INSURANCE

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Proposed Readoption with Amendments: N.J.A.C. 11:21-1 through 3, 4 through 7, 8, 10, 17, 18, 23 and Appendix Exhibits A, F, G, H, N, O, T, V, W, Y, BB Parts 1 and 2, CC, DD, II and KK.

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

Authority: N.J.S.A. 17B:27A-17 et seq. P.L. 2007, c. 345 and P.L. 2008, c. 38

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

Proposal number: PRN-2008-

Interested persons may testify with respect to the standard health benefits plans, set forth in Appendix Exhibits A, F, G, H, N, O, T, V, W, Y, DD, HH and II to N.J.A.C. 11:21 at a public hearing to be held at 9:30 a.m. on December17, 2008 at the New Jersey Department of Banking and Insurance, Room 218 20 West State Street, Trenton, New Jersey.

Submit comments by January 19, 2009 to:

Ellen DeRosa

Executive Director

New Jersey Small Employer Health Benefits Program Board

P.O. Box 325

Trenton, NJ 08625-0325

Fax: 609-633-2030

E-mail: ellen.derosa@dobi.state.nj.us

The agency proposal follows:

Summary

Overview and Rulemaking Procedures

Pursuant to N.J.S.A. 52:14B-5.1c, N.J.A.C. 11:21 expires on February 19, 2009. Some of the subchapters contained within this chapter were promulgated by the Small Employer Health Benefits Program Board (SEH Board), the remainder were promulgated by the New Jersey Department of Banking and Insurance (Department). The SEH Board has reviewed those subchapters it promulgated and has determined that they are necessary, reasonable and proper for the purpose for which they were originally promulgated. Accordingly, the rules are being proposed for readoption, with amendments, noted herein.

The SEH Board was charged by the Legislature with implementing and regulating the reformed small employer health benefits coverage market pursuant to P.L. 1992, c.162 as amended, and codified at N.J.S.A. 17B:27A-17 et seq. (the "SEH Act"). The readoption of N.J.A.C. 11:21-1 is necessary because it implements the SEH Program.

P.L. 2008, c. 38 was approved on July 8, 2008 and becomes effective January 5, 2008. Among other things, P.L. 2008, c. 38 amends the SEH Act, and necessitates amendments to the rules regulating the SEH Program. Given the proximity of the effective date of P.L. 2008, c. 38 and the expiration of N.J.A.C. 11:21, the SEH Program Board is proposing amendments necessary to comply with P.L. 2008, c. 38 at the same time as the proposed readoption.

Significant among the amendments of P.L. 2008, c. 38 affecting the SEH Program Board's rules set forth in N.J.A.C. 11:21 are the following:

1. If a carrier issues small employer coverage in New Jersey the carrier must offer individual coverage and must make a good faith effort to market the individual coverage.
2. Carriers shall offer a choice of at least three small employer health benefits plans established by the SEH Board and are no longer required to offer all of the standard health benefits plans.
3. Carriers that offer optional benefit riders will be required to list the premium for the ridered plan separately from the premium for the standard plan without riders.
4. The Dependent to 30 continuation is amended to: allow an over-age dependent to remain covered until his or her 31st birthday; state that the person cannot be covered under another plan at the time the continuation begins; state that the dependent must either have evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan; and delete the requirement that employers provide notice of the continuation opportunity and add a requirement that carriers give quarterly notice of the opportunity for continuation.

P.L. 2007, c. 345, approved January 13, 2008 and effective April 13, 2008, requires carriers to provide benefits for orthotic and prosthetic appliances, and to reimburse in accordance with the Medicare schedule for such appliances. The new law necessitates amendments to the standard health benefits plans, other than Plan A which is the basic plan, and the existing SEH Program rules regarding the payment of benefits.

Concurrent with the publication of this proposal, the amendments to the Plan of Operation are being submitted to the Commissioner for his approval pursuant to N.J.S.A. 17B:27A-30. Pursuant to N.J.S.A. 17B:27A-30, the Plan of Operation and any subsequent amendments thereto shall be submitted to the Commissioner who shall, after notice and hearing, approve the plan if he finds that it is reasonable and equitable and sufficiently carries out the provisions of the SEH Act. The Plan of Operation shall become effective unless disapproved in writing by the Commissioner within 90 days of receipt by the Commissioner, or earlier if the Commissioner approves the Plan of Operation in writing prior to the expiration of the 90-day period.

SEH Rulemaking Procedures

The SEH Board proposes these amendments pursuant to N.J.S.A. 17B:27A-51, which provides a special procedure whereby the SEH Board may adopt certain actions. Pursuant to this procedure, the SEH Board is required to publish notice of its intended action in three newspapers of general circulation, which notice shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views regarding the intended action. Notice of the intended action also is required to be sent to affected trade and professional associations, carriers, and other interested persons who may request such notice. Concurrently, the SEH Board is required to forward the notice of the intended action to the Office of Administrative Law (OAL) for publication in the New Jersey Register. The SEH Board must provide a minimum 20-day period from the date of notice for all interested persons to submit their written comments on the intended action to the SEH Board. Given that this special procedure is being used in connection with a readoption, the SEH Board is allowing a 60-day comment period.

Pursuant to N.J.S.A. 17B:27A-51, the SEH Board may adopt its intended action immediately upon the close of the specified comment period by submitting the adopted action to the OAL. If the SEH Board elects to adopt the action immediately upon the close of the comment period, it shall nevertheless respond to the comments timely submitted within a reasonable period of time thereafter. The SEH Board shall prepare a report for public distribution, and publication by the OAL in the New Jersey Register. The report shall include a list of commenters, their relevant comments, and the SEH Board's responses.

Pursuant to N.J.S.A. 17B:27A-51, all actions adopted by the SEH 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 SEH Board uses its special rulemaking procedures.

Readoption of the remaining subchapters in Chapter 21 will be proposed separately by the Department.

Discussion of Readopted Rules

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-1 is necessary because N.J.A.C. 11:21-1 sets forth the definitions of terms used in Chapter 21, identifies how the SEH Board may be contacted, sets forth the penalties available under law, provides a severability clause for the subchapter and specifies the SEH Board's mission statement. The SEH Board is also proposing amendments to this subchapter. First, the proposed amendments would define the term "allowed charge" which would replace the term "reasonable and customary" as defined in the standard health benefits plans in the Exhibits of the Appendix to N.J.A.C. 11:21, and as used in N.J.A.C. 11:21-7.13. Although the definitions of "allowed charge" and "reasonable and customary" are substantially the same, the SEH Board believes the term "allowed charge" more

accurately describes what is being defined. Second, the SEH Board is proposing to delete the terms “coinsurance cap” and “coinsured charge limit.” The SEH Board eliminated the coinsurance cap and coinsured charge limit features from the standard plans in 2004. Since the new term “maximum out of pocket” only applied to plans as they were renewed, the SEH Board retained the definitions of the prior terms, coinsurance charge limit and coinsurance cap, to accommodate plans during the transition until all plans had their first renewal. The transition concluded in 2005 and the terms are no longer used and can thus be deleted. Third, the SEH Board is proposing to amend the definitions of maximum out of pocket and network maximum out of pocket to reference an exception found in N.J.A.C. 11:21-5.2 to the statement that all amounts accumulate toward the maximum out of pocket. Lastly, the SEH Board is proposing to update the address for written communications to reflect the fact the SEH Board maintains offices on the 11th floor.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-2, the SEH Board’s Plan of Operation, is necessary in general because N.J.A.C. 11:21-2 sets forth the purpose and structure of the SEH Program. Pursuant to N.J.S.A. 17B:27A-30, the SEH Board is required to promulgate a Plan of Operation, which outlines the key elements of the SEH Board’s administration of the Program under the law. Included in the items in the Plan are the powers of the SEH Board, the SEH Board’s structure and how it meets to deliberate, the committee structures and duties, the SEH Board’s selection of the Executive Director and Executive Director’s duties, the procedures for assessments for administrative and operating expenses, the reporting requirements for carriers, the financial administration of the program, identification of required record keeping for the SEH Board, the requirements for the auditing of the SEH Board's finances, penalties and adjustments of assessment disputes, indemnification for SEH Board

members and its staff, and procedures for amendment or the termination of the Plan of Operation.

The SEH Board proposes to amend N.J.A.C. 11:21-2.6(b)1 to update the name of the Finance and Operations Committee to the current name which is the Finance and Audit Committee which more correctly describes the responsibilities of this committee. The SEH Board proposes amending N.J.A.C. 11:21-2.7(d) to assure consistency with the requirements of N.J.S.A. 52:13B-23(a)(2) by specifically stating the Uniform Ethics Code governs the activities of all Board members in addition to any supplemental plan the SEH Board may adopt. The SEH Board proposes amending N.J.A.C. 11:21-2.7 (c)1 to omit the requirement that the Executive Director submit monthly reports to the SEH Board. Since the SEH Board receives financial reports on both a quarterly and an annual basis and only meets bi-monthly a monthly report is not warranted.

The SEH Board proposes amending N.J.A.C. 11:21-2.8(a)3 to remove the 45-day timeframe for preparing a final reconciliation following the conclusion of an audit. In preparing the final reconciliation it is necessary for the SEH Board to identify the appropriate carriers and addresses which is sometimes challenging when there have been acquisitions and mergers or office locations have changed. In the event carriers do not timely respond to requests for information to enable the SEH Board to verify current information, the SEH Board determined it best to not be in the position of possibly billing or paying the wrong carrier so as to satisfy the 45-day time period and thus proposes deleting it. The SEH Board also proposes an amendment to N.J.A.C. 11:21-2.8(c)1iii to specify that amounts collected as late fees will be used to reduce the liability of carriers that were not charged a late fee.

The SEH Board proposes to amend N.J.A.C. 11:21-2.11(c) revising the reference to the law governing the inspection and copying of records by referring to the statutory codification only.

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

The SEH Board proposes amending N.J.A.C. 11:21-3.1(b) to state that small employer carriers shall offer at least three of the health benefits plans, consistent with N.J.S.A. 17B:27A-19 which, as amended by P.L. 2008, c. 38, only requires small employer carriers to offer at least three health benefits plans beginning in 2009, rather than all of the SEH Board's standard plans. The Board proposes amending items 1 through 4 of N.J.A.C. 11:21-3.1(b) to specify that: carriers must offer Plan A subject to a specific deductible and maximum out of pocket amount; carriers may offer one or more of the plans labeled as Plans B through D using a range of deductibles and maximum out of pocket amounts; and, carriers may offer Plan E, but if it is offered must include the stated deductible and maximum out of pocket amounts.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(c) to clarify that HMO carriers may offer the HMO plan in lieu of at least three of the plans A though E, consistent with amended N.J.S.A. 17B:27A-19f.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(c)2iv, (d)3 and (e)3 to increase the maximum out of pocket amount that may be included in a standard health benefits plan such that it may not exceed $7,500, which is the maximum permitted by N.J.A.C. 11:22-5.

The SEH Board proposes amending N.J.A.C. 11:21-3.1(f), which permits a carrier to offer plans through a selective contracting arrangement, by clarifying that carriers must offer at least three standard health benefits plan, one of which must be Plan A.

The SEH Board proposes amending N.J.A.C. 11:21-3.2(a) to change the conjunction from "and" to "and/or" in recognition of the fact that carriers need only offer three plans.

The SEH Board proposes amending N.J.A.C. 11:21-3.2(d) to add a new item (6) addressing the listing of the premium for the ridered plan separately from that of the standard health benefits plan, consistent with N.J.S.A. 17B:27A-19i as amended by P.L. 2008, c. 38.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-4 is necessary because N.J.A.C. 11:21-4 sets forth the standard policy forms that carriers are required to use in issuing the standard plans. The subchapter references the Exhibits in the Appendix to N.J.A.C. 11:21 which set forth the policy forms, riders, and explanation of brackets in the standard forms. This subchapter also sets forth the rules for certification or filing of forms with the SEH Board, the SEH Board's standard for review, and guidance for a carrier's use of a compliance and variability rider.

The SEH Board proposes amending N.J.A.C. 11:21-4.2 to delete items (c) and (d) which address the filing of forms used by a hospital service corporations and another carrier in order to offer the small employer health benefits plans. As there are currently no hospital service corporations authorized to do business in New Jersey, a discussion of filings by such an entity is not necessary.

The SEH Board proposes deleting N.J.A.C. 11:21-4.3 in its entirety since it addresses the standards for review of filings made by a hospital service corporations and another carrier in order to offer the small employer health benefits plans. As there are currently no hospital service corporations authorized to do business in New Jersey, a discussion of the standards to review filings by such an entity is not necessary.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-6 is necessary because N.J.A.C. 11:21-6 sets forth the standard application form, employer certification form, and waiver form used by small employers in obtaining and renewing small employer health benefits plans. These standardized forms are necessary to effectuate the intent of the Legislature in having a standardized market that promotes access to coverage, and to help ensure that carriers administer their business in a fair and equitable manner. The SEH Board is proposing to readopt N.J.A.C. 11:21-6 and its related exhibits - the employer application set forth at Exhibit N the certification form set forth at Exhibit O, and the waiver form set forth at Exhibit T, without amendments.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-7 is necessary because N.J.A.C. 11:21-7 sets forth the key elements for SEH Program compliance for carriers. Included in the requirements are standards for carriers with respect to eligibility and issuance; restrictions on changing plans; minimum employee participation requirements; minimum employer contribution requirements; preexisting condition standards; effective date of coverage; price quotes and disclosures; tie-in sales; guaranteed renewability of coverage; enrollment reporting requirements; paying benefits; and permissible rate classification factors.

The SEH Board is proposing an amendment to N.J.A.C. 11:21-7.3(a)2 to revise the reference from five plans to at least three plans, consistent with N.J.S.A. 17B:27A-19a as

amended by P.L. 2008, c. 38. The SEH Board is proposing an amendment to N.J.A.C. 11:21-7.3(c) concerning eligibility of independent contractors to delete the requirement that the independent contractor work exclusively for the employer and add a requirement that the independent contractor not be considered an employee by the New Jersey Department of Labor. The SEH Board's intent in proposing this amendment is to use standards more consistent with the criteria used in the evaluation of independent contractor status by the New Jersey Department of Labor.

The SEH Board proposes amending N.J.A.C. 11:21-7.13 to address the payment of benefits for prosthetics and orthotics as required by P.L. 2007, c. 345. In addition, the SEH Board proposes replacing "reasonable and customary" with "allowed charge" where the allowed charge for services and supplies not subject to capitated or negotiated arrangements is the actual charge or the 80th percentile of the Prevailing Healthcare Charges System profile.

The SEH Board proposes a new rule at N.J.A.C. 11:21-7.16 to provide that a small employer carrier shall offer and make a good faith effort to market individual health benefits plans as required by N.J.S.A. 17B:27A-19a as amended by P.L. 2008, c. 38. The proposed rule sets forth the timetable within which carriers must satisfy such requirement.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-8 is necessary because N.J.A.C. 11:21-8 establishes which carriers are not members of the SEH Program and how those carriers may be certified as non-members. The SEH Board is proposing to readopt N.J.A.C. 11:21-8 without amendments.

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

assessment of operational and administrative expenses of the SEH Program. The SEH Board is proposing to readopt N.J.A.C. 11:21-10 without amendments.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-17 is necessary because N.J.A.C. 11:21-17 sets forth the standards for carriers for plan identification and marketing, retention of marketing and promotional material, provides for a certification of the marketing material using the certification set forth at Appendix Exhibit BB, Part 2, and outlines prohibited practices by carriers with respect to contracting with producers.

The SEH Board is proposing new rules N.J.A.C. 11:21-17.4 to address the listing of premium for ridered plans separately from the premium for the standard health benefits plan as required by N.J.S.A. 17B:27A-19j as amended by P.L. 2008, c.38.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-18 is necessary because N.J.A.C. 11:21-18 sets forth the procedures for interested parties to submit petitions for rulemaking. Under the Administrative Procedure Act (APA), N.J.S.A. 52:14B-1 et seq., all State agencies are required to promulgate regulations for such petitions. The APA provides for a uniform application and administration of the rulemaking process. The SEH Board is proposing to readopt N.J.A.C. 11:21-18 without amendments.

The SEH Board finds the proposed readoption of N.J.A.C. 11:21-23 is necessary because N.J.A.C. 11:21-23 sets forth the procedures that the SEH Board uses in providing notice of proposed rulemaking, receiving public comments regarding existing rules and proposed rulemaking, extending the public comment period, conducting a public hearing, and providing notice of public meetings. The SEH Board is proposing to readopt N.J.A.C. 11:21-23 without amendments.

Amendments to Standard Health Benefits Plans

Changes to comply with law.

To comply with P.L. 2007, c. 345, the definition section of the standard plans, except that of Plan A which is the basic plan, has been expanded to include definitions of orthotic alliance and prosthetic appliance and a new provision specifying the coverage for orthotic and prosthetic appliances has been included. The previous provisions affording limited benefits for prosthetics are being deleted.

To comply with section 33 of P.L 2008, c. 38 the New Jersey Continuation Rights for Over-Age Dependents provision is being amended to increase the limiting age to 31 years of age; to clarify that the over-age dependent cannot be covered under any other group or individual plan or entitled to Medicare on the date the over-age continuation would begin; and to revise the conditions for making an election such that the over-age dependent need have evidence of prior creditable coverage or receipt of benefits. In addition, the special enrollment period which expired May 11, 2007 is being deleted from the standard plans.

To comply with N.J.S.A. 17B:27-46.1y regarding coverage for colorectal cancer screening and methods and frequency in accordance with the most recent published guidelines of the American Cancer Society, the colorectal cancer screening benefit in the standard plans, other than Plan A, is being amended to include stool DNA tests and computed tomography colonography.

Board Initiated Changes

The SEH Board proposes increasing the maximum out of pocket as illustrated in the specimen schedule pages to $7,500, as permitted by N.J.A.C. 11:22-5.

The SEH Board proposes redefining “reasonable and customary” as “allowed charge” since the SEH Board believes the new term more appropriately identifies what is being defined.

References to reasonable and customary as they appear throughout the standard plans are being amended to state allowed charge.

The SEH Board proposes amending the Eligible Dependents for Dependent Health Benefits section to clarify that neither domestic partners nor civil union partners have COBRA continuation rights nor do the provisions for Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability apply to such dependents. The Medicare as Secondary Payor provisions are being amended to similarly state the ineligibility for a domestic partner or a civil union partner.

The SEH Board proposes amending the COBRA Continuation Rights provisions to clarify that a domestic partner, a civil union partner, a child of a domestic partner and a child of a civil union partner cannot be considered qualified continuees for purposes of COBRA continuation rights, but can be qualified continuees for purposes of New Jersey continuation.

Social Impact

The small employer health insurance market has been regulated substantially as set forth in the proposed readoption with amendments for almost fifteen years, and the SEH Board believes it is important for the existing rules to be readopted substantially as is, although proposing amendments to address the changes created by P.L. 2008, c. 38, as well as P.L. 2007, c. 345. Arguably, the proposed amendments permitting carriers to offer only three of the standard health benefits plans (as permitted by P.L. 2008, c. 38) may have a negative social impact upon consumers because fewer standard plan options may be available; however, the SEH Board expects each carrier will continue to offer the plans most frequently purchased by small employers, minimizing the potential negative social impact. The proposed amendment requiring carriers offering standard plans in the SEH market to also offer plans in the Individual

Health Coverage (IHC) Program market or withdraw from the SEH market will have a negative social impact upon some consumers, who will be forced to find coverage from other carriers if their existing carrier withdraws. Most of the carriers offering coverage in the SEH market are also offering coverage in the IHC market, so the number of carriers likely to withdraw – and the number of employers who may be affected – is limited. Because coverage is guaranteed issue, small employers should not encounter much difficulty replacing coverage in the event of withdrawal, but employers are likely to be unhappy when coverage replacement is not the result of employer choice.

The SEH Board believes the proposed readoption with amendments implementing section 33 of P.L. 2008, c. 38 (addressing the continuation of coverage for over-age children) should have a positive social impact for consumers and the State of New Jersey. Not only do the amendments increase the age for coverage by one more year (to an over-age child's 31st birthday), but they also significantly increase an over-age child's eligibility to make the over-age dependent continuation election by essentially eliminating the requirement that the over-age child have aged-out of policies delivered in New Jersey, and clarifying that the over-age child is only ineligible if actually covered by another group health plan or Medicare on the date of enrollment in the parent's coverage. These proposed amendments should allow more over-age children to take advantage of group coverage, often at rates that would be less expensive than if the over-age child were to purchase an individual policy.

Although the proposed readoption with amendments implementing P.L. 2007, c. 345, will have a negligible social impact for most consumers, the SEH Board believes that providing more extensive coverage for prosthetic and orthotic appliances will enhance the quality of life for a class of New Jersey residents covered by small employer health benefits plans.

Economic Impact

The SEH Board is uncertain what the economic impact of the proposed readoption with amendments will be. The SEH Board believes the proposed amendments may have a potentially negative impact initially for carriers and possibly some consumers. Carriers that elect to comply with the new dual-market requirement in P.L. 2008, c. 38 by entering the IHC market will incur some costs for start-up, as well as for on-going marketing and servicing of IHC plans. Similarly, carriers that elect to comply with the new dual-market requirement by withdrawing from the SEH market will incur costs associated with the withdrawal process, in addition to the loss of their SEH market business for at least five years. Employers faced with replacing a withdrawn plan (whether because a carrier is exiting the SEH market, or is choosing to reduce the number of plans offered) has no guarantee that replacement coverage will be available at a comparable premium and it is possible the employer may not be able to secure the identical coverage elsewhere.

The SEH Board believes the requirement in P.L. 2008, c. 38 that premiums for standard plans and riders be disclosed separately may be economically beneficial for small employers who wish to have greater insight into the costs associated with coverage of interest to them. The SEH Board believes that these disclosures will allow interested small employers to more easily compare costs across plans and help those employers to decide which plans and riders are of most importance to their needs. However, the SEH Board believes that, depending upon how carriers currently maintain and display pricing data for rate quotes and marketing purposes, compliance with the requirement may have a negative economic impact for some carriers.

The SEH Board does not anticipate any significant economic impact, positive or negative, related to the SEH Board's regulatory functions with respect to the SEH market. The

SEH Board will have to revise some of its informational materials and address new sets of questions related to the proposed readoption with amendments but expects the costs associated with these activities will be within the SEH Board's existing budget and resources.

Federal Standards Statement

The rules proposed for readoption comply with the following federal laws: the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), 29 U.S.C. §§1161 et seq.; the Employee Retirement Security Act of 1974 (ERISA), 29 U.S.C. §§1001 et seq. and implementing regulations at 26 C.F.R. Part 54, 29 CFR Parts 2520 and 2560 and 2590, and 32 C.F.R. Part 220; Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. §1395y(b)(1994) and implementing regulations at 45 C.F.R. Part 411; the Public Health Service Act 42 U.S.C.A. §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. 2935 (1996); and the Women's Health and Cancer Rights Act of 1998, Pub.L. 105-277, Title IX, §903, 112 Stat.) and implementing regulations at 45 C.F.R. Parts 145 and 146.

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

Jobs Impact

The SEH Board believes the proposed readoption with amendments will neither generate jobs nor result in the loss of jobs.

Agricultural Industry Impact

The SEH Board believes the proposed readoption with amendments will have no impact upon the agriculture industry.

Regulatory Flexibility Statement

The proposed readoption with amendments substantially maintain existing reporting and compliance requirements for carriers, and indeed, increase such requirements for carriers, some of which may be "small businesses" as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. As noted in the Economic Impact statement, the SEH Board does not anticipate any carrier currently operating in the SEH market will need to take on any new or additional professional services in order to comply with the proposed amendments. However, a carrier currently offering coverage in the SEH market but not offering standard plans in the Individual Health Coverage (IHC) market will incur costs to comply with the requirement to offer IHC standard plans, or incur costs associated with withdrawal from the SEH market (whether or not specific additional professional services are needed). Similarly, carriers may incur costs in developing a format and system to display rates for standard plans and riders separately. However, the requirement to offer coverage in the IHC market if offering coverage in the SEH market, and to do so in good faith (or withdraw), and the requirement to display standard plan and rider rates separately is set forth by P.L. 2008, c. 38. The statute makes no distinctions for carrier compliance based on whether a carrier is a small business, and it would appear that doing so could be harmful to consumer. Consequently, the SEH Board does not believe regulatory flexibility is warranted.

Smart Growth Impact

The SEH Board believes the proposed readoption with amendments will have no impact upon the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact Analysis

In accordance with N.J.S.A. 52:14B-4.1b, a housing affordability impact analysis is required unless an agency determines that the "scope of the [proposal] is minimal, or there is an extreme unlikelihood that the [proposal] would evoke a change in the average costs associated with housing." The SEH Board has determined a housing affordability impact analysis is not required for the Board's proposed readoption with amendments because the scope of the proposal is entirely unrelated to housing, and the proposed readoption with amendments and proposed new rules are extremely unlikely to evoke a change in the average costs associated with housing.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:21.

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

CHAPTER 21. SMALL EMPLOYER HEALTH BENEFITS PROGRAM
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.

"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.

["Coinsurance cap" means the maximum amount a covered person is required to pay as a result of the application of the coinsurance under the standard plans, as set forth in the Appendix Exhibits to this chapter. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsurance cap.]

["Coinsured charge limit" means, with respect to a preferred provider organization (PPO) plan, or a point of service (POS) plan, developed based on the standard health benefit plans set forth in the Appendix Exhibits to this chapter, the amount of covered charges a covered person must incur before no coinsurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsured charge limit.]

"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 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 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 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.

"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. **[All]** **<u>Except as provided in N.J.A.C. 11:22-5.2, all</u>** amounts paid as copayment, deductible and coinsurance shall count toward the maximum out of pocket. Once the maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for covered services and supplies for the remainder of the calendar year.

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

"Medical care" means amounts paid:

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

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

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

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

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

"Network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all services and supplies provided by network providers in a calendar year. **[All]** **<u>Except as provided in N.J.A.C. 11:22-5.2, all</u>** amounts paid as copayment, deductible and coinsurance shall count toward the network maximum out of pocket. Once the network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by network providers for the remainder of the calendar year. If a carrier wishes to use a common maximum out of pocket provision in a plan that has both network and non-network benefits, the network maximum out of pocket shall mean the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all services and supplies provided by network providers and non-network providers in a calendar year. **[All]** **<u>Except as provided in N.J.A.C. 11:22-5.2, all</u>** 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, 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 but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two eligible employees 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.

"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, **[10th]** **11th** Floor

PO Box 325

Trenton, New Jersey 08625-0325

Fax: (609) 633-2030

§ 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.

§ 11:21-2.1 Purpose and structure

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

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

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

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

(e) The Board shall consist of 18 persons, including the Commissioners of Health and Senior Services and Banking and Insurance or their designees, both of whom shall serve ex officio, and 10 public members who shall be elected by the members of the Program, subject to approval by the Commissioner, and six public members who shall be appointed by the Governor with the advice and consent of the Senate. Initially, three of the elected public members of the Board shall be elected for a three year term, three shall be elected for a two year term, and three shall be elected for a one year term. The tenth elected public member, added by P.L. 1994, c.97, shall be elected for a three year term. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Thereafter, all public members of the Board shall be elected or appointed for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. No carrier shall have more than one representative on the Board, nor shall an HMO carrier and its

affiliated insurance company, health service corporation, hospital service corporation, or medical service corporation have more than one representative on the Board.

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

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

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

3. A health, hospital or medical service corporation;

4. Two health maintenance organizations; and

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

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

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

2. One representative of organized labor;

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

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

§ 11:21-2.2 Definitions

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

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

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

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

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

§ 11:21-2.3 Powers of the Board

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 11:21-2.4 Plan of Operation

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

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

§ 11:21-2.5 Board structure and meetings

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

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

2. Initially, three of the elected public members shall serve for a term of three years; three shall serve for a term of two years; and three shall serve for a term of one year. The tenth elected public member, added by P.L. 1994, c.94 shall be elected for a three year term. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Thereafter, all public members shall serve for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. The public directors shall serve their terms of office until their replacements are duly elected or pursuant to the terms of their appointments as applicable.

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

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

iii. At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote absentee on or before a

date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

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

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

vi. The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:21-2.11.

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

(b) The votes of the Board shall be on a one person, one vote basis. An elected public member, other than the three small employer representatives provided for in Section 13 of the Act (N.J.S.A. 17B:27A-29) as amended by P.L. 1994, c.97, and the Commissioners of Health and Senior Services and Banking and Insurance or their designees, may designate a voting alternate employed by the same carrier or same State agency, as appropriate. Appointed public members and the three small employer representatives, all of whom are appointed or elected as individuals, may not designate a voting alternate.

(c) A majority of the Directors shall constitute a quorum for the transaction of business. The acts of the majority of the Directors at a meeting at which a quorum is present shall be the acts of the Board, except as otherwise provided herein.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 11:21-2.6 Committees

(a) Appointments to Standing and other committees shall be approved by a majority of the Board present. Each of the Standing Committees shall include no more than seven directors, but the Board Chair may appoint additional persons, who need not be directors, as needed, with the approval of a majority of the Board. A written record of the proceedings of each committee shall be maintained by the Administrator or Executive Director. Committee members are responsible for providing staff support, but may recommend that the Board provide funding for outside contractors. Committees may not take final action; however, within the scope of their mission and duties, Committees may make recommendations and reports to the Board for its decision and action.

(b) Standing Committees shall include the following:

1. A Finance and **[Operations]** <u>**Audit**</u> Committee which shall make recommendations to the Board with respect to:

i. The methods and rules for calculating assessments;

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

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

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

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

vi. The Plan amendments thereto;

vii. The selection of an independent auditor for the annual audit of the Program operations;

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

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

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

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

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

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

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

iii. Proposed amendments to the Act for Board approval;

iv. Contracts and legal documents for the Program;

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

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

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

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

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

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

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

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

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

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

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

i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of health benefits plans to eligible employees;

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

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

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

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

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

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

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

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

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

v. Substantive and structural plan design issues.

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

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

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

3. Abolish any committees, in its discretion;

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

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

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

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

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

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

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

1. Preparing and submitting an annual report to the Board and the Commissioner no later than September 1; **[preparing and submitting monthly reports to the Board];**

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

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

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

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

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

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

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

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

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

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

(d) The Administrator or Executive Director shall maintain calendar year records of premiums, reimbursements, and fiscal year operating and administrative expenses of the Program and shall

retain these records for a period of seven years following the end of such calendar year or as otherwise required pursuant to N.J.S.A. 47:3-15 et seq.

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

§ 11:21-2.8 Assessments for administrative and operating expenses

(a) [Within 45 days after approving] **Following approval of** a final audited Program statement, the Board shall determine the final administrative expense total for the fiscal year, if any.

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

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

3. Members shall be assessed for a proportionate share of the final administrative expenses for the fiscal year on the basis of health benefits plan earned premiums for the calendar year that includes the first six months of the fiscal year. The administrative expense assessment for each member shall be equal to the total of all administrative expenses for the fiscal year multiplied by the ratio of that member's earned premium for health benefits plans to the earned premium for health benefits plans of all members of the calendar year that includes the first six months of the fiscal year.

i. Beginning in Fiscal Year 2005, if a member's proportionate share of the interim assessment or final administrative assessment is less than $ 5.00, the carrier shall not be assessed and the amounts uncollected will be reapportioned proportionally, based on market share, among the member carriers.

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

(c) Assessment amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer--State of New Jersey, SEH Program, and mailed to the Executive Director at the address in N.J.A.C. 11:21-1.3.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 45 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid as permitted by N.J.S.A. 17B:27A-32c.

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

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

<u>iii. The interest so collected shall be applied in the assessment of the final administrative expenses as set forth in N.J.A.C. 11:21-2.8(a)3 above to reduce the liability of those members that were not subject to the payment of an interest penalty.</u>

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

3. A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:21-15.

i. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice to be held in an interest bearing account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

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

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

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

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

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

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

(f) If a member determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the Board may provide to the Commissioner a notice of the member's failure to make payment along

with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State or to take such other action against the carrier as may be authorized by law. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

§ 11:21-2.9 Reporting requirements

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

§ 11:21-2.10 Financial administration

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

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

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

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

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

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

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

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

iv. Other records required by the Board.

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

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

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

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

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

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

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

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

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

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law. All investment income earned shall be credited to the Program and shall be applied to reduce future assessments of members for the Program administrative expenses.

§ 11:21-2.11 Records

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

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

1. Minutes of all Board meetings;

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

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

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

5. The Plan of Operation and any amendments thereto;

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

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

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

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to **[the "Right-to-Know" Law]** **[**(**]**N.J.S.A. 47:1A-1 et seq.**[**)**]** except that information in filings determined by the Board or the Department by regulation to be confidential and proprietary shall not be subject to public inspection and copying, and except that written communications of the Board, its staff, or committees, including, but not limited to, reports, opinions, and recommendations, where such communications contain discussion of litigation strategy, attorney-client advice or other privileged information, shall not be available for public inspection and copying.

§ 11:21-2.12 Audit functions

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

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

2. The annual fiscal report of the Program.

§ 11:21-2.13 Penalties/adjustments and dispute resolution

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

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

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

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

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

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

(c) A carrier which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the Board consistent with the appeals procedures set forth at N.J.A.C. 11:21-2.17.

§ 11:21-2.14 Indemnification

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

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

§ 11:21-2.15 Amendment and termination

(a) This Plan may be amended by a majority vote of the entire Board, subject to approval of the Commissioner as provided hereinafter. A vote on an amendment may be taken at any meeting called, in whole or in part, for the purpose of considering a proposed amendment. Written notice of any meeting at which an amendment to the Plan is to be considered shall be sent to each Director by mail or facsimile transmission at least 10 days (exclusive of the meeting day) prior to the date of the meeting. Such notice shall state that an amendment to the Plan is to be considered at the meeting and shall set forth the substance of any amendments which have been proposed or a description of the section or sections which are proposed to be amended. Notice to a Director shall be deemed sufficient if mailed, postage prepaid, to the most recent address provided by the Director to the Board or sent by facsimile transmission to the most recent facsimile reception number provided by the Director. At any meeting for the consideration of an amendment to the Plan, for which proper notice has been given pursuant to this section, the Board may vote on any amendment proposed by a Director prior to, or during the meeting. Any amendment adopted by the Board shall be submitted to the Commissioner for approval. Any such amendment submitted to the Commissioner shall be deemed approved no later than 90 days after receipt by the Commissioner unless expressly disapproved in writing by the Commissioner before expiration of the approval period. Amendments to the Plan must be adopted pursuant to P.L. 1993, c.162.

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

§ 11:21-2.16 (Reserved)

§ 11:21-2.17 Appeals

(a) If the Board denies a member's request for relief made pursuant to this chapter, or if the member objects to the terms of the relief granted, the member may request a hearing on the Board's determination within 20 days from the date of receipt of such determination as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, daytime telephone number, and fax number of a contact person familiar with the matter;

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the material facts in dispute and describing the basis for which the member believes that the Board's findings of fact are erroneous.

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are material issues of fact in dispute.

3. The Board shall, within 45 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. If the Board finds that the matter constitutes a contested case, it shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. In a matter which has been determined to be a contested case, if the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

ii. If the Board finds that the matter does not constitute a contested case, it may, with the approval of the Director of the Office of Administrative Law, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21. If the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

§ 11:21-3.1 Benefits provided

(a) The standard health benefits plans established by the Board contain the benefits, limitations and exclusions 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. Plan B, "The Small Group Health Benefits Policy B," Exhibit F and W;

3. Plan C, "The Small Group Health Benefits Policy C," Exhibit F and W;

4. Plan D, "The Small Group Health Benefits Policy D," Exhibit F and W;

5. Plan E, "The Small Group Health Benefits Policy E," Exhibit F and W;

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

8. 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 **[all]** **Plan A and at least two** of the health benefits **plans designated as** Plans **[A,]** B, C, D and E as set forth in Exhibits A and F, V and W, in the Appendix, **subject to items _1 - 4 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;

[i] **ii.** **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

[ii] **iii**. **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. Plans B, C, **[and]** **and/or** D **may be offered. Members offering these plans** shall **[contain]** **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.

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

(1) 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. **Members offering** Plans B, C, **[and]** **and/or** D shall **[contain]** **include** maximum out of pocket provisions consistent with the following specifications:

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 **[contain]** **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 **<u>of at least three of the plans designated as</u>** Plans A 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.

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.

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.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $ 250.00 and not greater than $ 2,500 per person. 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]** **<u>$7,500</u>**, 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.

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.

iii. Prescription drugs covered under the HMO plan, as opposed to under a separate prescription drug rider, shall be subject to 50 percent coinsurance, or a $ 15.00 copayment, 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. 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 N.J.A.C. 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, 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 **[$ 5,000]** **$7,500** per covered person, 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 **[$ 5,000]** **$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) 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** **[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** **[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 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 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 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 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) 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.

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.

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.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $ 250.00 and not greater than $ 2,500 per person. 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 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.

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.

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 coinsurance.

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

(a) Members that offer health benefits Plans B, C, D **[and]** **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) In addition to the standard optional benefit riders listed in (c) above, 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)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 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 plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)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 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)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.

6. A member making an informational filing to the Board pursuant to (d)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;

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. 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; **[and]**

(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 N.J.A.C. 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 **[45]** **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 **[45]** **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 **[45]** **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) 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) 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) 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) 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) 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) 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) 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 thereunder.

[(c) All forms to be used by a hospital service corporation and another carrier in conjunction in order to offer the small employer health benefits plans pursuant to N.J.S.A. 17B:27A-19e shall be submitted simultaneously to the Board and the Commissioner, and shall not be used until approved by the Board in consultation with the Commissioner.

1. Forms shall be submitted as set forth in (a)2 above.

2. Carriers shall submit a certification of substantial compliance and a description of the differences between the combined forms and the forms promulgated by the Board. The certification of substantial compliance shall be certified by a duly authorized officer of each of the carriers.

3. The Board shall notify the small employer carriers in writing within 60 days of receipt by the Board and the Commissioner of a completed submission, whether the combined forms are approved.

4. The small employer carriers shall have a right of appeal if the Board, in consultation with the Commissioner, disapproves the combined forms, in accordance with procedures established by the Board in its Plan of Operation.

(d) If the SEH Board adopts changes to the standard policy forms, a hospital service corporation and the carrier or carriers writing in conjunction with the hospital service corporation that has received approval by the SEH Board to issue plans pursuant to N.J.S.A. 17B:27A-19e shall submit revised forms to the SEH Board for review and approval within 60 days of the Board's adoption of changes to the standard policy forms. The revised forms shall not be used until approved by the Board in consultation with the Commissioner. Approval of previously approved forms will be withdrawn as of 60 days following the date the Board adopts changes to the standard policy forms.]

[§ 11:21-4.3 Standards for review

(a) In determining whether to approve combined forms (of a hospital service corporation and another small employer carrier), a carrier shall consider in submitting in its certification of substantial compliance (with respect to combined forms), and the Board and Commissioner shall consider in their review whether:

1. The inclusion of words, terms and descriptions that are not contained in the Board's forms changes the meaning or effect of any material aspect of the small employer health benefits plans and other attendant Board forms;

2. The combined forms contain all provisions required by New Jersey law and the small employer health benefits plans forms which, if not the same as that required by law or in the small employer health benefits plans forms, is at least as favorable to the covered person;

3. The combined forms contain all coverages, coverage limits and exclusions set forth in the small employer health benefits plans forms; and

4. Easy comparison with the appropriate small employer health benefits plans forms by the consumer, the Board or the Commissioner is impeded.

(b) In addition to (a) above, the Board, in consultation with the Commissioner, may disapprove combined forms on the grounds that its provisions are unjust, unfair, inequitable, misleading, contrary to law or to the public policy of this State.]

§ 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-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-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 5. (RESERVED)

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 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 specified in Exhibit O of the Appendix to this chapter incorporated herein by reference.

§ 11:21-6.2 Annual Small Employer Certification Form

Small employer carriers shall require each small employer covered by a small employer health benefits plan issued by the small employer carrier to that small employer to complete each year the New Jersey Small Employer Certification form approved by the Board and 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.

§ 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.

§ 11:21-7.3 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 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 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 **[the five] standard health benefits Plan A and at least two of standard health benefits Plans B, C, D and E [standard health benefits plans]**, 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 at least two employees on the first day of the plan year.

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.

(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 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. Is working exclusively for the employer;]

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

[4] 3. Works on other than a temporary or substitute basis; [and]

[5] 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 pursuant to N.J.S.A. 43:21-19 and applicable law.

(d) 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.

(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) 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), 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 health benefits plan.

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

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

2. Explains why the lesser requirement is reasonable; and

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

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

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

§ 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.

§ 11:21-7.7 Preexisting condition standards

(a) A health benefits plan shall not include a 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.

§ 11:21-7.8 Effective date of 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. 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) 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. Waiting periods may be applied to these employees by class of employee based upon conditions pertaining to employment.

(d) 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;

2. The small employer fails to comply with a small employer carrier's employer contribution requirements;

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 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] 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 **[medical]** services, **[on a reasonable and customary]** **using either the allowed charges** or actual charges**[, and, for hospital services, based on actual charges]**. **[Reasonable and customary]** **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 **[allowable]** **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, 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.

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 or 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:

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

ii. 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 8. CARRIER CERTIFICATION OF NON-MEMBER STATUS

§ 11:21-8.1 Purpose and scope

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

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

§ 11:21-8.2 Definitions

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

§ 11:21-8.3 Non-member status

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

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

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

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

§ 11:21-8.4 Non-member certification requests

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

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

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

Attn: SEH Annual Certification of Non-Member Status

Life/Health Actuarial Services

New Jersey Department of Banking and Insurance

PO Box 325

Trenton, NJ 08625-0325

§ 11:21-8.5 Decisions on filings by the Board

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

§ 11:21-8.6 Review

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

SUBCHAPTER 10. THE MARKET SHARE REPORT

§ 11:21-10.1 Scope and applicability

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

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

§ 11:21-10.2 Definitions

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

§ 11:21-10.3 Filing of the Market Share Report

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

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

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

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

§ 11:21-10.4 Net earned premium

(a) Every member's net earned premium for the preceding calendar year ending December 31 shall be set forth in Part C of the Market Share Report.

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers, less any refunds paid by the carrier during that calendar year as a result of the application of the minimum loss ratio requirement.

2. Net earned premium reported in Part C of the Market Share Report shall be based upon, if not the same as, the data set forth in the member's annual NAIC statement blank, adjusted to meet the definition of group health benefits plan and exclude refunds as described in (a)1 above, as necessary.

§ 11:21-10.5 Certification

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

§ 11:21-10.6 Failure to comply

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

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 **[(Reserved)]** **Disclosure of Premiums for Riders**

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

(b) A small employer carrier that files an optional benefit rider pursuant to N.J.A.C. 11:21-3.2 shall include, as part of the certification required by N.J.A.C. 11:21-3.2(d)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.

SUBCHAPTER 18. PETITIONS FOR RULES

§ 11:21-18.1 Scope

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

§ 11:21-18.2 Procedure for petitioner

(a) Any person who wishes to petition the Board to promulgate, amend or repeal a rule shall submit to the Board, in writing, the following information:

1. Name and address of the petitioner;

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

3. The reasons for the request and the petitioner's interest in the request;

4. References to the statutory authority of the Board to take the requested action; and

5. A caption at the top of the document identifying it as a petition for rulemaking pursuant to N.J.S.A. 52:14B-4(f) and this subchapter.

(b) The petition shall be sent to the Executive Director at the address in N.J.A.C. 11:21-1.3.

(c) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

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

§ 11:21-18.3 Procedure of the Board

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

1. The name of the petitioner;

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

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

4. The date the petition was received.

(b) Within 60 days of receiving a petition in compliance with N.J.A.C. 11:21-18.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;

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

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

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

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

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

1. Denying the petition;

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

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

SUBCHAPTER 23. RULEMAKING; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST

§ 11:21-23.1 Purpose and scope

(a) The purpose of this subchapter is to establish the procedures that the Board uses in providing notice of proposed rulemaking, receiving public comments regarding existing rules and proposed rulemaking, extending the public comment period, conducting a public hearing, and providing notice of public meetings.

(b) This subchapter shall apply to all rulemaking of the Board.

§ 11:21-23.2 Public notice regarding proposed rulemaking

(a) Unless the Board proposes a rule pursuant to the special procedures set forth at N.J.S.A. 17B:27A-51, the Board shall provide for the following four types of public notice for rule proposals in accord with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30:

1. The rule proposal shall be filed with the Office of Administrative Law for publication in the New Jersey Register;

2. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be posted and made available electronically on the Department of Banking and Insurance website at: http://www. njdobi.org;

3. The news media maintaining a press office in the State House Complex shall be provided notice of the rule proposal, as posted and made available electronically on the New Jersey Department of Banking and Insurance website; and

4. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be made available to the Board's list of "interested persons" by e-mail or hard copy. Interested persons are those who have informed the Board in writing that they wish to receive notice of the Board's proposed regulations, as well as those people or entities that the Board determines are the subject of or significantly related to the rulemaking so that the persons most likely to be affected by or interested in the intended action receive notice.

§ 11:21-23.3 Extension of the public comment period

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C.

1:30, may extend the time for submission of public comments on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall extend the time for submission of public comments for an additional 30-day period, if, within 30 days of the publication of a notice of proposal, sufficient public interest is demonstrated in an extension of time to submit comments.

(c) The Board shall determine that a sufficient public interest for the purpose of extending the public comment period has been demonstrated if any of the following has occurred:

1. Comments received indicated a previously unrecognized impact on a regulated entity or persons; or

2. Comments received raise unanticipated issues related to the notice of proposal.

§ 11:21-23.4 Conducting a public hearing

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may conduct a public hearing on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall conduct a public hearing if sufficient public interest has been demonstrated.

(c) A person interested in having a public hearing held on a notice of proposal shall submit an application within 30 days following the publication of the notice of proposal in the New Jersey Register in a form prescribed by the Board, to the Executive Director at the address listed in N.J.A.C. 11:21-1.3. The application shall contain the following information:

1. The person's name, address, telephone number, agency or association (if applicable);

2. The citation and title of the proposed rule and the date the notice of proposal was published in the New Jersey Register; and

3. The reasons a public hearing regarding the notice of proposal is considered necessary pursuant to (d) below.

(d) The Board shall determine that a sufficient public interest has been demonstrated for the purpose of holding a public hearing if the application demonstrates that additional data, findings and/or analysis regarding the notice of proposal are necessary for the Board to review prior to adoption of the proposal in order to ensure that the notice of proposal does not violate the intent of the statutory law.

§ 11:21-23.5 Public notice regarding board meetings

(a) The Board shall adopt an annual schedule of regular meetings to be held by it the following calendar year.

(b) The Board may schedule meetings in addition to those set forth in the annual schedule.

(c) The Board shall provide public notice for all meetings by:

1. Posting of a notice at the office of the Secretary of State;

2. Posting of a notice at the office of the Board at the address set forth at N.J.A.C. 11:21-1.3;

3. Posting of a notice on the Department of Banking and Insurance website at: http://www.njdobi.org;

4. Posting of the notice in two newspapers of general circulation designated by the Board; and

5. Mailing, either by hard copy or electronically, of the notice to a distribution list of those persons who have requested in writing to be informed of the Board's meeting schedule.

§ 11:21-23.6 Board mailing list of interested parties

(a) For the purpose of disseminating information about the SEH Program, including information about rulemaking and meeting dates, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of members shall be based upon the member carriers' addresses filed with its most recently filed Exhibit CC Market Share Report.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and mailing address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications, other than copies of proposals, from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.