INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Small Employer Health Benefits Program
Informational Rate Filing Requirements Pursuant to the Small Employer Health Benefits Program

Adopted New Rule: N.J.A.C. 11:21-9.6

Adopted Recodification with Amendment: N.J.A.C. 11:21-9.7 as 9.8

Adopted Amendments: N.J.A.C. 11:21-9.2 and 9.3

Proposed: February 19, 2002 at 34 N.J.R. 826(a)

Adopted: February 18, 2003 by Holly C. Bakke, Commissioner, Department of Banking and Insurance

Filed: February 19, 2003, as R. 2003 d.126 **with substantive and technical changes** not requiring additional public notice and comment (N.J.A.C. 1:30-6.3)

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, and 17B:27A-25f and g.

Effective Date: March 17, 2003

Expiration Date: September 25, 2003

Summary of Public Comments and Agency Response:

The Department of Banking and Insurance ("Department") received timely comments from AmeriHealth Insurance Company of New Jersey, The Guardian Life Insurance Company of America, Health Net of New Jersey, Inc. and Horizon Blue Cross Blue Shield of New Jersey.

COMMENT: One commenter states that the proposed changes to N.J.A.C. 11:21-9.3(a)1v, compelling carriers to establish different rates for individuals for whom

Medicare is primary, goes beyond the jurisdiction of the Department and is the province of the SEH Benefits Program Board. The commenter goes on to state that it is the responsibility of the Board to promulgate rating factors. Furthermore, the commenter states that in implementing modified community rating, the Legislature limited the extent to which premiums are differentiated to reflect claim expense. The commenter also states that "this initiative is at odds with the current industry standard in New Jersey, under which rates for all employees reflect the saving attributable to primary payments by Medicare."

RESPONSE: The Department disagrees with the commenter on all points. First, the Department does not consider Medicare status to be a rating factor upon which the rate differential may be based. Such rating factors are limited by law, and neither the Department nor the Board can permit or compel use of rating factors not specified by law (see N.J.S.A. 17B:27A-25). Medicare status affects the plan of benefits provided. The Department, in reviewing rates, must examine the reasonableness of the relationship between rates for various plans of benefits.

The Department also disagrees with the commenter's assertion that the Legislature's enactment of modified community rating was impelled by a public policy purpose to limit the extent to which premiums are differentiated to reflect claims experience. Modified community rating limits the extent to which premiums are based on the permitted rating factors of age, gender, and territory. Modified community rating prohibits any variation in premium based on other conceivable rating factors, such as

group size or group claim experience. Further, modified community rating places no limitations on the relative premiums of different plans of benefits.

Pursuant to the Medicare as Secondary Payor Federal Rules, when determining the order of payment for persons eligible for Medicare due to age, Medicare is primary for groups with fewer than 20 employees and is secondary for groups with more than 20 employees. Therefore, the effect of the system that the proposed rule prohibits is to disproportionately favor larger groups over smaller groups in the allocation of savings attributable to Medicare primary.

Finally, the Department disagrees with the comment that not differentiating by Medicare primary status is the "current industry standard." Some carriers differentiate; some do not. Two comments were received taking the opposite position from that taken by this commenter, that is, that correct pricing would cause carriers to reflect this differential voluntarily. Thus, the available empirical data does not support the commenter's position that a standard form exists.

COMMENT: Two commenters state that the requirement for a reduced premium reflecting Medicare primary was appropriate and sensible, and that carriers who do not do so would be uncompetitive.

RESPONSE: The Department agrees with these comments. In theory, a competitive market should not remove from its rating system a variable (Medicare status) which is both easily determinable and which appears to be related to cost. The Department also believes a rule is necessary to arrive at a reasonable relationship

between rates and to inform the regulated community of the Department's position on this issue.

COMMENT: Several commenters state that it is overly expensive or burdensome to require at N.J.A.C. 11:21-9.3(a)1v that the Medicare primary status of spouses, as well as that of employees, be reflected in the rates.

RESPONSE: The Department agrees and the rule has been changed to permit, but not require, that the Medicare status of a covered spouse be reflected in the rate.

COMMENT: One commenter states that the rationale for requiring a cost reduction for Medicare primary status due to disability, rather than due to age, is not established.

RESPONSE: The Department agrees. The rationale for requiring a cost reduction for Medicare primary status due to disability was not established because it was not the Department's intention to require a cost adjustment for disability. N.J.A.C. 11:21-9.3(a)1v has been clarified to only require a cost reduction when the employee is Medicare primary due to age. Rates for parent/child or family coverage cannot reflect the Medicare status of a covered child under either the existing or the proposed rules.

COMMENT: Several commenters state that the requirement in the proposed new rule at N.J.A.C. 11:21-9.6 should have a materiality threshold for reporting and

rectification. The comment uses the example of rounding errors. The commenters suggested various thresholds, such as one percent, $200.00 per group, or $10,000 in total.

RESPONSE: The Department agrees. It was never the intention of the Department to include immaterial errors such as rounding errors. Therefore, a change is being made upon adoption to establish a threshold, albeit at a lower level than that suggested in these comments. The additional text specifies that an immaterial error is one for which rectification or other action by the Department would not be considered worth the administrative cost and effort. Consequently, the rule has been rewritten to clarify the reporting requirement by establishing a materiality threshold of .25 percent of each affected rate or a rounding error of less than $1.00.

COMMENT: One commenter states that the wording of N.J.A.C. 11:21-9.6(a) should be changed to indicate that notice is required for an undercharge only if the carrier wishes to correct the situation (that is, raise rates).

RESPONSE: The Department believes that notice of an undercharge is appropriate, even if the carrier chooses not to correct the situation. The policyholder may notice an inconsistency between charged rates and either rates on file or those charged to other policyholders. In addition, a future rate increase may appear to be disproportionately large if the policyholder is not advised of the error.

COMMENT: One commenter states that the wording of N.J.A.C. 11:21-9.6(a)2 should permit a carrier to communicate the undercharge to the policyholder and to seek a mutually agreed upon remedy.

RESPONSE: The Department does not believe that it is appropriate to include this in the rule. The carrier and the policyholder do not always have equal information and bargaining power in this situation, and thus a truly “mutual” agreement is not achievable. The rule does not prohibit the carrier from discussing such a remedy and bringing it to the Department for review. However, the carrier can not unilaterally recoup the undercharges.

COMMENT: One commenter states that the period for which an erroneous rate must continue (N.J.A.C. 11:21-9.6(a)3) should be shortened from 60 days to 30 days.

RESPONSE: The Department disagrees. The Department believes that 60 days is the minimum adequate time for the policyholder to seek alternative insurance coverage in the face of an unanticipated change in rates.

COMMENT: One commenter states that the proposed amendment to N.J.A.C. 11:21-9.3(a)3v(3) will significantly increase paperwork because it will require the average and maximum increase for every plan, and that, due to optional riders, there may be thousands of plans. The comment suggests that only the average change and maximum change for all plans should be required.

RESPONSE: The Department believes that the commenter is misinterpreting the term "plan" as used in the SEH market. There are only five standard health benefits plans. A rider which modifies the benefits under such a standard plan does not create a separate plan. The intent of the rule was to require carriers to provide the type of comprehensive information mentioned in the comment. However, the Department has decided to eliminate the requirement to provide the average and maximum increase upon adoption.

COMMENT: One commenter states that the proposed amendment to N.J.A.C. 11:21-9.3(a)3v(3) for average changes is difficult to implement at the plan design level, due to multiplicity of non-standard plans. They suggest that only particular plans with annual increases over a threshold level, such as 10 percent, be disclosed.

RESPONSE: The Department believes that the actuary can reasonably interpret the term “plan” in the non-standard context to refer to similar groupings of specific plan designs, thus reporting averages for “plans” that would be grouped for pricing purposes.

COMMENT: One commenter states that the proposed change to N.J.A.C. 11:21-9.3(a)3v(3) requires the listing of every possible permutation of group structure in order to provide the necessary information regarding changes in rates from a prior period. This is stated to "not be practicable,” and to have no useful purpose in the context of an

informational rate filing. A related comment states that the requirement was unclear and required examples.

RESPONSE: The intent of the provision was to display the maximum increase for any group actually covered, rather than for any theoretical permutation. However, in view of the potential complexity in compliance, the Department has determined not to adopt this proposed amendment

COMMENT: One commenter states that N.J.A.C. 11:21-9.3(a)3vi(7) errs in requiring a certification that the methodology for reflecting age and gender is "sufficient." The comment states that it is up to the Department, rather than the certifying actuary, to determine the sufficiency of the explanation. Another comment asks if this narrative is truly necessary or may be simplified.

RESPONSE: The Department understands the comment regarding "sufficient," The term "sufficient" may not have been the most appropriate; the sense intended in the proposal was "complete" rather than "adequate." The provision regarding the methodology has been deleted from this adoption, therefore, this provision regarding its certification is deleted as well.

COMMENT: One commenter questioned the requirement that compliance with the 2:1 age/sex restriction be "proved" with every filing. The suggestion is that this could be proved initially, and then only addressed in the future if there are changes to the

rating methodology. Another commenter requested clarification on how this restriction was to be used.

RESPONSE: There is no requirement to prove compliance with the 2:1 age/sex restriction in either the existing rule or the proposal. The example calculation required by N.J.A.C. 11:21-9.3(a)2iii must demonstrate compliance. The actuarial certification must certify to compliance (N.J.A.C. 11:21-9.3(a)3iv(4)). Therefore, demonstration and certification (as opposed to proof) at the time of each filing is appropriate.

COMMENT: The definition of "list bill" is unclear.

RESPONSE: The Department agrees that the term "list bill" and its definition does not describe what was intended, a rating system where there was an identifiable charge for each covered person. The definition and requirements using the definition have been eliminated in the adoption.

COMMENT: One commenter noted that it appeared that the reference in N.J.A.C. 11:21-9.3(a)2iv(9) to N.J.A.C. 11:21-9.3(a)2iv(1)(A) should be to N.J.A.C. 11:21-9.3(a)2iv(1)(B). The commenter noted that this change would be consistent with the notion that a carrier that rates on the basis of the population of eligibles would bear some risk of change in the demographic composition of the covered population.

RESPONSE: The commenter is correct, as is the general reasoning reflected in the comment. However, no change is required, as this language has not been included

in the adoption because proposed N.J.A.C. 11:21-9.3(a)2iv(9) has been eliminated from the adoption.

COMMENT: One commenter had several questions relating to the proposed changes to N.J.A.C. 11:21-9.3(a)2iv requiring an explanation of the methodology used to determine the age and gender factors in calculating new issue and renewal rates. They stated it sounded as if the regulation was asking for an explanation of how age and gender factors were developed while the context of the regulation didn't support this. They stated the 10 percent threshold was too large and asked for clarification of what constituted rate changes for carriers that used list billing. Another commenter found N.J.A.C. 11:21-9.3(a)2iv(5) not feasible to implement and N.J.A.C. 11:21-9.3(a)2 iv(8) and (9) very confusing.

RESPONSE: These comments as well as those previously addressed focused upon the complexity of the issues raised by the proposed amendment. The Department has determined to take all comments under advisement and not adopt the proposed changes to N.J.A.C. 11:21-9.3(a)2iv at this time.

Summary of Changes Upon Adoption

The following changes to the proposal will be made on adoption based on the comments received and summarized above:

1. The definition of "list billing" is not adopted in N.J.A.C. 11:21-9.2, Definitions, as all references to list billing will not be adopted.

2. N.J.A.C. 11:21-9.3(a)1v is amended to limit the required Medicare primary reduction to Medicare based on age only and to employee only.
3. The proposed language to N.J.A.C. 11:21-9.3(a)2iv, 3v(3) and 3vi(7) is not adopted.
4. N.J.A.C. 11:21-9.6(d) is added to create a materiality standard for reportable errors.
5. Current N.J.A.C. 11:21-9.6 and 9.7 are recodified as N.J.A.C. 11:21-9.7 and 9.8.

Federal Standards Statement

A Federal standards analysis is not required because the adopted new rule and amendments are not subject to any Federal standards requirements.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from the proposal indicated in brackets with asterisks *[thus]*:

11:21-9.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A-17 or N.J.A.C. 11:21-1.2 unless defined below or the context clearly indicates otherwise.

. . .

[“List bill” or “list billing” means a bill or billing which has a rate for each covered employee that may differ from employee to employee based upon each employee’s age, gender and coverage tier (for example, family).]

. . .

11:21-9.3 Informational rate filing requirements for small employer health benefits plans issued or renewed after December 31, 1993

(a) All carriers issuing policies, contracts or certificates under health benefit plans to small employers, including any standard or nonstandard rider option, prior to issuing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the following data:

1. A plan schedule for each of the standard health benefits plans and nonstandard health benefits plans offered, outlining*[**.**]* *__:__*

i–iv. (No change.)

v. The basic premium rate or rating factors applicable for each option including *[the difference when Medicare is primary or secondary, based on actual employee or spouse Medicare coverage status.* *[reduced]* ***__Reduced__*** premium rates or rating factors *[where]* ***__must be provided when__*** Medicare is primary for an employee *[or spouse based on the actual Medicare coverage status of the employee or spouse]* ***__eligible for Medicare by reason of age__***; and

vi. (No change.)

2. A rate manual containing :

i-iii. (No change)

iv. ***A specification of the rule, which must be invariable, stating if the issue rate is based on the issue enrollment or the proposal rate**.* [An explanation of the methodology used to determine the age and gender factors used in calculating new issue and renewal rates. The methodology shall satisfy the following requirements:

(1) The explanation shall explicitly specify whether the determination of age and gender factors is based on:

(A) in the case of a new issue or renewal, the population actually enrolled on the effective date or the renewal date;

(B) in the case of a new issue or renewal, the entire population of the group eligible to be covered at the time of preparation of the proposed rate; or

(C) in the case of a renewal, the population actually covered at the time of preparation of a proposed rate.

(2) The explanation shall explicitly specify which of the methods listed above is used for new issues and which method is used for renewals. Different methods may be used for new issue rates and for renewal rates.

(3) If different methodologies are used for new issues and renewals, the explanation shall indicate the circumstances under which a renewal would be rated as a new issue (for example, change in plan of coverage)

(4) The methodology cannot vary based on group size.

(5) If a carrier uses the method in (a)2iv(1)(B) above for new issues and/or renewals, it shall exclude from the population all persons who waive coverage pursuant to N.J.A.C. 11:21-6.4 in determining the age and gender factors. Redetermination of age and gender factors is permitted for waivers that are withdrawn.

(6) If a carrier determines age and gender factors based on the method in (a)2iv(1)(A) above for new issues and/or renewals, and the difference between the rate produced by the method in (a)2iv(1)(A) above and the proposed rate results in a rate change of less than 10 percent of the proposed rate, the carrier may charge the proposed rate. This practice must be disclosed in the explanation of the methodology, and it must be applied uniformly to all groups.

(7) Only carriers that use the method in (a)2iv(1)(A) above may use list billing. If list billing is used, it must be used for both new issue and renewal rates, and it must be used regardless of group size. Carriers that use list billing may adjust the rate

based on changes in the age and gender characteristics of the group during any rate guarantee period. The use of list billing and this adjustment must be disclosed in the explanation of the methodology.

(8) Carriers that use the method in (a)2iv(1)(A) above but that do not use list billing, can change the rate based on a change in the age and gender characteristics of the covered population during any rate guarantee period. The use of this adjustment must be disclosed in the explanation of the methodology.

(9) Carriers that use the method in (a)2iv(1)(A) above cannot change the rate based on changes in the age and gender characteristics of the covered population during any rate guarantee period.]*

3. A detailed actuarial memorandum setting forth the assumptions and methods used in the development of the rate, which shall include:

i-iv. (No change from proposal.)

v. A summary of the overall change in rate levels, including:

(1) The average percentage change, for each standard and nonstandard plan, between the rates contained in the rate filing and the rates that were in effect one year prior to the effective date of the rate filings; ***and***

(2) The average percentage change, for each standard and nonstandard plan, between the rates contained in the rate filing and the rates contained in the immediately prior rate filings; *[and]*

[(3) The maximum percentage and dollar change in rates per employee, for each standard and nonstandard plan, for any age, gender, or geographical location combination, between the rates contained in the rate filing and the rates that were in effect one year prior to the effective date of the rate filing;]

vi. A certification signed by a member of the American Academy of Actuaries attesting as follows:

(1) – (6) (No change)

[(7) The methodology for calculating age and gender adjustments, and the explanation of that methodology in the actuarial memorandum, complies with (a)2iv, above and is a sufficient explanation of the methodology for reflecting age and gender in rates; and]

vii. (No change from proposal.)

(b) – (d) (No change.)

11:21-9.6 Errors in rate quotations and rate calculation

(a) – (c) (No change from proposal.)

<u>* (d) The requirements of this section shall not apply to any deviation in rates from the filed rates that is less than one quarter of one percent (.25 percent) or that arises from a rounding error of less than $1.00.*</u>

11:21- *[9.6]* * **<u>9.7*</u>** Penalties (No change.)

11:21-*[9.7]* * **<u>9.8*</u>**

Failure to comply with the provisions of this subchapter may result in the imposition of fines or other penalties provided by N.J.S.A. 17B:27A-43.

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