INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Small Employer Health Benefit Plans

Proposed Readoption: N.J.A.C. 11:21-18 and Appendix Exhibits BB Part 2 and DD.

Proposed Readoption with Amendments: N.J.A.C. 11:21-1 through 3, 4 through 7, 10, 17, 23 and 11:21 Appendix Exhibits D, F, G, K, T, W, Y, BB Part 1, CC, HH and II

Proposed Repeals: N.J.A.C. 11:21-2.13, 7.13, 8, 17.4 and 11:21 Appendix Exhibits BB Part 6, and KK

Authorized By: New Jersey Small Employer Health Benefits Program Board of Directors (Ellen DeRosa, Executive Director).

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

Calendar Reference: See Summary below for the explanation of exception to the calendar requirement.

Proposal Number: PRN 2016-.

As required by N.J.S.A. 17B:27A-51, interested parties may testify with respect to the standard health benefits plans, set forth in N.J.A.C. 11:21 Appendix Exhibits D, F, G, W, Y, HH, and II at a **public hearing** to be held August 18, 2016, at 9:00 A.M. in the New Jersey Department of Banking and Insurance, 11th floor Conference Room, 20 West State Street, Trenton, New Jersey.

Submit written comments by August 22, 2016, to:

Ellen DeRosa, Executive Director

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The agency proposal follows:

Summary

Pursuant to N.J.S.A. 52:14B-5.1c, N.J.A.C. 11:21 expires on August 18, 2016. N.J.A.C. 11:21 implements the Small Employer Health Benefits Program Act ("SEH Act"), P.L. 1992, c. 162, as subsequently amended (codified at N.J.S.A. 17B:27A-17 et seq.). Some of the subchapters contained within this chapter (specifically, subchapters 1, 2, 3, 4, 6, 7, 8, 10, 17, 18 and 23) as well as some exhibits within the Appendix to N.J.A.C. 11:21 (specifically, Exhibits D, F, G, K, T, W, Y, CC, DD, HH, II, and KK) were promulgated by the Small Employer Health Benefits Program Board (SEH Board or Board), while the remainder of the subchapters and exhibits not otherwise reserved were promulgated by the New Jersey Department of Banking and Insurance (Department). (Exhibit BB of the Appendix is shared by the SEH Board and the Department, and is separated into several different parts, with Parts 1, 2 and 6 being SEH Board exhibits.) The SEH Board has reviewed those subchapters and related exhibits it promulgated and has determined that most are necessary, reasonable and proper for the purpose for which they were originally promulgated. The Board believes that some of its rules require amendment

in order to more accurately reflect changes in laws and market practices. The Board acknowledges that some of its rules are no longer necessary. Accordingly, the rules promulgated by the Board are being proposed for readoption, with amendments and repeals, noted herein.

Concurrent with the publication of this proposal, the amendments to the Plan of Operation are being submitted to the Commissioner of the Department of Banking and Insurance for his approval pursuant to N.J.S.A. 17B:27A-30. In accordance with N.J.S.A. 17B:27A-30, the Commissioner shall, after notice and hearing, approve the amendments to the Plan of Operation if he finds that they are reasonable and equitable and sufficiently carry out the provisions of the SEH Act. The amendments to the Plan of Operation shall become effective unless disapproved in writing by the Commissioner within 90 days after receiving them, or earlier if the Commissioner approves the amendments in writing prior to the expiration of the 90-day period.

Discussion of Readopted Rules

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-1 is necessary because N.J.A.C. 11:21-1 sets forth the definitions of terms used in Chapter 21, identifies how the SEH Board may be contacted, sets forth the penalties available under law, provides a severability clause for the subchapter and specifies the SEH Board's mission statement. The SEH Board proposes various amendments to this subchapter.

The SEH Board proposes deletion of the term "allowed charge" since the term is used only in N.J.A.C. 11:21-7.13 which the SEH Board is proposing to repeal. The SEH Board's reasons for repealing N.J.A.C. 11:21-7.13 are set forth under the discussion of the amendments to Subchapter 7.

The SEH Board proposes an amendment to the definition of "dependent" to clarify that legal spouse includes a civil union partner for purposes of dependent eligibility but not for

purposes of determining employee status. The SEH Board affirms that an employee may cover a civil union partner as a dependent under the plan. The SEH Board notes that if a business owner has a civil union partner and such civil union partner works as an employee in the business the civil union partner should be considered as an employee.

The SEH Board proposes to delete the term "eligible employee," and to amend the definitions of "employee" and "small employer" in order to better align New Jersey's rules with Federal law. In general, the Federal Patient Protection and Affordable Care Act, Pub. Law 111-148, as amended and supplemented by the Health Care and Reconciliation Act, Pub. Law 111-152 (collectively, the Affordable Care Act, or ACA), defines employee as set forth by the Employee Retirement Income Security Act (ERISA) at 29 U.S.C. 1002, or as set forth in the Internal Revenue Code (Code), and respective implementing regulations. In both instances, employee is defined using common law principles based on the employer-employee relationship. Federal regulations implementing ERISA and certain provisions of the Code also establish additional standards for counting employees for purposes of determining whether an employer is actually offering a group health plan, and the employer's size (with different rights and obligations inuring as a matter of multiple Federal laws, depending on the size of the employer and the status of the health coverage offered). Regulations implementing ERISA at 29 CFR 2510.3-3 establish that a group only exists if there are employees covered under the plan, and specifies that an individual and his or her spouse, and partners in a partnership are not considered employees for this purpose if the business is wholly owned by the spouse(s) or the partners. (Owners can be covered under the plan, but if they are the only people covered, the plan is not a group health plan.) Regulations at 26 CFR 54.4980H-0 through -6 establish the method for determining whether employers are so-called Applicable Large Employers, or small employers –

excluding sole proprietors, partners in a partnership, 2-percent S-corporation shareholders and leased employees – which in turn determines whether the employer must offer federally defined minimum essential coverage or possibly incur excise taxes under the ACA. When the SEH Board initially amended its rules to accommodate both the Federal and State law, the Board believed it was appropriate to retain aspects of the New Jersey definition of eligible employee and to modify the definition of small employer, creating a two-part definition. The Board also adopted a definition of employee similar to that at 26 CFR 54.4980H. Since adoption of those definitions the SEH Board has received myriad questions from employers, producers and carriers which led the Board to again consider how to best define employee and small employer. Following careful analysis the Board believes it is not necessary to retain either the definition of eligible employee which is more restrictive than the Federal law or a two-part definition of small employer in order to to effectuate both the Federal and State law. Further, the Board believes that maintaining the definition of eligible employee and a two-part definition of small employer is inefficient and has proven to be confusing for anyone engaged in the administration of the group health plans for small employers. Not merely is it an issue in determining whether an employer is eligible to be offered a small employer health benefits plan, but it becomes problematic for carriers in trying to determine how to address continuation requirements under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), Federal Medicare as Secondary Payor requirements and other Federal laws, and there are tax implications as well for the employers who may find themselves classified as small employers for some purposes and large employers for others. Consequently, the Board is proposing to delete the definition of eligible employee, and references to the term throughout the rules (replacing it with the term employee or full-time employee, as appropriate), and the Board is proposing to delete the first

part of the definition of small employer. In turn, the Board proposes to amend the definition of "employee" to remove reference to that part of the small employer definition proposed to be deleted. The Board is also proposing to amend the definition of employee to add language similar to 29 CFR 2510.3-3 to further clarify which individuals are excluded from the definition of employee when determining which employers are small employers.

The SEH Board proposes an amendment to the definition of "employer open enrollment period" to explain that contribution and participation requirements do not apply during the one month period.

The SEH Board proposes to add a new definition of "full-time employee" that would be used to determine eligibility for coverage under a small employer plan and to calculate participation requirements. For these purposes, full-time means 25 or more hours per week. The SEH Board notes that the 25-hour requirement is consistent with the hourly requirement established in the definition of eligible employee in N.J.S.A. 17B:27A-17.

The SEH Board proposes to update the e-mail address in N.J.A.C. 11:21-1.3 and throughout the regulation.

The SEH Board proposes to update the agency name for the New Jersey Department of Health in N.J.A.C. 11:21-1.6 and throughout the regulation.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-2, the SEH Board's Plan of Operation, is necessary because N.J.A.C. 11:21-2 sets forth the purpose and structure of the SEH Program. Pursuant to N.J.S.A. 17B:27A-30, the SEH Board is required to promulgate a Plan of Operation, which outlines the key elements of the SEH Board's administration of the Program under the law. Included in the items in the Plan are the powers of the SEH Board, the SEH Board's structure and how it meets to deliberate, the committee structures and duties, the

SEH Board's selection of the Executive Director and Executive Director's 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 SEH Board, the requirements for the auditing of the SEH Board's finances, penalties and adjustments of assessment disputes, indemnification for SEH Board members and its staff, and procedures for amendment or the termination of the Plan of Operation.

The SEH Board proposes to amend N.J.A.C. 11:21-2.1to re-name the section as Purpose and delete items (d) through (g). The content of items (d) through (g) is addressed in N.J.A.C. 11:21-2.5 and there is no reason to repeat the text in N.J.A.C. 11:21-2.1.

The SEH Board proposes amending N.J.A.C. 11:21-2.2 to replace the definition of "administrator or executive director" with the term "executive director." The SEH Board has had an executive director rather than an administrator since 1994. Throughout the regulation all references to "administrator" are being deleted.

The SEH Board proposes the various corrections discussed below in N.J.A.C. 11:21-2.3. The Board proposes to delete item (a)5, which indicates that the Board may establish additional policy forms to address dual contracts; the remaining subparagraphs would be renumbered accordingly. Dual contract policy form text was eliminated some years ago and the reference in the Plan of Operations was inadvertently retained; the language is no longer necessary. Also in N.J.A.C. 11:21-2.3, the SEH Board proposes to amend renumbered item 7 to delete the reference to five standard plans. Although the SEH Board was required to eliminate standard Plan A effective December 31, 2013 to comply with the ACA, the reference to five plans was retained in this rule inadvertently. The Board proposes to amend renumbered item 9, to correct a grammar error by replacing advise with advice. The SEH Board proposes to amend renumbered item 13

of N.J.A.C. 11:21-2.3 to delete the provision for a reasonable charge for the buyer's guide because the SEH Board provides the Buyer's Guide and other informational materials free of charge, and does not anticipate charging for such information in the foreseeable future.

The SEH Board proposes an amendment to N.J.A.C. 11:21-2.5(b) to clarify which Board members may designate a voting alternate. The SEH Board proposes an amendment to N.J.A.C. 11:21-2.5(d) and N.J.A.C. 11:21-2.5(e)6 to delete the specificity with respect to the scheduling of Board meetings and filling of vacancies on the Board. In N.J.A.C. 11:21-2.5(e)4 the SEH Board proposes to permit the Board to review and make changes to the communications program without necessarily waiting for recommendations from the Marketing and Communications Committee. The SEH Board proposes to amend N.J.A.C. 11:21-2.5(g) to replace the word "comprehensive" with the word "comprehensible" consistent with the term used in N.J.S.A. 10:4-14 and to remove the requirement to provide two copies of the minutes to the Commissioner since the minutes are provided electronically.

The SEH Board proposes an amendment to N.J.A.C. 11:21-2.6(a) to delete the text describing how committee membership is determined since necessary direction is set forth in N.J.S.A. 17B:27A-32e. The SEH Board is proposing to delete N.J.A.C. 11:21-2.6(b)1v and vi because there is no reinsurance mechanism for which oversight is required; the remaining subparagraphs would be renumbered accordingly.

The SEH Board proposes amendments to N.J.A.C. 11:21-2.6(b)2i to expand the scope of the matters considered by the Legal Committee to include consideration of applicable law in recognition of the fact that the SEH Act must often be understood in light of other applicable law.

The SEH Board proposes amendments to N.J.A.C. 11:21-2.8(c)3i and (f) to clarify that the request for a deferral of a carrier's obligation to pay an assessment must be made by the carrier within the specified days *after* the date of the invoice rather than of the date *of* the invoice.

The SEH Board proposes amendments to N.J.A.C. 11:21-2.11(c) to more closely align the text with N.J.S.A. 47:1A-1 et seq.

The SEH Board proposes the repeal of N.J.A.C. 11:21-2.13 which addresses penalties, adjustments and dispute resolution. The SEH Board believes errors in reporting are sufficiently addressed in N.J.A.C. 11:21-2.8 and this additional section is not necessary, and in fact has not been the basis for any SEH Board action in the past.

The SEH Board is proposing to amend N.J.A.C. 11:21-2.15 to provide greater flexibility in Board communications, permitting options to communicate with the directors of the Board by email, and for other parties to provide email as a form of communication between themselves and the Board. These amendments are consistent with actual practice.

The SEH Board is proposing to delete N.J.A.C. 11:21-2.17 since this section addresses an appeal from a request for relief. Subchapter 15 which is a subchapter promulgated by the Department, not the SEH Board, is the only provision in N.J.A.C. 11:21 addressing a request for relief. Since any request for relief would be submitted to the Department and not to the SEH Board, the SEH Board has determined it inappropriate for the SEH Board to provide a mechanism to appeal any decision made by the Department. N.J.A.C. 11:21-7.5(d) and 7.6(d) which refer to the appeal provisions in the Plan of Operations are proposed to be amended to delete the references to such appeal mechanism since it is being deleted. The SEH Board notes

any carriers appeal of decisions made pursuant to N.J.A.C. 11:21-7.5 and 7.6 would not be made with the SEH Board.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-3 is necessary because N.J.A.C. 11:21-3 sets forth the standard health benefits plans. Small employer carriers are required to select at least three of such health benefits plans to offer. N.J.A.C. 11:21-3 also sets forth the deductible and copay options and ranges that carriers are permitted to may offer. Finally, the subchapter sets forth the procedures for filing optional nonstandard benefit riders of increasing value with the SEH Board.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(a) to more clearly identify the plans and their associated appendix exhibits for contracts and related certificates or evidences of coverage. The SEH Board is proposing amendments to N.J.A.C. 11:21-3.1(b) to clarify the requirements that carriers must meet in offering plan deductibles and maximum out-of-pocket cost-sharing for Plans B through E. Similarly, the SEH Board is proposing amendments to N.J.A.C. 11:21-3.1(c) to clarify the requirements that HMOs must meet in offering one or more HMO plans (i.e., at least one HMO plan must be offered using copayments, but an HMO may offer additional HMO plans using other permitted cost-sharing arrangements).The SEH Board is not proposing amendments that in any way change the existing requirements.

The SEH Board proposes to delete the phrase “incorporated herein by reference” as used in N.J.A.C. 11:21-3.1, 4.1, 4.2 and 10.3 because the Appendix Exhibits to which the phrase refers are in fact part of the Chapter.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(e) and (f) to clarify that the requirement to offer plans in all areas of the state is limited by the carrier’s license if that license only authorizes the carrier to write health benefit plans in specific counties in the state. In

addition, the SEH Board proposes to amend N.J.A.C. 11:21-3.1(g) to update the citation to the HMO rules, and to remove redundant language at N.J.A.C. 11:21-3.1(g)2iv.

The SEH Board proposes amending N.J.A.C. 11:21-3.2 throughout to eliminate use of the phrase "or amendment thereof" because any amendment to a rider would create a new rider. The SEH Board proposes deleting N.J.A.C. 11:21-3.2(a)1 which addresses decreasing riders because 45 CFR 156.80 requires that all small employer plans must include the essential health benefits defined by the New Jersey benchmark plan and no benefit may be less rich than that contained in the benchmark plan. The SEH Board proposes renumbering the remaining subparagraphs accordingly. The Board proposes amendments to renumbered N.J.A.C. 11:21-3.2(a)2i to remove references to the Covered Charges with Special Limitations section of the standard policies and certificates because the SEH Board proposes to combine that section in the standard plans with the Covered Charges section in the standard plans, and if adopted, Covered Charges with Special Limitations will no longer be a separately named section.

The SEH Board proposes amending renumbered N.J.A.C. 11:21-3.2(a)5v(3), (4) and (5) to clarify that the availability of an increasing rider creates two distinct plans, one distinct plan with the rider and another distinct plan without the rider and carriers must offer each plan to all small employers.

The SEH Board proposes amending N.J.A.C. 11:21-3.2(c) to remove the requirement to file Exhibit BB Part 6 since riders are no longer sold as separate riders but rather are embedded in some plans. The SEH Board proposes to repeal Exhibit BB Part 6.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-4 is necessary because N.J.A.C. 11:21-4 sets forth the standard policy forms that carriers are required to use in issuing the standard plans. The subchapter references the Exhibits in the Appendix to N.J.A.C. 11:21

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 SEH Board's standard for review, and guidance for a carrier's use of a compliance and variability rider.

The SEH Board proposes amending N.J.A.C. 11:21-4.1(a) to delete an erroneous reference to Exhibit V which is currently reserved. The SEH Board proposes to delete N.J.A.C. 11:21-4.1(g) because it is redundant with paragraph (c) of that rule; paragraph (h) would be renumbered as paragraph (g) accordingly. The SEH Board proposes amending N.J.A.C. 11:21-4.2(a)1 to delete the reference to Exhibit BB Part 6 which is proposed to be repealed. The proposed amendment to N.J.A.C. 11:21-4.4(c) is to correct an incorrect citation.

N.J.A.C. 11:21-5 is reserved.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-6 is necessary because N.J.A.C. 11:21-6 sets forth the requirements for the employer application form, employer certification form, and waiver form used by small employers in obtaining and renewing small employer health benefits plans. 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 SEH Board is proposing to readopt N.J.A.C. 11:21-6 and the waiver form set forth at Exhibit T with an amendment to N.J.A.C. 11:21-6.4 with respect to the term eligible employee, as explained above and amendments to Exhibit T as discussed later in this proposal readoption.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-7 is necessary because N.J.A.C. 11:21-7 sets forth the key elements for SEH Program compliance for carriers. Included in the requirements are standards for carriers with respect to the determination of small employer

status; eligibility and issuance; restrictions on changing plans; minimum employee participation requirements; minimum employer contribution requirements; open enrollment periods; 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 SEH Board is proposing amendments to N.J.A.C. 11:21-7.2(a), (c) and (e)2, and proposing to delete paragraph (b) and (e)1 to remove references to eligible employee and the two-part definition of small employer consistent with the proposed amendments to those definitions as discussed above. The SEH Board is proposing to add a reference at paragraph (c) to identify full-time employees for purposes of the definition of small employer as those individuals generally working 30 hours per week, consistent with the standards of Federal regulations at 26 CFR 54.4980H-1(a)(21)(i). . In addition, the SEH Board is proposing to add language at N.J.A.C. 11:21-7.2(c)3 regarding who should and should not be included as an employee, to be consistent with 29 CFR 2510.3-3, while deleting the references to (c)1 and (c)2, because the standard is not specific to just those two provisions.

The SEH Board is proposing to delete N.J.A.C. 11:7.3(a)4i(1) and (2) to remove references to a two-part definition of small employer.

The SEH Board proposes an amendment to N.J.A.C. 11:21-7.5(a) to define the employees to be considered when calculating the 75 percent participation requirement. The SEH Board recognizes that participation is currently measured using “eligible employees” which means employees working 25 or more hours per week. Since full-time continues to be defined in the standard plans as 25 hours per week for purposes of eligibility for coverage, the SEH Board proposes using the full-time employee reference to define the employees considered in the participation requirement calculation. The SEH Board proposes an additional amendment to

N.J.A.C. 11:21-7.5(a) to include participation credit for coverage under an individual plan with respect to business through the Small Business Health Options Program (SHOP) only as required by 45 CFR 155.705(b)(10). The SEH Board notes that for purposes of the SHOP full-time is defined as 30 hours for all purposes, not just the definition of small employer.

The SEH Board is proposing an amendment to N.J.A.C. 11:21-7.7A(b) to add a court order requiring coverage of a dependent as a triggering event, as required by 45 CFR 155.420(b)(2)(v).

The SEH Board is proposing to add language at N.J.A.C. 11:21-7.10 to require carriers selling health benefits plans without an embedded pediatric dental benefit to obtain reasonable assurance that purchasers obtain pediatric dental coverage from a qualified stand-alone dental plan. The Board is proposing this because 42 U.S.C. 18022 states that pediatric dental services are part of essential health benefits that are to be offered as part of qualified health plans. However, Federal regulations at 45 CFR 155.1065 permit pediatric dental benefits either to be embedded in the medical plan or secured as stand-alone benefits, provided that carriers will secure a reasonable assurance that pediatric dental benefits have been obtained.

Consistent with the proposed deletion of the defined term “allowed charge,” the SEH Board proposes repealing N.J.A.C. 11:21-7.13. N.J.A.C. 11:21-7.13(a) requires carriers to use a standard that has not been updated since 2010. The standard is used solely with respect to the out of network benefits provided under a small employer plan that features out of network benefits such as a preferred provider organization plan (PPO) or point of service plan (POS). The application of the standard is further limited by the fact that New Jersey law precludes payment of benefits at the out of network level in emergency situations (N.J.A.C. 11:4-37.3, 11:24-5.3, N.J.A.C. 11:24-9.1(d), N.J.A.C. 11:24A-2.5 and 2.6) and while the member is an

inpatient with respect to services provided during the hospitalization such as anesthesia and radiology (N.J.A.C. 11:22-5.8(b)). The SEH Board refers to the small percent of claims to which out of network reimbursement is applied as voluntary out of network claims to distinguish them from out of network claims that are processed subject to New Jersey law cited above such that the member is held harmless.

Because the SEH Board has defined the basis for paying voluntary out of network benefits for over 20 years, it is important to consider why this has been the case. P.L. 1992 c. 162 charged SEH Board with the development of standard policy forms. When developing the standard policy forms in early 1993 the SEH Board reviewed policy forms from a host of carriers to ensure that the benefits included in the standard plans would be comparable to the benefits small employers purchased prior to standardization. At that time the only plans using network negotiated rates were HMO plans, and HMO coverage was not widely selected. For the most part, employers bought indemnity plans which had no networks, no requirements for referrals and patients selected doctors and hospitals at will. Carriers paid the allowed charge for the submitted bills subject to applicable cost sharing. Because an allowed charge determination was a key element of the insurance benefit for every claim, the SEH Board determined that standardization of the policy forms necessitated standardization of the determination of allowed charge. Some of the larger carriers such as Prudential and Horizon (at the time known as Blue Cross Blue Shield) had sufficient claims data to develop their own allowed charge data bases. Smaller carriers relied on Health Insurance Association of America (HIAA) data. To ensure all carriers could have access to and be able to use the same basis to determine the allowed charge, the Board proposed and adopted regulations that required carriers to use the 80th percentile of

HIAA data. Through purchases the data later became known as the Prevailing Healthcare Charges System (PHCS) and was owned by Ingenix.

As managed care plans with out of network benefits such as PPO and POS were introduced in the late 1990s consumers and employers began to buy such plans because they were generally less expensive than indemnity plans and allowed members the opportunity to use out of network providers. Services rendered by network providers are covered subject to negotiated rates. The PHCS data was used solely in cases in which the patient voluntarily chose to use an out of network provider and thus became less significant in terms of standardization.

In 2016, all plans offered in the small employer market are network-based managed care plans. HMO and Exclusive Provider Organization (EPO) plans are network only plans and do not cover any voluntary out of network services, while PPO and POS plans include out of network benefits. Yet, the number of available PPO and POS plans has diminished primarily because plans with out of network benefits are more expensive than network only HMO and EPO plans. Some small employers still demand the opportunity to buy plans with out of network benefits, but as of 4Q15 only 28 percent of small employer plans feature out of network benefits.

As a result of legal action in New York the PHCS data base was eliminated in 2010. No updated data has been produced since that time. As required by regulation, small employer carriers that already had the 2010 data have continued to process voluntary out of network claims using 2010 data. Carriers that did not exist in 2010 have no ability to access the 2010 PHCS data and thus have not been able to offer plans with out of network benefits, impeding employer choice and potentially skewing market competition.

Although small employers and their employees prefer plans with out of network benefits many do not buy them because they are more expensive than EPO and HMO plans. The SEH

Board believes that allowing carriers to use an appropriate basis to determine the allowed charge would help bring the premiums closer to the premiums for comparable EPO and HMO plans and expand employer choice.

The SEH Board notes that small employer plans feature cost sharing incentives for patients to use network providers and as a result most care is rendered by network providers and is paid based on the negotiated fee. However, carriers report that from 10 percent to 20 percent of claims dollars are spent on out of network services and have explained that low utilization of out of network services does not equate to low claims dollars because of the higher cost of out of network services. Thus a low volume of claims produces significant claims expenses which has an impact on premiums. Thus, there are multiple inequities in having some carriers using increasingly outdated data that other carriers cannot even purchase. The SEH Board believes that elimination of the reimbursement standard at N.J.A.C. 11:21-7.13 would be more equitable for the small employer market as a whole.

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The SEH Board believes the necessity to standardize the determination of allowed charge that arose from the indemnity plan products available in 1993 does not exist in 2016. As explained above, most care is provided by network providers. The SEH Board considered mandating a replacement for PHCS but determined that a standardized basis to determine the allowed charge for a low volume of claims is not warranted. The SEH Board hopes to encourage carriers to offer more plans with out of network benefits. Carriers in the large group market already offer many plans with out of network benefits and have multiple methods to determine the allowed charge for out of network benefits under such plans. The SEH Board believes giving small employer carriers the opportunity to determine the allowed charge for voluntary out of

network benefits under small employer plans will encourage small employer carriers to make more plans with out of network benefits available. It is worth noting that New Jersey has been unique as compared to other states in terms of regulating the basis for the determination of the allowed charge for voluntary out of network claims. As a result, carriers offering plans in the small employer market have been required to use a basis that is specific to the New Jersey small employer market for that small segment of business whereas in the large group market in New Jersey as well as all markets in which the carriers offer plans in other states, have used the basis the carrier determined to be best suited for voluntary out of network claims.

The SEH Board notes a common concern with PHCS was its lack of transparency. Thus, as part of proposed amendments to the standard plans set forth in exhibits in the Appendix to N.J.A.C. 11:21, the SEH Board proposes to require carriers to specifically identify the standard for the determination of allowed charges within the definition of allowed charge contained in the standard plans. The SEH Board is proposing that the standard used by a carrier must allow consumers the opportunity to learn the allowed charge amount for any given service or supply.

The SEH Board notes that N.J.A.C. 11:21-7.13 also includes language in paragraph (b) establishing an exemption from the reimbursement method with respect to the payment of claims for prosthetics and orthotics, because a different standard for paying claims for those services is required by statute. The Board is proposing to delete the exemption, because there would be no reason for an exemption if the general out-of-network reimbursement method is deleted. In addition, carriers must comply with the prosthetic and orthotic statutes (see, N.J.S.A. 17B:27A-19.17) whether or not the SEH Board sets forth the obligation in its rules.

The SEH Board proposes the repeal of N.J.A.C. 11:21-8, which requires carriers to annually certify whether they are nonmembers of the SEH Program, because the Board believes

this rule is no longer necessary, given changes over the years to the SEH Program. In addition, since SEH Program member is defined in N.J.S.A. 17B:27A-17 to mean carriers issuing health benefit plans and health benefit plans is limited to those plans issued to small employer groups, the universe of carriers that are members is well-known to the SEH Board. The SEH Board believes the completion of the non-member certification places an unnecessary filing requirement on carriers that are not members and provides no information that is not already known to the SEH Board; thus, consistent with the goals of the New Jersey Red Tape Commission, proposes to repeal the rule and remove the reporting requirement. The Board proposes a concomitant repeal of Exhibit KK in the Appendix to N.J.A.C. 11:21.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-10 is necessary because N.J.A.C. 11:21-10 sets forth annual reporting requirements of market share data for the assessment of operational and administrative expenses of the SEH Program.

The SEH Board is proposing to delete N.J.A.C. 11:21-10.2 which is intended to set forth definitions that are particular to subchapter 10. Since there are no such definitions, the SEH Board determined the section is not necessary.

The SEH Board is proposing grammatical amendments at N.J.A.C. 11:21-10.3(a)1 for purposes of accuracy and clarity.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-17 is necessary because N.J.A.C. 11:21-17 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 SEH Board is proposing to repeal N.J.A.C. 11:21-17.4 which addresses the listing of premium for ridered plans separately from the premium for the standard health benefits plan. The SEH Board has determined the rule is unnecessary. As explained with respect to proposed amendments N.J.A.C. 11:21-3.2, the availability of riders creates distinct plans under the ACA, and rates are already required to be displayed for all distinct plans in accordance with the Federal law.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-18 is necessary because N.J.A.C. 11:21-18 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 SEH Board is proposing to readopt N.J.A.C. 11:21-18 without amendments.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-23 is necessary because N.J.A.C. 11:21-23 sets forth the procedures that the SEH 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. The SEH Board is proposing to amend N.J.A.C. 11:21-23.2(a)2 and 23.5(c)3 to update the Department's website address.

Discussion of Amendments and Repeals to the Appendix

The SEH Board has determined that readoption of the Appendix to N.J.A.C. 11:21 is necessary for the operation of the SEH Program. The Appendix contains the standard health benefits plans (standard plans) that may be offered in the small employer market in New Jersey, pursuant to authority of P.L. 1992, c. 162 (codified at N.J.S.A. 17B:27A-17 et seq.), as

subsequently amended and supplemented, instructions to carriers on how to use bracketed language in the standard plans, enrollment-related forms, and multiple reporting forms. The language for the policy forms for the standard plans known as Plans B, C, D, and E is in Exhibit F of the Appendix, while the language of the certificates is contained in Exhibit W; the language for the contract form for the HMO Plan is in Exhibit G; the language for the HMO evidence of coverage is in Exhibit Y; and the language for the HMO-POS Plan contract form is in Exhibit HH, while the language for the HMO-POS evidence of coverage is in Exhibit II. In developing their policies/contracts and certificates/evidences of coverage, carriers also refer to Exhibit K, which provides explanations about how carriers may use certain variable language in the standard plans.

The following proposed amendments generally apply to each of the standard plans set forth in Exhibits F, G, W, Y, HH, and II and are substantially the same across the exhibits.

The SEH Board is proposing numerous grammatical changes throughout the forms to enhance accuracy and consistency in the texts. Among other things, these proposed changes include more consistent capitalization of defined terms, and numerical changes primarily to reflect changes in years.

To comply with 45 CFR 155.205(c)(2)(iii)(A) the SEH Board proposes including direction to carriers to include language tagline information to alert consumers that are not English speakers and/or readers to resources for obtaining information and help in other languages.

As required by 45 CFR 147.126(a)(2)the annual limits specified for out of network preventive services and for out of network use of an ambulatory surgical center are proposed to

be deleted. The SEH Board notes that while annual limits cannot be applied to non-network preventive services carriers may apply non-network cost sharing to non-network preventive services.

The SEH Board proposes an amendment to the Participation Requirements provision consistent with the amendment to N.J.A.C. 11:21-7.5(a) to define the employees to be considered when calculating the 75 percent participation requirement. The SEH Board proposes calculating the participation requirement using full-time employees which means employees working 25 or more hours per week.

The SEH Board proposes an amendment to the payment of claims provision to allow carriers to address reimbursement policy guidelines as commonly used by the industry and Medicare. For example, reimbursement policy guidelines address circumstances of charges being included within another charge such that there should not be a separate liability. The text is proposed as variable meaning a carrier may choose whether or not to include the text.

The SEH Board proposes an amendment to the definition of allowed charge to replace the text referring to a standard approved by the Board with direction for carriers to specify the methodology for determining allowed charges and requiring carriers to explain how a consumer can learn the allowed charge for services to be received. This amendment to the standard plans is being proposed for the reasons already stated with respect to the proposed repeal of N.J.A.C. 11:21-7.13. In addition, the SEH Board proposes removing the statement that the section of the standard plans discussing coordination of benefits contains a distinct definition of allowed charge, because this statement unnecessarily emphasizes the fact that the coordination of benefits provision contains specific definitions.

The SEH Board proposes combining the section entitled Covered Charges with the section entitled Covered Charges with Special Limitations. Since inception the non-HMO standard plans have included distinct sections to specify covered charges and covered charges with special limitations. Benefits were generally included in the Covered Charges with Special Limitations section because of internal limits such as dollar limits. Since 45 CFR 147.126(a)(2) prohibits the imposition of dollar limits on essential health benefits the distinction between covered charges and covered charges with special limitations is less important. For simplicity, the SEH Board proposes combining the covered charges under one section called covered charges. Throughout the standard plans all references to covered charges with special limitations are proposed to be deleted.

The SEH Board previously adopted amendments to the standard plan provision for treatment of autism and other developmental disability to address the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity Equity and Addiction Act of 2008 (MHPAEA), Public Law 110-343;, section 511 and 512; as implemented in regulations by the U.S. Department of Labor at 29 CFR 2590.712; and the U.S. Department of Health and Human Services at 45 CFR 147.160. The SEH Board neglected to similarly amend the definition of developmental disability to remove the age 22 limit. In addition, to comply with Rosa's Law (Pub. L. 111-256) the term mental retardation as used in the definition of developmental disability is replaced with intellectual disability.

As discussed above with respect to the proposed repeal of the term eligible employee, the SEH Board proposes to delete the definition of employee in the standard plans that was based on the term eligible employee. The SEH Board proposes to amend the remaining definition of employee to clarify that an individual and spouse, if at least one of them owns the business,

cannot be considered an employee. Related to the employee definition, the SEH Board proposes to amend the definition of full-time to note that the definition of small employer uses a definition of full-time that is specific to the definition of small employer.

The SEH Board proposes to amend the standard plans throughout to recognize a change in the name of the Joint Commission on the Accreditation of Health Care Organizations to The Joint Commission, and is relocating the related definition alphabetically.

The SEH Board proposes to add a definition of primary care provider consistent with the definition in N.J.A.C. 11:22-5.2. All references in the standard plans to primary care physician are proposed to be amended to use the term primary care provider instead.

The SEH Board is proposing to amend the definition of Skilled Nursing Facility to remove reference to specific types of nurses, and simply refer to Nurse and nursing services, because the specificity is unnecessary for purposes of defining the type of facility in question and the term Nurse is a defined term in the standard plans.

The SEH Board is proposing to amend the definition of small employer in the standard plans for the reasons discussed above with respect to the proposed amendment of the term small employer at N.J.A.C. 11:21-1.2, and to assure that the rules and the standard plans are consistent.

The SEH Board proposes to expand the optional definition of telemedicine to address audiovisual means.

The SEH Board proposes an amendment to the Continuation of Care provision to address a situation in which the provider attests that discontinuance of care would worsen the patient's condition or interfere with anticipated outcomes. The proposed amendment is consistent with 45 CFR 156.230(d)(2)(i)(D).

The SEH Board proposes to delete the provision entitled Payment Limits because dollar limits are prohibited by 45 CFR 147.126(a)(2).

The SEH Board proposes to include optional text in the prescription drug provision of the Covered Charges section to address the option for a "split-fill" of certain specialty drugs. Carriers may elect whether to use the optional text. The split fill is intended to help manage the use of medications that often have side-effects and may need to be changed before the supply of the medication is completely used; split fill avoids leaving the patient with unused medication for which the patient has paid the cost sharing.

In order to be consistent with 29 CFR 2590.701-3(a) and 45 CFR 147.108, which prohibit both actual preexisting condition exclusions and provisions that may have the effect of excluding coverage of preexisting conditions, the SEH Board proposes an amendment to the dental care and treatment provision to state that all treatment must be finished within six months following the later of the date of the injury or the effective date of the person's coverage. This amendment would assure treatment of injuries occurring prior to the effective date of coverage is not excluded.

The SEH Board proposes to delete all references in the standard plans to sole discretion belonging to the carrier in certain decision-making in order to be compliant with N.J.A.C. 11:4-58.3.

To comply with provisions of the ACA addressing nondiscrimination (42 U.S.C. 18116), and guidance from the Office of Civil Rights within the Department of Health and Human Services, including recently adopted 45 CFR 92.1 et seq. implementing 42 U.S.C. 18116, the SEH Board is proposing to delete the exclusion of coverage for surgery, hormones, and related medical, psychological and psychiatric services to change a covered person's gender, including

services and supplies arising from complications of sex transformation. The recently adopted Federal regulations at 45 CFR 92.207, and other Federal guidance, would not permit discrimination in the provision of coverage or claims payment based on the fact that an individual's sex assigned at birth is different from the one to which particular health care services are ordinarily or exclusively available, and further, would prohibit categorical exclusion or limitation of coverage for all health services related to gender transition. Neither the Federal law nor removal of the exclusion requires carriers to cover services they do not otherwise cover; rather, carriers would not be permitted to exclude benefits for covered services based on the underlying health condition or the covered person's gender.

In addition, the SEH Board proposes amendments to Exhibits D, T, BB, CC and KK.

The SEH Board proposes to amend the Over-Age Dependent Coverage Rider set forth as Appendix Exhibit D to revise the limiting age to 26 consistent with the requirements of Federal law. Pursuant to the ACA, and implementing regulations at 45 CFR 147.20, carriers are required to permit coverage of child dependents up to the age of 26. This requirement has been in effect since 2010. The Board has inadvertently not updated the Over-Age Dependent Coverage Rider, which permits the coverage of child dependents up to the age of 31 under New Jersey law. The SEH Board proposes changing the limiting age from 19 or 23 years old to 26 years old consistent with the Federal law.

The SEH Board proposes to amend Exhibit T, which contains the form employees typically use to waive a small employer's offer of coverage. The form needs to be updated because of changes resulting from the ACA; thus, the Board proposes to remove reference to the possibility of late enrollees being subject to a preexisting condition limitation period when they

enroll in the small employer's plan, and adjust the duration of subsequent enrollment opportunities.

The SEH Board proposes to amend Part 1 and repeal Part 6 of Exhibit BB, also known as The Certification of Compliance with Small Employer Health Benefits Plan. Part 1 of Exhibit BB requires carriers to submit plan-specific information. Because of changes in the regulatory process with the passage of the ACA, the SEH Board believes that submission of the information in Exhibit BB is unnecessary because of other reporting requirements with which carriers must comply. Accordingly, the SEH Board proposes to delete the requirements for carriers to provide plan-specific information. With respect to Part 6 of Exhibit BB, which is the form carriers have been required to use annually to report information about optional benefit riders, the SEH Board proposes to delete all of Part 6, for the reasons discussed regarding proposed amendments to N.J.A.C. 11:21-3.2.

The SEH Board proposes amendments to the Market Share Report found in Appendix Exhibit CC to provide additional explanatory instructions regarding the information required to be filed for affiliated carriers and to address the reduction in net earned premium by the amount of refunds paid.

For the reasons noted in the discussion regarding the proposed repeal of N.J.A.C. 11:21-8, the SEH Board proposes repeal of Exhibit KK, Certification of Non-member Status, the reporting form associated with N.J.A.C. 11:21-8.

SEH Rulemaking Procedures

The SEH Board is proposing these amendments in accordance with the special action process established at N.J.S.A. 17B:27A-51, as an alternative to the common rulemaking process specified at N.J.S.A. 52:14B-1 et seq. Pursuant to N.J.S.A. 17B:27A-51, the SEH Board may

expedite adoption of certain actions, including modification of the SEH Program's health benefits plans and policy forms, if the SEH Board provides interested parties a minimum 20-day period during which to comment on the Board's intended action following notice of it in three newspapers of general circulation, with instructions for obtaining a detailed description of the proposed action and the manner for submitting comments to the Board. Concurrently, the SEH Board must forward notice of the proposed action to the Office of Administrative Law (OAL) for publication in the New Jersey Register (note, however, that the comment period runs from the date the notice of the proposed action is submitted to the newspapers and OAL, not from the date of publication of the notice in the New Jersey Register.) The SEH Board is also required to send notice of the intended action to affected trade and professional associations, carriers, and other interested persons who may request such notice. In addition, for intended modifications to the health benefits plans, the SEH Board must allow for testimony to be presented at a public hearing prior to adopting any such modifications. The date, time, and place of the public hearing for these specific proposed amendments is presented at the beginning of this notice.

Subsequently, the SEH Board may adopt its proposed action immediately upon the close of the comment period or the public hearing (whichever occurs later) by submitting the adopted action to the OAL for publication. The adopted action is effective upon the date of its submission to the OAL, or such later date as the Board may designate. The Board need not respond to commenters as part of the notice of adoption, but if the Board does not, the Board will respond to (timely submitted) comments shortly thereafter in a separately-prepared report which will be submitted to OAL for publication in the New Jersey Register.

Because expedited actions adopted by the Board pursuant to N.J.S.A. 17B:27A-51 are accomplished notwithstanding the provisions of the Administrative Procedure Act, the quarterly

calendar requirement established by the Administrative Procedure Act (as amended) and set forth at N.J.A.C. 1:30-3.1 is not applicable when the Board uses its special rulemaking procedures. Please note that the SEH Board is allowing a 60-day comment period

Social Impact

The SEH Board expects the social impact of the proposed readoption with amendments and proposed repeals to be positive. The SEH Board believes N.J.A.C. 11:21 continues to fulfill its general purpose, which is to implement provisions of N.J.S.A. 17B:27A-17 et seq. Notwithstanding the enactment of Federal laws establishing standards for health benefits plans, there continues to be a significant role for the States in regulating their respective health insurance markets. The Board believes maintaining the existing regulatory scheme in New Jersey helps to maintain as stable and healthy a health insurance marketplace for small employers as is reasonably possible.

The SEH Board expects that a generally positive social impact will result from the proposal to further align how New Jersey determines eligibility for coverage under small employer health benefits plan with how Federal law distinguishes between large and small employers, and determines the existence of a group health plan. The SEH Board notes that the proposal to simplify the definition of employee and the determination of small employer status should ease confusion, reduce administrative hurdles, and reduce misinformation in the market, and make it easier for carriers, agents, and employers to operate appropriately.

The SEH Board anticipates that the proposal to eliminate N.J.A.C. 11:21-7.13 will have a positive social impact. Since 1994 N.J.A.C. 11:21-7.13 has required carriers to use data currently known as PHCS data to pay allowed charges for voluntary out-of-network services. However, the requirement has become untenable because the PHCS data became unavailable

after 2010, meaning that some carriers now offering standard health benefits plans in the small employer market have never had the opportunity to procure the PHCS data which means they cannot offer plans with out of network benefits, while carriers that have been in the SEH market for a longer time have continued to make reimbursements based on data that is increasingly outdated. The use of outdated data to pay out-of-network benefits is not beneficial for anyone: health care providers are not reimbursed using a current standard, members may not receive the benefits to which they would otherwise be entitled, and carriers are required to maintain a claims payment methodology of limited utility while establishing alternate systems for other lines of business in New Jersey, and in other jurisdictions for those carriers that also do business outside New Jersey. Further, all carriers consider the PHCS requirement to be a barrier to offering small employer health benefits plans with out-of-network benefits. The SEH Board's proposal to eliminate the requirement, and instead permit carriers to determine the allowed charge methodology which carriers will be required to explain in the policies, certificates or evidences of coverage issued to employers and employees will provide transparency to the out of network benefit calculation. The SEH Board expects that the proposed deletion of N.J.A.C. 11:21-7.13 will encourage carriers to offer more plans with out-of-network benefits, the pricing of such plans will be more competitive than it is now, and consumers will have information to make informed decisions regarding whether to voluntarily use out-of-network providers. It may be noted that the SEH Board recognizes that the underlying purpose of N.J.A.C. 11:21-7.13 which was to enhance standardization in the provision of benefits in the small employer market is no longer necessary or appropriate. As explained earlier in this proposal, the Board is not proposing a specific alternative reimbursement methodology in light of the relatively low utilization of voluntary out-of-network services today, which is a far different situation from the market that

existed in 1994. In addition, the methodologies carriers use for reimbursement of voluntary out of network claims in the large employer market in New Jersey and in other states has enabled carriers to offer plans with out of network benefits that provide meaningful benefits for persons who choose to use out of network providers. Both of these developments ease the concerns the Board had in the 1990s regarding the standardization of benefits and payment practices with respect to non-contracted health care providers.

The SEH Board believes the proposed deletion of the exclusion with respect to services related to sex transformation will have a positive social impact with respect to consumers and providers since medically necessary services and supplies that are currently covered to treat other types of medical conditions will be covered in connection with sex transformation. Carriers have noted that coverage of these services is being included under many large group plans and thus support a consistent approach with respect to small employer plans.

Economic Impact

The SEH Board anticipates the economic impact of the proposed readoption with amendments and proposed repeals to be generally positive. The SEH Board believes N.J.A.C. 11:21 continued to fulfill its general purpose by implementing provisions of N.J.S.A. 17B:27A-17 et seq. The Board believes that readoption of N.J.A.C. 11:21 with the amendments and repeals proposed will enhance the stability of the small employer health insurance market, and may result in more competitive pricing of products in the small employer health insurance market.

Specifically, the SEH Board expects a positive economic impact from the proposal to streamline the process for determining small employer status so that it aligns with the determination of status used under Federal law. There should be savings because of reductions

in the administrative costs of making the determination of small employer status, and there should be reduced costs associated with compliance efforts in other areas where compliance depends on the determination of employer size.

In addition, the SEH Board believes that the proposal to eliminate N.J.A.C. 11:21-7.13 will have a positive economic impact.

Use of the 2010 PHCS data modules has required carriers to bear the cost of maintaining multiple claims payment processes. In order to address the data gaps that exist with the 2010 PHCS data, carriers have been allowing full billed charges for voluntary out of network services. While considering the full billed charge as allowable may seem to benefit consumers such perception is flawed because such a structure necessarily results in increased premiums that are borne by all small employers and it discourages carriers from offering competitively priced plans with out-of-network benefits. In addition, carriers that entered the New Jersey small employer market after 2010 that cannot buy any PHCS modules and are thus at a competitive disadvantage in that they cannot offer plans with out of network benefits.

The proposal to remove N.J.A.C. 11:21-7.13 will allow carriers to use more appropriate methodologies to determine allowed charges for voluntary out of network services. Those carriers that have been maintaining the system will save costs by eliminating that administrative burden, and all carriers will benefit by integrating their claims payment processes for the small employer market into their systems for other lines of business. Many health care providers are also likely to benefit economically from the proposed change because it will eliminate one methodology and bring the payment system more in line with what each payer is doing in other markets (typically, the large group business, where far more claims are generated) allowing providers to better anticipate the allowed charge for services. As noted above, the transparency

of the methodology will provide access to information that was previously unknown to out of network providers.

It is more difficult to discern the actual economic impact on covered members/patients. However, the proposal seeks to increase transparency in the allowed charge methodology for all parties concerned, including members. The SEH Board is proposing that carriers explain what the methodology is, and how members can obtain more information about the allowed charges for particular services. The Board anticipates that as members become more aware of the ability to access this information, they will benefit in the decision whether to seek voluntary services out-of-network, and find lower costs when they are able, or at least be knowledgeable about what costs to expect, and what costs they will need to finance themselves. Overall, the SEH Board believes that increased information will benefit consumers economically.

Federal Standards Statement

State agencies that propose to adopt or amend State rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. The proposed readoption with amendments is subject to Federal requirements addressing certain standards for health insurance contracts. The SEH Board does not believe the proposed readoption with amendments exceeds the Federal requirements.

Jobs Impact

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

Agriculture Industry Impact

The SEH Board does not believe the proposed readoption with amendments will have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

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

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

Housing Affordability Impact Analysis

The SEH Board does not believe the proposed readoption with amendments will have an impact on housing affordability in this State in that the proposed readoption with amendments relates to the benefit levels and terms of standard health benefits plans offered in New Jersey for purchase by small employers.

Smart Growth Development Impact Analysis

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

Full text of the proposal follows:

11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended (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.

(b) Provisions of the New Jersey Small Employer Health Benefits Act and of this chapter shall be applicable to all carriers that are members of the Small Employer Health Benefits Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Small Employer Health Benefits Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

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.

"Act" means P.L. 1992, c.162, as adopted and subsequently amended (N.J.S.A. 17B:27A-17 et seq.), also referred to herein as the Small Employer Health Benefits Act.

"Affiliated carrier" means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another carrier.

"Affiliated company" means a person that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another person. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

["Allowed charge" means an amount that is not more than the lesser of the allowance for the service or supply as determined by the standard approved by the Board as set forth at N.J.A.C. 11:21-7.13 or the negotiated fee schedule.]

"Board" means the Board of Directors of the New Jersey Small Employer Health Benefits Program established by the Act.

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company authorized to issue health insurance, a health maintenance organization, a hospital

service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this chapter, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Carrier coinsurance" means the percentage of a covered charge paid by a carrier.

"Cash deductible" or "deductible" means the amount of covered charges that a covered person must pay before the health benefits plan pays any benefits for such charges.

"Coinsurance" means the percentage of a covered charge that must be paid by a covered person. Coinsurance does not include cash deductibles, copayment, or non-covered charges.

"Commissioner" means the Commissioner of **the** New Jersey Department of Banking and Insurance.

"Copayment" or "copay" means a specified dollar amount a covered person must pay for specified covered charges.

"Department" means the New Jersey Department of Banking and Insurance.

"Dependent" means the spouse or child of [an eligible] **a full-time** employee subject to applicable terms of the employee's health benefits plan. [The] **For purposes of dependent eligibility only, the** reference to "spouse" includes a civil union partner pursuant to P.L. 2006, c.

103, and same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage, except that spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended. At the option of the small employer, "spouse" includes a domestic partner pursuant to P.L. 2003, c.246.

["Eligible employee" means a full-time, bona fide employee who works a normal work week of 25 or more hours. The term excludes a sole proprietor, a partner of a partnership, or an independent contractor and does not include employees who work less than 25 hours a week, work on a temporary or substitute basis, or are participating in an employee welfare arrangement pursuant to a collective bargaining agreement.]

"Employee"[as used in paragraph 2 of the definition in this section of "small employer"] means an individual who is an employee under the common law standard as described in 26 CFR 31.3401(c)-1. **For purposes of determining whether an employer is a small employer**, [Employee] **employee** excludes **an individual and his or her spouse when the business is owned by the individual or by the individual and his or her spouse,** a sole proprietor, a partner in a partnership, and more than a two percent shareholder in a Subchapter S corporation as well as immediate family members of such individuals. Employee also excludes a leased employee.

"Employee open enrollment period" means the 30-day period each year designated by the small employer during which:

1. Employees and dependents who are eligible under the small employer's plan but who are late enrollees may enroll for coverage under the small employer's plan; and

2. Employees and dependents who are covered under the small employer's plan may elect coverage under a different policy, if any, offered by the small employer.

"Employer open enrollment period" means the period from November 15 through December 15 each year [beginning in 2014] **during which minimum participation and contribution requirements do not apply in accordance with 45 CFR 147.104**.

"Enrollment date" means, with respect to a person covered under a health benefits plan, the date of enrollment of the person in the health benefits plan or, if earlier, the first day of the waiting period for such enrollment. If an employee changes plans or if the employer transfers coverage to another carrier, the covered person's enrollment date does not change.

“Full-time employee” as used to determine eligibility for coverage under a small employer health benefits plan and satisfaction of participation requirements means an employee who works a normal work week of 25 hours or more hours per week. Note that the determination of small employer status in N.J.A.C. 11:21-7.2 uses a different definition of full-time employee.

"Group health plan" means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital or medical services corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any

carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19), or any other similar contract, policy or plan issued to a small employer not explicitly excluded from the definition of health benefits plan. For purposes of this Act, "Health benefits plan" shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395(g)(1)); and coverage supplemental to the coverage

provided under chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

"Health status-related factor" means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

"Late enrollee" means [an eligible] **a full-time** 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.

"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.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

"Medical care" means amounts paid:

1. For the diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and

2. Transportation primarily for and essential to medical care referred to in paragraph 1 above.

"Medicare" means coverage provided pursuant to Title XVIII of the Federal Social Security Act, Pub. L. 89-97 (42 U.S.C. § 1395 et seq.) and amendments thereto.

"Member" means a carrier that issues health benefits plans in New Jersey on or after November 30, 1992.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, as determined by the commissioner and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"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.

"Plan sponsor" has the meaning given that term under Title I of section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(16)(B)).

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to the Act.

"Public health plan" means any plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

"Small employer" means[:

1. In connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible employees on

business days during the preceding calendar year and who employs at least one eligible employee on the first day of the plan year; or

2. In]**in** connection with a group health plan with respect to a calendar year and a plan year, an employer with a business location in the State of New Jersey who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year; and who employs at least one employee on the first day of the plan year.

[With respect to 1 and 2 above, any] **Any** person treated as a single employer under subsection (b), (c), (m), or (*o*) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer. **Additionally, small employer includes an employer that employs more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers. As used in the definition of small employer full-time means an employee works 30 or more hours per week.**

"Small employer carrier" means any carrier that offers health benefits plans covering [eligible] **full-time** employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan issued to small employers pursuant to N.J.S.A. 17B:27A-19.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board, described at N.J.A.C. 11:21-3.1, and set forth in the Appendix to this chapter.

"State" means the State of New Jersey.

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Small Employer Health Benefits Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $ 20,000 per covered person per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

11:21-1.3 Communications with the Board

All written communications with the SEH Board shall be submitted to the SEH Board at the following address:

New Jersey Small Employer Health Benefits Program Board

20 West State Street, 11th Floor

PO Box 325

Trenton, New Jersey 08625-0325

Fax: (609) 633-2030

E-mail: [ellen.derosa@dobi.state.nj.us]**ellen.derosa@dobi.nj.gov**

11:21-1.4 Penalties

Failure of a carrier to comply with any provision of this chapter shall result in the 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.

11:21-1.5 Severability

If any provision of this chapter or the application thereof to any person or circumstance is found to be invalid for any reason, the remainder of the chapter and the application thereof to other persons or circumstances shall not be affected thereby.

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

11:21-2.1 Purpose[and structure]

(a) The Program has been created pursuant to section 12 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-28) as amended to assure the availability of the [five] standardized health benefits plans to New Jersey small employers, their [eligible] **full-time** employees and the dependents of those [eligible] **full-time** employees, on a guaranteed issue basis.

(b) The Board has been created pursuant to Section 13 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-29) to administer the Program reasonably and equitably under law.

(c) The Program Plan of Operation ("Plan") has been created in accordance with Section 14 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-30) to set forth as completely as possible the reasonable and equitable manner by which the Board will administer the Program under applicable law.

[(d) The Program shall be administered by the Board. The Board shall administer the Program in accordance with the Plan developed and adopted by the Board pursuant to law, subject to the review and approval of the Commissioner of Insurance.

(e) The Board shall consist of 18 persons, including the Commissioners of Health and Senior Services and Banking and Insurance or their designees, both of whom shall serve ex officio, and 10 public members who shall be elected by the members of the Program, subject to approval by the Commissioner, and six public members who shall be appointed by the Governor with the advice and consent of the Senate. Initially, three of the elected public members of the Board shall be elected for a three year term, three shall be elected for a two year term, and three shall be elected for a one year term. The tenth elected public member, added by P.L. 1994, c.97, shall be elected for a three year term. 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. 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. Thereafter, all public members of the Board shall be elected or appointed 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. No carrier shall have more than one representative on the Board, nor shall an HMO carrier and its affiliated insurance company, health service corporation, hospital service corporation, or medical service corporation have more than one representative on the Board.

(f) The following categories shall be represented among the elected public members:

1. Three carriers whose principal health insurance business is in the small employer market;

2. One carrier whose principal health insurance business is in the larger employer market;

3. A health, hospital or medical service corporation;

4. Two health maintenance organizations; and

5. Three persons representing small employers, at least one of whom represents minority small employers.

(g) The following categories shall be represented among the appointed public members:

1. Two insurance producers licensed to sell health insurance pursuant to N.J.S.A. 17:22A-1 et seq.;

2. One representative of organized labor;

3. One physician licensed to practice medicine and surgery in this State; and

4. Two persons who represent the general public and are not employees of a health benefits plan provider.]

11:21-2.2 Definitions

The words and terms used in this Plan shall have the meanings set forth at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.2 or as further defined below:

["Administrator" or "Executive Director" means that person, persons, or entity selected by the Board to effectuate the administrative functions of the Program.]

"Deferral" means a deferment, in whole or in part, of payments by a member of any assessment issued by the SEH Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-38 and N.J.A.C. 11:21-15.

"Earned premiums" means the premium earned in New Jersey on health benefits plans less returned premiums thereon.

"Executive Director" means that person, persons, or entity selected by the Board to effectuate the administrative functions of the Program.

"Plan of Operation" means the plan of operation of the Program, including articles, by-laws and operating rules approved by the Board pursuant to the Act.

11:21-2.3 Powers of the Board

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

1. Adopt rules and regulations to establish a voluntary risk pooling arrangement.

2. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Act;

3. Sue or be sued, including taking any legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims;

4. Establish benefit levels, deductibles and copayments, exclusions, and limitations for the standard health benefits plans in accordance with applicable law;

[5. Establish additional policy forms by which a small employer carrier, other than a health maintenance organization, may provide indemnity benefits for health maintenance organization enrollees by direct contract with the enrollees' small employer through the issuance of dual contracts to the small employer;]

[6]**5.** Assess members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organization and reasonable operating expenses. Such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

[7]**6**. Establish rules, conditions and procedures pertaining to the assessment of the members of the Program;

[8]**7**. Establish [a] standard policy [form]**forms** for [five]**the** standard health benefits plans and [five] rider packages, as provided in the Act;

[9]**8**. Appoint from among the members appropriate legal, actuarial, and other committees as necessary to provide technical and other assistance in the operation of the Program, policy and other contract design, and any other functions within the authority of the Program;

[10]**9**. Employ or retain such persons, firms or corporations to perform such functions as are necessary for the Board's performance of its duties. The Board may use the mailing address of such person, firm or corporation as the official address of the Program. Such persons may include an [Administrator or] Executive Director with such authority as may be delegated by the Board to implement and carry out broad directives of the Board made pursuant to statutory powers. Such persons may include actuaries, accountants, auditors, insurance producers and such other specialists or persons whose [advise]**advice** or assistance is deemed by the Board to be necessary to the discharge of its duties under the Act. The Board may agree to compensate such persons so as best to serve the interests of the Program and the public. Such persons, firms or corporations shall keep and maintain such records of their activities as may be required by the Board.

[11]**10**. Develop a method of handling and accounting for assets and moneys of the Program and an annual fiscal reporting to the Commissioner;

[12]**11.** Develop a means of providing for the filling of vacancies on the Board, subject to the approval of the Commissioner;

[13]**12**. Address any additional matters which are appropriate to effectuate the provisions of this Act; and

[14]**13**. Develop a buyers' guide or other informational material for the Program[, and provide for a reasonable charge for the use and distribution of such informational material].

11:21-2.4 Plan of Operation

(a) The Board shall perform its function under this Plan, and in accordance with the Act. The Plan is intended to assure the fair, reasonable and equitable administration of the Program and shall constitute a public record and accordance with the Act.

(b) The Plan does not, nor is it intended to, create any contractual or other rights or obligations between the Program and any entity or any person insured by any carrier. It does not provide any benefits or create any obligation, contractual or otherwise, to any person or entity.

11:21-2.5 Board structure and meetings

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

1. The Board shall be made up of the Commissioner, the Commissioner of Health [and Senior Services], or their designees (who shall serve ex officio) and 16 public members. The composition of the Board shall be as described in N.J.S.A. 17B:27A-29 as amended. No person representing one of the public members shall serve, or continue to serve, on the Board unless such person represents one of the categories specified in N.J.S.A. 17B:27A-29 as amended.

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

ii. Following the close of the nomination period, the Board shall determine from among the carriers and/or small employers representatives nominated those persons that are eligible and willing to serve in the position for which nominated. Carriers may be placed on the ballot for only one position, and may not hold more than one seat on the Board. If a carrier is nominated for two or more positions for which it is eligible, the carrier shall notify the Board as to the single position for which it will accept the nomination, and be designated on the ballot.

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

iv. Affiliated carriers shall have no more than one vote for each position subject to vote and no two affiliated carriers shall serve on the Board at the same time.

v. Elections shall be by the highest number of votes properly cast in person and absentee.

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. 11:21-2.11.

3. The Board may elect a Chair and Vice Chair from among its Directors, as well as other officers, as it deems appropriate. The election of officers shall be held annually or more frequently if needed to fill vacancies. Subject to the provisions of the Act and as authorized by the Board, such officers are authorized to serve as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(b) The votes of the Board shall be on a one person, one vote basis. An elected [public]**carrier** 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) A majority of the Directors shall constitute a quorum for the transaction of business. The acts of the majority of the Directors at a meeting at which a quorum is present shall be the acts of the Board, except as otherwise provided herein.

(d) [A meeting]**Meetings** of the Board shall be held [no later than the first Tuesday in April each year] in accordance with the State's Open Public Meetings Act.

(e) At least once each year, the Board shall meet to:

1. Review the Plan and submit proposed amendments, if any, to the Commissioner for review;

2. Review reports of the committees established by the Board;

3. Review and approve the rate of interest to be charged for late payments;

4. Review and approve changes in the communications program[, as recommended by the Marketing and Communications Committee];

5. Determine whether any technical corrections or amendments to the Act should be recommended to the Commissioner;

6. Fill any vacancies among the Directors who represent carriers which exist or which will exist [within 10 business days following the date of the election meeting] pursuant to a resolution of the Board or the expiration of a Director's normal term of office; and

7. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the program.

(f) The Board shall hold other meetings upon the request of the Chair or three or more Directors, as deemed appropriate. A meeting may be held in person or by telephone. Notice of such a meeting and its purpose shall be provided to the general public and to the Directors in accordance with the State's Open Public Meetings Act.

(g) The Board shall keep reasonably [comprehensive] **comprehensible** minutes of all its meetings showing the time and place, the Directors present, the subjects considered, the actions taken, the vote of each Director, and any other information required to be shown in the minutes by law. The original of the public record shall be retained by the Board or its agent and shall be promptly available to the public to the extent that making such matters public shall not be inconsistent with Section 7 of the Open Public Meetings Act (N.J.S.A. 10:4-12). [At least two

copies of the]**The** minutes of each meeting of the Board shall be delivered forthwith to the Commissioner; delivery to the Commissioner's designee on the Board shall satisfy this requirement.

(h) The Board may establish rules of the Program consistent with the Act and this Plan.

(i) Amendments to the Plan or suggestions for technical corrections to the Act shall require the concurrence of a majority of the entire Board.

(j) Directors shall not be compensated by the Program for their services but may be reimbursed for reasonable unreimbursed travel expenses incurred in attending Board and committee meetings pursuant to the State Travel Guidelines issued by the Department of the Treasury.

(k) The Board may adopt rules for the taking of testimony from the public, which may include rules relating to the time and place of any such public hearing, and reasonable rules for the length and format of testimony from individuals, groups and organizations.

(l) The Board may take up any additional matters which are appropriate to effectuate the provisions of this Act.

(m) The affirmative vote of at least two-thirds of the Directors present at a meeting shall be required to authorize assessments and the expenditure of Program funds.

11:21-2.6 Committees

(a) Appointments to Standing and other committees shall be approved by a majority of the Board present. [Each of the Standing Committees shall include no more than seven directors, but the Board Chair may appoint additional persons, who need not be directors, as needed, with the approval of a majority of the Board.] A written record of the proceedings of each committee

shall be maintained by the [Administrator or] Executive Director. Committee members are responsible for providing staff support, but may recommend that the Board provide funding for outside contractors. Committees may not take final action; however, within the scope of their mission and duties, Committees may make recommendations and reports to the Board for its decision and action.

(b) Standing Committees shall include the following:

1. A Finance and Audit Committee which shall make recommendations to the Board with respect to:

i. The methods and rules for calculating assessments;

ii. Assessment of members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organizational and reasonable interim operating expenses;

iii. Independent consulting actuaries who may be approved by the Board;

iv. Establishment of rules, conditions, and procedures pertaining to the registry of multiple employer arrangements in accordance with the provisions of the Act; and

[v. Oversight of studies necessary for development of reinsurance mechanisms;

vi. The Plan amendments thereto;]

[vii]**v**. The selection of an independent auditor for the annual audit of the Program operations;

[viii]**vi**. The review of reports prepared by independent auditors and other audit-related matters the Board deems necessary;

[ix]**vii**. Contracts which are necessary or proper to carry out the provisions and purposes of the Act;

[x]**viii**. Developing the means to select [a Program Administrator or]**an** Executive Director, a statement of the powers and duties of the [Administrator or] Executive Director, the compensation of the [Administrator or] Executive Director, and a statement of the efficiency standards an [Administrator or] Executive Director must meet; and

[xi]**ix**. Recommendations for employing or retaining persons, firms or corporations to perform the functions necessary for the Board's performance of its duties, including retention of an [Administrator or] Executive Director for the Program;

2. A Legal Committee which shall make recommendations to the Board with respect to:

i. Appropriate interpretations of the Act **and other applicable law**, and such other matters as the Board may desire, including rules and regulations promulgated by the Board pursuant to the Act;

ii. Amendments to the Plan, and the various health benefits plans proposed by the Board for compliance with the Act, and by implication under Federal or other State legislation;

iii. Proposed amendments to the Act for Board approval;

iv. Contracts and legal documents for the Program;

v. All litigation and other disputes involving the Program and its operations;

vi. Maintenance of a written record of all written requests for a formal opinion of the Board received and responses provided by the Board.

vii. Coordination with legal counsel for the Board, as needed, on matters relating to the Program operations, including proposed contracts, operational practices, and statutory construction;

viii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the Program or a member;

ix. The Board's entering into contracts necessary or proper to carry out the provisions and purposes of the Act; and

x. Legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims and other matters related to lawsuits by or against the Board;

xi. Whether and how to respond to interpretations of the Board's rules made by carriers and inquiries and complaints received from consumers, policyholders, carriers or others.

(1) Recommendations by the Legal Committee may include a recommendation that the Board issue a statement interpreting its regulations, seek declaratory or injunctive relief as may be appropriate, or other administrative or legal remedies as may be available.

(2) In an effort to answer any inquiry or resolve any dispute or complaint, the Legal Committee, Administrator, or Executive Director may seek the input of other appropriate Committees in order to assist the Legal Committee in reaching a recommendation.

(3) The Legal Committee may refer matters as necessary to any other Committee which may also make recommendations to the Board.

3. A Marketing and Communications Committee which shall make recommendations to the Board with respect to:

i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of health benefits plans to [eligible] **full-time** employees;

ii. Marketing and communication plans for the Program, as needed;

iii. Issues or concerns arising out of the marketing of Program coverage;

iv. The development of information concerning the Program to be released to the general public; and

v. Reviewing marketing material submitted by carriers in accordance with the Act; and

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

i. Optional benefit rider filings received pursuant to N.J.A.C. 11:21-3.2(d);

ii. Modifications to the standard health benefits plan policy forms and related forms;

iii. Interpretations of the standard health benefits plans and policy forms;

iv. Development of new standard health benefits plan policy forms as permitted by statute; and

v. Substantive and structural plan design issues.

(c) The Board may appoint other committees. The Board may by resolution adopted by a majority of the entire Board:

1. Determine the size of and appoint members to and/or fill any vacancy in any committee;

2. Appoint one or more persons to serve as alternate members of any committee, to act in the absence or disability of members of any committee with all the powers of such absent or disabled members;

3. Abolish any committees, in its discretion;

4. Remove any person from membership on any committee at any time, with or without cause; and

5. Authorize or appoint the use of consultants or other advisors to work with any committee.

(d) All committee members, including those committee members who are not also members of the Board, shall be subject to the Uniform Ethics Code pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D-12 et seq. Committee members who are not also members of the Board shall be required to file a Certification, in a form to be provided by the Board, stating that they, and the respective entities and/or carrier by whom they are employed, agree to be subject to all applicable terms set forth in the Uniform Ethics Code and any Supplemental Code of Ethics the Board adopts.

11:21-2.7 [Administrator or]Executive Director selection and duties

(a) The [Administrator or] Executive Director shall be selected by the Board.

(b) The [Administrator or] Executive Director shall perform the administrative functions required under the Act and the Plan. The [Administrator or] Executive Director is responsible, along with the Board, for the fair, equitable and reasonable administration of the Program.

(c) The [Administrator or] Executive Director shall perform all administrative functions developed by the Board including the following:

1. Preparing and submitting an annual report to the Board and the Commissioner no later than September 1;

2. Establishing the procedures and installing the systems needed to properly administer the operations of the Program;

3. Establishing with Board approval, one or more depository accounts for the transaction of Program business;

4. Collecting assessments due to the Program on a timely basis;

5. Depositing all moneys collected on behalf of the Program on a timely basis in the State Treasury in an account established for that purpose;

6. Issuing checks or drafts[,] on [and or] **and/or** approving charges against bank accounts of the Program;

7. Keeping all accounting, administrative and financial records of the Program;

8. Acting as a resource for carriers in complying with the Program;

9. Calculating all assessments in accordance with the methodology approved by the Board; notifying members of amounts due; tracking the amount of assessments in dispute or subject to deferral request; coordinating with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters;

10. Preparing an annual estimate of the operating and administrative expenses of the Program; and

11. Performing other functions as agreed between the Board and the [Administrator or]Executive Director.

(d) The [Administrator or]Executive Director shall maintain calendar year records of premiums, reimbursements, and fiscal year operating and administrative expenses of the Program and shall retain these records for a period of seven years following the end of such calendar year or as otherwise required pursuant to N.J.S.A. 47:3-15 et seq.

(e) The Board may select, and establish compensation for, such other staff as may be necessary for the administration of the Program.

11:21-2.8 Assessments for administrative and operating expenses

(a) Following approval of a final audited Program statement, the Board shall determine the final administrative expense total for the fiscal year, if any.

1. Each member's final assessment shall be reduced by any interim assessment paid by the member or credited to the member by the Board.

2. Each member's final assessment shall be reduced by any deferred assessments paid by assessed carriers in proportion to the original additional assessment made to cover the deferred amount.

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] **member** shall not be assessed and the amounts uncollected will be reapportioned proportionally, based on market share, among the member carriers.

(b) The Board may make an interim assessment of members for reasonable and necessary organizational expenses and to cover anticipated interim operating expenses. At the discretion of the Board, interim assessments may be made on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses.

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

ii. Payment of an assessment, or portion of an assessment, for which an interest penalty amount has accrued, shall include the interest penalty amount accrued as of the invoice date; otherwise, payment shall not be considered to be in full.

iii. The interest so collected shall be applied in the assessment of the final administrative expenses as set forth in (a)3 above to reduce the liability of those members that were not subject to the payment of an interest penalty.

2. Carriers that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the Board, shall be assessed for and make payment of the full amount of the assessment invoice, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that carrier, or, if a contested case, the Board has rendered a final determination in favor of that carrier in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

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]**after** the date of the invoice, that member may make payment of the amount of the assessment invoice to be held in an interest bearing account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

ii. If the member withholds payment, as permitted herein and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth herein, accruing from the date of the invoice for the assessment.

4. Amounts deferred by the Commissioner or subject to dispute, which dispute is resolved in favor of the carrier, shall be redistributed among all other members proportionately.

(d) The [Administrator or] Executive Director shall coordinate with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters, and develop appropriate procedures for such matters, and disburse funds for administrative expenses upon the directive of the Board.

1. Amounts of assessment in dispute or subject to deferral request, including any interest penalty paid by a carrier pursuant thereto, shall not be disbursed by the [Administrator or] Executive Director until such time as the dispute has been settled against the disputing carrier, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed immediately according to Board directive.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing carrier, or a deferral is granted, shall be returned to the appropriate carrier within 15 days of the date that the [Administrator or] Executive Director receives notice of the determination by the Board or the Commissioner, as applicable along with the proportionate amount of interest penalty, if any, paid by the carrier for late payment of the amount.

(e) A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the [Administrator or] Executive Director in order to preserve its right to the moneys owed and paid pursuant to the invoice for assessment.

(f) If a member determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days [of]**after** the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State or to take such other action against the carrier as may be authorized by law. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

11:21-2.9 Reporting requirements

Carriers shall submit statements, assessments and other reports as may be required by the Board pursuant to the Act **and these rules**.

11:21-2.10 Financial administration

(a) The Board shall maintain the books and records of the Program so that financial statements can be prepared to satisfy the Act. Further, these books shall satisfy any additional requirements of the Board and outside auditors.

1. The receipt and disbursement of cash by the Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when assets or liabilities should be realized by the Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the Program shall be calculated for each carrier and confirmed as deemed appropriate by the Board or when requested by the respective carrier. These balances should be supported by a record of each individual carrier's financial transactions with the Program. These records include:

i. Any adjustments to assessments as explained in this Plan;

ii. Adjustments to the amount due to/from the Program based upon corrections to carrier submissions;

iii. Interest charges due from a carrier for late payment of amounts due to the Program; and

iv. Other records required by the Board.

5. The Board shall maintain a general ledger which balances are used to produce the Program's financial statements in accordance with generally accepted accounting principles. The balances

in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

6. The Board's fiscal year shall begin on July 1 and end on June 30.

7. Assessments shall be paid when billed. If the assessment is not received by the Board within 45 days of the invoice date, the carrier shall pay interest on the assessment from the invoice date at the rate of 1.5 percent per month except if the carrier is granted a deferral.

(b) All funds of the Program shall be deposited in, and all disbursements made from, the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget, and all financial records shall be kept in a form acceptable to the Office of Management and Budget.

1. Funds of the Program shall be deposited into a dedicated account within the General Fund.

2. Moneys shall be credited from the General Fund, with the approval of Director of the Division of Budget and Accounting to the Program's bank accounts upon request by the Board through the Department.

3. The [Administrator or] Executive Director shall make such requests for funds as directed by the Board and shall deposit all moneys received from the Treasury in a Board bank account.

(c) A bank checking account and interest-bearing investment accounts shall be established separately in the name of the Program and shall be approved by the Board.

1. The Board shall authorize individuals to sign checks on behalf of the Board.

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. All investment income earned shall

be credited to the Program and shall be applied to reduce future assessments of members for the Program administrative expenses.

11:21-2.11 Records

(a) The Board shall provide for the maintenance and retention of its official records in accordance with the Destruction of Public Records law (N.J.S.A. 47:3-15-32 **et seq**.) and all other applicable laws.

(b) The Board's records shall include the following:

1. Minutes of all Board meetings;

2. Written reports and recommendations of committees to the Board;

3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules;

4. Riders proposed or adopted by the Board, including all comments received;

5. The Plan of Operation and any amendments thereto;

6. Records concerning the election of Directors and appointment of committees and committee members;

7. Regulations or actions proposed or adopted by the Board, including all comments received; and

8. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to N.J.S.A. 47:1A-1 et seq. except that **the following documents shall not be subject to public inspection and copying pursuant to N.J.S.A. 47:1A-1 et seq.:**

1. [information]**Information** in filings determined by the Board or the Department by regulation to be confidential and proprietary**; [**shall not be subject to public inspection and copying, and except that]

2. [written]**Written** communications of the Board, its staff, or committees, including, but not limited to, reports, opinions, and recommendations, where such communications contain discussion of litigation strategy, attorney-client advice or other privileged information[, shall not be available for public inspection and copying]**;**

3. Any other information that is not subject to inspection or copying pursuant to N.J.S.A. 47:1A-1 et seq. or any other law.

11:21-2.12 Audit functions

(a) The Program shall have an annual audit of its operations conducted by an independent certified public accountant approved by the Board. This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for the Program; and

2. The annual fiscal report of the Program.

11:21-2.13 (Reserved)[Penalties/adjustments and dispute resolution

(a) Numerous factual determinations and tasks shall be performed by carriers relative to their participation in the Program. It is expected that all carriers will exercise good faith and due diligence in all aspects of their relationship with the Program. Errors may occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

1. Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, except as provided herein.

2. All other additional sums due to the Program as a result of errors made by carriers shall be paid immediately, with interest.

3. If the Board determines that the nature or extent of errors made by a particular carrier evidences gross negligence or intentional misconduct, the Board may, after notice, recommend to the Commissioner, Attorney General, and other appropriate officials, penalties and sanctions as may be appropriate in accordance with the Act.

4. All interest payments required under this Plan shall be calculated at 1.5 percent per month, from the date the incorrect payment occurred or a payment should have been made, through the date the correct payment is made. Errors reported by carriers within 60 days of their occurrence shall not be subject to interest.

(b) A carrier seeking to challenge the amount of an assessment shall do so within 20 days of receiving the notice of assessment following the procedures in (d) below.

(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.]

11:21-2.14 Indemnification

(a) A member or employee of the Board, including the [Administrator or] Executive Director and staff, shall not be liable in an action for damages to any person for any action taken or recommendation made by him or her within the scope of his or her functions as a member or employee, if the action or recommendation was taken or made without malice.

(b) The members of the Board shall be indemnified and their defense of any action provided for in the same manner and to the same extent as employees of the State under the "New Jersey Tort Claims Act," P.L. 1972, c.45, on account of acts or omissions in the scope of their employment.

11:21-2.15 Amendment and termination

(a) This Plan may be amended by a majority vote of the entire Board, subject to approval of the Commissioner as provided hereinafter. A vote on an amendment may be taken at any meeting called, in whole or in part, for the purpose of considering a proposed amendment. Written notice of any meeting at which an amendment to the Plan is to be considered shall be sent to each Director by mail**, electronic mail** or facsimile transmission at least 10 days (exclusive of the meeting day) prior to the date of the meeting. Such notice shall state that an amendment to the Plan is to be considered at the meeting and shall set forth the substance of any amendments which have been proposed or a description of the section or sections which are proposed to be amended. Notice to a Director shall be deemed sufficient if mailed, postage prepaid, to the most recent address provided by the Director to the Board or sent by facsimile transmission to the most recent facsimile reception number provided by the Director **or sent by email to the email address provided by the Director**. At any meeting for the consideration of an amendment to

the Plan, for which proper notice has been given pursuant to this section, the Board may vote on any amendment proposed by a Director prior to, or during the meeting. Any amendment adopted by the Board shall be submitted to the Commissioner for approval. Any such amendment submitted to the Commissioner shall be deemed approved no later than 90 days after receipt by the Commissioner unless expressly disapproved in writing by the Commissioner before expiration of the approval period. Amendments to the Plan must be adopted pursuant to P.L. 1993, c.162.

(b) The Program shall continue in existence subject to termination in accordance with the laws of this State or the United States of America. In case of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the Program, the Program shall terminate and conclude its affairs. Any funds or assets held by the Program following the payment of all claims and expenses of the Program shall be distributed to the members at that time in accordance with the then-existing assessment formula.

11:21-2.16 (Reserved)

11:21-2.17 (Reserved) [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) The standard health benefits plans established by the Board contain the benefits, limitations, [and] exclusions **and other terms** set forth in **exhibits in** the Appendix to this chapter[which is incorporated herein by reference as follows:]**.**

1. Plan B, "The Small Group Health Benefits Policy B," **set forth in** Exhibits F and W [featuring]**features** carrier coinsurance of 50 percent or 60 percent[;]**.**

2. Plan C, "The Small Group Health Benefits Policy C," **set forth in** Exhibits F and W [featuring]**features** carrier coinsurance of 70 percent[;]**.**

3. Plan D, "The Small Group Health Benefits Policy D," **set forth in** Exhibits F and W [featuring] **features** carrier coinsurance of 80 percent[;]**.**

4. Plan E, "The Small Group Health Benefits Policy E," **set forth in** Exhibits F and W [featuring]**features** carrier coinsurance of 90 percent[;]**.**

5. Exhibit F contains those items of Plans B, C, D, and E which are common among the plans as well as text which is unique to Plans B, C, D, and E, where such [Plan unique]**Plan-unique** text is clearly identified **and Exhibit W contains corresponding certificate text for each of the plans**[;]**.**

6. HMO Plan, "The Small Group Health Maintenance Organization Contract," **is set forth in** Exhibits G and Y[; and]**.**

7. HMO-POS Plan, "The Small Group Health Maintenance Organization Point of Service ("POS") Contract," **is set forth in** Exhibits HH and II.

8. Exhibits G and HH contain the group contract text for the HMO plan and the HMO-POS plan. Exhibits Y and II contain the evidence of coverage text for the HMO plan and the HMO-POS plan.

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall offer at least three of the health benefits plans designated as Plans B, C, D, and E as set forth in Exhibits V and W, in the Appendix, subject to (b)1 and 2 below and except as set forth in (c) below.

1. [Plans B, C, D, and/or E may be offered.] Members offering [these plans] **Plans B, C, D and/or E** shall include annual deductible provisions consistent with the following specifications:

i. The per covered person annual deductible may not exceed the maximum deductible permitted by 45 CFR 156.130 **and N.J.A.C. 11:22-5.3(a).**

ii. The per covered family annual deductible shall be two times the per covered person annual deductible, satisfied on an aggregate basis.

2. Members offering Plans B, C, D, and/or E shall include maximum out of pocket provisions such that the maximum out of pocket amount shall not exceed the annual limitation on cost sharing specified in 45 CFR 156.130 for both self-only and other than self-only coverage.

(c) HMO members may offer the HMO Plan, as set forth in Exhibit G of the Appendix, in lieu of at least three of the plans designated as Plans B through E in (a) above. HMO members [offering the HMO Plan]shall offer one or more [of the following plan designs] **HMO plans** using copayments **as described in (c)1 below** and may[, at the option of the HMO members,] also

offer HMO plans using deductible and coinsurance provisions **consistent with (c)2 below**. All[options offered by the] HMO **plans shall comply with (c)3 below and** [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 consistent with N.J.A.C. 11:22-5.5(a).

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, and prescription drugs shall be consistent with N.J.A.C. 11:22-5.5(a).

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be consistent with N.J.A.C. 11:22-5.5(a).

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, or pre-natal care**,** shall be consistent with the requirements of N.J.A.C. 11:22-5.3 and 45 CFR 156.130. The covered family deductible shall be two times the per person deductible satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies, shall be a percentage between 10 percent and 50 percent, inclusive.

iv. The maximum out of pocket shall be a dollar amount, which shall not exceed the annual limitation on cost sharing set forth at 45 CFR 156.130, and the maximum out of pocket 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 not exceed the amount permitted by N.J.A.C. 11:22-5.5(a).

ii. Pre-natal care shall be covered without cost sharing.

iii. Prescription drugs covered under the HMO plan, as opposed to under a separate prescription drug rider, shall be subject to deductible and/or coinsurance, or copayment(s) consistent with N.J.A.C. 11:22-5.5(a).

(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 (N.J.S.A. 17B:27A-54). 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 **45 CFR 156.130 and** N.J.A.C. 11:4-37.3(b)6 and 11:22-5;

2. The network annual deductible shall be consistent with the requirements of N.J.A.C. 11:22-5.3 and 45 CFR 156.130 and for a covered family shall not exceed two times the per covered person annual deductible, satisfied on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies;

3. The network maximum out of pocket shall not exceed the annual limitation on cost sharing set forth at 45 CFR 156.130 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; and

6. The HMO Plan standard copayment levels for practitioner visits, emergency room and hospital confinements may be substituted for deductibles applicable to network benefits.

(e) An insurer with an approved selective contracting agreement, like all other carriers, shall offer at least three of 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 **in which the insurer is authorized to write health benefit plans**.

1. If an insurer's approved service area for its selective contracting arrangement includes all geographic areas in the State, the insurer shall offer at least three of the standard health benefits plans as either indemnity plans or through or in conjunction with a selective contracting arrangement, or both, in all geographic areas in the State.

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. At least three of the standard health benefits plans as indemnity plans in all areas in the State **in which the insurer is authorized to write health benefit plans that otherwise are** not included in its approved **selective contracting arrangement** service area; and

ii. At least three of 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. If an insurer with a limited approved service area chooses to offer at least three of the standard health benefit plans only through or in conjunction with a selective contracting arrangement in its limited approved service area, and later receives approval for its selective contracting arrangement in additional geographic areas in the State, the insurer shall not be required to offer the standard health benefits plans as indemnity plans in the newly approved areas, but shall be required to renew the in force standard health benefits plans in the newly approved service areas.

(f) 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 shall offer the standard health benefits plans whether as indemnity plans or as PPO, POS, or EPO plans in all geographic areas of the State.

1. If such a carrier has agreements with participating providers in all geographic areas of the State, the carrier shall offer the standard health benefits plans either as indemnity plans or as PPO, POS, or EPO plans or any such combination in all geographic areas of the State.

2. If such a carrier has agreements with participating providers only in certain geographic areas of the State, the carrier shall offer:

i. The standard health benefits plans as indemnity plans in all geographic areas of the State **in which the carrier is authorized to write health benefits plans** where it does not have agreements with participating providers; and

ii. The standard health benefits plans whether as indemnity plans or as PPO, POS, or EPO plans or any such combination in all geographic areas of the State where it has agreements with participating providers.

3. If such a carrier which has agreements with participating providers only in certain geographic areas of the State chooses to offer the standard health benefits plans only as PPO, POS, or EPO plans in such areas and later expands the area in which it has agreements with providers, the carrier shall not be required to offer the standard health benefits plans as indemnity plans in the expanded area, but shall be required to renew the in force standard health benefits plans in the newly expanded area.

(g) 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] **11:24-14**, 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 (g)1, 2, and 3 below with respect to their 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 consistent with N.J.A.C. 11:22-5.5(a).

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, and prescription drugs shall be consistent with N.J.A.C. 11:22-5.5(a).

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be consistent with N.J.A.C. 11:22-5.5(a).

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, or pre-natal care shall be consistent with the requirements of N.J.A.C. 11:22-5.3 and 45 CFR 156.130. The covered family deductible shall be two times the per person deductible satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies, 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 [the maximum out of pocket shall not exceed] the annual limitation on cost sharing set forth at 45 CFR 156.130, 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 not exceed the amount permitted by N.J.A.C. 11:22-5.5(a).

ii. Pre-natal care shall be covered without cost sharing.

iii. Prescription drugs covered under the HMO-POS plan, as opposed to under a separate prescription drug rider, shall be subject to deductible and/or coinsurance or copayment(s) consistent with N.J.A.C. 11:22-5.5(a).

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

(a) Members may offer riders that [revise in any way]**increase** the coverage offered by Plans B, C, D, E, HMO, and HMO POS plan subject to the provisions set forth in (a)1 through [8]**6** below.

[1. Before a member may sell a rider or amendment thereof that decreases any one benefit or decreases the actuarial value of Plans B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof for informational purposes with the Board, and for approval by the Commissioner. No rider filed with the Commissioner may be sold until approved by the Commissioner.]

[2]**1**. Before a member may sell a rider [or amendment thereof] that increases any benefits or increases the actuarial value of Plans B, C, D, E, HMO, or HMO POS, the member shall file the rider [or amendment thereof]with the Board for informational purposes.

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

i. The types and extent of services and supplies described in the "Covered Charges,"["Covered Charges with Special Limitations,"] and "Exclusions" sections of Plans B, C, D, and E the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan, and the "Covered Services and Supplies," "Covered Charges,"["Covered Charges with Special Limitations,"] and "Non-Covered Services and Supplies and Non-Covered Charges" sections of the HMO POS plan;

ii. Deductibles, coinsurance, copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans 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. Eligibility as set forth in the "Employee coverage," "Dependent coverage," and "Continuation rights" sections of Plans B, C, D, and E, the "Eligibility" and "Continuation Provisions" of sections of the HMO plan, and the "Eligibility" and "Continuation Rights" sections of the HMO POS plan.

[4]**3**. "Coverage" offered by the four plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (a)2 above does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:21-1.2, except for dental coverage for persons age 19 or older where the additional dental coverage is subject to the standard plan's deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:21-1.2.

[5]**4**. In addition to (a)1, 2, 3, and 4 above, any benefit rider [or amendments thereof]shall be subject to the provisions of Sections 2, 3(b), 6, 7, 8, 9, and 11 of P.L. 1992, c.162, as amended.

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

i. Submit 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 through paper or electronic means;

ii. Submit 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. Specify whether the rider[or amendment thereof] is to be used in connection with standard health benefit Plans B, C, D, E, HMO, or HMO POS plan and provide clear and conspicuous notice of such on the forms submitted for each rider;

iv. The standard group policy and employee certificate language shall not be altered, and the benefit modifications shall appear only on the rider or riders; and

v. [For riders of increasing value only, submit]**Submit** copies of a certification signed by a duly authorized officer of the member that states clearly:

(1) That the rider [or amendment thereof] increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan B, C, D, E, HMO, or HMO POS;

(2) That the filing is complete and in accordance with all the requirements of this subsection and applicable New Jersey statutes and regulations;

(3) That the member will offer [the rider or amendment thereof to any] **all** small [employer]**employers** [seeking to purchase] the health benefits plan [it]**the rider** modifies **as a plan including the rider and as a plan without the rider**;

(4) That a rate filing for **plans including and without** the rider has been made with the Commissioner pursuant to N.J.A.C. 11:21-9;

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement or the HMO POS contract, that the plan [as ridered] **including**

the rider continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and[8:38-14.4(c)]**11:24-14.4(c),** as applicable[; and]**.**

[(6) That the premium or percentage change for a ridered standard plan shall be listed separately from the premium or percentage change for the unridered standard plan when rates are illustrated on rate quotes prepared by the carrier.]

[7]**6**. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in compliance with this subsection, within 60 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 60 days of the Board's receipt of the submission, the informational filing shall be deemed complete.

i. If an informational filing is incomplete and not in 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 complete.

ii. If the Board takes no action within 60 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 complete.

(b) A carrier may provide for alternative means of administering aspects of the standard forms which administration does not affect the benefits provided in the standard policy forms and

riders. Administration includes, but is not limited to, administration of claims, COBRA, premium collection, and issue functions. The delegation of administrative functions shall be achieved by a separate contract between the carrier and/or the small employer, and a third party. Such arrangements shall not alter the standard group policy and certificate language.

[(c) 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 B, C, D, and E which are set forth in the Appendix to this chapter as Exhibits F,[V,] and W subject to the "Explanation of Brackets" set forth in Exhibit K 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 K.

(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 of the Appendix[, incorporated herein by reference].

(c) Members shall use the standard policy form for HMO-POS [plan]**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 K of the Appendix[, incorporated herein by reference].

(d) All health benefits plans and optional benefits riders issued to small employers on and after January 1, 1994 shall be issued in accordance with [these rules]**this subchapter**.

(e) 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" set forth in Exhibit K of the Appendix[, incorporated herein by reference].

(f) 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" set forth in Exhibit K of the Appendix[, incorporated herein by reference].

[(g) 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" set forth in Exhibit K of the Appendix, incorporated herein by reference.]

[(h)**](g)** All small group health benefits certificates and employee evidences of coverage issued to employees covered under small employer health benefits plans on and after January 1, 1994, shall be issued in accordance with [these rules]**this subchapter**.

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[,]**and** 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. A carrier shall submit completed Certification of Compliance forms to the Board, at the address set forth at N.J.A.C. 11:21-1.3.

3. Certification of Compliance forms shall be certified by a duly authorized officer of the carrier.

(b) Carriers that submit Certification of Compliance forms may issue and make effective small employer health benefits plans upon filing such forms with the Board and the Commissioner, and may continue to do so until such time as the filing is disapproved in writing by the Board (in consultation with the Commissioner), following an opportunity for a hearing held in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and any rules promulgated thereunder.

11:21-4.3 (Reserved)

11:21-4.4 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, [Members] **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 B, C, D, E, HMO, and

HMO POS 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 B-E, HMO, and HMO POS contracts, certificates, or evidences of coverage. Nothing contained herein shall prevent a Member from issuing a standard policy form Plans B-E, HMO, or HMO POS contract, certificate, or evidence of coverage which has incorporated [Board promulgated] **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 B, C, D, E, HMO, and HMO POS consistent with the variability as explained in Exhibit K to this Appendix through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix.

(c) Members may use the Compliance and Variability Rider only as permitted by (a) and (b) above. In no event shall the Compliance and Variability Rider be used in lieu of optional benefit riders which riders are subject to filing requirements set forth in N.J.A.C. [11:21-3.2(d)] **11:21-3.2**.

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

11:21-6.1 Standard application form

(a) All small employer carriers offering small employer health benefits plans with an effective date on or after January 1, 1994, shall use the standard application form approved by the Board and available on the Board's website at www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html.

(b) Small employer carriers shall require any small employer applying for a small employer health benefits plan to be issued by that small employer carrier to complete, as part of the application, the New Jersey Small Employer Certification form approved by the Board and available on the Board's website at www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html.

(c) The application requires the following [types of]information:

1. The policyholder name and contact information;

2. The Federal Tax ID Number;

3. The type of business and nature of the business;

4. The number of employees, classes of employees, and coverage type;

5. The status with respect to COBRA and Medicare as secondary payor;

6. The waiting period;

7. The contribution percentage;

8. Affiliates;

9. Benefit options;

10. Replacement information;

11. Continued coverage;

12. Agent/producer information; and

13. A signature section.

(d) The [certification]**New Jersey Small Employer Certification** requires the following[types of]information:

1. The status as small employer;

2. Work locations;

3. The participation calculation;

4. The application of Federal laws; and

5. The certification signature.

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 available on the Board's website at www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. This 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 information requested on the certification form is set forth at N.J.A.C. 11:21-6.1(d).

11:21-6.3 (Reserved)

11:21-6.4 Waiver

Any [eligible] **full-time** 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].

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] **full-time** employees, and the dependents of those [eligible] **full-time** employees.

11:21-7.2 Determination of small employer status

(a) To determine whether an employer qualifies as a small employer, as defined in N.J.A.C. 11:21-1.2, a carrier shall evaluate whether an employer satisfies the requirements[in either paragraph 1 or 2] of the definition. [If the employer satisfies either paragraph 1 or 2, then the employer shall be considered to be a small employer.

(b) With respect to paragraph 1 of the definition of small employer, a small employer carrier shall include all persons who meet the definition of eligible employee.

1. The small employer carrier shall include all full-time bona-fide employees who work 25 or more hours per week.

(c) With respect to paragraph 2 of the definition of small employer, a] **(b) A** small employer carrier shall add the number of full-time employees **(where full-time means 30 or more hours per week for purposes of the determination of small employer status)** to the number that

results from the part-time employee calculation **in subsection 2 below**, and if the sum is at least one but not more than 50, the employer shall be considered to be a small employer.

1. Employees working 30 or more hours per week are full-time employees and each full-time employee counts as one.

2. Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time employee works per week multiplied by four and the product divided by 120 and rounded down to the nearest whole number.

3. Small employer carriers shall not include **an individual and his or her spouse when the business is owned by the individual or by the individual and his or her spouse,** sole proprietors, partners of partnerships, or two percent or more owners of Subchapter S corporations, or their immediate family members as employees [in (c)1 or 2 above] even if such persons will be covered under the employer's plan.

[(d)]**(c)** Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of P.L. 1992, c. 162 (N.J.S.A. 17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition.

[(e)]**(d)** 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[:

1. The average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year with respect to small employers that meets paragraph 1 of the definition of small employer; or

2. The] **the** average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year[with respect to small employers that meets paragraph 2 of the definition of small employer].

11:21-7.3 Eligibility and issuance

(a) 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] **full-time** 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 geographical location of the employees of the small employer, except that an HMO carrier or other carrier issuing a network-based plan 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.

2. Every small employer carrier except small employer carriers that are HMOs, shall, as a condition of transacting business in this State, actively offer to small employers at least three of standard health benefits Plans B, C, D, and E, including all riders it has elected to write, except as such riders may be restricted to specific standard health benefits plans. Small employer carriers that are HMOs shall, as a condition of transacting business in this State, actively offer to

small employers every standard health benefits plan it writes, including all riders it has elected to write, except as such riders may be restricted to specific standard health benefits plans.

3. A small employer carrier shall consider the number of all [eligible] employees of all affiliated companies of a small employer in determining whether an employer is a small employer and in determining participation levels.

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. If an employer qualifies as a small employer in the immediately preceding calendar year, the employer shall be considered a small employer regardless of the status of the employer on the date of application or the effective date of coverage so long as it employs[:

(1) At least one eligible employee on the first day of the plan year with respect to a small employer that satisfies paragraph 1 of the definition of small employer in N.J.A.C. 11:21-1.2; or

(2) At] **at** least one employee on the first day of the plan year[with respect to a small employer that satisfies paragraph 2 of the definition of small employer in N.J.A.C. 11:21-1.2].

ii. If an employer did not qualify as a small employer in the immediately preceding calendar year, the employer shall not be considered a small employer, regardless of the status of the employer on the date of application or the proposed effective date of coverage, if any.

iii. In the case of an employer that was not in existence during the preceding calendar year, refer to N.J.A.C. 11:21-7.2(e).

(b) A small employer carrier shall issue only standard health benefits plans to an association, trust, or multiple employer arrangement to provide coverage to member small employers.

1. No carrier shall issue a health benefits plan to any association, trust or multiple employer arrangement which bases membership criteria of any small employer or employee of the small employer, in whole or in part, upon the health status or claims experience of the employer or employee.

2. Every small employer member of an association, trust or multiple employer arrangement shall be offered coverage under every health benefits plan issued to the association.

(c) Employees who enroll within 30 days of first becoming eligible for coverage shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to their risk characteristics or that of their dependents. Employees who are late enrollees shall be accepted for coverage by the small employer carrier if enrollment is requested during the employee open enrollment period.

(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 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 Limitations on purchase by small employers of health benefits plans [or riders] with different actuarial value than existing plan

(a) A small employer who purchases a health benefits plan [or rider] pursuant to the Act shall not be permitted to purchase a health benefits plan [or rider] with a greater actuarial value until the first anniversary date of the small employer's existing health benefits plan.

(b) When a small employer replaces a health benefits plan or rider with a health benefits plan [or rider] of greater actuarial value, the small employer shall not be permitted to change the health

benefits plan or rider to one of less actuarial value until the anniversary date of the small employer's health benefits plan.

(c) A small employer who has purchased a health benefits plan [or rider] pursuant to the Act may purchase a health benefits plan [or rider] of lesser actuarial value prior to the anniversary date of the existing health benefits plan [or rider], provided that the existing health benefits plan [or rider] was purchased at least 12 months prior to the latest anniversary date of the health benefits plan[or rider].

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] **full-time** employees **(where full-time means 25 or more hours per week for purposes of eligibility for coverage and participation requirements)** who are not serving under a waiting period as permitted under N.J.A.C. 11:21-7.8(d), 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] **a full-time** employee who:

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

2. Is covered under Medicare;

3. Is covered under Medicaid or NJ FamilyCare;

4. Is covered under another group health benefits plan;

5. Is covered under a spouse's group health benefits plan; [or]

6. Is covered under Tricare[.]**or**

7. With respect to Small Business Health Options Program coverage only, is covered under an individual plan.

(b) A small employer carrier may, upon approval by the Board, require a minimum participation of less than 75 percent provided that the small employer carrier:

1. Notifies the Board in writing of its minimum requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) 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.

[(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser participation requirements, in accordance with procedures established by the Board in its Plan of Operation.]

[(e)]**(d)** A small employer carrier shall not require a minimum participation under the small employer's health benefits plan of 75 percent of [eligible] **full-time** employees with respect to employer applications received during the employer annual open enrollment period.

11:21-7.6 Contribution requirements

(a) A small employer carrier shall not require a minimum small employer contribution of more than 10 percent of the annual cost of the small employer's health benefits plan. This contribution requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers.

(b) A small employer carrier may, upon approval of the Board, require a minimum contribution of less than 10 percent provided that the small employer carrier:

1. Notifies the Board in writing of its contribution requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) 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.

[(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser contribution requirements, in accordance with procedures established by the Board in its Plan of Operation.]

[(e)]**(d)** A small employer carrier shall not require any minimum contribution toward the annual cost of the small employer's health benefits plan with respect to employer applications received during the employer annual open enrollment period.

11:21-7.7 Employee open enrollment period

(a) Each small employer shall designate a 30-day period each year as the employee open enrollment period. Such period shall begin no more than 90 days prior to the start of the plan year.

(b) Employees and dependents who are eligible under the small employer's plan but who are late enrollees may enroll for coverage under the small employer's plan during the employee open enrollment period.

(c) Employees and dependents who are covered under the small employer's plan who wish to elect coverage under a different policy, if any, offered by the small employer, may enroll for coverage under the alternate plan during the employee open enrollment period.

(d) The effective date of coverage applied for during the employer open enrollment period shall be the start of the plan year.

11:21-7.7A Special enrollment period

(a) The special enrollment period means a period of time that is no less than 30 days following the date of a triggering event listed in (b)1 through 5 below and no less than 60 days following a triggering event listed in (b)6 below during which:

1. [Eligible] **Full-time** employees and dependents who are late enrollees are permitted to enroll under the small employer's plan; and

2. [Eligible**]** **Full-time** employees and dependents who already have coverage are allowed to replace current coverage with a different plan, if any, offered by the small employer.

(b) Triggering events are:

1. The date [an eligible] **a full-time** employee or dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a triggering event;

2. The date [an eligible] **a full-time** employee acquires a dependent or becomes a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care;

3. The date [an eligible] **a full-time** employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation, or inaction by the Federal government;

4. The date [an eligible] **a full-time** employee or eligible dependent demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

5. The date the [eligible]**full-time** employee or dependent gains access to new qualified health plans as a result of a permanent move; [and]

6. The date the [eligible]**full-time** employee or dependent loses or gains eligibility under Medicaid or NJFamilyCare**; and**

7. The date of a court order that requires coverage for a Dependent.

(c) The effective date of the employee's coverage or dependent's coverage shall be:

1. The day after the loss of minimum essential coverage as described in (b)1 above;

2. The date of marriage, birth, adoption, placement for adoption, or placement in foster care as described in (b)2 above; [or]

3. The first of the month following receipt of the enrollment form with respect to the events described in (b)3, 4, 5, and 6 above**; or**

4. The date specified in the court order with respect to item (b)7 above.

(d) If [an eligible**] a full-time** employee initially waived coverage and stated at that time that such waiver was because he or she was covered under another group plan, and the employee subsequently elects to enroll under the small employer's plan, the employee and his or her dependents will not be late enrollees.

1. The employee may enroll under the small employer's plan within 90 days of the date any of the events described in (d)2 below occurs. The small employer carrier will assign an effective date as of the day after the event described in (d)2 below occurs.

2. The employee is not considered to be a late enrollee if the coverage under the other plan ends due to one of the following events:

i. Termination of employment or eligibility;

ii. Reduction in the number of hours of employment;

iii. Involuntary termination;

iv. Divorce or legal separation or dissolution of the civil union or termination of the domestic partnership;

v. Death of the [eligible] **full-time** employee's spouse;

vi. Termination of the policyholder's contribution toward coverage; or

vii. Termination of the other plan's coverage.

(e) The [eligible] **full-time** employee must enroll within 90 days of the date that any of the events described in (d) above occur. Coverage will take effect as of the date the applicable event occurs.

11:21-7.8 Effective date of employer's coverage

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

1. A completed small employer standard application form including the small employer certification form in accordance with N.J.A.C. 11:21-6.1(a) and (b);

2. Complete employee enrollment forms and waiver forms; and

3. An advance premium payment not to exceed one month's premium, which shall be refunded to the employer if the health benefits plan is not issued by the small employer carrier.

(b) A small employer carrier shall provide notice to the employer within 15[working] **business** days of receipt by the small employer carrier of the information set forth in (a) above whether the small employer carrier approves or disapproves the employer's application for the health benefits plan. Except as stated in (c) below, if approved, the effective date of coverage under the health benefits plan shall be no later than the first day of the month following the date of notice of such approval by the small employer carrier unless the small employer has requested a later effective date which is agreed to by the small employer carrier.

(c) The effective date of coverage under a health benefits plan issued to an employer as a result of an application received during the employer annual open enrollment period shall be January 1 of the year following the employer annual open enrollment period.

(d) At the option and upon the request of the small employer, a waiting period may be applied by the small employer carrier with respect to employees when they first become eligible for coverage, not to exceed 90 days. Waiting periods may be applied to these employees by class of employee based upon conditions pertaining to employment.

(e) A small employer carrier may offer an automatic checking withdrawal option to small employer groups for the monthly or quarterly payment of premiums. In the event that a small employer carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all small employer groups, regardless of the size of the group or the type of health benefits plan.

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 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) Each small employer carrier shall make reasonable disclosure in price quotes provided to small employers of the provisions concerning the small employer carrier's right to change premiums and the criteria in the small employer carrier's rate filing which affect changes in premium rates.

11:21-7.10 Tie-ins

A small employer carrier that does not embed pediatric dental benefits in the health benefits plans offered to small employers shall obtain a reasonable assurance that the small employer has purchased a stand-alone pediatric dental benefit plan from a carrier that offers a qualified pediatric dental benefit plan. A small employer carrier shall not require, as a condition to the offer or sale of a health benefits plan to a small employer, that the small employer purchase or qualify for any other insurance products or services.

11:21-7.11 Guaranteed renewal

(a) All health benefits plans that are issued or renewed on or after January 1, 1994, must be guaranteed renewable at the option of the policy or contract holder or small employer, except that a carrier may discontinue a health benefits plan pursuant to (b) below or nonrenew a health benefits **plan** pursuant to (c) below.

(b) A carrier may discontinue a health benefits plan only if:

1. The policyholder, contract holder, or employer has failed to pay premiums or contributions in accordance with the terms of the health benefits plan or the carrier has not received timely premium payments; or

2. The policyholder, contract holder, or employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(c) A carrier may nonrenew a health benefits plan only if:

1. The number of employees covered under the health benefits plan is less than the number or percentage of employees required by participation requirements under the health benefits policy

or contract unless renewal coincides with an employer open enrollment period. Minimum participation rates are calculated once per year at the time of initial group submission and subsequently at the time of renewal;

2. The small employer fails to comply with a small employer carrier's employer contribution requirements unless renewal coincides with an employer open enrollment period. Minimum contribution rates are calculated once per year at the time of initial group submission and subsequently at the time of renewal;

3. The carrier files with the Commissioner to withdraw from the small employer market and meets the requirements of N.J.A.C. 11:21-16;

4. The small employer ceases its membership in an association or trust of employers where the health benefits plan was issued in connection with such membership;

5. The carrier receives approval to cease offering and renewing a particular type of a plan and meets the requirements of N.J.A.C. 11:21-13;

6. The SEH Board discontinues a particular standard health benefits plan or plan option; or

7. In the case of a health maintenance organization plan issued to a small employer:

i. An eligible person who no longer resides, lives, or works in the carrier's approved service area, but only if coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

ii. A small employer that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the carrier and the carrier would deny enrollment with respect to such plan pursuant to N.J.S.A. 17B:27A-26.

11:21-7.12 Reporting requirements

(a) A small employer carrier shall file with the Board, quarterly no later than 60 days after the end of the fiscal quarter, the following information reported with respect to standard health benefits plans:

1. The number of small employers, covered employees, and dependents that were issued health benefits plans in the previous calendar quarter, reported separately as to newly issued plans and renewals, and separately for standard health benefits plans B, C, D, and E; plans B, C, D, and E sold through or in conjunction with a selective contracting arrangement; HMO; and HMO POS; and

2. The total number of health benefits plans in force at the end of the quarter, and the total number of employees and dependents covered, reported separately for each standard health benefits plan B, C, D, and E; plans B, C, D, and E sold through or in conjunction with a selective contracting arrangement; HMO; and HMO POS.

(b) Quarterly reports shall be filed at the address listed in N.J.A.C. 11:21-1.3.

(c) An insurance company, health service corporation, hospital service corporation, or medical service corporation and affiliated health maintenance organization shall file separate reports.

11:21-7.13 (Reserved) [Paying benefits

(a) Except as stated in (b) below for prosthetic and orthotic appliances, 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 services, using either the allowed charges or actual charges. Allowed charge 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 Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

1. The maximum allowed charge shall be based on the 80th percentile of the profile.

2. Carriers shall use the profile effective as of July 1993, and shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

(b) In paying benefits for prosthetic and orthotic appliances as required by P.L. 2007, c. 345, reimbursement shall be at the same rate as reimbursement for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or out-of-network basis. However, if the carrier's contract rate with a network provider of orthotic and prosthetic appliances exceeds the Medicare reimbursement rate, the carrier's contract rate should be paid.]

11:21-7.14 Permissible rate classification factors

(a) For health benefits plans issued or renewed on or after January 1, 2014, a carrier shall not differentiate premium rates charged to different small employers for the same health benefits plan except on the basis of age and geography in accordance with the following restrictions:

1. Rates shall vary by age for each covered person age 21 or older. There shall be a per child rate for children under age 21 with a limit applied to the number of children rate equal to three times the child rate.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the counties listed below. A carrier shall determine which territory applies to a small

employer on the basis of the address of the small employer's principal place of business. The six territories are the following:

i. Territory A consists of Essex, Hudson, and Union counties;

ii. Territory B consists of Bergen and Passaic counties;

iii. Territory C consists of Monmouth, Morris, Sussex, and Warren counties;

iv. Territory D consists of Hunterdon, Middlesex, and Somerset counties;

v. Territory E consists of Burlington, Camden, and Mercer counties; and

vi. Territory F consists of Atlantic, Cape May, Ocean, Salem, Cumberland, and Gloucester counties.

11:21-7.15 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.

11:21-7.16 Obligation to offer individual health benefits plans

Members that offer small employer health benefits plan in this State shall offer and make a good faith effort to market individual health benefits plans pursuant to N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20-24.6. Such requirement may be satisfied by the member or the member's affiliate since the definition of "carrier" at N.J.S.A. 17B:27A-2 says carriers that are affiliated companies shall be treated as one company.

SUBCHAPTER 8**. (Repealed)** [CARRIER CERTIFICATION OF NON-MEMBER STATUS

11:21-8.1 Purpose and scope

(a) The purpose of this subchapter is to establish which carriers are not members of the SEH Program and how those carriers may be certified as non-members.

(b) This subchapter applies to any carrier which files Annual Statements with the Department evidencing premium earned on group health insurance.

11:21-8.2 Definitions

Words and terms used in this subchapter shall have the meanings set forth in the Act or N.J.A.C. 11:21-1.2, unless the context indicates otherwise.

11:21-8.3 Non-member status

(a) A carrier shall be a non-member of the SEH Program for the calendar year for which it submits a completed request for non-member certification unless the non-member certification is disapproved in writing by the Board. A carrier shall use the "Carrier Request for Non-Member Certification in the New Jersey Small Employer Health Benefits Program" form provided as Exhibit KK of these rules.

(b) A request for non-member certification shall state that:

1. The carrier neither issued nor had in force a group health benefits plan covering New Jersey small employers during the calendar year for which certification is submitted;

2. Other reasons which under law permit a carrier or entity to be certified a non-member.

11:21-8.4 Non-member certification requests

(a) To be considered a non-member in any calendar year, a carrier or entity shall file with the Board a completed request for non-member certification no later than March 1 of the following calendar year. Such request shall be sent to the SEH Program Administrator or Executive Director as specified at N.J.A.C. 11:21-1.3.

(b) All requests for non-member certification shall contain the statements required in N.J.A.C. 11:21-8.3 and be certified by a duly authorized officer of the carrier.

(c) A copy of such request also shall be filed by the carrier or other entity with the Commissioner as follows:

Attn: SEH Annual Certification of Non-Member Status

Life/Health Actuarial Services

New Jersey Department of Banking and Insurance

PO Box 325

Trenton, NJ 08625-0325

11:21-8.5 Decisions on filings by the Board

The Board shall, if it determines that a carrier's non-member certification is incomplete, incorrect, or not in substantial compliance with this subchapter or other law, deny a request for non-member certification in writing, stating the reasons for the determination, after review of a carrier's filing. A copy of such decision shall be sent to the carrier and to the Commissioner.

11:21-8.6 Review

A carrier which has been denied non-member certification may contest that determination by filing an appeal with the Board pursuant to procedures set forth in N.J.A.C. 11:21-2.17.]

SUBCHAPTER 10. THE MARKET SHARE REPORT

11:21-10.1 Scope and applicability

(a) This subchapter sets forth annual reporting requirements of market share data for the assessment of operational and administrative expenses of the SEH Program.

(b) This subchapter shall apply to all carriers that are, or become, members of the SEH Program for any portion of a calendar year for which reports under this subchapter are required to be filed, whether or not the carrier is a member on the report filing due date.

11:21-10.2 (Reserved) [Definitions

Words and terms used in this subchapter shall have the meanings as set forth in the Act or the chapter, unless the context clearly indicates otherwise.]

11:21-10.3 Filing of the Market Share Report

(a) Every member of the SEH Program shall file the Market Share Report set forth as Exhibit CC in the Appendix to this chapter[, incorporated herein by reference,] on or before March 1. Every member shall complete Parts A, B, C and D of the Market Share Report.

1. Affiliated carriers shall submit a combined Market Share Report, except as **stated in** (a)2 below [implies]. The combined Market Share Report shall be submitted under the name of one of the affiliated carriers' members.

2. Any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in the State, and any health maintenance organization located in the State that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall submit separate Market Share Reports.

(b) Certified Market Share Reports shall be submitted by mail or facsimile to the SEH Program [Administrator or] Executive Director, as set forth at N.J.A.C. 11:21-2.

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 NAIC statement blank, adjusted to meet the definition of group health benefits plan and exclude refunds as described in (a)1 above, as necessary.

11:21-10.5 Certification

All reports shall be certified as accurate, complete and conforming with the requirements of this subchapter by the Chief Financial Officer or other duly authorized officer of the member.

11:21-10.6 Failure to comply

Failure to comply with the reporting provisions of this subchapter shall result in the Board determining that the premium set forth in the member's most recent Annual Statement filed with the Department is the premium based upon which that member's market share allocation of assessments shall be calculated by the Board.

Nothing in this subchapter shall be construed to contravene any rights of policyholders concerning cancellation requirements or obligations set forth in a policy or contract issued by a small employer carrier.

SUBCHAPTER 17. FAIR MARKETING STANDARDS

11:21-17.1 Plan identification and marketing materials

(a) Each small employer carrier which issues marketing and/or promotional materials in conjunction with the standard health benefits plans may attach its own name or identification to each of the plans, but shall also identify each of those standard health benefits plans by the alphabetical designation (B, C, D, E, HMO, HMO POS) assigned to it in N.J.A.C. 11:21-3.1. The alphabetical designation shall be clearly identified in the designation of each of the small employer carrier's standard health benefits plans.

(b) All 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.

11:21-17.2 Retention of marketing and promotional materials

Small employer carriers shall maintain a complete file of all marketing and promotional material specific to the health benefits plans, which it disseminates to consumers, producers, or otherwise publicly disseminates. Small employer carriers shall retain each piece of promotional and marketing materials for a period of three calendar years from the last date the material is publicly disseminated, which shall be deemed its complete file for the purposes of this subchapter. Upon written request of the Board, a small employer carrier shall, within three business days, make available for inspection its complete file of marketing and promotional material to the Board.

11:21-17.3 Certification

(a) Each small employer carrier disseminating marketing and promotional material shall certify that its marketing and promotional material conforms with the requirements of this subchapter. The certification, set forth in Part 2 of Exhibit BB of the Appendix[, incorporated herein by reference,]shall be signed by a duly authorized officer of the small employer carrier. Each small employer carrier shall file its initial certification with the Board no later than the first day upon which the small employer carrier disseminates promotional or marketing materials for the health benefits plans to consumers, producers or the public in general.

(b) Small employer carriers shall continue to file a certification as required in (a) above on an annual basis, on or before March 1 of each year following the filing of its initial certification.

11:21-17.4 (Reserved)[Disclosure of premiums for riders

(a) A small employer carrier that offers standard health benefits plans as amended by one or more optional benefit riders shall list the premium or percentage change for the ridered plan separately from the premium or percentage change for the unridered standard health benefits plan on rate quotes prepared by the small employer carrier.

(b) A small employer carrier that files an optional benefit rider pursuant to N.J.A.C. 11:21-3.2 shall include, as part of the certification required by N.J.A.C. 11:21-3.2(a)6v(6), a statement that the premium or percentage change for ridered standard health benefits plans will be listed separately from the premium or percentage change for the unridered standard health benefits plan on rate quotes prepared by the carrier.]

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] **full-time** employees or dependents, the average number of [eligible] **full-time** 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 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

11:21-18.1 Scope

This subchapter shall apply to all petitions made by interested persons for the promulgation, amendment or repeal of any rule by the Board, pursuant to N.J.S.A. 52:14B-4(f).

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;

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.

(c) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board

shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

(d) Any document submitted to the Board which is not in substantial compliance with (a) above shall not be deemed to be a petition for a rule requiring further Board action pursuant to N.J.S.A. 52:14B-4(f).

11:21-18.3 Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:21-18.2 the Board shall, within 15 days, file a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;

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

3. The problem or purpose which is the subject of the request; and

4. The date the petition was received.

(b) Within 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. The name of the petitioner;

2. The New Jersey Register citation for the notice of petition, if that notice appeared in a previous New Jersey Register;

3. Certification by the Board that the petition was duly considered pursuant to law;

4. The nature or substance of the Board's action upon the petition; and

5. A brief statement of reasons for the Board's action.

(c) Board's action on a petition may include:

1. Denying the petition;

2. Filing a notice of proposed rule or a notice of pre-proposal for a rule with the Office of Administrative Law; or

3. Referring the matter for further deliberations, the nature of which shall be specified and which shall conclude upon a specified date. The results of these further deliberations shall be mailed to petitioner and submitted to the Office of Administrative Law for publication in the New Jersey Register.

SUBCHAPTER 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 website at:[http://www. njdobi.org] **www.dobi.nj.gov**;

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 website; 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 website at: [http://www.njdobi.org]**www.dobi.nj.gov**;

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.

APPENDIX

OFFICE OF ADMINISTRATIVE LAW NOTE: The New Jersey Small Employer Health Benefits Program Board is proposing amendments to N.J.A.C. 11:21 Appendix Exhibits D, F, G, K, T, W, Y, BB Parts 1 and 2, CC, DD, HH and II. Pursuant to N.J.S.A. 52:14B-7(c) and N.J.A.C. 1:30-5.2(a)2, the Exhibits as proposed for amendment are not published herein, but may be reviewed by contacting:

New Jersey Small Employer Health Benefits Program

20 West State Street, 11th Floor

PO Box 325

Trenton, NJ 08625-0325

New Jersey Office of Administrative Law

9 Quakerbridge Plaza

PO Box 049

Trenton, NJ 08625-0049