subsection, (h), is being recodified as subsection (a) and addresses remaining loss assessment funds prior to disbursement of funds. At the time of this proposed readoption with amendments the Board is holding funds pending conclusion of open loss audits

Consistent with the elimination of most of N.J.A.C. 11:20-2.17, the Board proposes amending N.J.A.C. 11:20-2.18, which addresses minimum assessments, to remove references to loss assessments and references to N.J.A.C. 11:20-2.17.

Subchapter 3 addresses benefits offered in the individual market. N.J.A.C. 11:20-3.1 and 3.2 provide a description of the standard health benefits plans that must be offered by carriers in the individual market, as well as various options that may be offered by carriers in the individual market. Examples of these options include the option to offer high deductible health plans which meet the deductible and out of pocket

requirements under federal law for use with a health savings account, and the option for an HMO plan to include deductible and coinsurance provisions. N.J.A.C. 11:20-3.2(d) sets forth the requirements for carriers that choose to make the standard indemnity plans available through or in conjunction with a selective contracting arrangement. The Compliance and Variability Rider, set forth as N.J.A.C. 11:20 Appendix Exhibit D, is the form a carrier must use if the carrier desires to modify a plan without having to reissue the entire policy or contract. This rider may only be used in a manner consistent with the directions set forth in N.J.A.C. 11:20-3.3.

N.J.A.C. 11:20-3.1(a) provides direction with regard to N.J.A.C. 11:20 Appendix Exhibit A, which includes specified pages which are unique to Plans A/50, B, C and D as well as pages that are shared among these four alphabetically-named plans.

N.J.A.C. 11:20-3.1(b) addresses the mandatory and optional cost sharing features for Plans A/50, B, C and D. N.J.A.C. 11:20-3.1(c) addresses the mandatory and optional cost sharing features for HMO plans. N.J.A.C. 11:20-3.1(c)1i states that carriers must offer a $30.00 copayment HMO plan. N.J.A.C. 11:20-3.1(c)1ii gives carriers the additional option to offer $15.00, $40.00 and/or $50.00 copayment HMO plans. N.J.A.C. 11:20-3.1(c)2 permits HMO carriers to use deductible and coinsurance features in the HMO plan and sets forth the permissible deductible, coinsurance and maximum out of pocket amounts a carrier may include in the HMO plan.

N.J.A.C. 11:20-3.1(d) addresses the option for carriers to offer Plans A/50, B, C and D through or in conjunction with a selective contracting arrangement and sets forth the parameters for such plan offerings.

N.J.A.C. 11:20-3.1(e) requires carriers to file an Identification of Standard Plans that identifies the standard plans the carrier offers individual consumers. The Identification of Standard Plans form is set forth as N.J.A.C. 11:20 Appendix Exhibit H.

N.J.A.C. 11:20-3.3 addresses the Compliance and Variability Rider, set forth as N.J.A.C. 11:20 Appendix Exhibit D, which allows carriers to make certain changes to the text of a standard health benefits plan without necessitating the reissue of the entire policy. The Compliance and Variability Rider can also be used to include coverage required to be offered as a mandated offer pursuant to New Jersey law.

N.J.A.C. 11:20-3.4 addresses a plan update rider that carriers would issue to covered persons whose plans have been "force converted" pursuant to N.J.A.C. 11:20-24.7. The Plan Update Rider is set forth as N.J.A.C. 11:20 Appendix Exhibit G.

N.J.A.C. 11:20-3.5 addresses the basic and essential healthcare services plan (B&E Plan), which, although not a standard plan, is a plan all carriers issuing coverage in the individual market must make available pursuant to P.L. 2001, c. 368 (N.J.S.A. 17B:27A-4.4 et seq.). The purpose of including a reference to the basic and essential health care services plan in this subchapter, which addresses standard plans, is to serve as a cross reference to Subchapter 22, which sets forth the rules governing the basic and essential health care services plan. A specimen policy form for a B&E plan is set forth as Appendix Exhibit F.

Subchapters 3A, 6 and 7 are Department-promulgated subchapters and therefore are not included in this proposed readoption with amendments. The Department's notice of proposed readoption is published separately in this issue of the New Jersey Register.

Subchapter 8 sets forth reporting and certification requirements. The Assessment Report is the form for reporting under this subchapter and is set forth as Exhibit K in the Appendix to N.J.A.C. 11:20.

The Board is proposing various amendments to Subchapter 8 and N.J.A.C. 11:20 Appendix Exhibit K to eliminate the reporting requirements for the data that were required to administer the reimbursement, loss assessment and exemption mechanism

which the legislature eliminated in P.L. 2008, c. 38. The final loss assessment was for the 2007/2008 calculation period and therefore all of the associated reports are no longer necessary.

The Board proposes amending N.J.A.C. 11:20-8.1 to delete the requirement to supply non-group enrollment data and premium, claims and net investment income data specific to individual health benefits plans. Such data was only necessary to calculate loss assessment liability.

The Board proposes amending N.J.A.C. 11:20-8.2 to delete all requirements associated with N.J.A.C. 11:20 Appendix Exhibit K part D Enrollment Data Worksheet. Such enrollment data was only necessary to calculate loss assessment liability.

The Board proposes repealing N.J.A.C. 11:20-8.4 as the enrollment data required by this section was only necessary to calculate loss assessment liability.

The Board proposes repealing N.J.A.C. 11:20-8.5 since net paid losses or gains only have meaning in connection with the loss assessment mechanism that no longer exists.

The Board proposes amending N.J.A.C. 11:20-8.6 to delete the reference to a certification related to the enrollment data worksheet and the certification for the calculation of net investment income. These were required in connection with the loss assessment and are no longer necessary.

The Board proposes amending N.J.A.C. 11:20-8.7 to delete the reference to reimbursement of losses and minimum enrollment share, neither of which have meaning in the absence of the loss assessment mechanism.

The Board proposes repealing N.J.A.C. 11:20-8.8 since audits of reimbursable losses only have meaning in connection with the loss assessment mechanism that no longer exists.

The Board proposes repealing N.J.A.C. 11:20-8.9 since hearings concerning denied reimbursement of losses only have meaning in connection with the loss assessment mechanism that no longer exists.

The Board is allowing Subchapter 9 to expire. The subchapter provided information concerning filing for a conditional exemption from loss assessment. As P.L. 2008, c. 38 eliminated the loss assessment mechanism the conditional exemption process is no longer necessary.

The Board is allowing Subchapter 10 to expire. Subchapter 10 established performance standards and reporting requirements which a member shall meet in order to receive reimbursement of losses. As P.L. 2008, c. 38 eliminated the loss assessment mechanism performance standards for seeking reimbursement are no longer necessary.

Subchapter 11 is a Department-promulgated subchapter and therefore is not included in this proposed readoption with amendments. The Department's notice of proposed readoption of this subchapter is published separately in this issue of the New Jersey Register.

Subchapter 12 establishes the standards for determining who is eligible to be covered under standard individual health benefits plans, the standards for obtaining a standard plan by persons covered by, or eligible for, a group health benefits plan and by persons already covered under another individual health benefits plan. The goal of the restriction on the purchase of individual coverage by persons already with coverage is not only to help protect against adverse selection, but also to allow individuals to purchase coverage that better suits their needs and circumstances.

For purposes of determining eligibility for individual coverage by persons eligible for, or covered by, a group health benefits plan, the Board is guided by the requirements set forth in N.J.S.A. 17B:27A-3d, which prohibit such a person from obtaining coverage

in the individual market which is the "same or similar" to the person's group coverage. The rules set forth in the proposed readoption with amendments outline which types of coverage a person may obtain that are not the "same or similar." The rules also set forth when a person can change from one individual plan to another outside of the open enrollment period, and when the person is limited to changes during the open enrollment period.

The Board proposes amending N.J. A.C. 11:20-12.2, 12.4 and 12.5 to remove all references to the Special Open Enrollment Period. The Special Open Enrollment Period was defined as January 5, 2009 through March 31, 2009, and thus has expired. The Open Enrollment Period which takes place every calendar month of November continues to exist.

Subchapter 17 establishes quarterly and annual submissions of enrollment status reports by all carriers issuing individual health benefits plans and the B&E Plan, and sets forth procedures and format for those reports. The enrollment status reports are set forth as N.J.A.C. 11:20 Appendix Exhibit L, Parts 1 and 2.

Subchapter 18 is a Department-promulgated subchapter and therefore is not included in this proposed readoption with amendments. The Department's notice of proposed readoption of this subchapter is published separately in this issue of the New Jersey Register.

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

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

Subchapter 22 implements the provisions of P.L. 2001, c. 368, which established the B&E Plan. The subchapter establishes the procedures and standards for carriers to meet their obligations under that law. N.J.S.A. 17B:27A-4.5d provides that, "Carriers

may offer enhanced or additional benefits for an additional premium amount in the form of a rider or riders, each of which shall be comprised of a combination of enhanced or additional benefits, in a manner which will avoid adverse selection to the extent possible." The rules are intended to ensure that riders filed by carriers do not lead to adverse selection in a manner which could be avoided. Because the IHC Board views this as an ongoing obligation, the rules require that carriers that file B&E riders provide the Board with certain information on a quarterly basis, and other information on an annual basis, that is designed to evaluate over time whether the rider is leading to adverse selection. Subchapter 22 identifies the specimen policy form for the basic and essential health care services plan, which is set forth as Exhibit F.

The Board proposes amending N.J.A.C. 11:20-22.5(e) to delete paragraph (e)2. The Board has monitored the prior coverage data carriers have supplied in response to the specific requirements set forth in paragraph (e)2 for a number of years and has determined that the information that has been provided has not been helpful with determining whether adverse selection is avoided to the extent possible. The Board believes the data required by N.J.A.C. 11:20-22.5(e)1 provides a sufficient basis to determine whether adverse selection is being avoided to the extent possible.

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

11:20-23.6 sets forth where the Board shall provide public notice of board meetings. N.J.A.C. 11:20-23.7 sets forth the requirements for inclusion on the Board's list of interested parties.

Subchapter 24 establishes certain standards that carriers issuing individual coverage must meet. N.J.A.C. 11:20-24.2 sets forth standards for eligibility and issuance. N.J.A.C. 11:20-24.3 sets forth information about the payment of premium. N.J.A.C. 11:20-24.4 establishes standards for effective dates of coverage. N.J.A.C. 11:20-24.5 establishes standards for the payment of benefits that are not subject to capitated or negotiated fee arrangements.

Standard Health Benefits Plans and Basic and Essential Healthcare Services Specimen Plan

As required by N.J.S.A. 17B:27A-7, the IHC Board established the contract forms and benefit levels to be made available by all carriers for the standard health benefit plans required to be issued. N.J.A.C. 11:20-3 identifies the standard health benefit plans, Plans A/50, B, C, D and HMO, which carriers offering coverage in the individual market must issue and renew. The text of the plans is set forth in Appendix Exhibits A and B, with variable text detailed in N.J.A.C. 11:20 Appendix Exhibit C. The text of the specimen B&E plan that carrier may use to comply with the plan design requirements set forth in N.J.S.A. 17B:27A-4.5 is set forth as N.J.A.C. 11:20 Appendix Exhibit F.

The IHC Board notes that on October 4, 2010 it adopted amendments to the standard health benefits plans and the B&E specimen plan to address recent requirements found in New Jersey and Federal law. No further amendments are required at this time. and thus the Board proposes the readoption of N.J.A.C. 11:20 Appendix Exhibits A, B, C and F without amendments.

As the Board has provided a 60-day comment period on this notice of proposal, this notices is excepted from the rulemaking calendar requirements, pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

The rules proposed for readoption with amendments and repeals at N.J.A.C. 11:20 (excluding N.J.A.C. 11:20-3A, 6, 7, 11 and 18) implementing the provisions of IHC Act will continue to affect the member carriers, producers, and individual consumers of health benefits coverage. Currently, there are approximately 90 individual health coverage program member carriers, of which approximately 10 carriers are currently offering individual coverage. Member carriers are those carriers with accident and health premium in New Jersey, exclusive of those that are Medicaid only carriers. Approximately 120,675 persons are covered under individual health benefits plans.

The social impact of the rules proposed for readoption with amendments and repeals is the continued implementation of New Jersey's health insurance reforms in the individual market. Prior to New Jersey's health insurance reform in the individual market, individuals lacked choice of and access to health coverage, and there was a concentration of high-risk individuals in one carrier. The goals of reform were to make good health coverage accessible to individuals on a voluntary basis, to provide for renewability and portability of coverage, and to distribute among many carriers the concentration of high-risk individuals.

The IHC Act and the rules proposed for readoption with amendments and repeals provide for guaranteed access to coverage for all New Jersey residents not eligible to be covered under a group health plan or Medicare regardless of health status. The statute and rules also provide for guaranteed renewability and portability of coverage, as well as restrictions on the use of preexisting conditions limitations. The reformed market is also

characterized by standardized health benefits plans, which are designed to assist consumers in shopping for coverage. Other protections of the law that are governed by the Department of Banking and Insurance include requirements concerning premium rates and a minimum loss ratio requirement.

The amendments proposed in this readoption with amendments and repeals are consistent with the requirements of P.L. 2008, c. 38 which eliminated the loss assessment mechanism and therefore reimbursement of losses after the 2007/2008 calculation period.

Economic Impact

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

N.J.S.A. 17B:27A-2 et seq. sets forth criteria for a carrier being considered an IHC Program member carrier. As IHC Program member carriers encompass every carrier that has net earned health benefit premium in New Jersey during a two-year calculation period, the rules will impact not just those carriers that elect to market individual health benefit plans to residents of New Jersey, but also those carriers that elect not to market individual coverage. Carriers that elect to market individual coverage in New Jersey will have to bear the costs associated with selling individual plans which include creating and maintaining the provisions of the standard plans and the basic and essential health care services plan as well as rates for such plans, plan marketing, plan administration as well as reporting of enrollment, loss ratios and various certifications. All member carriers must pay the administrative assessment described in the proposed readoption with amendments. Carriers that were member carriers during prior calculation periods for which there were loss assessments continue to have responsibility for those periods with respect to interim and final reconciliations.

Brokers will be economically affected by the rules proposed for readoption with amendments and repeals due to the time they must take from selling to devote to reviewing and understanding the requirements set forth in the rules proposed for readoption with amendments and repeals with respect to standard plans and the B&E plan. Some brokers may choose to take advantage of continuing education classes discussing the proposed readoption with amendments. To the extent a broker sells coverage where the carrier pays a commission, the broker will be compensated for assisting consumers with the purchase of individual coverage.

Consumers will be economically affected by the rules proposed for readoption with amendments and repeals. The availability of standard plans allows consumers to transfer easily from one carrier to another in order to find the lowest cost option. Transfer from one individual plan to another is governed by Subchapter 12. Premium information regarding all available plans is updated monthly on the Board's website.

Since the Board is not proposing any amendments to the standard plans, carriers will not incur any costs to update or re-issue plans coincident with this readoption.

Carriers are unlikely to require any new or additional professional or technical services to accommodate these proposed amendments beyond those already at their disposal.

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Federal Standards Analysis

The rules proposed for readoption with amendments and repeals comply with the following Federal laws: the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191; Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. § 1395y(b) (1994) and implementing regulations at 45 CFR Part 411; the Public Health Service Act, 42 U.S.C. §§ 300gg et seq., (incorporating the

Federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191; the Newborns' and Mother's Health Care Protection Act of 1998, Pub.L. 104-204, 110 Stat. 2935 (1996); and the Women's Health and Cancer Rights Act of 1998, Pub.L. 105-277, Title IX, §903, 112 Stat.) and implementing regulations at 45 CFR Parts 145 and 146.

The rules do not expand upon the requirements set forth in the above Federal laws.

The rules proposed for readoption with amendments and repeals also comply with the PPACA. Although the IHC Board is not actively seeking to exceed the Federal requirements, the State standards may do so in one instance described below. The Federal PPACA requires that coverage for child dependents be extended up to age 26, based solely on the relationship of the child to the policyholder. The standard plans cover an eligible child until age 26 as required by PPACA. It may be noted, however, that New Jersey recognizes civil union partnerships and domestic partnerships, and by law must treat civil union partners and domestic partners the same as married spouses for insurance purposes. Accordingly, the class of children who must be covered until age 26 – including children of a policyholder's civil union partner or domestic partner – may be somewhat broader in New Jersey than may be required by the Federal law. The Federal law does not preempt more generous State laws in this instance. Thus, the eligibility provision in the individual health benefits plans is necessary to ensure compliance with both the State and Federal law.

There are no other Federal laws that apply to these rules.

Jobs Impact

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

Agriculture Industry Impact

The rules proposed for readoption with amendments and repeals will have no impact on the agriculture industry, other than the general impact felt by all industry groups and the general public.

Regulatory Flexibility Analysis

The IHC Board believes that all carriers subject to these rules have in excess of 100 full-time employees or are located outside of the State of New Jersey and thus are not "small businesses" as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, a regulatory flexibility analysis is not required. Nevertheless, to the extent that there may be carriers that meet the definition of a "small business," the following analysis would apply.

These rules may impose a greater impact in that small businesses may be required to devote proportionally more staff and financial resources to achieve compliance. The IHC Board has found, however, that any additional costs do not pose an undue burden in that the requirements herein are readily within a carrier's ability to comply.

The development of the filings required under this chapter fall within the normal functions a carrier performs in complying with any State insurance law or regulations. An exemption from the filing requirements would be inappropriate because the filing requirements are essential for determining a carrier's assessment liability and for protecting the individuals covered by individual health benefits plans.

The Individual Health Insurance Reform Act does not vary compliance requirements based on business size. To ensure consistency and uniformity in the market these rules proposed for readoption with amendments and repeals provide no differentiation in compliance requirements based on business size.

No additional professional services would have to be employed in order to comply with the rules proposed for readoption with amendments and repeals.

Smart Growth Impact

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

Housing Affordability Impact

The IHC Board does not believe the rules proposed for readoption with amendments and repeals will have an impact on housing affordability in this State in that the rules relate to the provision of individual health insurance.

Smart Growth Development Impact

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

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

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:20-2.13, 8.4, 8.5, 8.8 and 8.9.

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

(**Agency Note:** N.J.A.C. 11:20 Appendix Exhibit K is reproduced below as proposed for amendment, as discussed in the Summary above, without the use of

boldface and brackets to show proposed changes, due to the use of boldface and the grid structures within the form.)

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.2 Definitions

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

…

"Family unit" means:

1. – 6. (No change.)

7. An adult and his or her dependent child(ren), as the term dependent is defined in the individual health benefits plan[, who are members of the same household]; and

8. (No change.)

…

"Pre-existing condition" means **for a covered person age 19 or older** a condition that, during a specified period of not more than six months immediately preceding the enrollment date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the enrollment date of coverage.

…

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM PLAN OF OPERATION

11:20-2.1 Purpose and structure

(a) – (g) (No change.)

(h) All documents or other communications directed to the Board shall be sent to the Executive Director of the IHC Program at the address set forth below. Communications sent by regular mail must be sent to the PO Box:

New Jersey Individual Health Coverage Program

20 West State Street, 11th Floor

PO Box 325

Trenton, NJ 08625-0325

Telephone: (609)633-1882 x[50306]**50302**

Fax: (609) 633-2030

11:20-2.2 Definitions

(a) (No change.)

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

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

…

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

(a) (No change.)

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

1. – 7. (No change.)

[8. Establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the IHC Program and provide for performance audits;]

Recodify existing 9. – 13. as **8. - 12.** (No change in text.)

[14.] **13.** Establish rules, conditions and procedures pertaining to the sharing of IHC Program [losses and] administrative expenses among the members of the IHC Program;

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

i. – ii. (No change.)

Recodify existing 16. – 22. as **15. – 21.** (No change in text.)

11:20-2.6 Committees

(a) – (c) (No change.)

(d) Standing committees shall include the following:

1. A Technical Advisory Committee, which shall make recommendations to the Board with respect to:

i. (No change.)

ii. A uniform Audit Program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier; **and**

[iii. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time;

iv. Conditional and final exemptions from assessments; and]

[v.] **iii**. (No change in text.)

2. – 3. (No change.)

4. An Operations and Audit Committee, which shall make recommendations to the Board with respect to:

i. – v. (No change.)

vi. Methods for calculating assessments; **and**

vii. Uniform audit program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier**.**[; and

viii. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time.]

(e) – (f) (No change.)

11:20-2.7 Financial administration

(a) – (b) (No change.)

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

1. (No change.)

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

i. (No change.)

ii. All investment income earned on loss assessment funds shall be credited to the IHC Program and shall be applied to reduce [future loss] assessments of members of the IHC Program, except as provided in N.J.A.C. 11:20-2.17[(h)]**(a)**[, and except that interest earned on loss assessment funds due to a carrier shall be paid to that carrier to the extent that the investment income is earned during a subsequent loss assessment cycle in which the carrier is no longer seeking reimbursement].

(d) – (f) (No change.)

11:20-2.8 Audits

(a) – (b) (No change.)

[(c) The Board shall conduct a full or partial audit of a carrier filing for reimbursement of losses. Carriers filing for reimbursement of losses shall provide, within 90 days of the Board's written request such information as the Board shall request, including, but not limited to:

1. With respect to information regarding premium earned:

i. Detailed electronic data files of premiums which, in total, agree to the premiums earned reported to the IHC Board on the Exhibit K Assessment Report. The data file or files shall include sufficient detail to identify the dollar amounts of premiums, by subscriber or contract number;

ii. All underwriting and premium records relating to the premiums earned on the data files, including, but not limited to, subscriber applications, billing records, cash receipt and disbursement records, advance premium and premium receivable records and rate filings;

iii. A reconciliation, if necessary, between the total premiums earned per the data files requested in (c)1i above and the premium earned amount reported to the IHC Board on the Exhibit K Assessment Report, including an explanation of reconciling items; and

iv. A reconciliation, if necessary, between the premiums earned amount reported to the IHC Board on the Exhibit K Assessment Report and premiums earned amount set forth in the Member's Annual Statement Blank filed with the Department or Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

2. With respect to claims paid:

i. Detailed electronic data files of claims paid which, in total, agree to the claims paid reported to the IHC Board on the Exhibit K Assessment Report. The data files shall include sufficient detail to identify the dollar amounts of claims paid, by claim and subscriber number, and the payment reference such as check or wire transfer number. All claim file and disbursement records relating to the claims paid on the data file, such as claims submission forms, provider invoices, pricing data, eligibility investigations, canceled checks and wire transfer documentation;

ii. A reconciliation, if necessary, between the total claims paid per the data files requested in (c)2i above and the claims paid amount reported to the IHC Board on the Exhibit K Assessment Report, including an explanation of reconciling items; and

iii. A reconciliation, if necessary, between the claims paid amount reported to the IHC Board on the Exhibit K Assessment Report and the claims paid amount set forth in the Member's Annual Statement Blank filed with the Department or the Department of Health and Senior Services, as appropriate, including an explanation of reconciling items.

3. With respect to investment income:

i. Detailed schedules of net investment income which, in total, agree to the net investment income reported to the IHC Board on the Exhibit K Assessment Report. The

schedules shall set forth the Member's calculation of net investment income allocated to the New Jersey individual line of business and shall include sufficient detail to identify the nature and source of the components used to calculate net investment income; and

ii. All source documentation used in the Member's calculation of net investment income, including, but not limited to, schedules used in the calculation of mean funds by line of business, cash receipt and disbursement records used in the cash flow schedules, and calculations for the Member's investment rate of return.]

11:20-2.13 (Reserved)

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

[(a) The Board shall assess members for reimbursable net paid losses, pursuant to N.J.S.A. 17B:27A-11a and 12, according to the procedures set forth in this Plan of Operation.

(b) The IHC Program Board shall determine the preliminary total reimbursable net paid losses, if any, for each preceding two-year calculation period beginning in 1997/1998 based upon the information submitted by members in Part E of the Exhibit K Assessment Report, completed pursuant to N.J.A.C. 11:20-8 (formerly known as the Carrier Net Paid Gain (Loss) Report and set forth in a superseded version of Exhibit K to N.J.A.C. 11:20). The Board shall determine the preliminary total reimbursable net paid losses, if any, approximately 60 days after all IHC members have provided complete Exhibit K Assessment Report filings.

(c) The total reimbursable net paid losses for the preceding two-year calculation period shall be the aggregate of the reimbursable net paid losses for all members issuing

individual health benefits plans, reporting net paid losses for that two-year calculation period, subject to any independent audit performed pursuant to N.J.A.C. 11:20-8.8. The loss assessment shall provide for full reimbursement of reimbursable losses, notwithstanding the granting of exemptions pursuant to N.J.A.C. 11:20-9. No member shall be entitled to reimbursement of net paid losses if the member has not issued individual health benefit plans during the two-year calculation period or if the member has applied for a conditional exemption for the two-year calculation period.

(d) Every member shall be liable for its proportional share of the total reimbursable net paid losses for the preceding two-year calculation period unless the Board has granted the member an exemption from assessments for the preceding two-year calculation period in accordance with N.J.A.C. 11:20-9.

1. The Board shall provide a preliminary written notice to members of the total of all members' reimbursable net paid losses for the preceding two-year calculation period and the amount of each member's anticipated loss assessment liability. This written notice shall be sent approximately 60 days after every IHC member has provided a complete Exhibit K Assessment Report as required by N.J.A.C. 11:20-8.

2. As necessary, the Board shall make adjustments to the preliminary notice of the loss assessment prior to issuing the loss-assessment invoice. Those adjustments may include, among other things, adjustments in market share, adjustments in net paid losses, and adjustments for deferrals granted pursuant to N.J.S.A. 17B:27A-12d(3) and N.J.A.C. 11:20-11.

3. The Board shall notify each member by invoice of its share of the loss assessment for the two-year calculation period. This invoice shall be sent approximately 60 days after the Board has completed its review of the Exhibit K Assessment Report filings for

accuracy, including, but not limited to, consistency with other public filings provided to the State by the members.

4. The Board may issue interim assessments and reconciliations after the issuance of the loss-assessment invoice and before the issuance of the final reconciliation set forth in (d)5 below.

5. The Board shall notify each member of the final reconciliation of the loss assessment for the calculation period by issuing an invoice setting forth the dollar amount payable by the member or credit due to the member. The final reconciliation shall be issued approximately 90 days after all outstanding matters have been resolved, including but not limited to the completion of the independent audit of each member seeking reimbursement of losses, and the issuance of a final judicial determination of every appeal, including, but not limited to, those relating to the loss assessment for the two-year calculation period, exemptions from the loss assessment, independent net paid loss audits, and the payment of reimbursable losses. Any monies determined to be owed to or by the Board as a result of the final reconciliation shall be calculated without provision for interest.

(e) The Board shall determine each member's loss assessment share by multiplying the member's market share, as determined pursuant to (e)1 below, by the total reimbursable net paid loss amount for the two-year calculation period.

1. The Board shall determine each member's market share by dividing the member's adjusted net earned premium, as determined pursuant to (e)1i, (e)1ii, or (e)1iii below, for the two-year calculation period by the aggregate adjusted net earned premium of all members for the two-year calculation period.

i. For a member that has been granted a full exemption, the member's adjusted net earned premium shall be $0.

ii. For a member that has been granted a pro rata exemption, the member's adjusted net earned premium shall be calculated as the reported net earned premium in Part C of its Exhibit K Assessment Report multiplied by (100 percent minus the percentage of the non-group enrollment target the member satisfied).

iii. For a member that has not been granted a full or pro rata exemption, the member's adjusted net earned premium shall be the same as the net earned premium that the member has reported in Part C of its Exhibit K Assessment Report.

2. Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by a member after the dispute is resolved in favor of the disputing member, shall be apportioned to the remaining members based on their respective market shares.

i. A member granted a deferral shall remain liable to the IHC Program for the amount deferred and for any additional amounts required by N.J.A.C. 11:20-11.6.

ii. Upon eventual payment of the deferred amount to the IHC Program, the members to whom the deferred amounts were reapportioned will be credited for those amounts previously apportioned to them.

3. A member shall not be liable for a loss assessment that is less than the minimum assessment set forth in N.J.A.C. 11:20-2.18.

(f) Loss assessment amounts are due and payable upon a member's receipt of the invoice for the loss assessment. Payment shall be either by bank draft made payable to the Treasurer--State of New Jersey, IHC Program, and sent to the address set forth in N.J.A.C. 11:20-2.1(h), or by wire transfer consistent with instructions in the invoice. The funds are deposited into the Board's account in Treasury.

1. Pursuant to N.J.S.A. 17B:27A-10f(4), members shall be subject to payment of an interest penalty on any loss assessment, or portion of a loss assessment, not paid within

30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent of the loss assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of a loss assessment, or portion of an assessment, for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full, and the interest penalty shall continue to accrue on the unpaid amount.

iii. Good faith errors that members report to the Board within 60 days of their occurrence shall not be subject to the interest penalty set forth in (f)1i above. If a member makes an error relating to or involving a loss assessment or any other error resulting in non-payment or underpayment of funds, the member shall make payment of additional amounts due within five days of identifying the good faith error.

2. A member that disputes whether it is subject to a loss assessment, or that disputes the amount of the loss assessment for which it has been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount shown on the assessment invoice, including any interest penalty accruing thereon. The member shall identify the amount in dispute, subject to verification by the Board. The Board shall not be liable for any misidentification by the member of the disputed amount that results in an insufficient amount being held by the Board. The disputed amount of the assessment shall be held in a segregated interest-bearing account until there has been a final adjudication of the dispute, or until such time as the Board determines that the member's appeal should be granted.

(g) A member may request that the Commissioner grant a deferral of its obligation to pay a loss assessment in accordance with N.J.A.C. 11:20-11.

1. 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 pursuant to (e) above, to be held in a segregated interest-bearing account in accordance with the procedures set forth in (h) below, pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (g)1 above, and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (f)1 above, accruing from the date of the invoice for the assessment.]

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

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

be disbursed to members having reimbursable net paid losses for the applicable two-year calculation period year [in accordance with (h) above]**.**

2. (No change.)

11:20-2.18 Minimum assessment

If the total amount of a member's assessment invoice would be less than [$10.00 in the case of either a loss assessment or both a loss assessment and an administrative assessment, or less than] $5.00 in the case of an administrative assessment [only], the member shall not be liable for that amount and that amount shall be reapportioned pursuant to N.J.A.C. 11:20-2.12 [and 2.17 as appropriate]**.** This provision shall apply to an invoice for administrative expenses issued pursuant to N.J.A.C. 11:20-2.12[, an invoice for reimbursable net paid losses issued pursuant to N.J.A.C. 11:20-2.17, or a combined invoice for both administrative expenses and net paid losses].

SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

11:20-8.1 Scope and applicability

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

(b) (No change.)

11:20-8.2 Filing of the assessment report form

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

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

1. (No change.)

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

[3.] **2**. The combined affiliated carriers, identified using a single carrier name, shall file one copy of the Exhibit K Assessment Report. The information specified on the Exhibit K Assessment Report shall be the aggregated information supplied on the Premium Data Worksheets for all affiliated carriers [and the Enrollment Data Worksheets for those affiliated carriers with non-group person enrollment].

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

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

(c) (No change.)

11:20-8.4 and 8.5 (Reserved)

11:20-8.6 Certifications

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

[(b) The Chief Financial Officer, or other duly authorized officer, of a member which has filed for reimbursement of losses shall certify, on or before April 1 of the year following every two-year calculation period that the net investment income reported on the Exhibit K Assessment Report has been allocated on a basis consistent with N.J.A.C. 11:20-8.5(d) or, if not, the changes have been outlined in detail including the impact and reason for the change.]

11:20-8.7 Failure to file Exhibit K Assessment Report

[(a)] Failure to file in a timely manner the Exhibit K Assessment Report and certification[s] required by this subchapter shall result in the Board's using the premium set forth in the member's most recent Annual Statements filed with the Department as the

premium base to calculate that member's market share allocation of assessments [for reimbursement of losses and minimum number of non-group persons] **for that calculation period**.

11:20-8.8 and 8.9 (Reserved)

SUBCHAPTERS 9 AND 10 (RESERVED)

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

11:20-12.2 Definitions

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

. . .

["Special open enrollment period" means January 5, 2009 through March 31, 2009.]

11:20-12.4 Covered under an individual plan: replacement only during Open Enrollment Period [or Special Open Enrollment Period]

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

services plan for which the monthly premium is greater than the monthly premium for the existing health benefits plan.

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

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

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

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

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

(g) The effective date of the replacement plan issued as a result of (a) though (e) above will be January 1 of the year following the Open Enrollment Period [and no later than April 1, 2009 in the case of the Special Open Enrollment Period].

(h) - (i) (No change.)

11:20-12.5 Covered under or eligible to participate in a group health benefits plan

(a) A person who is covered under or eligible to participate in a group health benefits plan that is not the same as or similar to the individual plan for which application has been made may elect only during the Open Enrollment Period [or Special Open Enrollment Period] to be covered under a standard health benefits plan or a basic and essential healthcare services plan. The effective date of the individual plan will be January 1 of the year following the Open Enrollment Period [or no later than April 1, 2009 in the case of the Special Open Enrollment Period].

(b) - (c) (No change.)

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

essential healthcare services plan, the standard individual health benefits plan or basic and essential healthcare services plan shall be of no force and effect and premium paid shall be refunded.

SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

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

(a) – (d) (No change.)

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

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

i. – iii. (No change.)

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

2. For basic and essential health care services plans issued during the calendar quarter with a rider, the carrier shall submit:

i. The number of persons enrolled who were previously uninsured; and

ii. For all persons previously insured, the numbers of persons whose prior source of coverage was group; COBRA/state continuation; standard IHC plan; unridered basic and essential health care services plans plan, or other basic and essential health care services plans with rider.]

(f) – (i) (No change.)

EXHIBIT K

New Jersey Individual Health Coverage Program Assessment Report
For the Two-Year Calculation Period_____

All carriers reporting accident and health premium to the New Jersey Department of Banking and Insurance shall submit this report and attachments in accordance with the provisions of N.J.A.C. 11:20-8. Reports must be completed and returned on or before April 1, _____.

Part A. Carrier Information

Carrier's Name:	
NAIC Number:	
Affiliated Carriers: (Name and NAIC Number)	

Part B. Information of Person completing this Report

Name:			
Title:			
Phone:		Fax:	
Email:			
Mailing Address:			

Part C. Program Membership for the Two-Year Calculation Period (Attach worksheet(s))

Members and Non-members with reportable accident and health premium in New Jersey MUST complete and return one copy of the attached "Exhibit K-Part C Premium Data Worksheet" for each of the affiliates listed above. If any of the affiliates has any net earned premium for the two-year period, the carrier is a Member and shall record the amount below. If no affiliates have net earned premium, then the carrier is a Non-member and the carrier shall check the Non-member box below.

Member's net earned premium, including all affiliates, for the two-year period:	$
OR □ Non-member of the IHC Program with no net earned premium.	

Part D. Certification

I certify that I am an officer of the company, that the information provided in this report and all attachments is accurate and complete, and that it has been prepared in accordance with the provisions of N.J.A.C. 11:20-8.

Printed Name:	
Title:	
Signature:	Date:

Exhibit K Part C Premium Data Worksheet

The purpose of this Part C Premium Data Worksheet is to demonstrate whether a carrier is a member of the IHC Program by virtue of having any "net earned premium" during the two-year calculation period. "Net earned premium" means the premiums earned in this State on "health benefits plans," less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business. Health benefits plans include health insurance for individuals or groups of any size, but shall not include any premium associated with the benefits enumerated in Section 2 of Part C of the Premium Data Worksheet.

Directions:
Copy the attached worksheet, if necessary, and provide the following information for each affiliate:

- The name of the affiliate.
  - Section 1: The total accident and health premium reported on the annual NAIC statement blank for both calendar years of the two-year calculation period for that affiliate.
  - Section 2: The total premium amounts earned in each calendar year of the two-year calculation period for each of the excepted types of coverage listed on the worksheet for each affiliate.
  - Section 3: To arrive at the net earned premium in section 3, subtract the total excepted premium totals reported in Section 2 from the accident and health premium totals reported in Section 1. All premium that is not from some type of excepted coverage is net earned premium from health benefits plans.
  - Each affiliate's worksheet shall be attached to the carrier's one-page Exhibit K.

Members shall report the combined two-year net earned premium calculated from each affiliate's Exhibit K Part C Premium Data Worksheet on Part C of the Exhibit K Assessment Report.

If the combined two-year net earned premium total from each affiliate's Exhibit K Part C Premium Data Worksheet is zero either because all of the premium is from excepted coverages or because the carrier had no accident and health premium, then the carrier shall assert Non-member status by checking the Non-member box on Exhibit K Part C, and completing the certification in Part D.

Exhibit K Part C Premium Data Worksheet for the Two-Year Calculation Period ____

Name of Affiliate: _____ Name of Carrier on Exhibit K: _____

Carriers shall complete and return this page for each affiliate along with Exhibit K.

Section 1: Total A&H Premium	Premium for ____	Premium for ____	Two-Year Total
Amount of Accident & Health Premium on New Jersey NAIC Statement Blank:	$	$	$

Section 2: List of Excepted Benefits and Premium	Premium for ____	Premium for ____	Two-Year Total
a. Medicare Advantage and Medicare + Choice coverage and Medicare Demonstration and Medicare Part D Coverage	$	$	$
b. contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. § § 8901-8914	$	$	$
c. excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan	$	$	$
d. Medicare supplement policies or contracts	$	$	$
e. non-expense incurred specified disease coverage	$	$	$
f. coverage only for accident, disability income insurance, or any combination	$	$	$
g. coverage issued as a supplement to liability insurance	$	$	$
h. liability insurance, including general liability insurance and automobile liability insurance	$	$	$
i. workers' compensation or similar insurance	$	$	$
j. automobile medical payment insurance	$	$	$
k. credit-only insurance	$	$	$
l. coverage for on- site medical clinics	$	$	$
m. other similar insurance coverage, as specified in federal regs., under which benefits for medical care are secondary or incidental to other insurance benefits	$	$	$
n. limited scope dental or vision benefits*	$	$	$
o. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof *	$	$	$
p. such other similar, limited benefits as are specified in federal regulations*	$	$	$
q. hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor	$	$	$
r. coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.)	$	$	$
s. similar supplemental coverage provided to coverage under a group health plan	$	$	$
Total excepted premium:	$	$	$

*Include as an excepted benefit if the coverage is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of the plan.

Section 3: Calculation of "Net Earned Premium"	Premium for ____	Premium for ____	Two-Year Total
Net Earned Premium = (Section 1 premium – Section 2 premium)	$	$	$