INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program Rules and Standard Plans

Proposed Amendments: N.J.A.C. 11:21-1, 3, 4, 6, 7, and 17 and N.J.A.C. 11:21 Appendix Exhibits F, G, K, W, Y, HH and II.

Proposed Repeals and New Rules: N.J.A.C. 11:21-7.2 and 7.7

Proposed New Rules; N.J.A.C. 11:21-7.7A

Proposed Repeals: **N.J.A.C. 11:21 Appendix Exhibits A, H, N, O and V.**

Authorized By: New Jersey Small Employer Health Benefits Program, Ellen DeRosa, Executive Director

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

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

Proposal Number: PRN 2013-

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 Exhibits F, G, K, W, Y, HH and II of the Appendix to N.J.A.C. 11:21 at a **public hearing** to be held on December 10, 2013 at 9:00 a.m. in the 11th floor Conference Room, 20 West State Street, Trenton, New Jersey.

Submit written comments by December 17, 2013 to:

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The agency proposal follows:

Summary

The Small Employer Health Benefits (SEH) Program was established by P.L. 1992, c. 162. The SEH Program is administered through a Board of Directors (Board). One of the primary functions of the SEH Program and its Board is the creation of standard health benefits plans (standard plans) to be offered in the small employer market in New Jersey. Standard plans have been established through regulation, and are set forth in Exhibits A, F, G, V, W, Y, HH and II of the Appendix to N.J.A.C. 11:21 along with Exhibit K, which provides explanations of how variables in the standard plans may be used by carriers. In this proposal, the Board proposes the repeal of standard Plan A set forth in Appendix Exhibits A and V since such plan is inconsistent with essential health benefits as discussed later in this Summary.

The SEH Board proposes amendments to the rules including the standard plans to comply with the federal mandates of the Federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (collectively, the Federal law). The requirements of the Federal law necessitate amendments to definitions, the determination of small employer status, eligibility for coverage, open enrollment rules as well as the rules governing the standard plans. The rules are found in N.J.A.C. 11:21-1, 3, 4, 6, 7 and 17. The text for standard plans B, C, D and E is set forth in Appendix Exhibits F and W. The text for the standard HMO Plan is set forth in Appendix Exhibits G and Y and the

text for the standard HMO-POS plan is set forth in Appendix Exhibits HH and II. The explanation of brackets for the standard plans is set forth in Appendix Exhibit K.

At this time the SEH Board proposes amendments to the rules and standard health benefits plans to comply with the requirements of the Federal law that will be effective for policies issued on or after January 1, 2014.

Changes to Chapter 21

The SEH Board is proposing to amend N.J.A.C. 11:21-1.2 for several reasons: to consolidate location of the definitions; to bring definitions into alignment with federal law; to clarify certain terminology; or, to delete terms or portions of definitions that no longer have application within N.J.A.C. 11:21. The SEH Board is proposing to move "affiliated company" from N.J.A.C. 11:21-7.2 to N.J.A.C. 11:21-1.2, because it believes it will be easier for readers to find definitions if they are all housed in one location. The SEH Board is proposing to add the term "carrier coinsurance" at N.J.A.C. 11:21-1.2 to add clarity as to how a coinsurance requirement is meant to be understood (i.e., carrier coinsurance in the plans may vary within a range of 50% to 100%, meaning the carrier pays within a range of 50% to 100% of the allowed charge). The SEH Board is proposing to eliminate the following terms, because they will no longer have applicability for plan years starting in 2014: "church plan," "creditable coverage," "federally-qualified HMO," "governmental plan," "non-standard health benefits plan," "preexisting condition exclusion," and "state approved HMO."

Several of the terms proposed to be deleted (church plans, creditable coverage, governmental plan) were introduced to the Board's rules because of the federal Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. 104-191, specifically Title I), which,

among other things, established limits on the application of preexisting condition exclusion and limitation periods and required carriers (and self-funded plans) to reduce preexisting condition limitation periods further if someone had previously had creditable coverage. The term "preexisting condition exclusion" has been a part of the SEH Board's rules since the SEH Program's inception. However, because of provisions of the Federal law that amended HIPAA and certain other provisions of the federal Public Health Services Act (see 42 U.S.C. 300gg-3, for instance), starting in 2014, carriers will not be permitted to apply preexisting condition limitation periods at all with respect to small employer coverage issued after the Federal law's effective date; consequently, prior creditable coverage is also no longer applicable. The result is that terms related to preexisting condition exclusions or limitation periods and creditable coverage are no longer necessary. Similarly, the SEH Board is proposing to amend the term "late enrollee." Under HIPAA, late enrollees could be subjected to preexisting condition periods and creditable coverage reductions, but as of 2014, that will no longer be the case. However, the Board is not proposing to delete the term, because late enrollee still has meaning in distinguishing when someone who initially waives employer coverage may subsequently enroll.

Several of the terms the SEH Board is proposing to delete (federally-qualified HMO, non-standard health benefits plan, and state approved HMO) have become obsolete because of gradual changes over time in markets and regulatory policy. There are currently no non-standard health benefits plans (plans issued prior to 1994) in force and there is no opportunity for a carrier to issue such a plan. With respect to HMOs, there is no practical difference accorded to HMOs that may have federal qualification at this point, and the rules no longer reference HMOs in terms of whether they are federally qualified or state approved. Thus, the SEH Board has no need for these terms at this time.

The SEH Board is proposing to add the following new terms to N.J.A.C. 11:21-1.2 in order to align the rules more closely with provisions of the Federal law: "employee," "employee open enrollment period," and "employer open enrollment period." Similarly, the SEH Board is proposing to amend the definitions of "eligible employee" and "small employer" to help align the term with the federal law. The federal regulations, at 45 C.F.R. 155.20, combined with the operation of the proposed federal regulations at 26 C.F.R. 54.4980H-1 and -3 (published in the Federal Register, vol. 78, No. 1, on January 2, 2013), and guidance from the IRS in Notice 2012-58, establish definitions of "employee," that differ from the definition of "eligible employee" in the SEH statutes and rules, and thus, result in different standards for determining which employers are small employers. The SEH Board is proposing to incorporate both standards within its rules in an effort to harmonize the regulatory systems, and thus, minimize the differences between the federal Small Business Health Options Program (SHOP) and the small employer program, and to assure that carriers are able to operate within both segments of the market without violating either state or federal law. The SEH Board is proposing to include the term "employee open enrollment period" and "employer open enrollment period," because the federal regulations require that carriers provide open enrollment periods for small employers generally (see 45 C.F.R. 147.104, 45 C.F.R. 155.410). Further, the Board believes that the standards used for such enrollment periods should be as consistent with those established for the SHOP at 45 C.F.R. 155.725 as is possible, to make it easier for carriers and employers alike.

The SEH Board is proposing to amend three additional definitions: "dependent," "maximum out of pocket," and "network maximum out of pocket." The SEH Board is also proposing to amend "dependent" to reflect recent changes to federal law and the impact on the opportunity for a COBRA election.

With respect to the terms “maximum out of pocket” and “network maximum out of pocket,” the SEH Board is proposing to remove the cross-reference to N.J.A.C. 11:22-5.2, because that regulation permits carriers to exclude prescription drug charges from the accumulation of the maximum out of pocket. As required by 42 U.S.C. § 18022 all charges, including those for prescription drugs, must accumulate toward the maximum out of pocket.

The SEH Board proposes numerous amendments to N.J.A.C. 11:21-3.1 which provides detail regarding the benefits provided under the standard health benefits plans.

The SEH Board proposes amending N.J.A.C. 11:21-1.3 to include an email address as an acceptable means of written communication.

In N.J.A.C. 11:21-3.1(a) the SEH Board proposes deleting text regarding Plan A. Plan A is a limited benefits plan and does not satisfy the essential health benefits (EHB) standards required by 42 U.S.C. 18022(a). The SEH Board proposes specifically noting the carrier coinsurance requirement associated with plans B, C, D and E in the rule. Such coinsurance requirements already appear in Appendix Exhibits F and W.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(b) to remove the requirement that carriers offer plan A and state that the carrier must satisfy its obligation to offer at least three plans (see N.J.S.A. 17B:27A-19) by offering the three plans from among plans B, C, D and E.

In N.J.A.C. 11:21-3.1(b) the SEH Board proposes deleting text regarding Plan A. Plan A is a limited benefits plan and does not satisfy the essential EHB standards required by 42 U.S.C. 18022(a). The SEH Board also proposes amending the deductible and maximum out of pocket requirements such that the deductible may not exceed the maximum deductible permitted by 45 CFR 156.130 and the maximum out of pocket shall not exceed the annual limits on cost sharing also specified in 45 CFR 156.130.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(c) to delete the reference to a state approved or federally qualified HMO and delete the reference to Plan A for the reasons discussed above. In addition, the SEH Board proposes to amend the parameters for a copayment design to be subject to the requirements of N.J.A.C. 11:22-5.5(a), deductible and coinsurance design to be subject to the requirements of N.J.A.C. 11:22-5.3 and 45 CFR 156.130 and maximum out of pocket to be subject to the requirements of 45 CFR 156.130. Further, the SEH Board proposes that the emergency room copayment shall comply with the requirements of N.J.A.C. 11:22-5.5(a)4, that there be no cost sharing for pre-natal care as required by 42 U.S.C. § 300gg-3 and that prescription drug cost sharing be 50 percent or subject to the requirements of N.J.A.C. 11:22-5.5(a).

The SEH Board proposes amending N.J.A.C. 11:21-3.1(d) to address the deductible requirements of N.J.A.C. 11:22-5.3 and 45 CFR 156.130 and the maximum out of pocket requirements of 45 CFR 156.130.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(e) to delete text regarding Plan A for the reason previously stated.

The SEH Board proposes amending N.J.A.C. 11:21-3-1(f) to specify that an Exclusive Provider Organization (EPO) is an available plan design.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(g) to state that HMO plan copayments shall be consistent with the requirements of N.J.A.C. 11:22-5(a), deductibles shall be consistent with N.J.A.C. 11:22-5.3 and 45 CFR 156.130 and the maximum out of pocket shall be subject to the federal requirements of 45 CFR 156.130. Further, the SEH Board proposes that the emergency room copayment shall comply with the requirements of N.J.A.C. 11:22-5.5(a)4, that there be no cost sharing for pre-natal care as federally required by 42 U.S.C. § 300gg-13 and

that prescription drug cost sharing be 50 percent or subject to the requirements of N.J.A.C. 11:22-5.5(a).

The SEH Board proposes amending N.J.A.C. 11:21-3.2 to delete (a) through (c) which refer to standard riders developed by the SEH Board. The SEH Board proposes Exhibit H, the prescription drug rider, for repeal. Carriers have elected to develop their own prescription drug riders and therefore a standard prescription drug rider is no longer necessary.

The SEH Board proposes amending the provision that will be recodified as N.J.A.C. 11:21-3.2(a) to delete the references to Plan A, delete the reference to standard riders, and refer to four plans rather than five for the reasons described above. In addition, the SEH Board proposes amending N.J.A.C. 11:21-3.2(d)4ii with respect to dental coverage. Since the plans include pediatric dental benefits as a required EHB, the excepted dental benefits are for persons age 19 or older. The SEH Board proposes amending N.J.A.C. 11:21-3.2(d)6i to allow filings to be submitted through paper or electronic means. This amendment recognizes the opportunity for carriers to use an electronic filing system that saves mailing time. The SEH Board proposes amending N.J.A.C. 11:21-3.2(d)6 to delete references to Plan A and to delete the requirement that the carrier include copies of the pages to be amended as part of the filing as such copies are no longer necessary for the review process.

The SEH Board proposes amending N.J.A.C. 11:21-4 which addresses policy forms. The proposed amendments delete references to Plan A and the standard prescription drug rider, as discussed earlier in this proposal.

The SEH Board proposes amending N.J.A.C. 11:21-6 which addresses the standard employer application and annual certification form. The proposed amendments repeal Appendix Exhibits N and O and provide that the text of the standard application and certification form is

available on the SEH Board's website. The proposed amendments list the type of information that is included on the employer application and certification forms.

The SEH Board proposes substantial revisions to subchapter 7, Program Compliance, in order to address various requirements of the Federal law.

The SEH Board proposes the repeal of current N.J.A.C. 11:21-7.2 because the majority of the definitions are no longer necessary in light of the elimination of the pre-existing condition exclusion, as discussed earlier in this proposal. Two of the definitions are necessary. The definition of affiliated company is proposed to be moved to the definitions provision at N.J.A.C. 11:21-1.2. The definition of late enrollee is also necessary. Such definition is already included in the definitions provision at N.J.A.C. 11:21-1.2.

The SEH Board proposes amending N.J.A.C. 11:21-7.3(a) to delete the requirement that the majority of employees be employed in New Jersey since such requirement is inconsistent with the guaranteed issue requirements of 45 CFR 147.104 and 42 U.S.C. 300gg-1. The SEH Board proposes expanding the requirement that the employee live, work or reside in the service area beyond HMO plans to include all network-based plans.

The SEH Board proposes the repeal of current N.J.A.C. 11:21-7.7 because that rule addresses pre-existing condition standards. As discussed earlier in this proposal, 42 U.S.C. § 300gg-3 prohibits the imposition of a pre-existing condition exclusion.

The SEH Board proposes adding new N.J.A.C. 11:21-7.2 to address the rules governing the determination of whether an employer meets the definition of small employer under New Jersey law or Federal law. The definition of small employer set forth in N.J.S.A. 17B:27A-17 is the basis for the definition in proposed N.J.A.C. 11:21-7.2(b) and the definition of small employer set forth at 45 CFR 155.20 is the basis for the definition in proposed N.J.A.C. 11:21-

7.2(c). An employer is a small employer if the employer satisfies the requirements of either definition. Proposed N.J.A.C. 11:21-7.2(d) and (e) address ongoing status of a small employer and the method to made a determination as to whether an employer is a small employer for employers that were not in existence during the preceding calendar year.

The SEH Board proposes amendments to N.J.A.C. 11:21-7.3 to remove the references to nonstandard plans (plans issued prior to 1994) since there are no longer any nonstandard plans, to address the two-part definition of small employer and to refer to new N.J.A.C. 11:21-7.2 for the rule to address employers not in existence during the preceding calendar year. The SEH Board proposes deleting N.J.A.C. 11:21-7.3(c) which currently addresses requirements for coverage of independent contractors. Federal regulations at 45 CFR 155.20 precludes considering anyone an employee who is not an employee. The SEH Board proposes amending N.J.A.C. 11:21-7.3(d) which currently addresses the enrollment of late enrollees at any time subject to the imposition of a pre-existing condition exclusion with an enrollment opportunity during the employee open enrollment period. This amendment is consistent with the open enrollment periods set forth in 45 CFR 147.104. The SEH Board proposes deleting N.J.A.C. 11:21-7.3 (e), (f) and (g) which addresses limited opportunities to cover part-time employees and retirees. The limited opportunity relied on coverage having been made available prior to 1994 and maintained thereafter. Since no carriers have maintained coverage of part-time employees and retirees the provisions are not necessary.

Consistent with federal regulations at 45 CFR 155.705(b)(10)(i) the SEH Board proposes amending N.J.A.C. 11:21-7.5 to include coverage under Tricare as coverage for which participation credit is given. In addition the Board proposes adding new N.J.A.C. 11:21-7.5(e) to address the waiver of the participation requirement during open enrollment set forth in 45 CFR

147.104. Similarly, the Board proposes adding new N.J.A.C. 11:21-7.6(e) to address the waiver of the contribution requirement during open enrollment set forth in 5 CFR 147.104.

The SEH Board proposes new N.J.A.C. 11:21-7.7 to address the employee open enrollment period set forth in 45 CFR 147.104 .

The SEH Board proposes new N.J.A.C. 11:21-7.7A to address the special enrollment period and triggering events as required by federal regulations at 45 CFR 155.725 and the enrollment periods required by HIPAA as implemented at 29 CFR 2590.701-6.

The SEH Board proposes amending N.J.A.C. 11:21-7.8 to delete an erroneous reference to an exception in N.J.A.C. 11:21-7.5(d)2, to include an effective date rule for the new employer annual enrollment period which is required by federal regulations at 45 CFR 147.104 and 45 CFR 155.410 and to delete an option for carriers to require employers to make payments using an automatic checking withdrawal option because such option is inconsistent with the guaranteed issue requirements of 147.104.

The SEH Board proposes amending N.J.A.C. 11:21-7.11 to add exceptions to nonrenewal if the renewal coincides with the employer annual open enrollment period and to specify the times during which minimum participation and contribution requirements are calculated.

The SEH Board proposes amending the reporting requirements in N.J.A.C. 11:21-7.12 to allow carriers 60 days following the close of each calendar quarter to file the quarterly report and to replace the incomplete description of the information contained in the report with reference to the report form itself.

The SEH Board proposes amending the provisions discussing rate classification factors in N.J.A.C. 11:21-7.14. As required by 45 CFR 147.102 as of January 1, 2014 rates may vary based on age and geography but may not vary based on gender. In addition, rates for persons age 21

and older will vary each year and the rates for persons under age 21 will be subject to a child rate but subject to a limit applied to the number of children of three times the child rate. Pursuant to federal guidance, territories may no longer be defined by ZIP code, so they are being deleted. The family structure rating tiers are no longer meaningful and are being deleted.

The SEH Board proposes amending the fair marketing standards in N.J.A.C. 11:21-17 to delete the reference to Plan A.

Changes to the Standard Plans

In accordance with 42 U.S.C. 18022(a), all health benefits plans offered in a state for individuals and small employers must comply with essential health benefits (EHB) standards. A health benefits plan that will be offered on the SHOP must be certified as a Qualified Health Plans (QHP). (See 42 U.S.C. 18031(b)(1)(B) and (d)) QHPs are a category of EHB-compliant health benefits plans. Although EHB-compliant health benefits plans, including QHPs, are not required to be issued until January 2014, the Federal law authorizes the federal Secretary of the U.S. Department of Health and Human Services (HHS) to establish open enrollment periods for QHPs in advance of the January 1 date, so that individuals may purchase the coverage and have it take effect as of the beginning of 2014.

The SEH Board is proposing the following specific amendments to N.J.A.C. 11:21 Appendix Exhibits F, G, W, Y, HH and II.

The federal regulations at 45 CFR 156.130 set forth the annual limit on network cost sharing applicable to all health benefits plans in 2014, pursuant to 42 U.S.C. 18022. The standard plans refer to the annual cost limitations as the Maximum Out of Pocket, which for 2014 is $6,350 for single coverage and $12,700 for other than single coverage. The amount for 2015 and subsequent years will adjust consistent with sections 223(c)(2)(A)(ii)(I) and

223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986, as prescribed by 42 U.S.C. 18022(c)(1)(A). The amount is consistent with the tax-favored contribution limits permitted for high deductible health plans issued in conjunction with a federally tax-favored Health Savings Account.

All copays, deductible and coinsurance payments must accumulate toward the Maximum Out of Pocket. The amendments to the permissible dollar amount of the Maximum Out of Pocket and to what charges accumulate toward the Maximum Out of Pocket appear on the Schedule page text, the Covered Charges and Covered Services and Supplies text. Consistent with the annual limit on cost sharing the SEH Board proposes an amendment to the range of permissible deductibles such that the maximum per person deductible may not exceed an amount permitted by 42 U.S.C. 18022(c)(2). (See also 45 CFR 156.130).

As required by 45 CFR 147.126(a)(2), which prohibits the use of annual dollar limits for EHBs, the standard plans are being amended to remove the annual dollar limits for hearing aids. The amendments appear on Schedule page text, the Covered Charges and Covered Services and Supplies text As required by 42 U.S.C. 300gg-13 which requires coverage of preventive services without cost sharing, the specific copayment associated with pre-natal care has been removed. The amendment appears on the Schedule page.

One of the required EHBs is habilitative services – that is, services such as occupational, physical, and speech therapy, that are designed to help people acquire, maintain, or improve skills and functioning for daily living. (See 42 U.S.C. 18022(b)(1)(G)). While the standard plans already include coverage for services that qualify as habilitative services, they are not specially identified as such. Recognizing that consumers might expect to see coverage for a service that at least notes the services that are habilitative the Board proposes specifically identifying the

services as habilitative. The amendments appear on the schedule page and the Covered Services and Supplies provision.

As required by federal law and regulations (See 42 U.S.C. 300gg-14 and 45 CFR 147.120), which require that children may be covered based on relationship to the insured rather than based on a dependency test, clarifying amendments to the Eligibility provision allows for single coverage as well as various combinations of coverage with spouse and/or child dependents.

As required by federal law (See 42 U.S.C. 300gg-7 and 45 CFR 147.116) the Board proposes amending the waiting period provision to specify that the maximum duration of the waiting period is 90 days. In addition, the provision includes variable text to address employees who are still in a waiting period as of the effective date.

Federal statutes and regulations (See 42 U.S.C. 18022 and 45 CFR 156.115) require that covered benefits for health benefits plans be substantially equal to those contained in the selected EHB benchmark plan. (States select a benchmark plan that is EHB-compliant. In New Jersey, the benchmark plan is a standard small employer HMO plan.) Since the benchmark plan used to define essential benefits features an unlimited benefit for extended care or rehabilitation charges the 120-day limit that currently exists in non-HMO standard plans has been removed. The amendment appears in the Covered Charges and Covered Services and Supplies and Exclusions provisions. Similarly since the benchmark plan used to define essential benefits features a limited benefit for home health care, a 60-visit limit has been added. The SEH Board notes that the 60-visit limited benefit is consistent with the requirements of N.J.S.A. 17B:27- 51.5.

42 U.S.C. 18022 states that EHB includes coverage of pediatric dental and vision services. 45 CFR 156.110, recognizing that many benchmark plans do not typically include

dental and vision services, requires supplementing benchmark plans with pediatric dental and vision services to be substantially similar to those contained in either a State's CHIP package of services or the Federal Employee Vision and Dental Insurance Plan package of services. Based on the election made by New Jersey to supplement the EHB benchmark plan with CHIP dental services, the standard plans include a listing of pediatric dental benefits consistent with the dental benefits currently provided under the New Jersey FamilyCare program. The Exclusions are amended to remove exclusion of services added by the new provision. The provision is variable since policies issued on the Marketplace may exclude coverage for pediatric dental services if such services are covered under a standalone dental policy. Consistent with N.J.A.C. 11:22-5.8 the pediatric dental services may be covered as network only benefits.

Similarly, New Jersey elected to supplement the benchmark plan using the FEDVIP for pediatric visions services, so amendments to the standard plans include a listing of pediatric vision benefits consistent with the benefits under the Federal Vision program. The Exclusions are amended to remove exclusion of service added by the new provision.

As noted above, Federal statutes and regulations (See 42 U.S.C. 18022 and 45 CFR 156.115) require that covered benefits for health benefits plans be substantially equal to those contained in the selected EHB benchmark plan. Plan A, which was developed to address the requirements of N.J.S.A. 17B:27A-19a, specifically excludes coverage for multiple services and supplies that are contained in the selected EHB benchmark plan. Since adding those services and supplies to Plan A would result in Plan A containing the same services and supplies as Plans B through E, the Board proposes the repeal of Appendix Exhibits A and V, which create Plan A.

As required by 42 U.S.C. 300gg-3 and 45 CFR 147.108 preexisting conditions exclusions are prohibited. Accordingly, all definitions of a pre-existing condition and all exclusions of a

pre-existing condition have been deleted. The amendments appear in the definitions, over-age dependent, and exclusions provisions. Additionally, the pre-existing condition limitation has been removed as penalty for late enrollment

The Board proposes an amendment to the participation requirement set forth in the group policy and contract forms to provide variable language to accommodate differences in standards between participation requirements applicable to policies offered inside the SHOP (See 45 CFR 155.705(b)(10)) and participation requirements outside the SHOP. The amendment appears also in the Term of the Policy – Renewal privilege – Termination provision which ties to participation requirements.

The SEH Board proposes amended definitions for the terms Employee, Full-time and Small Employer to accommodate the definitions included in the Federal law. (See 26 CFR 54.4980H-1(4) (small employer); -1(13) (employee) and 26 U.S.C. 4980H(c)(4) (full-time).)

The SEH Board proposes deleting the definitions of creditable coverage and public health plans. These defined terms were used in conjunction with the application of the pre-existing condition exclusion, which is being eliminated as required by 42 U.S.C. 300gg-3 and 45 CFR 147.108.

The SEH Board is also proposing to amend "dependent" to reflect recent changes to federal law and the impact on the opportunity for a COBRA election.

The SEH Board proposes defining an employee open enrollment period as the period during which late enrollees may enroll for coverage. In addition, if an employer offers more than one plan, such period would be the timeframe within which employees may switch from one

plan to another. The SEH Board identified use of an open enrollment period as a means to mitigate the consequences of the elimination of the pre-existing condition exclusion.

As required by 45 CFR 147.131, as amended, the SEH Board proposes a variable exclusion for preventive contraceptive services and supplies.

The SEH Board proposes adding new definitions of special enrollment period and triggering event as required by 45 CFR 155.725.

The SEH Board proposes including a new benefit for clinical trials as required by Public Health Service Act section 2709(a) (42 U.S.C. 300gg-8). .

The Board proposes eliminating the optional text from Exhibits F, G W and Y that allowed the creation of a Dual contract option. The text was specifically included a number of years ago upon request of a carrier; however, no carrier has used the text.

The SEH Board is proposing new optional text to allow the potential for a tiered network. With a tiered network one or more types of network providers are separated into two "tiers" of network providers. The proposed amendment calls them Tier 1 and Tier 2. Carriers may use alternate terms. Carriers establish the criteria for a Tier 1 or Tier 2 designation using a combination of quality and cost measures. The covered person is encouraged to use a Tier 1 provider by means of lower cost sharing. The proposed amendments allow a carrier to accumulate deductible and maximum out of pocket provisions to further encourage use of Tier 1 providers. The proposed amendments appear on the Schedule page, in the text describing HMO, PPO, POS and EPO delivery systems and in the benefit provision.

The SEH Board proposes including alternate text to describe the prescription drug coverage. The alternate text may be used by carriers that prefer to describe the prescription drug coverage in terms more commonly found in separate prescription drug riders. In addition, the

Board proposes specifically including a "dispense as written" requirement which will require a consumer to pay a greater cost if the prescription allows a generic substitution but the consumer insists on the brand name drug.

The SEH Board proposes adding a new definition of Complex Imaging Services. These services are a subset of diagnostic services and are services for which a carrier may wish to require pre-approval and greater cost sharing.

The SEH Board proposes expanding the examples listed in the definition of Durable Medical Equipment to include hearing aids.

The SEH Board proposes amending the definition of pre-approval to allow a carrier to refer to information on its website for more details regarding the pre-approval process.

The SEH Board proposes adding an optional definition of Specialty Pharmaceuticals and a corresponding requirement that pre-approval is required for such drugs. The amendments appear on the Schedule and the Definitions section.

The SEH Board proposes deleting the definitions of health center and care manager, as well as references to associated medical groups, health center and care manager. Such terms are no longer consistent with the ways carriers provide coverage.

The second surgical opinion benefit states that the services are covered without application of the deductible. For consistency, the Board proposes adding the service called second surgical opinion to the schedule text to show no deductible.

Since rates for coverage are provided to the employer when the employer is making a purchase selection the SEH Board proposes referring to that rate document on the premium rates page rather than repeating the same rate information in the body of the policy form. The amendment appears on the Schedule.

The Board proposes clarifying the limited fertility benefit regarding coverage for prescription drugs. Covered prescription drugs do not include those used in connection with procedures that are not covered.

The SEH Board proposes an amendment to the Preventive Care Colorectal Screening provision to allow network only plans to eliminate all references to the limited benefits payable for use of an out of network provider.

The Coordination of Benefits provision is being amended to add references to Exclusive Provider Organization (EPO) coverage. The proposed amendment would treat EPO coverage the same as HMO coverage.

The SEH Board proposes variable text to allow a carrier to eliminate the $500 and $750 limits for out of network preventive care.

Amendments to N.J.A.C. 11:21-3 Corresponding to Changes in the Standard Plans

The Board proposes amendments to N.J.A.C. 11:21-3 which addresses benefits provided.

The Board proposes amendments to N.J.A.C. 11:21-3.1(a) to delete all references to Plan A. The design of Plan A, which is found in N.J.S.A. 17B:27A-19(a), is inconsistent with the design of the selected benchmark plan which defines the benefits that must be included. (See 42 U.S.C. 18022 and 45 CFR 156.115) As discussed earlier in this proposal, the Board could amend Plan A to include the necessary benefits. Such amendments would result in Plan A being essentially the same as Plans B through E. Rather than duplicate Plans B through E the Board proposes that Plan A be eliminated. The Board proposes removing references to Plan A throughout N.J.A.C. 11:21-3 (as well as the remainder of N.J.A.C. 11:21).

As addressed in the proposed amendments to N.J.A.C. 11:21-3.1(b) through (d) and (h), the cost sharing provisions included in Appendix Exhibits F, G, K, W, Y, HH and II must

comply with the cost sharing requirements of 45 CFR 156.130 as well as N.J.A.C. 11:22-5.3. The maximum out of pocket provisions must be consistent with sections 223(c)(2)(A)(ii)(I) and 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986. The schedule pages in the standard plan text illustrate possible cost sharing arrangements.

Consistent with the elimination of Plan A, the Board proposes deleting N.J.A.C. 11:21-3.1(e).

The Board proposes amending N.J.A.C. 11:21-3.1(g) to include reference to an EPO plan which is a potential delivery system.

The Board proposes amending N.J.A.C. 11:21-3.2 to eliminate references to Plan A and refer to four plans rather than five plans.

The Board proposes amending N.J.A.C. 11:21-3.(9d)4ii to specify that any dental coverage would be for persons age 19 or older.

Amendments are proposed to the Explanation of Brackets (Appendix Exhibit K) to address the new areas of variability introduced by the amendments, as included in the proposal.

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 the intended action in three newspapers of general circulation, with instructions on how to obtain a detailed

description of the intended action and the time, place, and manner by which interested parties may present their views regarding the intended action. Concurrently, the SEH Board must forward notice of the intended action to the Office of Administrative Law (OAL) for publication in the *New Jersey Register*, although the comment period runs from the date the notice is submitted to the newspapers and OAL, not from the date of publication of the notice in the *New Jersey Register*. The SEH Board also sends notice of the intended action to affected trade and professional associations, carriers, and other interested persons who may request such notice. In addition, for intended modifications to the health benefits plans, the SEH Board must allow for testimony to be presented at a public hearing prior to adopting any such modifications. Subsequently, the SEH Board may adopt its intended action immediately upon the close of the specified comment period or close of a public hearing (whichever is later) by submitting the adopted action to the OAL for publication. The adopted action is effective upon the date of its submission to the OAL, or such later date as the Board may designate. If the Board does not respond to commenters as part of the notice of adoption, the Board will respond to the comments timely submitted within a reasonable period of time thereafter in a separately-prepared report which will be submitted to OAL for publication in the *New Jersey Register*.

Pursuant to N.J.S.A. 17B:27A-51, all actions adopted by the Board are subject to the requirements of this special rulemaking procedure notwithstanding the provisions of the Administrative Procedure Act. As a result, the quarterly calendar requirement set forth at N.J.A.C. 1:30-3.1 is not applicable when the Board uses its special rulemaking procedures.

Please note that the unique provisions of N.J.S.A. 17B:27A-51 may result in the publication of this rule proposal in the New Jersey Register after the comment period has concluded.

Social Impact

Substantially all of the proposed amendments, repeals, and new rules are required for purposes of complying with Federal law. The Federal law requires that health benefits plans offered in the small employer market meet minimum standards that differ from the standards heretofore applicable to the standard plans offered in New Jersey. The SEH Board anticipates there will be varied social impacts resulting from these proposed amendments, repeals, and new rules because the impacts on small employers will be very fact-specific based on each employer's circumstances, but cannot predict with certainty the degree to which any aspect produces a social impact because these proposed amendments, repeals, and new rules are only one component of more wide-ranging health insurance changes at the federal level. These proposed amendments, repeals, and new rules will result in changes to the products available in the small employer market, the access that employees and their dependents have to healthcare services, and the delivery system for healthcare services. However, these proposed amendments, repeals, and new rules will not operate in a vacuum; changes required in rating standards and risk pooling, in addition to creation of new federal programs, and revised eligibility for public health insurance programs, among other things, will have a significant influence upon the social impact of these proposed amendments, repeals, and new rules when implemented.

First, the Federal law requires all health benefits plans to provide coverage of 10 categories of "essential health benefits" (EHBs), and sets other cost-sharing parameters. While the SEH standard plans already cover most EHB categories, the revised EHB categories may result in coverage for a few limited additional benefits such as pediatric vision and pediatric dental services. The EHB designation may revise certain limits on benefits that the Federal law

does not permit with respect to EHBs. For example, current standard plans provide coverage for prescriptions, but do not permit prescription costs to accumulate towards the maximum out-of-pocket (MOOP) limits; the proposed amendments will count allowed prescription costs towards the MOOP, which means lower total out-of-pocket costs for prescriptions. It is possible that the expansion of covered services and the elimination of certain limitations on cost-sharing will have an impact for those obtaining coverage, for example, anyone who utilizes healthcare services with greater frequency. However, to the extent that expanded coverage results in an increase in premiums, it is entirely possible there will be small employers who find the purchase of coverage to be cost-prohibitive, possibly decreasing the number of small employers who might otherwise have become covered in the small employer market.

Second, because of the differences between the current New Jersey requirements and the Federal law, the current plans will no longer be available for sale in 2014. Discontinuance of all of the existing plans may have varied social impacts. Although many small employers will have access to health benefits plans that provide similar benefits, thereby providing access to healthcare services when needed, it is also true that current small employers could face increasing premiums, due at least in part to the federally-required single risk pool. The SEH Board anticipates some small employers who presently offer group plans will choose not to replace their plan with a new plan compliant with federal law for various reasons resulting from an involuntary change of circumstances.

Third, the proposed amendments, repeals, and new rules alter the process for accessing health insurance in the small employer market. Currently, New Jersey has a continuous open enrollment for SEH plans, meaning that an employee or dependent does not necessarily have to enroll upon first becoming eligible and can delay enrollment until he or she chooses to enroll.

When enrollment is delayed the enrollee is referred to as a late enrollee. To discourage the effects of adverse selection that arise because people choose not to buy insurance until they think or know they need healthcare services, late enrollees are currently subject to a preexisting condition limitation period, during which they receive no coverage for treatment of conditions existing prior to becoming insured. The Federal law prohibits application of a preexisting condition limitation period for plan years beginning in 2014; consequently, the preexisting condition limitation period in the SEH plans is proposed to be eliminated. This elimination of preexisting condition limitation periods may provide people more immediate access to needed healthcare services, and has a positive social impact, but it also tends to increase claims costs and, by extension, potentially increase plan premium costs, creating a negative social impact. In an attempt to mitigate the effects of not having a preexisting condition limitation period, the federal law limits the periods of time during which late enrollees may enroll. The SEH Board proposes amending its continuous open enrollment opportunity for late enrollees by establishing a distinct and limited enrollment period to align with the enrollment periods provided in the large employer market. Some people may consider imposition of enrollment periods to have a negative social impact, since the opportunity to enroll will be reduced from 365 days per year to about 30 days per year. However, the intent is to reduce the potential for adverse selection, which increases the cost of coverage. Naturally, as premiums increase, affordability decreases. Although this restricted enrollment period may be viewed as a negative social impact in specific instances, the SEH Board anticipates that the State's approach to mitigate adverse selection will have a countervailing social impact in general, by maintaining more affordable coverage options.

Economic Impact

The SEH Board cannot conclude with certainty the economic impact of these amendments in part because these proposed amendments, repeals, and new rules are only one component of the more wide-ranging health insurance changes mandated by Federal law, and in part because the degree of impact depends upon business decisions of carriers and the unique, fact-specific circumstances of each small employer. The majority of the proposed amendments, repeals, and new rules are required for purposes of complying with the Federal law. The Federal law requires that health benefits plans offered in the small employer market meet minimum standards that differ from the standards now applicable to the standard plans offered in New Jersey. These differences will result in a change in the products available in the small employer market, the access that small employers have to healthcare services, and the delivery system for healthcare services. However, these proposed amendments, repeals, and new rules will not operate in a vacuum; changes required in rating standards and risk pooling, in addition to creation of new federal programs, and revised eligibility for public health insurance programs, among other things, will have a significant, and indeterminate, influence upon the economic impact of these proposed amendments, repeals, and new rules when implemented.

As previously noted, the Federal law requires all health benefits plans to provide coverage of ten categories of EHBs without annual or lifetime limits, and sets other cost-sharing parameters. The current SEH standard plans already cover most EHB categories. In addition, current plans include cost containment limitations on EHBs that will no longer be permitted by the Federal law. The proposed amendments, repeals, and new rules add coverage, and the associated undetermined costs for services not previously included, and they remove design features required by the Federal law to be eliminated as of 2014. It is arguable that expansion of covered services and the limitations on cost-sharing will have some economic impact for those

obtaining coverage and for healthcare providers; however, it is still too early to account fully for this. For example, the proposed amendments, repeals, and new rules specify that all costs for EHBs will accumulate towards the MOOP, which will reduce the out-of-pocket costs for employees and dependents, notably with respect to prescription drug coverage that does not now accumulate towards the MOOP. However, these proposed changes will likely increase claims costs, and increased claims costs tend to lead to increased premiums and reduced affordability of the insurance, which is adverse to the economic interests of small employers seeking to buy coverage.

The SEH Board notes that any additional costs on carriers are unavoidable as these changes are mandated by the Federal law. Additionally, any adverse economic impacts that could result from the loss of the cost controls provided by the current preexisting condition limitation provision will likely be offset by the positive economic impact created through limitations on the open enrollment periods.

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. These proposed amendments, repeals, and new rules are subject to Federal requirements addressing certain standards for health insurance contracts in the Federal law and the corresponding rules governing the small employer market. Specifically, the Federal law requires that health benefits plans offered to individuals and small groups include coverage for certain categories of services, referred to earlier as EHB. Because HHS permitted States to establish the benefits for the EHB benchmark plan (within parameters), and the amendments,

repeals, and new rules are bringing the SEH standard plans into compliance with the selected EHB benchmark, the SEH Board does not believe the proposed amendments, repeals, and new rules exceed the Federal standards. The amendments, repeals, and new rules the Board proposes to N.J.A.C. 11:21-1, 3, 4, 6, 7 and 17 are required to implement the various provisions of the Federal law, as discussed above. Consequently, the SEH Board does not believe a Federal standards analysis is required.

Jobs Impact

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

Agriculture Industry Impact

The SEH Board does not believe the proposed amendments, repeals, and new rules will have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The SEH Board does not believe the proposed amendments, repeals, and new rules apply to "small businesses," as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., but acknowledges the possibility that one or more carriers might meet that definition. The proposed amendments, repeals, and new rules do not establish new or additional reporting or

recordkeeping requirements, but have the effect of establishing new compliance requirements, as described in the Summary above.

No differentiation in compliance requirements is provided based on business size. The requirements of and the goals to be achieved by the Federal law in question does not vary based on business size of a carrier, and the 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 amendments, repeals, and new rules provide no differentiation in compliance requirements based on business size. No additional professional services would have to be employed in order to comply with the proposed amendments, repeals, and new rules.

Housing Affordability Impact Analysis

The SEH Board does not believe the proposed amendments, repeals, and new rules will have an impact on housing affordability in this State in that the proposed amendments, repeals, and new rules relate to the benefit levels and terms of standard health benefits plans offered in New Jersey for purchase by individuals.

Smart Growth Development Impact Analysis

The SEH Board does not believe the proposed amendments, repeals, and new rules will have an impact on the number of housing units or the availability of affordable housing in the State, or that the proposed amendments, repeals, and new rules 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 amendments, repeals, and new rules relate to the benefit levels and terms of standard health benefits plans offered in New Jersey.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:21-7.7 and 7.7.

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

Full text of the proposal follows:

SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

"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.

["Church plan" has the same meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(33)).]

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

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

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

["Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.); Title XIX of the Federal Social Security Act (42 U.S.C. §§ 1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the Federal Social Security Act (42 U.S.C. § 1396s); Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§ 1397aa through 1397jj); chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §§ 8901 et seq.); a public health plan as defined by Federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. §§ 2504(e)); or coverage under any other type of plan as set forth by the Commissioner by regulation. Creditable coverage shall not include coverage consisting solely 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; coverage, as specified in Federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.]

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

"Dependent" means the spouse or child of an eligible employee subject to applicable terms of the employee's health benefits plan. 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[the] Federal **law** [Defense of Marriage Act, 1 U.S.C. § 7,] 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. [Thus, for purposes of COBRA, the term "spouse" does not include a civil union partner.] 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 [includes] excludes a sole proprietor, a partner of a partnership, or an independent contractor[, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but] **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 subsection b of the definition in this section of "small employer" means an individual who is an employee under the common law standard as described in 26CFR 31.3401(c)-1(b). Employee excludes a sole proprietor, a partner in a partnership and a 2 percent S corporation shareholder 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:

a) **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**

b) **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.

"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.

["Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the Health Maintenance Organization Act of 1973, Pub. L. 93-222 (42 U.S.C. §§ 300 et seq.)] ["Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(32)) and any governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of that government.]

"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 employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. [An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, death of a spouse, or

divorce or legal separation or dissolution of a civil union or termination of a domestic partnership; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; the individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order or initially waived coverage under the policy for himself or herself and any then existing dependents provided the employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the policy within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.]

"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. [Except as provided in N.J.A.C. 11:22-5.2, all] **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. [Except as provided in N.J.A.C. 11:22-5.2, all] **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. [Except as provided in N.J.A.C. 11:22-5.2, all] **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.

["Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.]

"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)).

["Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be considered as a preexisting condition.]

"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:

a) 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 [two] **one** but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least [two eligible employees] **one eligible employee** on the first day of the plan year. , [and the majority of the eligible employees are employed in New Jersey; 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.

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. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L. 1992, c.162 (N.J.S.A. 17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such employer] **or**

b) 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 1 but not more than 50 employees on business days during the preceding calendar year; and who employs at least 1 employee on the first day of the Plan Year.

With respect to (a) and (b) above, 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.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible 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.

["State approved HMO" is a health maintenance organization which is approved pursuant to P.L. 1973, c.337 (N.J.S.A. 26:21-1 et seq.).]

"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

§ 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 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 set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

[1. Plan A, "The Small Group Health Benefits Basic Policy," Exhibit A and V;]

[2]**1**. Plan B, "The Small Group Health Benefits Policy B," Exhibit F and W **featuring carrier coinsurance of 50% or 60%**

[3] **2**. Plan C, "The Small Group Health Benefits Policy C," Exhibit F and W **featuring carrier coinsurance of 70%**

[4]**3**. Plan D, "The Small Group Health Benefits Policy D," Exhibit F and W **featuring carrier coinsurance of 80%**;

[5]**4**. Plan E, "The Small Group Health Benefits Policy E," Exhibit F and W **featuring carrier coinsurance of 90%**;

[6]**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 text is clearly identified;

[7]**6**. HMO Plan, "The Small Group Health Maintenance Organization Contract," Exhibit G and Y; and

[8]**7**. HMO-POS Plan, "The Small Group Health Maintenance Organization Point of Service ("POS") Contract," Exhibit HH and II.

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall offer [Plan A and]at least [two] **three** of the health benefits plans designated as Plans B, C, D and E as set forth in Exhibits [A and F,] V and W, in the Appendix, subject to (b)1 [through 4] **and 2** below and except as set forth in (c) below.

[1. Plan A is the basic plan. Every member shall offer Plan A consistent with the following specifications:

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

(1) A deductible of $ 500.00 per covered family, to be satisfied by two separate covered persons and a per person maximum out of pocket of $ 7,750; or

(2) A deductible of $ 750.00 per covered family, to be satisfied on an aggregate basis and a per person maximum out of pocket of $ 7,750.]

[2]**1**. Plans B, C, **D** and/or [D] **E** may be offered. Members offering these plans shall include annual deductible provisions consistent with the following specifications:

i. The per covered person annual deductible [shall be an amount not less than $ 250.00 and not greater than $ 5,000] **may not exceed the maximum deductible permitted by 45 CFR 156.130.**

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

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

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

[3]**2**. Members offering Plans B, C, **D** and/or [D] **E** shall include maximum out of pocket provisions [consistent with the following specifications:] **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.**

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

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

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

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

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

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

4. Plan E may be offered. Members offering Plan E shall include a deductible of $ 150.00 per covered person and:

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

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

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

1. Copayment Design:

i. The hospital inpatient copayment shall be [: $ 75.00; $ 100.00; $ 150.00; $ 200.00; $ 300.00; $ 400.00; or $ 500.00] **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,[pre-natal care**]** and prescription drugs shall be [: $ 5.00; $ 10.00; $ 15.00; $ 20.00; $ 30.00; $ 40.00; or $ 50.00, respectively**] 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 [: $ 5.00; $ 10.00; $ 15.00; $ 20.00; $ 30.00; $ 40.00; or $ 50.00**] 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 **[**or prescription drugs **]**shall be **[**an amount not less than $ 250.00 and not greater than $ 2,500 per person**] 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 [and may, at the option of the HMO, either be satisfied by two separate covered persons or may be**]** satisfied on an aggregate basis.

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

iv. The maximum out of pocket shall be a dollar amount **[**not to exceed $ 7,500**], 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 [be, at the option of the carrier, $ 50.00, $ 75.00 or $ 100.00**.]** **not exceed the amount permitted by N.J.A.C. 11:22-5.5(a).**

ii. [The pre-natal care/maternity copayment, which shall only be required at the initial visit, shall be, at the option of the carrier, either $ 25.00, or equal to the copayment applicable to a primary care physician visit.] **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 [50 percent**] deductible and/or** coinsurance, or **[**a $ 15.00**]**copayment**(s) consistent with N.J.A.C. 11:22-5.5(a)** [at the option of the HMO].

(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 N.J.A.C. 11:4-37.3(b)6 and 11:22-5;

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

3. The network maximum out of pocket shall not exceed [$ 7,500 per covered person,] **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) The standard health benefits Plan A may be offered through or in conjunction with a managed care arrangement, and shall be subject to the following:

1. For those services which are subject to 20 percent coinsurance, the network benefit shall not be subject to coinsurance;

2. For those services which are subject to 50 percent coinsurance, the network coinsurance shall be 30 percent;

3. The network maximum out of pocket shall not exceed $ 7,500 per covered person. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies; and

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

([f]e) An insurer with an approved selective contracting agreement, like all other carriers, shall offer at least three of the standard health benefits plans [where one plan is Plan A], whether as indemnity plans or through or in conjunction with a selective contracting arrangement, in all geographic areas in the State.

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 **[**provided that one of the plans offered is Plan A].

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 not included in its approved service area **[**provided that one of the plans offered is Plan A]; 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 [provided that one of the plans offered is Plan A].

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.

([g]) 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 **[or]** 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**[or]** 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 where it does not have agreements with participating providers; and

ii. The standard health benefits plans whether as indemnity plans or as PPO**, [or]** 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**, [or]** 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.

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

1. Copayment Design:

i. The hospital inpatient copayment shall be**[:$ 75.00; $ 100.00; $ 150.00; $ 200.00; $ 300.00; $ 400.00; or $** 500.00**] consistent with N.J.A.C. 11:22-5(a).**

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, [pre-natal care] and prescription drugs shall be[: $ 5.00; $ 10.00; $ 15.00; $ 20.00; $ 30.00; $ 40.00; or $ 50.00, respectively**] consistent with N.J.A.C. 11:22-5(a)**.

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be[: $ 5.00; $ 10.00; $ 15.00; $ 20.00; $ 30.00; $ 40.00; or $ 50.00**] consistent with N.J.A.C. 11:22-5(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 [or prescription drugs**]** shall be **[**an amount not less than $ 250.00 and not greater than $ 2,500 per person**] 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 **[**and may, at the option of the HMO, either be satisfied by two separate covered persons or may be**]** satisfied on an aggregate basis.

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

iv. The maximum out of pocket shall be a dollar amount not to exceed [$ 5,000**] 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 be, at the option of the carrier, $ 50.00, $ 75.00 or $ 100.00**]** **not exceed the amount permitted by N.J.A.C. 11:22-5.5(a).**

ii. **[**The pre-natal care/maternity copayment, which shall only be required at the initial visit, shall be, at the option of the carrier, either $ 25.00, or equal to the copayment applicable to a primary care physician visit.] **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[the non-network**]** 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 that offer health benefits Plans B, C, D and/or E may offer one or more of the standard optional benefit riders set forth in (c)1 and 2 below. Members that offer the HMO health benefits plan may offer the prescription drug riders set forth in (c)3 below. All riders shall contain the benefits, limitations and exclusions set forth in the Appendix which is incorporated herein by reference and shall be issued in the standard form set forth in the Appendix which is incorporated herein by reference. A member electing to offer an optional benefits rider with a standard health benefits plan (Plan B, C, D, E, HMO plan, or HMO POS plan as applicable) must offer the rider to any employer seeking to purchase that health benefits plan.

(b) Any member electing to offer one or more standard optional benefits riders shall file a statement identifying the rider(s) to be offered and identifying the health benefits plan(s) with

which the rider will be offered. The statement shall be filed with the Board no later than 30 days prior to the date the rider is to be offered to employers, and shall set forth the date on which the carrier proposes to offer such rider(s).

(c) The standard optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select the following rider, set forth at Exhibit H, to be offered with each health benefits Plan (Plan B, C, D or E):

i. Mail order and card;

ii. Card only; or

iii. Mail order only; and

2. Replacement prescription drug benefits for the HMO Plan or the HMO POS Plan. The carrier may select the following rider, set forth at Exhibit H, to be offered with the HMO or HMO POS health benefits plan:

i. Mail order and card;

ii. Card only; or

iii. Mail order only.]

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

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

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

i. The types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations" and "Exclusions" sections of Plans **[A,]** 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," "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 **[A,]** B, C, D, E, HMO, and HMO POS as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident; and

iii. Eligibility as set forth in the "Employee coverage," "Dependent coverage" and "Continuation rights" sections of Plans **[A,]** 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. "Coverage" offered by the **[five] four** plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to[(d)] **(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. In addition to [(d)] **(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 [(d)] **(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 **[A,]** 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;

[v. Submit copies of the standard group policy and certificate page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders;] and

[vi**] [v].** For riders of increasing value only, 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 **[A,]** 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 small employer seeking to purchase the health benefits plan it modifies;

(4) That a rate filing for 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 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), 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. 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.

[(e)](**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.

[(f)] **(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 [A,]B, C, D, and E which are set forth in the Appendix to this chapter as Exhibits A, F, V, and W subject to the "Explanation of Brackets" set forth in Exhibit K 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 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) In issuing standard optional benefit riders pursuant to N.J.A.C. 11:21-3.2(c), members shall use the standard rider form which is set forth in the Appendix to this chapter as Exhibit H.]

[(e)] **(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.

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

[(g)] **(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.

[(h**)] (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.

[(i)] **(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.

[(j) Members that wish to use the standard Prescription Drug Rider shall use the form set forth in the Appendix to this chapter as Exhibit H.]

[(k)] **(h**) 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.

§ 11:21-4.2 Certification or filing of forms

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

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

2. 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 there under.

§ 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 may incorporate regulatory changes required to be made to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans [A,] B, C, D, E, HMO, and HMO POS [and for the standard riders promulgated by the Board,] through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix, incorporated herein by reference, subject to the following:

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

(b) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, members may make any changes to the standard policy forms, standard HMO and HMO POS contracts, certificates, and

evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS [and for the standard riders promulgated by the Board] consistent with the variability as explained in Exhibit K 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).

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/devision_insurance/ihcseh/sehforms.html [and specified in Exhibit N of the Appendix to this chapter incorporated herein by reference].

(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/devision_insurance/ihcseh/sehforms.html [and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference].

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

1) **Policyholder name and contact information**
2) **Federal Tax ID Number**
3) **Type of business nature of the business**
4) **Number of employees, classes of employees, coverage type**
5) **Status with respect to COBRA and Medicare as Secondary Payor**
6) **Waiting period**
7) **Contribution percentage**
8) **Affiliates**
9) **Benefit options**
10) **Replacement information**
11) **Continued coverage**
12) **Agent/producer information**
13) **Signature section**

(d) The certification requires the following types of information:

1) **Status as small employer**
2) **Work locations**
3) **Participation calculation**
4) **Application of federal laws**

5) Certification signature

§ 11:21-6.2 Annual Small Employer Certification Form

(a)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/devision_insurance/ihcseh/sehforms.html [and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference]. This form shall be sent to the small employer for completion no earlier than 150 days prior to the renewal of the small employer's health benefits plan.

(b) The certification requests the following types of information:

1) Status as small employer

2) Work locations

3) Participation calculation

4) Application of federal laws

5) Certification signature

§ 11:21-6.3 (Reserved)

§ 11:21-6.4 Waiver

Any eligible employee who declines coverage under the small employer health benefits plan shall complete the employee waiver form approved by the Board and specified in Exhibit T of the Appendix to this chapter incorporated herein by reference.

SUBCHAPTER 7. PROGRAM COMPLIANCE

§ 11:21-7.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering, issuing and renewing all health benefits plans to any small employer, the small employer's eligible employees, and the dependents of those eligible employees.

§ 11:21-7.2 [Definitions

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

"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.

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.); Title XIX of the Federal Social Security Act (42 U.S.C. §§ 1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the Federal Social Security Act (42 U.S.C. § 1396s); Title XXI of the Social Security Act (State Children's Health Insurance Program) (42

U.S.C. §§ 1397aa through 1397jj), chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; and a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §§ 8901 et seq.); a public health plan as defined by Federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. § 2504(e)); or coverage under any other type of plan as set forth by the Commissioner by regulation. Creditable coverage shall not include coverage consisting solely 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; coverage, as specified in Federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

"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.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment

that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such a statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, termination of the employer's contribution toward coverage, death of a spouse, or divorce or legal separation; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the small employer is employed by an employer which offers multiple health benefits plans and the small employer elects a different plan during an open enrollment period; the small employer had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order. An eligible employee and his or her dependent spouse, if any, will not be considered late enrollees because the eligible employee initially waived coverage under the health benefits plan for himself or herself and any then existing dependents provided the eligible employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the plan within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.

"Non-standard health benefits plan" means only a health benefits plan that was issued to cover one or more small employers by or through a carrier, association, multiple employer arrangement or out-of-State trust prior to January 1, 1994, and which was in effect on February 28, 1994.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy is not a preexisting condition.

"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.

§ 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 (a) or (b) of the definition. If the employer satisfies either (a) or (b) then the employer shall be considered to be a small employer.

(b) With respect to part (a) 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 part (b) of the definition of small employer a small employer carrier shall add the number of full-time employees to the number that results from the part-time employee calculation, and if the sum is at least 1 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 1;**
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 4 and the product divided by 120 and rounded down to the nearest whole number.**
3. **Small employer carriers shall not include sole proprietors, partners of partnerships, or 2 percent or more owners of Subchapter S corporations, or their immediate family members as employees in items 1 or 2 above even if such persons will be covered under the employer's plan.**

(d) 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) 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 part (a) of the definition of small employer; or**
2. **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 part (b) of the definition of small employer.**

§ 11:21-7.3 Eligibility and issuance

(a) [Except as may otherwise be provided in N.J.A.C. 11:21-3A with respect to nonstandard health benefits plans, 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 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:

[i. The small employer carrier shall refuse to issue coverage to an employer if the majority of its eligible employees are not employed within the State of New Jersey; or]

[ii.] 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 [standard health benefits Plan A and] at least [two] **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

(a) at least [two] **one eligible** [employees] **employee** on the first day of the plan year **with respect to a small employer that satisfies part (a) of the definition of small employer; or**

(b) at least one employee on the first day of the plan year with respect to a small employer that satisfies part (b) of the definition of small employer.

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,[the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. An employer that was not in existence during the preceding calendar year must have at least two eligible employees when completing the employer certification and on the first day of the plan year to be considered a small employer] **refer to N.J.A.C. 11:21-7.2** (e).

(b) [Except as otherwise provided in N.J.A.C. 11:21-3A with respect to the issuance of non-standard health benefits plans, a] **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 [or to two or more eligible employees of a member small employer].

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) In determining an employer's number of eligible employees, a small employer carrier shall consider in the calculation the number of independent contractors that the employer may include on its application for coverage to the extent that each independent contractor:

1. Is performing a service for the employer pursuant to a written contract for monetary or other legal consideration;

2. Works 25 or more hours per week for the employer;

3. Works on other than a temporary or substitute basis;

4. The independent contractor relationship has been established to serve a substantial business need of the employer and is not intended primarily to obtain insurance coverage; and

5. Is not considered to be an employee by the New Jersey Department of Labor and Workforce Development pursuant to N.J.S.A. 43:21-19 and applicable law.]

[(d**)](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[, except that a small employer carrier may exclude coverage for preexisting conditions consistent with the provisions of N.J.A.C. 11:21-7.7]. Employees who are late enrollees shall be accepted for coverage by the small employer carrier[, but a small employer carrier may exclude coverage for preexisting

conditions consistent with the provisions of N.J.A.C. 11:21-7.8. Small employer carriers shall not delay the effective date or eligibility date of a late enrollee until an "open enrollment" period] **if enrollment is requested during the employee open enrollment period.**

[(e) A small employer carrier may elect to provide coverage to a small employer's part-time employees (that is, working fewer than 25 hours per week), if the small employer covered part-time employees under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all part-time employees of all such small employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts.

2. Such covered employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(f) A small employer carrier may elect to provide coverage to a small employer's retired employees, if the small employer's retired employees were covered under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all retired employees of all such employers so renewing or reinstating such health benefits plans and/or converting to standard health

benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts; and

2. Such covered retired employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(g) A small employer carrier may elect to provide coverage to retired employees and/or part-time employees of an employer that becomes a small employer subsequent to January 1, 1994, if the employer covered retired and/or part-time employees under a group health plan issued prior to January 1, 1994, under a health benefits plan renewed or reinstated by the carrier in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or a standard health benefits plan issued to the small employer by the carrier, subject to the requirements of (e)1 and 2 and (f)1 and 2 above.]

[(h**)](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 employees who are not serving under a waiting period as permitted under N.J.A.C. 11:21-7.8[c**)](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 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;[or]

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

6. Is covered under Tricare.

(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) **A small employer carrier shall not require a minimum participation under the small employer's health benefits plan of 75 percent of eligible 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) **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 [Preexisting condition standards

(a) A health benefits plan shall not include preexisting condition exclusion, except as provided in (b) or (c) below.

(b) A health benefits plan issued to a small employer with five or fewer eligible employees, as determined on the effective date of the plan and on each subsequent policy anniversary, may contain a preexisting condition exclusion. However, a preexisting condition exclusion shall not exclude coverage for a period of more than 180 days following the enrollment date, and shall relate to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of the enrollee and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date.

(c) A health benefits plan issued to a small employer may contain a preexisting condition exclusion that may apply to a late enrollee. However, a preexisting condition exclusion shall not exclude coverage for a period of more than 180 days following the enrollment date of coverage, and shall relate to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of the enrollee and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date of coverage. If 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition exclusion shall apply to any such enrollee.

(d) In determining whether a preexisting condition provision applies to an eligible employee or dependent, carriers shall credit the time that person was covered under previous creditable coverage if the creditable coverage was continuous to a date not more than 90 days prior to the

effective date of the new coverage, exclusive of any waiting period under such plan. A carrier shall provide credit pursuant to this provision pursuant to one of the following methods:

1. A carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period; or

2. A carrier shall count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits specified in Federal regulation rather than the method provided in (d)1 above. This election shall be made on a uniform basis for all covered persons. Under this election, a carrier shall count a period of creditable coverage with respect to any class or category, of benefits if any level of benefits is covered within that class or category. A carrier which elects to provide credit pursuant to this provision shall comply with all Federal notice requirements.

(e) A health benefits plan shall not impose a preexisting condition exclusion for the following:

1. A newborn child who, as of the last date of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of the adoption or placement for adoption; or

3. Pregnancy.

§ 11:21-7.7] Employee open enrollment period

(a) Each small employer must 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 such 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 such 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 – 5 below and no less than 60 days following a triggering event listed in b) 6 below during which:

1) eligible employees and dependents who are late enrollees are permitted to enroll under the small employer's plan; and

2) eligible 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 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 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 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 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 employee or dependent gains access to new qualified health plans as a result of a permanent move.**

6) **The date the eligible employee or dependent loses or gains eligibility under Medicaid or NJFamilyCare.**

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 of placement in foster care as described in b) 2 above**
   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.**

d) If an eligible 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 item (2) below occurs. The small employer carrier will assign an effective date as of the day after the event described in item (2) 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 employee's spouse;**
   - vi. **termination of the policyholder's contribution toward coverage; or**
   - vii. **termination of the other plan's coverage.**

e) The eligible 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[, except as provided in N.J.A.C. 11:21-7.5(d)2,] 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 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**] 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.

[(c)] **(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 [six months] **ninety days.** Waiting periods may be applied to these employees by class of employee based upon conditions pertaining to employment.

[(d)] **(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.

[(e) A small employer carrier may require that its small employer groups make monthly or quarterly premium payments through an automatic checking withdrawal option. In the event that a small employer carrier elects to require that its small employer groups pay premiums through an automatic checking withdrawal option, the small employer carrier shall apply this requirement to every small employer group, 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 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 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 [45]**60** days after the end of the fiscal quarter, the following information reported [separately]with respect to standard [and non-standard] health benefits plans:

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

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

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

(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 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[September 11, 1994] **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[, gender,] and geography in accordance with the following restrictions:

[1. [Age factor categories shall be limited to the following increments: 24 and under; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; 70 and over.] **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 first three digits of the U.S. Postal Service zip codes or] 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 [zip codes 070-073 or]Essex, Hudson and Union counties;

ii. Territory B consists of [zip codes 074-076]Bergen and Passaic counties;

iii. Territory C consists of [zip codes 077-079 or]Monmouth, Morris, Sussex and Warren counties;

iv. Territory D consists of [zip codes 088-089 or]Hunterdon, Middlesex and Somerset counties;

v. Territory E consists of zip codes [081, 085-086 or]Burlington, Camden, and Mercer counties; and

vi. Territory F consists of zip codes[080, 082-084, and 087 or]Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

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

1. Employee only;

2. Employee and spouse;

3. Employee and child(ren); and

4. Family.]

§ 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

[(a)] 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.

[(b) Members that offer small employer health benefits plans in this State that do not offer individual health benefits plans as of January 4, 2009 shall:

1. File the required forms and rates to enter the individual market within 60 days following January 4, 2009; or

2. File to withdraw from the small employer market pursuant to N.J.A.C. 11:21-16 within 60 days following January 4, 2009.]

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 ([A,]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 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(d)6] **N.J.A.C. 11:21-3.2(a)6.v.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 employees or dependents, the average number of eligible employees or the average number of employees enrolled in small employer plans placed by the producer with the carrier, or the occupation or geographic location of the small employer groups placed by the insurance producer with the small employer carrier.

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