(3) May—June: 10.5 percent, a 214-pound trip limit and a maximum of seven days per week that a vessel may land summer flounder, or a [500-pound] **375-pound** trip limit and a maximum of [three] **four** days per week that a vessel may land summer flounder, or a 750-pound trip limit and a maximum of two days per week that a vessel may land summer flounder, or a 1,500-pound trip limit a maximum of one day per week that a vessel may land summer flounder;

(4) July—August: 10.5 percent, a 214-pound trip limit and a maximum of seven days per week that a vessel may land summer flounder, or a [500-pound] **375-pound** trip limit and a maximum of [three] **four** days per week that a vessel may land summer flounder, or a 750-pound trip limit and a maximum of two days per week that a vessel may land summer flounder, or a 1,500-pound trip limit and a maximum of one day per week that a vessel may land summer flounder;

(5)-(7) (No change.)

iii.-xiii. (No change.)

3.-9. (No change.)

(j)-(y) (No change.)

HEALTH

(a)

HEALTH SYSTEMS BRANCH
OFFICE OF POLICY AND STRATEGIC PLANNING
OFFICE OF VITAL STATISTICS AND REGISTRY
Notice of Readoption
Certificate of Domestic Partnership
Readoption: N.J.A.C. 8:2B

Authority: N.J.S.A. 26:8A-1 et seq., particularly 26:8A-12.

Authorized By: Kaitlan Baston, MD, MSc, DFASAM, Commissioner, Department of Health.

Effective Date: December 23, 2024.
New Expiration Date: December 23, 2031.

Take notice that, pursuant to N.J.S.A. 52:14B-5.1, N.J.A.C. 8:2B, Certificate of Domestic Partnership, was scheduled to expire on January 29, 2025. N.J.A.C. 8:2B implements the Domestic Partnership Act, N.J.S.A. 26:8A-1 et seq. (Act), and establishes the procedures for filing affidavits of domestic partnerships, issuing domestic partnership certificates, and maintaining domestic partnership records.

Subchapter 1 provides the application and scope of the rules and establishes definitions of terms. Subchapter 2 establishes the process for filing an affidavit of domestic partnership and issuance of a certificate of domestic partnership, the filing fee, and civil penalties applicable to violations of the Act and/or the chapter. Subchapter 3 sets forth who may receive a certified copy, and who may receive a certification of the content of a domestic partnership affidavit or certificate, and the applicable corresponding fee for each. Subchapter 4 establishes the requirement for reporting facts regarding domestic partnerships to the State Registrar of Vital Statistics, the manner to correct a certificate of domestic partnership, and the means to terminate a domestic partnership.

The Commissioner has reviewed existing N.J.A.C. 8:2B and determined that the existing chapter remains necessary, proper, reasonable, efficient, understandable, and responsive for the purposes for which it was originally promulgated, as amended and supplemented over time, and should be readopted. Therefore, pursuant to N.J.S.A. 52:14B-5.1.c(1), N.J.A.C. 8:2B is readopted and shall continue in effect for seven years.

(b)

HEALTH SYSTEMS BRANCH
DIVISION OF CERTIFICATE OF NEED AND LICENSING
OFFICE OF HEALTH CARE FINANCING
Notice of Readoption
Hospital Financial Transparency
Readoption: N.J.A.C. 8:96

Authority: N.J.S.A. 26:2H-1 et seq., particularly N.J.S.A. 26:2H-5, 5.1a, 5.1b, 12.50, and 14.

Authorized By: Kaitlan Baston, MD, MSc, DFASAM, Commissioner, Department of Health, with the approval of the Health Care Administration Board.

Effective Date: December 24, 2024.
New Expiration Date: December 24, 2031.

Take notice that, pursuant to N.J.S.A. 52:14B-5.1.c, the Commissioner of the Department of Health (Department) hereby readopts N.J.A.C. 8:96, Hospital Financial Transparency, which was scheduled to expire on February 5, 2025.

N.J.A.C. 8:96, Hospital Financial Transparency, establishes standards applicable to hospitals that the Department licenses pursuant to the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., as well as owners of hospitals. N.J.A.C. 8:96 became effective February 5, 2018, and operative March 7, 2018, with an administrative correction on May 6, 2019 (see 51 N.J.R. 617(a)) (see 49 N.J.R. 1293(a); 50 N.J.R. 815(a)).

Subchapter 1, General Provisions, establishes general provisions.

Subchapter 2, Financial Statements, establishes requirements for disclosure of hospitals' financial statements.

Subchapter 3, Public Meeting Pursuant to N.J.S.A. 26:2H-12.50, addresses the public meeting requirements that hospitals must convene at least annually pursuant to the provisions at N.J.S.A. 26:2H-12.50.

Subchapter 4 establishes requirements for hospitals' disclosure of participation in insurance networks.

Subchapters 5, Ownership Interests of Hospitals, Management Companies, and Related Organizations, addresses hospital ownership interests, management companies, and related organizations.

Subchapter 6, Business Transactions with Interested Persons, addresses hospital business transactions with interested persons.

Subchapter 7, Sale, Lease, Sale-Leaseback, or Other Transfer of Hospital Building or Grounds, addresses sales, leases, sale-leasebacks, and other transfers of properties and/or buildings at which general and specialty heart hospitals exist.

Subchapter 8 remains reserved.

Subchapter 9 establishes enforcement remedies for hospitals' noncompliance with this chapter.

The Commissioner has reviewed N.J.A.C. 8:96 and determined that the chapter remains necessary, adequate, reasonable, efficient, and understandable, and responsive to the purposes for which it was promulgated and should be readopted.

Therefore, pursuant to N.J.S.A. 52:14B-5.1.c(1), N.J.A.C. 8:96 is readopted and shall continue in effect for seven years.

INSURANCE

(c)

DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF SOLVENCY REGULATION
Corporate Governance Annual Disclosure
Adopted New Rules: N.J.A.C. 11:1-48

Proposed: October 7, 2024, at 56 N.J.R. 1932(a).
Adopted: December 18, 2024, by Justin Zimmerman, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, and 17:23-38 et seq.

Filed: December 19, 2024, as R.2025 d.017, **without change**.

Effective Date: January 21, 2025.
Expiration Date: April 22, 2026.

Summary of Public Comments and Agency Responses:
No comments were received.

Federal Standards Statement

A Federal standards analysis is not required because the adopted new rules are not subject to any Federal requirements or standards.

Full text of the adopted new rules follows:

SUBCHAPTER 48. CORPORATE GOVERNANCE ANNUAL DISCLOSURE

11:1-48.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD), deemed necessary by the Commissioner to carry out the provisions at N.J.S.A. 17:23-38 et seq.

(b) This subchapter shall apply to all insurers and any entity subject to N.J.S.A. 17:23-38 et seq.

11:1-48.2 Definitions

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

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

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

"Insurance group" means those insurers and affiliates included within an insurance holding company system as defined at N.J.S.A. 17:27A-1 et seq.

"Insurer" shall have the same meaning as set forth at N.J.S.A. 17:27A-1, and shall include any insurer or entity subject to rehabilitation or liquidation pursuant to N.J.S.A. 17:30C-1 et seq. and 17B:32-31 et seq., including licensed organized delivery systems and reciprocal insurance exchanges.

"NAIC" means the National Association of Insurance Commissioners.

"Senior management" means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the chief executive officer (CEO), chief financial officer (CFO), chief operations officer (COO), chief procurement officer (CPO), chief legal officer (CLO), chief information officer (CIO), chief technology officer (CTO), chief revenue officer (CRO), chief visionary officer (CVO), or any other "C" level executive.

11:1-48.3 Filing procedures

(a) An insurer, or the insurance group of which the insurer is a member, required to file a CGAD at N.J.S.A. 17:23-38 et seq., shall, no later than June 1 of each calendar year, submit to the Commissioner a CGAD that contains the information described at N.J.A.C. 11:1-48.4.

(b) The CGAD shall include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's board of directors (Board) or the appropriate committee thereof.

(c) The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Commissioner to gain an understanding of the corporate governance structure, policies, and practices utilized by the insurer or insurance group.

(d) For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level, and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined; or the level at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen, collectively, and at which the supervision of those factors are coordinated and exercised; or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(e) Notwithstanding (a) above, and as outlined at N.J.S.A. 17:23-42, if the CGAD is completed at the insurance group level, then it shall be filed with the lead state, or group-wide supervisor, as defined at N.J.S.A. 17:27A-5.2, if applicable, for the insurance group, in accordance with the laws of that state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD shall also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

(f) An insurer or insurance group may comply with this section by referencing other existing documents (for example, Own Risk and Solvency Assessment (ORSA) Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, or foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described at N.J.A.C. 11:1-48.4. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed with or available to the Commissioner.

(g) Each year, following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where any changes have been made to such filed CGAD. If no changes were made in the information or activities reported by the insurer or insurance group, the filing shall so state.

11:1-48.4 Contents of Corporate Governance Annual Disclosure

(a) The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, as these documents may provide a means to demonstrate the strengths of their governance framework and practices.

(b) The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following:

1. The board of directors (Board) and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (for example, ultimate control level, intermediate holding company, or legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and

2. The duties of the Board and each of its significant committees and how they are governed (for example, bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of chief executive officer (CEO) and chairman of the Board within the organization.

(c) The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

1. How the qualifications, expertise, and experience of each Board member meet the needs of the insurer or insurance group;

2. How an appropriate amount of independence is maintained on the Board and its significant committees;

3. The number of meetings held by the Board and its significant committees over the past year, as well as information on director attendance; and

4. How the insurer or insurance group identifies, nominates, and elects members to the Board and its committees. The discussion shall include, but not be limited to, the following:

i. Whether a nomination committee is in place to identify and select individuals for consideration;

ii. Whether term limits are placed on directors;

iii. How the election and re-election processes function;

iv. Whether a Board diversity policy is in place, and if so, how it functions; and

v. The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

(d) The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors:

1. Any processes or practices (that is, suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience, and integrity to fulfill their prospective roles, including:

i. Identification of the specific positions for which suitability standards have been developed and a description of the standards employed; and

ii. Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes;

2. A discussion of the insurer's or insurance group's code of business conduct and ethics, which discussion shall include, but not be limited to, the following:

i. Compliance with laws, rules, and regulations; and

ii. Proactive reporting of any illegal or unethical behavior;

3. The insurer's or insurance group's processes for performance evaluation, compensation, and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Examples of the elements to be discussed include, but are not limited to, the following:

i. The Board's role in overseeing management compensation programs and practices;

ii. The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

iii. How compensation programs are related to both company and individual performance over time;

iv. Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

v. Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted; and

vi. Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees; and

4. The insurer's or insurance group's plans for chief executive officer and senior management succession.

(e) The insurer or insurance group shall describe the processes by which the Board, its committees, and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, which shall include a discussion of the following:

1. How oversight and management responsibilities are delegated between the Board, its committees, and senior management;

2. How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks;

3. How reporting responsibilities are organized for each critical risk area. The description shall be sufficient to allow the Commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the Board. This description may include, for example, the following critical risk areas of the insurer:

i. Risk management processes (an ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to N.J.S.A. 17:23-27 et seq.);

ii. Actuarial function;

iii. Investment decision-making processes;

iv. Reinsurance decision-making processes;

v. Business strategy/finance decision-making processes;

vi. Compliance function;

vii. Financial reporting/internal auditing; and

viii. Market conduct decision-making processes.

11:1-48.5 Severability

If any provision of this subchapter, or the application thereof, to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to that end, the provisions of this subchapter are severable.

11:1-48.6 Penalties

Any insurer failing, without just cause, to timely file the disclosure as required pursuant to N.J.S.A. 17:23-38 et seq., and as set forth in this subchapter shall be required, after notice and opportunity for a hearing, to pay a penalty of up to $5,000 for each day's delay.

(a)

DEPARTMENT OF BANKING AND INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD
Individual Health Coverage Program
Individual Health Benefits Plans
Adopted Amendments: N.J.A.C. 11:20 Appendix Exhibits A and B

Proposed: November 22, 2024 (see 57 N.J.R. 7(a)).
Adopted: December 20, 2024, by the New Jersey Individual Health Coverage Program Board, Sandi Kelly, Chairperson.

Authority: N.J.S.A. 17B:27A-2 et seq.

Filed: December 24, 2024, as R.2025 d.020, **without change**.

Effective Date: January 21, 2025.
Operative Date: April 1, 2025.
Expiration Date: December 12, 2031.

Summary of Hearing Officer's Recommendation and Agency Responses:

The New Jersey Individual Health Coverage Program Board (IHC Board) held a hearing on Monday, December 9, 2024, by Zoom to receive testimony with respect to the health benefits plans, set forth at N.J.A.C. 11:20 Appendix Exhibits A and B. Ava Rimal, Regulatory Officer, served as the hearing officer.

The hearing officer made no recommendations regarding the adopted amendments. The hearing record may be reviewed by contacting the New Jersey Individual Health Coverage Program Board, PO Box 325, Trenton, NJ 08625-0325.

Summary of Public Comments and Agency Responses:

No comments were received.

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. As discussed in the notice of proposal, the adopted amendments are intended to comply with newly enacted State law, and are not being proposed pursuant to the authority of, or in order to implement, comply with or participate in, any program established pursuant to Federal law or a State statute that incorporates or refers to Federal law, standards, or