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INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF LIFE AND HEALTH

Individual Health Coverage Program

Carriers Informational Rate Filing Requirements; Loss Ratio and Refund Reporting Requirements; Relief from Obligations Imposed by the Individual Health Insurance Reform Act and Withdrawals of Carriers from the Individual Market and Withdrawal of Plan, Plan Option or Deductible/Copayment Option

Proposed Readoption: N.J.A.C. 11:20-3A, 6, 7, 11 and 18 and 11:20 Appendix Exhibits E and J

Authorized By: Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B:27A-2 et seq., and P.L. 2008, c. 38.

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

Proposal Number: PRN 2011–013.

Submit comments by March 19, 2011 to:

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The agency proposal follows:

Summary

N.J.S.A. 17B:27A-2 (the IHC Act), originally effective November 30, 1992, established the New Jersey Individual Health Coverage (IHC) Program to provide requirements for the provision of individual health coverage plans in this State. Various responsibilities for the implementation of the Act were assigned to either the Commissioner of Banking and Insurance (Commissioner) or the IHC Board. Administrative rules to implement the IHC Act were adopted and codified at N.J.A.C. 11:20, originally effective 1993 and amended subsequently since that time. P.L. 2008, c. 38, approved July 8, 2008, amended various sections of the IHC Act. These changes included:

(i) Rate caps for in-force business and for certain new business for four years following the effective date of the statute (N.J.S.A. 17B:27A-3a);

(ii) IHC rates for new contracts and policy forms are now filed with the Commissioner for informational purposes rather than with the IHC Board (N.J.S.A. 17B:27A-9c);

(iii) Rates are to be formulated with an anticipated minimum loss ratio of not less than 80 percent, increased from 75 percent, and the loss ratio report is now to be filed with the Commissioner rather than with the IHC Board (N.J.S.A. 17B:27A-9e(1) and (2));

(iv) The IHC Board no longer has the authority to review rate applications and form filings (repeal of N.J.S.A. 17B:27A-11c);

(v) Rate changes are now filed with the Commissioner (N.J.S.A. 17B:27A-9d); and

(vi) The Commissioner now reviews applications to nonrenew a particular type of health benefits plan (N.J.S.A. 17B:27A-6c(3) or to cease doing business entirely in the individual health benefits market (N.J.S.A. 17B:27A-6c(4)).

In order to implement the amendments to the IHC Act, the IHC Board repealed various rules that no longer applied (see 40 N.J.R. 6904(a), 41 N.J.R. 799(b) and 41 N.J.R. 1875(a)). Simultaneously, the Department of Banking and Insurance (Department) adopted new rules at N.J.A.C. 11:20-3A (Policy Forms), 11:20-6 (Individual Health Benefits Carriers Informational Rate Filing Requirements), N.J.A.C. 11:20-7 (Loss Ratio and Refund Reporting Requirements), and N.J.A.C. 11:20-18 (Withdrawals of Carriers from the Individual Market and the Withdrawal of Plan, Plan Option, or Deductible/Copayment Option) to provide for the implementation of the

amendments to the IHC Act and to reflect the Department's new responsibilities under the amended law (see 41 N.J.R. 73(a) and 1866(c)). The Department's new rules generally reflected the rules that were previously adopted by the IHC Board, with appropriate changes to implement the IHC Act, as amended. In brief, N.J.A.C. 11:20-3A and 18 essentially restated the existing N.J.A.C. 11:20-3 and 18, with changes to reflect reviews of such filings by the Department, rather than the IHC Board. N.J.A.C. 11:20-6 and 7 essentially restated existing requirements in those subchapters, with appropriate changes to reflect review by the Department and the new minimum loss ratio requirements established by the IHC Act, as amended by P.L. 2008, c. 38. Thus, the requirements imposed by the rules generally continued those provided under the previous regulatory framework, as modified to reflect the new statutory requirements under the IHC Act, as amended.

In addition to the new rules adopted by the Department at N.J.A.C. 11:20-3A, 6, 7 and 18 as described above implementing the 2008 amendments to the Act, the Department continues to be responsible for N.J.A.C. 11:20-11 relating to the informational and procedural requirements for members requesting relief from obligations to pay assessments pursuant to N.J.S.A. 17B:27A-12 (including assessments for IHC program losses and administrative expenses), or to offer coverage or accept applications to provide a standard health benefits plan to eligible persons pursuant to N.J.S.A. 17B:27A-8. P.L. 2008, c. 38 established that the loss assessment for the 2007-2008 two-year calculation period shall be the last loss assessment, and that no further loss assessments shall be calculated or collected.

In accordance with the sunset provisions of Executive Order No. 66 (1978) and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., N.J.A.C. 11:20 is scheduled to expire on June 5, 2011. The Department has reviewed Subchapters 3A, 6, 7, 11 and 18, and Appendix Exhibits E and J, and determined that they are necessary, reasonable and proper for the purpose for which they were promulgated.

N.J.A.C. 11:20-3A.1 establishes the requirements and procedures by which carriers seeking to enter the individual plan market, and carriers issuing plans in the individual plan market, are to file individual policy or contract forms with the Department and certify that the health benefit plans to be used by the carrier are in substantial compliance with provisions in the approved individual plans pursuant to N.J.S.A. 17B:27A-7d. N.J.A.C. 11:20-3A.2 sets forth the requirements for the filing of a certification of compliance. Specifically, before marketing, issuing or renewing any standard policy forms, a member (that is, a carrier that issues or has in force health benefits plans in New Jersey, as defined at N.J.S.A. 17B:27A-2 and N.J.A.C. 11:20-1.2) is required to file with the Department a certification of compliance as set forth in Exhibit E of the Appendix to the chapter. N.J.A.C. 11:20-3A.3 sets forth requirements for basic and essential health care services policy forms. The rule requires that members file such policy forms with the Department before offering or issuing such a form. The rule sets forth the information that is required to be contained in a filing, and provides for the Department to notify a member in writing if the policy form filing is disapproved. Absent such notification within 30 days after a filing is received, a policy form will be deemed approved.

N.J.A.C. 11:20-6 establishes informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to N.J.S.A. 17B:27A-4, as well as the basic and essential health care services plan pursuant to P.L. 2001, c. 368. N.J.A.C. 11:20-6.2 sets forth definitions of terms used in the subchapter. N.J.A.C. 11:20-6.3 sets forth the requirements for informational rate filings. These requirements include that all members issuing standard health benefits plans on a new contract or policy form and the basic and essential health care services plan shall make, prior to issuing any standard health benefits plan or basic and essential health care services plan, an informational rate filing with the Department which includes the supporting data specified in the rules. This data includes: rate manuals; monthly premium rates and factors; a detailed actuarial memorandum; a certification signed by a member of the American Academy of Actuaries, Society of Actuaries or Casualty Actuarial Society that includes the information specified in the rule; and such other information and data that may be required or requested by the Department when analyzing a particular filing. N.J.A.C. 11:20-6.4 sets forth the procedures for informational rate filings. N.J.A.C. 11:20-6.5 sets forth permissible rate classification factors, including age factor categories and geographic categories.

N.J.A.C. 11:20-7 relates to loss ratio and refund reporting requirements. N.J.A.C. 11:20-7.1 sets forth the purpose of the rules. N.J.A.C. 11:20-7.2 sets forth the definitions of terms used in this subchapter. N.J.A.C. 11:20-7.3 requires that members file with the Commissioner an annual loss ratio report on the form appearing as Exhibit J in the Appendix to the chapter. N.J.A.C. 11:20-7.4 sets forth the specific content

required to be included in the loss ratio report, which includes: a member's name and address; a member's net earned premium for the preceding calendar year; a statement of the member's total losses incurred; the member's loss ratio; and a certification by a member of the Society of Actuaries, Casualty Actuarial Society, or American Academy of Actuaries that the information provided in the report is accurate, complete and that the carrier is in compliance with the requirements in N.J.S.A. 17B:27A-9. N.J.A.C. 11:20-7.5 provides that if the loss ratio determined pursuant to N.J.A.C. 11:20-7.4 is less than 80 percent, a member shall include with the report a plan to be approved by the Commissioner for a refund to policy or contact holders of an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amounts of dividends and credits equal 80 percent of the aggregate premiums collected for the policy or contract forms in the previous calendar year. This section also contains the requirements for any refund plan. N.J.A.C. 11:20-7.6 sets forth specific requirements related to unclaimed loss ratio refunds. N.J.A.C. 11:20-7.7 provides that, within 30 days of providing refunds to all policy or contractholders, a carrier required to provide a loss ratio refund pursuant to the subchapter shall provide a certification of compliance to the Department.

N.J.A.C. 11:20-11.1 sets forth the purpose and scope of this subchapter as described above. N.J.A.C. 11:20-11.2 contains definitions of words and terms used in the subchapter. N.J.A.C. 11:20-11.3 provides the application procedures and filing format for requests for relief from obligations under the Act. N.J.A.C. 11:20-11.4 sets forth the information to be filed and the application procedures to be used by carriers

when applying for allowable relief from obligations, and imposes a $1,000 filing fee. N.J.A.C. 11:20-11.5 provides that all information contained in the request for relief is confidential, except for specified information. N.J.A.C. 11:20-11.6 establishes the standards to be utilized by the Commissioner when determining whether or not to grant relief in accordance with the Act. N.J.A.C. 11:20-11.7 sets forth procedures by which carriers may request a hearing on the Commissioner's determination. N.J.A.C. 11:20-11.8 requires carriers requesting relief to notify the Program of the relief request and of the disposition of such requests by the Commissioner. N.J.A.C. 11:20-11.9 provides notice and filing requirements for a carrier that is a health maintenance organization asserting that it is not required to offer or accept applications pursuant to N.J.S.A. 17B:27A-8a because it lacks the capacity for additional enrollees. N.J.A.C. 11:20-11.10 states that these rules do not limit or preclude the Commissioner from instituting any other actions pursuant to law regarding a carrier's operations. N.J.A.C. 11:20-11.11 sets forth penalties for failure to comply with the subchapter.

N.J.A.C. 11:20-18 applies to withdrawals of carriers from the individual market and the withdrawal of plans, plan options or deductible/co-payment options. N.J.A.C. 11:20-18.1 sets forth the purpose and scope of the rules. N.J.A.C. 11:20-18.2 sets forth the definitions of terms used in this subchapter. N.J.A.C. 11:20-18.3 provides that no carrier with in-force individual plans shall cancel an individual plan, except in accordance with N.J.S.A. 17B:27A-6, or non-renew an individual plan upon the plan’s anniversary date, except in accordance with N.J.A.C. 11:20-18.5, 18.6 or 18.7. N.J.A.C. 11:20-18.4 sets forth specific requirements for carriers wishing to cease to offer and

issue individual plans. Specifically, a carrier may not cease to offer all of its individual plans to an eligible person unless the Commissioner has determined, pursuant to N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11, that the carrier does not have the financial resources necessary to underwrite additional coverage, and the carrier has provided timely written notice to the IHC Board and its plan policyholders. This section also provides that a carrier that notifies the Board shall continue to renew all in-force individual plans until it obtains the Department's approval for market withdrawal in accordance with N.J.A.C. 11:20-18.5. A carrier that has ceased offering and issuing individual plans, but that has not withdrawn from the market in accordance with N.J.A.C. 11:20-18.5, may resume issuing standard individual health plans after it has notified the Department and the IHC Board that it intends to resume offering such plans. Finally, this section provides that a carrier with in-force individual plans that has ceased to issue and offer all of its individual plans pursuant to the rules shall nevertheless continue to comply with all applicable provisions of law. N.J.A.C. 11:20-18.5 sets forth general provisions for market withdrawal. These requirements include: a carrier may not refuse to issue or renew an individual plan, except in accordance with applicable law, unless the carrier seeks and obtains approval from the Department to withdraw all of its individual plans; and a carrier that seeks to withdraw shall file with the Department an application for market withdrawal as set forth in this section, including the information set forth therein. N.J.A.C. 11:20-18.6 sets forth general provisions for withdrawal of plan, plan options or deductible/co-payment options. Specifically, this section provides that no carrier shall cease to issue or nonrenew an

individual plan, plan option or deductible/co-payment option required or permitted to be offered by N.J.A.C. 11:20-3.1 until the carrier submits a notice of intent to withdraw a plan, plan option or deductible/co-payment option with the Department, and the Commissioner approves such withdrawal in accordance with this section. This section also sets forth the prerequisites for ceasing to renew individual plans. N.J.A.C. 11:20-18.7 provides that a carrier that ceases to do business pursuant to N.J.A.C. 11:20-18.5 shall be prohibited from writing new individual plans and new small employer plans in New Jersey for a period of five years beginning on the termination date of the last standard individual health plan not renewed. N.J.A.C. 11:20-18.8 provides that a carrier issuing all of the standard individual plans in the IHC market on and before January 4, 2009 that elects to offer at least three but not all of the standard individual plans after January 4, 2009, as permitted by N.J.S.A. 17B:27A-4b, may either withdraw the plan or plans that the carrier elects to no longer offer, convert the in-force business in the plan or plans the carrier no longer offers pursuant to N.J.A.C. 11:20-24.7, or make a one-time election to continue to renew the in-force business in the plan or plans the carrier will no longer offer, provided the requirements in this section are satisfied. The purpose of this section is to minimize disruptions to policyholders that may result from carriers ceasing to offer coverages currently offered, as otherwise permitted pursuant to N.J.S.A. 17B:27A-4b. N.J.A.C. 11:20-18.9 provides that nothing in Subchapter 18 shall be construed to contravene any rights of policy or contractholders concerning other obligations set forth in the policy or contract issued by a carrier.

Readoption of the remaining subchapters in Chapter 20 is proposed separately by the New Jersey Individual Health Coverage Program Board elsewhere in this issue of the New Jersey Register, and completion of the readoption process will be coordinated between the agencies.

A 60-day comment period is provided for this notice of proposal, and therefore, pursuant to N.J.S.A. 52:14B-3(e) and N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

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

The specific subchapters proposed for readoption by the Department at N.J.A.C. 11:20-3A, 6, 7, 11 and 18, and Appendix Exhibits E and J, apply to IHC Program policy forms, rate and form filings, loss ratio requirements, relief from obligations imposed by the Act, and withdrawal requirements and will continue to have a beneficial social

impact by continuing the existing protections to policy and contractholders that help ensure adequate access to health insurance coverage by individuals of this State. The recently increased minimum loss ratio requirement (from 75 percent to 80 percent) contained in Subchapter 7 will continue to ensure that carriers are allocating an appropriate amount of their premium revenue toward payment of benefits. Additionally, Subchapter 11, which permits certain eligible carriers to request relief from paying assessments and/or offering coverage pursuant to the Act, will continue to maintain the financial stability of those carriers and their ability to pay existing claims liabilities. This protects current policyholders and subscribers, and benefits the insurance buying public and carriers generally.

Economic Impact

Members of the IHC Program will continue to be required to incur any costs associated with compliance with the rules proposed for readoption. This includes costs related to filing policy forms, loss ratio reports, certifications of compliance, and withdrawals from the individual health market. Members of the IHC Program will also incur ongoing costs related to the recently increased minimum loss ratio of 80 percent. The Department does not anticipate that any professional services will be required for carriers to continue to comply with the rules proposed for readoption beyond those currently required for compliance with existing rules and include professional, accounting, legal and actuarial services.

The proposed readoption of Subchapter 11, which permits eligible carriers to request relief from certain statutory obligations under the Act, should not have an

adverse economic impact on carriers. As originally intended, these rules will continue to aid carriers' administrative, financial and legal staff in initiating and executing applications for relief, as permitted under the Act, thus enabling carriers to avoid any adverse economic impact. Carriers seeking relief will, however, continue to bear costs of compiling and submitting the required information in the proper format, and pay the $1,000 filing fee unless the carrier is in rehabilitation or conservation. The Department does not believe that any additional adverse impact will be imposed on carriers because the information required to be submitted should be readily available and because the filing fee is reasonable in consideration of the costs incurred by the Department in reviewing such filings.

The Department will continue to bear the costs associated with the review of form, loss ratio, and withdrawal filings that were previously reviewed by the IHC Board, but which are now reviewed by the Department pursuant to current rules implementing the 2008 amendments to the Act.

The benefits of monitoring the financial condition of insurers in the IHC market and ensuring adequate access to coverage in that market for individual consumers justify the costs imposed on the industry by the reporting and compliance requirements established by the rules proposed for readoption.

Federal Standards Statement

The rules proposed for readoption comply with the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, and do not expand the requirements set forth in Federal law.

The rules proposed for readoption comply with the following Federal laws: Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. § 1395(b) (1994) and implementing regulations at 45 CFR Part 411; the Public Health Service Act, 42 U.S.C. §§ 300gg et seq. (incorporating the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191; the Newborns' and Mother's Health Care Protection Act of 1998, Pub. L. 104-204, 110 Stat. 1935 (1996); the Women's Health and Cancer Rights Act of 1998, Pub. L. 105-277, Title IX, §903, 112 Stat.), and implementing regulations at 45 CFR Parts 145 and 146; and The Patient Protection and Affordable Care Act, Public Law 111-148 (PPACA).

The PPACA was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act (Reconciliation Act) (Public Law 111-152) was enacted on March 30, 2010. The Federal Departments of Health and Human Services, Treasury and Labor are issuing regulations to implement the PPACA and the Reconciliation Act. The Federal law includes provisions regarding medical loss ratios in the individual market, including requirements for the payment of rebates to consumers. It is the Department's current understanding that the calculation of medical loss ratios and payment of rebates in accordance with existing New Jersey law does not prevent the application of the Federal law, and no changes to the current rules at N.J.A.C. 11:20-6 or 7 are being proposed at this time.

The rules proposed for readoption do not expand upon the requirements set forth in these Federal laws. There are no other Federal laws that apply to these rules.

Jobs Impact

The Department does not anticipate that any jobs will be generated or lost as a result of the rules proposed for readoption. The Department invites commenters to submit any data or studies on the potential jobs impact of the rules proposed for readoption.

Agriculture Industry Impact

The rules proposed for readoption will not have an impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The rules proposed for readoption apply to domestic insurers and health maintenance organizations authorized to issue health benefits plans in New Jersey which provide individual health insurance in this State. Some of these entities may be "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The costs for compliance and professional services required to continue to comply with the rules are as set forth in the Economic Impact above. The rules proposed for readoption provide no differentiation in compliance requirements based on business size. As noted above, the rules proposed for readoption continue to reflect the requirements imposed by the Act as amended in 2008, and the IHC Program rules, related to filings with the Department rather than with the IHC Board, and the recently increased minimum loss ratio requirement. The rules proposed for readoption further impose certain filing and fee requirements as discussed above in the Economic Impact above on those carriers seeking to obtain relief from certain statutory obligations under the Act. The purpose of the Act and the rules proposed for

readoption is to continue the regulatory framework for the provision of individual health insurance coverage in this State to help ensure that individuals have adequate access to such coverage. These goals do not vary based on business size.

Smart Growth Impact

The rules proposed for readoption will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact

The rules proposed for readoption will not have an impact on housing affordability in this State in that the rules relate to the provision of individual health insurance.

Smart Growth Development Impact

The Department believes that there is an extreme unlikelihood that the rules proposed for readoption would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan because the rules relate to the provision of health insurance.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:20-3A, 6, 7, 11 and 18 and 11:20 Appendix Exhibits E and J.