VOLUME 45, ISSUE 21

ISSUE DATE: NOVEMBER 4, 2013

RULE ADOPTIONS

INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

45 N.J.R. 2385(a)

Adopted Amendments: N.J.A.C. 11:20-1, 3, 12, 22, and 24 and *N.J.A.C. 11:20* Appendix Exhibits A, B, and C

Adopted Repeals and New Rules: *N.J.A.C. 11:20-12.3* and *12.5*

Adopted New Rules: *N.J.A.C. 11:20-3.2* and 24.2A

Adopted Repeals: *N.J.A.C. 11:20-3.4*, *12.2*, *12.4A*, and *24.7*

Individual Health Coverage Program

Individual Health Benefits Plans

Proposed: September 10, 2013 (see October 21, 2013 New Jersey Register, *45 N.J.R. 2310(a)*).

Adopted: October 1, 2013, by the New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director.

Filed: October 1, 2013, as R.2013 d.130, **with substantial and technical changes** not requiring additional public notice and comment (see *N.J.A.C. 1:30-6.3*).

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

Effective Date: October 1, 2013.

Operative Date: January 1, 2014.

Expiration Date: May 12, 2018.

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Individual Health Coverage Program Board (IHC Board) held a hearing on Tuesday September 24, 2013, at 9:30 A.M. at the Department of Banking and Insurance, 11th floor Conference Room, 20 West State Street, Trenton, New Jersey to receive testimony with respect to the standard health benefits plans, set forth in Exhibits A and B of the Appendix to *N.J.A.C. 11:20*. Ellen DeRosa, Executive Director of

the IHC Board, served as hearing officer. No testimony was provided during the hearing. The hearing officer made no recommendations regarding the proposed amendments. The hearing record may be reviewed by contacting Ellen DeRosa, Executive Director, New Jersey Individual Health Benefits Coverage Board, P.O. Box 325, Trenton, NJ 08625-0325.

Summary of Public Comments and Agency Responses:

The IHC Board received comments from the New Jersey Hospital Association.

COMMENT: The commenter stated that the definition of dependent is inconsistent with the Federal regulations addressing dependents established at *26 CFR 54.9815-2714T(b)* in that the definition at *N.J.A.C. 11:20-1.2* requires financial dependency and that the dependent reside in the applicant's house.

RESPONSE: The IHC Board disagrees that the dependent definition is inconsistent with the requirements of *26 CFR 54.9815-2714T(b)*. The definition of dependent at *N.J.A.C. 11:20-1.2* includes persons who would qualify as dependents under Federal law. As required by Federal law, there is no financial dependency or residency requirement for such dependents. The definition includes a separate class of dependents defined as persons with whom the policyholder has a legal or blood relationship and these are the persons for whom the requirements apply. As these persons are not dependents as defined in Federal law, the Federal law's requirements do not apply to such persons. No change is being made in response to the comment.

COMMENT: The commenter requested that the definition of triggering event be expanded to include an instance in which a plan has substantially violated a material provision of the contract.

RESPONSE: The IHC Board notes that *45 CFR 147.104(b)(2)* includes an individual demonstrating that a plan substantially violated a material provision of the contract among the list of triggering events. The IHC Board is amending the definition of triggering event at *N.J.A.C. 11:20-1.2* and adding N.J.A.C. 11:20-24.2A(b)8 upon adoption to include this event.

COMMENT: The commenter requested that the 60-day period allowed for a special enrollment period be measured from the date the person receives notice of the triggering event.

RESPONSE: The IHC Board notes that such a timeframe is inconsistent with the requirements of *45 CFR 147.104(b)(1)*ii, which measures the period from the date of a triggering event. No change is being made in response to this comment.

COMMENT: The commenter included a variety of benefit levels and plan design options and stated that a deductible that exceeds $ 2,000 violates *45 CFR 156.130(b)(i)*.

RESPONSE: The IHC Board intends that carriers issuing the standard plans have the opportunity to develop plans that respond to consumer's needs in terms of cost sharing and benefit design. The IHC Board notes that the $ 2,000 limit for the deductible which is specified in *42 U.S.C. § 18022*(c)(2) and *45 CFR 156.130* applies only to small employer plans. The option for an individual plan to feature a different deductible limit is consistent with the requirements of *42 U.S.C. § 18022*(c)(2) and *45 CFR 156.130*. No change is being made in response to the comment.

COMMENT: The commenter stated that Federal law at "section 1302(c)" requires that all catastrophic plans must cover certain benefits without cost sharing.

RESPONSE: The IHC Board notes that Federal regulation *45 CFR 156.155(b)* requires that a catastrophic plan must not impose cost sharing for these services and is therefore amending *N.J.A.C. 11:20-3.1(b)*3iii on adoption.

COMMENT: The commenter expressed concern with a plan that features 50 percent coinsurance and indicates such an option would not be permitted for plans issued through the marketplace. The commenter believes allowing such a plan design off the marketplace will lead to adverse selection.

RESPONSE: The IHC Board disagrees and notes that nothing prohibits the offering of a plan with 50 percent coinsurance. No change is being made in response to the comment.

COMMENT: The commenter suggested that the regulation at *N.J.A.C. 11:20-3.2* that addresses a cost sharing reduction is not appropriate for inclusion in the IHC Board's regulation.

RESPONSE: The IHC Board notes that the standard health benefits plans must be issued for all individual coverage sold in New Jersey. While the cost sharing reduction required by *42 U.S.C. §§ 18071* and 18082 would not be applicable to all plans, it would be applicable to a subset of the plans that qualify under *42 U.S.C. §§ 18071* and 18082. The regulation, as proposed, is necessary to address those situations in which it would apply. No change is being made in response to the comment.

COMMENT: The commenter suggested that the text in *N.J.A.C. 11:20-12.3(a)* should state that the consumer must elect an alternate plan rather than may elect an alternate plan.

RESPONSE: The IHC Board notes that consumers whose plans are non-renewed have options available to them. While one option is to elect coverage under an alternate plan, a consumer may have access to group coverage or may elect to be uninsured. No change is being made in response to the comment.

COMMENT: The commenter suggested that *N.J.A.C. 11:20-12.3(c)* does not adequately address the transition of coverage in light of the elimination of the basic and essential plan. The commenter is concerned that the consequence of failure to terminate a prior plan results in termination of the newly issued plan.

RESPONSE: The IHC Board expects that consumers who elect to replace a basic and essential plan will make the election based on an evaluation of their own circumstances. The IHC Board believes that part of that evaluation is recognition of the fact that the prior plan must be terminated. No change is being made in response to the comment.

COMMENT: The commenter requested that *N.J.A.C. 11:20-24.3* be amended to allow the types of payment methods that are addressed in *45 CFR 156.1240(a)(2)*.

[page=2386] RESPONSE: The IHC Board appreciates the comment but believes that requiring carriers to develop new methods for accepting premium payment because of a need anticipated in *45 CFR 156.1240(a)(2)* is premature. The IHC Board is unaware of any consumers that have been unable to purchase coverage because a carrier's permissible payment methods were too restrictive. No change is being made in response to the comment.

Summary of Agency-Initiated Changes:

As stated in the proposal, since the Board approved the proposal of the standard plans, the United States Department of Health and Human Services (HHS) and various agencies within HHS have made numerous pronouncements through rulemaking, bulletins, question and answer documents, and the like on the correct construction and interpretation of certain provisions in the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (collectively, PPACA) that relate to several of the amendments being proposed. As such, these changes are substantially required under the new Federal law. The IHC Board's analysis of those pronouncements continued during the period following the filing of the proposal. The IHC Board has concluded its analysis of the various Federal pronouncements on the PPACA and is making necessary changes upon

adoption, in accordance with the Administrative Procedure Act, *N.J.S.A. 52:14B-1* et seq., and *N.J.A.C. 1:30-6.3(c)*, so that the adopted policy forms set forth in Appendix Exhibits A and B comply with the requirements of PPACA. In addition, the IHC Board used this opportunity to correct errors and include text that will assist consumers with understanding the terms of coverage. The specific changes to the standard plans are discussed below.

Subsequent to the vote approving the proposal of the standard health benefit plan policy forms for publication, the IHC Board learned from HHS that low to moderate income consumers who qualify for a cost sharing reduction as provided by Sections 1402 and 1412 of PPACA *(42 U.S.C. §§ 18071* and 18082, respectively) will not be provided any documentation that specifies the reduced cost sharing. IHC Board believes consumers should be issued a policy that specifies the applicable cost sharing. Since the cost sharing reduction could result in a consumer being subject to a coinsurance percentage that is different from the percentages specified for a standard plan, the IHC Board is amending the Schedule pages of Appendix Exhibit A to require carriers to specify a coinsurance associated with an approved cost sharing reduction. Since carriers have expressly stated that 10 percent coinsurance will be a necessary coinsurance, the schedule page for Plan D which is included in Appendix Exhibit A is being amended to illustrate Plan D as featuring 20 percent or 10 percent coinsurance.

The IHC Board noted an error on the proposed Schedule page of Appendix Exhibit A. The vision benefit section incorrectly states that standard frames are covered every 24 months. The benefit description for vision benefits in the standard health benefits plans states that standard frames are covered every 12 months. The IHC Board is amending the schedule to correctly state the 12-month frequency.

Appendix Exhibits A and B include a list of services for which carrier pre-approval is required. The IHC Board recently noted that many carrier websites include helpful information regarding the pre-approval process. Upon adoption, the IHC Board is amending the pre-approval provisions in the standard health benefits plans to allow a carrier to direct a consumer to its website for more information regarding pre-approval.

Since *42 U.S.C. § 300gg-3* prohibits the imposition of a pre-existing condition exclusion, it is no longer necessary to define terms that were solely necessary for the administration of the pre-existing condition exclusion. Therefore, upon adoption, the IHC Board is amending the definitions section in the standard health benefits plans set forth in Appendix Exhibits A and B to delete the terms "creditable coverage," "federally-defined eligible individual," and "public health plan."

Upon adoption, the IHC Board is amending the list of services that could be included in the list defining "complex imaging services." The IHC Board inadvertently omitted Magnetic Resonance Spectroscopy (MRS) from the list and is including it upon adoption. The term "complex imaging services" is variable and thus may or may not be included in the standard health benefits plan a carrier issues. Carriers that elect to define the term may include some or all of the listed services.

Upon adoption, the IHC Board is amending the definition of "provider" as it appears in Appendix Exhibits A and B to include "tribal provider." The inclusion of this term will allow carriers to specify zero cost sharing for use of a tribal provider as required by *45 CFR 156.420(b)(2)*. The added text is variable and would be included when the policy is issued to a consumer who would access services from a tribal provider.

Upon thorough review and analysis of the Federal regulations governing open enrollment, the IHC Board concluded that the provisions governing the annual open enrollment period, special enrollment period, and triggering events apply to coverage issued through the marketplace as well as coverage issued outside the marketplace. These newly defined enrollment periods replace the current November open en-

rollment period and the limited opportunity to enroll outside that November period. The initial, annual, and special enrollment periods are required by *45 CFR 147.104(b)(1)*ii. A special enrollment period occurs following a triggering event as defined in *45 CFR 155.420(d)*. The Board is amending Appendix Exhibits A and B upon adoption to include definitions of initial enrollment period, annual open enrollment period, and special enrollment period and corresponding eligibility provisions that rely on these Federally-defined enrollment opportunities.

Upon adoption, the IHC Board is also amending the definition of "dependent" in Appendix Exhibits A and B to include foster children as required by *45 CFR 155.420(d)(2)*, which mandates that placement in foster care creates a special enrollment period which allows a foster child to be enrolled.

The IHC Board is also amending the definition of "eligible person" in Appendix Exhibits A and B upon adoption to remove the requirement that the person not be eligible for a group health benefits plan, group health plan, governmental plan, or church plan. This amendment is necessary to allow operation of the required enrollment periods. The definition of eligible person at *N.J.S.A. 17B:27A-2* excludes a person who is eligible to be covered under a group health benefits plan, group health plan, governmental plan, or church plan. *N.J.S.A. 17B:27A-3*.d allows such excluded persons to enroll for coverage in the individual market provided the coverage is not the same or similar as the group coverage for which the person is eligible. The IHC Board previously adopted regulations at *N.J.A.C. 11:20-12.5* to allow such excluded persons to enroll for individual coverage during an annual open enrollment period. As of 2014, all individuals will have the opportunity to enroll for coverage during the initial, annual, or special enrollment periods as discussed above. The result is that persons eligible for coverage under a group health benefits plan, group health plan, governmental plan, or church plan will have the same opportunities for enrollment as persons who are not eligible for such plans. To reconcile the required enrollment periods with the definition of an eligible person in Appendix Exhibits A and B, the IHC Board is amending the definition of eligible person to remove the requirement that the person not be eligible for a group health benefits plan, group health plan, governmental plan, or church plan.

As required by 45 CFR 155.40 and 155.4, all individuals, including dependents, must enroll during the initial, annual, or special enrollment periods. Therefore, upon adoption, the IHC Board is amending the "adding dependents" provision to address open enrollment, special enrollment, and the impact of triggering events in Appendix Exhibits A and B.

The definition of resident at *N.J.S.A. 17B:27A-2* requires that an individual's primary residence be in New Jersey at least six months of the calendar year. The IHC Board was recently notified by HHS that the six-month requirement would not be compliant with PPACA. Under section 2702, the Guaranteed Availability provision of PPACA (implemented in regulation at *45 CFR 147.104*), a carrier that offers coverage in the individual market in a state must offer to any individual in the state all products that are approved for sale in the applicable market, and must accept any individual who applies for any of these products regardless of the individual's duration of residency in a particular state. Therefore, upon adoption, the IHC Board is amending the definition of "resident" in [page=2387] Appendix Exhibits A and B to delete the six-month residency requirement.

The IHC Board is also amending the deductible credit provision in Appendix Exhibit A to expand the text of the note regarding coinsurance credit and render it consistent with PPACA. While coinsurance credit is not generally provided, pursuant to Sections 1402 and 1412 of PPACA *(42 U.S.C. §§ 18071* and 18082, respectively), coinsurance credit is given to persons who qualify for a cost sharing reduction provided there is no lapse in coverage between the plan being replaced and the replacement plan.

Upon adoption, the IHC Board is also amending Appendix Exhibits A and B to add a benefit for individuals participating in clinical trials as required by Public Health Service Act section 2709(a) and addressed in the HHS FAQs About Affordable Care Act Implementation (Part XV) dated April 29, 2013.

The IHC Board has recently learned that some carriers selling coverage in other states currently provide coverage for telephone consultations. In the event carriers offering coverage in New Jersey might be interested in including coverage for telephone consultations, upon adoption, the IHC Board is making the telephone consultations exclusion variable. Carriers may elect whether or not to exclude coverage of telephone consultations.

The IHC Board is also correcting the text of the grace period provision in Appendix Exhibits A and B so the timeframes coincide with those set forth in section 1412 of PPACA *(42 U.S.C. § 18082)* and the Federal regulations at *45 CFR 156.270*. The amended text replaces the reference to a 31-day period with a "month" which is the terminology used in the law.

As required by *45 CFR 156.290(c)*, marketplace coverage must be terminated upon decertification of a plan as a qualified health plan. Accordingly, upon adoption, the IHC Board is amending the list of events that result in termination in Appendix Exhibits A and B to include decertification of a plan.

Eligibility for purchase of a catastrophic plan as well as conditions for loss of eligibility for such catastrophic plan are governed by *42 U.S.C. § 18022*(e) and *45 CFR 156.155*. Upon adoption, the IHC Board is amending the list of events that result in termination in Appendix Exhibits A and B to include the reasons for loss of eligibility under a catastrophic plan.

Upon adoption, the IHC Board is amending item (d) the termination by request provision in the standard plans set forth in Appendix Exhibits A and B to replace the requirement that the policyholder be responsible for providing notice of termination with a requirement that the carrier must receive notice. The amended text would allow the policyholder or another person acting on behalf of the policyholder to provide the notice of termination that is required to be given to a carrier when the policyholder wants to terminate an existing policy because the policyholder has purchased a new policy as a replacement.

Finally, upon adoption, the IHC Board is amending the contract provision in Appendix Exhibits A and B to replace the provision with text that mirrors the requirements of *N.J.S.A. 17B:26-4*. The provision being replaced stated that the application is attached to the policy. However, the IHC Board recently learned from HHS that for plans issued through the marketplace the application will be retained by the marketplace and not made available to the carriers to attach to the policy. Since carriers will not be able to attach the application, the IHC Board is eliminating the requirement that the application be attached, and in so doing include text that mirrors the requirements of *N.J.S.A. 17B:26-4*.

In addition to the amendments to the standard plans discussed above, the IHC Board is clarifying the definition of triggering event as it appears in *N.J.A.C. 11:20-1.2* and N.J.A.C. 11:20-24.2A(b)1. The clarification, which appears in paragraph 1 of the definition and in N.J.A.C. 11:20-24.2A(b)1, inserts the words "eligibility for" preceding the term "minimum essential coverage." The clarification will help readers understand that a voluntary loss of minimum essential coverage by a person who is eligible for minimum essential coverage is not a triggering event. The amended text is consistent with the requirements of *45 CFR 155.420(d)*.

Federal Standards Statement

State agencies that propose to adopt or amend State rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. These adopted amendments, repeals, and new rules are subject to Federal requirements addressing certain

standards for health insurance contracts pursuant to PPACA and the corresponding rules governing the individual market. Specifically, PPACA requires that health benefits plans offered to individuals and small groups include coverage for certain categories of services, referred to as essential health benefits (EHB). Because HHS permitted states to establish the benefits for the EHB benchmark plan (within parameters), and the amendments, repeals, and new rules are bringing the IHC standard plans into compliance with the selected EHB benchmark, the IHC Board does not believe the adopted amendments, repeals, and new rules exceed the Federal standards. The adopted amendments to and adopted repeals and new rules in N.J.A.C. 11:20-1, 3, 12, 22, and 24 are required to implement the various provisions of PPACA, as discussed in the proposal Summary. Consequently, the IHC Board does not believe a Federal standards analysis is required.

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

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.1 Purpose and scope

(a)-(b) (No change.)

(c) Provisions of the New Jersey Individual Health Insurance Reform 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 August 1, 1993, except as the specific provisions of this chapter, the New Jersey Individual Health Insurance Reform Act, or applicable Federal laws state otherwise.

11:20-1.2 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 the New Jersey Individual Health Insurance Reform Act, P.L. 1992, c.161 (*N.J.S.A. 17B:27A-2* through 16.5), as it may be amended and supplemented from time to time.

. . .

"Annual open enrollment period" means October 15 through December 7 of each year beginning in 2014.

"Basic and essential health care services plan" means the health benefits plan set forth in *N.J.S.A. 17B:27A-4.4* through 4.7.

. . .

"Catastrophic plan" means a standard health benefit plan that is designed and offered in accordance with the requirements of Federal regulations at *45 CFR 156.155*.

. . .

"Dependent" means:

1.-3. (No change.)

4. The applicant's child, legally-adopted child, step child, foster child including a child placed in foster care, or child under a court-appointed guardianship;

5. A child of the applicant's domestic partner subject to applicable terms of the individual health benefits plan;

6. A child of the applicant's civil union partner subject to applicable terms of the individual health benefits plan; or

7. Any other child over whom the applicant has legal custody or legal guardianship or with whom the applicant has a legal relationship or a blood relationship provided the child depends on the applicant for most of the child's support and maintenance and resides in the applicant's household.

. . .

"Eligible person" means a person who is a resident of New Jersey who is not eligible to be covered under Part A or Part B of Title XVIII of the Federal Social Security Act *(42 U.S.C. §§ 1395* et seq.), commonly referred to as "Medicare."

[page=2388] "Enrollment date" means the effective date of coverage under the individual health benefit plan.

"Essential health benefits" or "EHB" means the categories of health care services required to be covered in accordance with *45 CFR 156.110*.

. . .

"Individual health benefits plan" means: (a) a health benefits plan for eligible persons and their dependents; and (b) a certificate issued to an eligible person which evidences coverage under a policy or contract issued to a trust or association, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy of contract pursuant to continuation of benefits provisions applicable under Federal or State law. The term "individual health benefits plan" shall include a policy, contract, or certificate evidencing coverage by a policy or contract issued to a trust or association, issued to an eligible person described in, but not limited to, the following examples: a student, except coverage issued to an institution of higher education for coverage of students and their dependents in New Jersey if such policy has been filed by the Commissioner as a discretionary group pursuant to *N.J.S.A. 17B:27-49*, an unemployed individual or part-time employee, except as may be provided pursuant to *N.J.S.A. 17B:27A-17* et seq. and *N.J.A.C. 11:21-7.3*; a self-employed person; an employer, when he or she (and dependents) is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to *N.J.S.A. 17B:27A-17* et seq. and *N.J.A.C. 11:21-7.6*; any person who is the sole employee seeking coverage by a health benefits plan, except as may be provided pursuant to *N.J.S.A. 17B:27A-17* et seq. and *N.J.A.C. 11:21-7.6*; and an employee who is one of several employees of the same employer who

are covered by certificates, contracts or policies issued by the same carrier, trust or association, if the employer does not contribute to, and remit payment for, the coverage of such employees.

The term "individual health benefits plan" shall not include a certificate issued under a policy or contract issued to a trust, or to the trustees of a fund, which trust or fund is an employee welfare benefit plan as defined by the "Employee Retirement Income Security Act of 1974" *(29 U.S.C. §§ 1001* et seq.), to the extent that the Employee Retirement Income Security Act preempts the application of the Act to that plan.

"Initial enrollment period" means October 1, 2013, through March 31, 2014, which is the period during which applications for standard health benefits plans or standard health benefits plans with riders must be received by the carriers.

"Marketplace" means the Federally-facilitated exchange as defined in Federal regulations at *45 CFR 155.20*, through which qualified individuals can purchase qualified health plans and obtain a determination of eligibility for a premium tax credit, cost-sharing reduction, or exemption from the requirement to purchase health insurance.

. . .

"Minimum essential coverage" means any of the following types of coverage:

1. Government sponsored programs. Coverage under:

i. The Medicare program under Part A of Title XVIII of the Social Security Act;

ii. The Medicaid program under Title XIX of the Social Security Act;

iii. The Children's Health Insurance Program (CHIP) program under Title XXI of the Social Security Act;

iv. Medical coverage under Chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;

v. A health care program under Chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary;

vi. A health plan under section 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers); or

vii. The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; *10 U.S.C. § 1587* note);

2. Employer-sponsored plan. Coverage under an eligible employer-sponsored plan;

3. Plans in the individual market. Coverage under a health plan offered in the individual market within a state;

4. Grandfathered health plan. Coverage under a grandfathered health plan; and

5. Other coverage. Such other health benefits coverage, such as a state health benefits high risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes.

Minimum essential coverage shall also include those additional types of coverage designated by the Secretary of the United States Department of Health and Human Services at *45 CFR 156.602*, including, but not limited to: self funded student health coverage offered by an institution of higher education; Refugee Medical Assistance supported by the Administration for Children and Families; and Medicare Advantage plans.

"Modified community rated" means, with respect to coverage under standard health benefit plans, a rating system in which the premium for all persons covered under a policy or contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographical location, or any other factor or characteristic of covered persons, other than age.

The rating system provides that the premium rate charged by a carrier for the highest rated individual or class of individuals shall not be greater than 300 percent of the premium rate charged for the lowest rated individual or class of individuals purchasing the same individual health benefits plan. The rate differential among the premium rates charged to individuals covered under the same individual health benefits plan shall be based on the actual or expected experience of persons covered under that plan; provided, however, that the rate differential may also be based upon age. The factors upon which the rate differential is applied shall be consistent with rules promulgated by the Commissioner, which include age classifications.

. . .

"Open enrollment" means the offering of a health benefits plan to any eligible person on a guaranteed issue basis during the initial enrollment period or an annual open enrollment period.

"Plan" means the plan of operation of the IHC Program, an individual health benefits plan, or a group health benefits plan, as the context indicates.

. . .

"Pre-existing condition" means for a plan issued or renewed prior to January 1, 2014, for a covered person age 19 or older a condition that, during a specified period of not more than six months immediately preceding the enrollment date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition or as to a pregnancy existing on the enrollment date of coverage.

. . .

"Qualified health plan" or "QHP" means a health benefits plan certified to meet the requirements specified at *45 CFR 156.200* et seq. for participation on a marketplace in accordance with *45 CFR 155.1000* et seq.

"Resident" means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of each calendar year, or, in the case of a person who has moved to New Jersey less than six months before applying for individual health coverage, who intends to be present in New Jersey for at least six months of each calendar year.

"Special enrollment period" means a period of time that is no less than 60 days following the date of a triggering event during which:

1. Individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and

2. Individuals who already have coverage are allowed to replace current coverage with a different standard health benefits plan or standard health benefits plan with rider.

"Standard health benefits plan" means a health benefits plan, including riders, if any, each of which is adopted by the IHC Program Board.

"Standard health benefits plan with rider" means a standard health benefits plan as amended with one or more optional benefit riders as permitted by *N.J.A.C. 11:20-3.6*.

[page=2389] . . .

"Subsidy" means a premium tax credit or a cost sharing reduction pursuant to 26 CFR 1.36B, *45 CFR 156.410*, and *45 CFR 156.425*.

"Triggering event" means an event that results in an individual becoming eligible for a special enrollment period. Triggering events are:

1. The date the eligible person loses ***eligibility for*** minimum essential coverage, or the eligible person's dependent loses ***eligibility for*** minimum essential coverage, including a loss of coverage resulting from the decertification of a QHP by the marketplace;

2. The date a dependent child's coverage ends as a result of attaining age 26 whether or not the dependent is eligible for continuing coverage in accordance with Federal or state laws;

3. The date a dependent child's coverage under a parent's group plan ends as a result of attaining age 31;

4. The effective date of a marketplace redetermination of an eligible person's subsidy, including a determination that an eligible person is newly eligible or no longer eligible for a subsidy;

5. The date an eligible person acquires a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care;

6. The date an eligible person who is covered under a standard health benefits plan or standard health benefits plan with rider or group health benefits plan moves out of that plan's service area; and

7. The date of a marketplace finding that it erroneously permitted or denied an eligible person enrollment in a QHP.

8. The date the eligible person demonstrates to the marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

Exception: A loss of coverage resulting from nonpayment of premium, fraud, or misrepresentation of material fact shall not be a triggering event.

. . .

11:20-1.4 Other laws of this State

All health benefits plans delivered or issued for delivery in New Jersey, as defined by this subchapter, shall be subject to the New Jersey Individual Health Insurance Reform Act, as well as all relevant statutes and rules of New Jersey not inconsistent with, amended or repealed by this Act.

SUBCHAPTER 3. BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 The standard health benefits plans

(a) (No change.)

(b) Members that offer individual health benefits plans in this State and members that offer small employer health benefits plans in this State pursuant to *N.J.S.A. 17B:27A-17* et seq. and *N.J.A.C. 11:21* shall offer at least three of the standard health benefits Plans A/50, B, C, D, and HMO as set forth in chapter Appendix Exhibits A and B, incorporated herein by reference with variable text as specified on the Explanation of Brackets, which is set forth as chapter Appendix Exhibit C, incorporated herein by reference, subject to the provisions set forth in (b)1 through 9 below and except as provided in (c) below.

1.-2. (No change.)

3. Members offering Plan A/50, and at least two of the plans designated as Plans B, C, D, and HMO shall offer at least two of the selected plans B, C, and/or D if not also offering HMO, and at least one of the selected Plans B, C, and/or D if offering the HMO, with annual deductible provisions as follows:

i. For a network-based plan, the network per covered person annual deductible shall not exceed $ 2,500.

ii. For a plan without a network, the per covered person annual deductible shall not exceed the maximum out of pocket as defined in (b)5 below.

iii. For a plan to be offered as a catastrophic plan, the per covered person annual deductible shall equal the greatest permissible maximum out of pocket as defined in (b)5 below except the deductible shall be waived for three physician visits per calendar year ***and shall not apply to preventive health services***.

iv. The corresponding per covered family annual deductible shall be an amount equal to two times the per covered person annual deductible, satisfied on an aggregate basis.

4. Members offering Plans A/50, B, C, and D may offer the plans with deductible provisions such that the plans may qualify as high deductible health plans:

i. In the case of single coverage, an amount to qualify as a High Deductible Health Plan under *Internal Revenue Code §223(c)(2)(A)* for the calendar year in which coverage is issued or renewed, per covered person;

ii. In the case of other than single coverage, an amount to qualify as a High Deductible Health Plan under *Internal Revenue Code §223(c)(2)(A)* for the calendar year in which coverage is issued or renewed, per covered family, with single and other than single deductibles accumulated in accordance with the requirements of Federal law.

5. When issued using deductible provisions set forth in (b)3 and 4 above, Plans A/50, B, C, and D shall contain maximum out of pocket provisions as follows:

i. The per covered person maximum out of pocket shall not exceed the maximum out of pocket specified in *sections 223(c)(2)(A)(ii)(I)* and *223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986*;

ii. (No change in text.)

iii. Deductible, coinsurance, and copayment under a standalone pediatric dental benefit plan issued to replace the pediatric dental benefits contained in Plans A/50, B, C, and D shall not count toward the maximum out of pocket.

6. Plan A/50 features 50 percent coinsurance, Plan B features 40 percent coinsurance, Plan C features 30 percent coinsurance, and Plan D may feature coinsurance of 20 percent or 10 percent.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in lieu of offering at least three of Plans A/50, B, C, and D in (a) above. State qualified HMOs may offer the HMO Plan, as set forth in Exhibit B of the Appendix, in addition to at least two of Plans A/50, B, C, and D in (a) above. HMO carriers offering the HMO Plan may offer a copayment plan design set forth in (c)1 below and/or the HMO plan using deductible and coinsurance provisions set forth in (c)2 below. All options offered by the HMO member shall be made available to every eligible individual 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 (d) below.

1. Carriers issuing HMO plans with a Copayment Design shall use the copayments consistent with the copayments permitted in *N.J.A.C. 11:22-5.5* with no copayment required for preventive care.

2. Carriers issuing HMO plans with a Deductible and Coinsurance Design shall use the copayments, cash deductible, and coinsurance consistent with the requirements of *N.J.A.C. 11:22-5.3* through *5.5*. The maximum out of pocket shall be consistent with the maximum out of pocket described in (b)5 above.

(d) Carriers issuing Plans A/50, B, C, D, and HMO shall include the following features which are common to all plans:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall not exceed $ 100.00.

ii. Pediatric dental and pediatric vision benefits may be subject to cost sharing at the discretion of the carrier provided any copayments for providers who qualify as specialists do not exceed the copayment as permitted by *N.J.A.C. 11:22-5.5*.

iii. Prescription drugs may be subject to 50 percent coinsurance or other types of cost sharing provisions such as copayments.

(e) The standard health benefits Plans A/50, B, C, and D may be offered through or in conjunction with a selective contracting arrangement approved pursuant to P.L. 1993, c. 162, §22. The standard health benefits Plans A/50, B, C, and D may be offered with the same selective contracting arrangement by a carrier that is exempt from the requirements of P.L. 1993, c. 162, §22, pursuant to *N.J.A.C. 11:4-37.1(b)*, but is permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through or in conjunction with an approved selective contracting arrangement and plans with selective contracting arrangement features issued by an entity exempt from the requirements of P.L. 1993, c. 162, §22 shall be subject to the following:

[page=2390] 1.-2. (No change.)

3. The HMO Plan copayment amounts for physician visits and hospital confinements and the prescription drug coinsurance may be substituted for deductibles applicable to network benefits;

4. (No change.)

5. The network maximum out of pocket shall be no greater than the amount specified in (b)5 above per covered person, and for a covered family shall be no greater than two times the per covered person network 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;

6.-7. (No change.)

(f) Network plans as permitted in (d) above and HMO plans may feature a tiered network.

1. If the deductibles for tier 1 and tier 2 are separately satisfied, the sum of the tier 1 deductible and the tier 2 deductible shall not exceed $ 2,500.

2. If the tier 1 deductible may be separately satisfied and is also applied toward the tier 2 deductible, the tier 2 deductible shall not exceed $ 2,500.

3. If the tier 1 and tier 2 maximum out of pocket amounts are separately satisfied, the sum of the tier 1 maximum out of pocket and the tier 2 maximum out of pocket shall not exceed the maximum out of pocket specified in *sections 223(c)(2)(A)(ii)(I)* and *223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986*.

4. If the tier 1 maximum out of pocket may be separately satisfied and is also applied toward the tier 2 maximum out of pocket, the tier 2 maximum out of pocket shall not exceed the maximum out of pocket specified in *sections 223(c)(2)(A)(ii)(I)* and *223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986*.

11:20-3.2 Sample schedule page text

(a) The standard plans set forth in Appendix Exhibits A and B include sample schedule page text. The sample schedule pages highlight some covered services. Carriers may include additional covered services on the schedule. Features included on one sample schedule page may be included on any schedule page, as appropriate to the plan design being offered.

(b) The standard plans set forth in Appendix Exhibit A may be issued to a covered person who qualifies for a cost sharing reduction. Carriers may include cost sharing amounts on the schedule that are appropriate to the cost sharing reduction a covered person receives.

11:20-3.3 Compliance and variability rider

(a)-(c) (No change.)

(d) Members may address the cost sharing reduction amounts referred to in *N.J.A.C. 11:20-3.2(b)* on the Compliance and Variability Rider.

(e) (No change in text.)

11:20-3.4 (Reserved)

11:20-3.5 Basic and essential health care services plan

The basic and essential health care services plan established by the Legislature contains the benefits, limitations, and exclusions set forth in *N.J.S.A. 17B:27A-4.5*. Rules regarding this plan are set forth at N.J.A.C. 11:20-22. A specimen policy form is set forth in Appendix Exhibit F. The basic and essential health care services plan shall not be issued after December 31, 2013.

SUBCHAPTER 12. PURCHASE OF A STANDARD HEALTH BENEFITS PLAN BY A PERSON COVERED UNDER AN INDIVIDUAL PLAN OR COVERED UNDER A GROUP PLAN

11:20-12.1 Purpose and scope

This subchapter sets forth the standards for purchasing a standard health benefits plan or a standard health benefits plan with rider by a person who is covered under an individual plan or a group health benefits plan.

11:20-12.2 (Reserved)

11:20-12.3 Replacement during initial enrollment period

(a) A person who is covered under a standard health benefits plan, or a standard health benefits plan with rider, a basic and essential health care services plan, a basic and essential health care services plan with

rider, or a group health benefits plan may elect to replace the plan or the coverage with a standard individual health benefits plan or a standard individual health benefits plan with a rider. The application must be received during the initial enrollment period.

(b) The effective date of the replacement plan will be January 1 if the application is received by December 31, 2013. The effective date will be the first of the following month for applications received January 1, 2014, through March 31, 2014. In addition, carriers may permit effective dates as of the 15th of the month in January, February, and March.

(c) The standard health benefits plan, or a standard health benefits plan with rider, a basic and essential health care services plan, a basic and essential health care services plan with rider, or a group health benefits plan coverage must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan or coverage will terminate the existing plan or coverage as of the midnight on the day before the effective date of the replacement plan if the existing carrier is notified of the replacement within 30 days after the effective date of the replacement plan. The new carrier may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan is not before the effective date of the replacement plan, the replacement plan shall be of no force and effect and premium paid shall be refunded.

11:20-12.4 Replacement during annual open enrollment period

(a) Except as stated in *N.J.A.C. 11:20-12.5* with respect to the special enrollment period, a person who is covered under a standard health benefits plan, standard health benefits plan with rider, or group health benefits plan may only elect during the annual open enrollment period to replace the plan or coverage with a standard health benefits plan or a standard health benefits plan with rider. The application must be received during the annual open enrollment period.

(b) The effective date of the replacement plan will be January 1 of the year following the annual open enrollment period.

(c) The existing standard health benefits plan, standard health benefits plan with a rider, or group health benefits plan coverage must be terminated with the effective date of termination being no later than the effective date of the replacement plan. The carrier that issued the existing plan will terminate the existing plan or coverage as of the midnight on the day before the effective date of the replacement plan if the existing carrier is notified of the replacement within 30 days after the effective date of the replacement plan. The new carrier issuing the replacement plan may require evidence of the termination of the existing plan. If the effective date of the termination of the existing plan or coverage is not before the effective date of the replacement plan, the replacement plan shall be of no force and effect and premium paid shall be refunded.

11:20-12.5 Replacement during special enrollment period

(a) A person covered under a standard health benefits plan or a standard individual health benefits plan with a rider or group health benefits plan may enroll for coverage under a different standard health benefits plan or standard individual health benefits plan with a rider during a 60-day special enrollment period that follows a triggering event.

(b) The effective date of the new standard health benefits plan or standard health benefits plan with a rider will be the first of the month following the date the carrier receives the application. In addition to the first of the month effective date, carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption, or placement for adoption or the date of placement in foster care.

[page=2391] SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

11:20-22.3 Obligation to offer a basic and essential health care services plan

(a) Every member that writes individual health benefits plans in New Jersey shall offer the basic and essential health care services plan through December 31, 2013. No member shall offer the basic and essential healthcare services plan as of January 1, 2014, or thereafter.

(b) (No change.)

11:20-22.5 Riders to amend the basic and essential health care services plan

(a) Members may develop optional benefit riders to amend the basic and essential health care services plan provided the riders increase the benefits provided under the basic and essential health care services plan and do not contain any feature that would represent a decrease in the coverage or the actuarial value of the plan. The enhanced or additional rider benefits must be included in a manner which will avoid adverse selection to the extent possible. No new optional benefit riders may be developed after December 31, 2013.

(b)-(d) (No change.)

(e) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in *N.J.A.C. 11:20-2.1(h)* no later than 60 days following the close of each calendar quarter. The final quarterly report shall be due March 1, 2015.

1. (No change.)

(f) A member that has one or more approved riders shall submit the information set forth below to the Executive Director at the address set forth in *N.J.A.C. 11:20-2.1(h)* no later than 90 days following the close of the calendar year. The final annual report shall be due April 1, 2015.

1. (No change.)

(g)-(i) (No change.)

11:20-22.6 Good faith effort to market the basic and essential health care services plan

(a) In order for the Board to determine whether a member has made a good faith effort to market the basic and essential health care services plan, as required by section 2g of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.5g), every member shall submit to the Board, at the address specified at *N.J.A.C. 11:20-2.1(h)*, on or before May

1 of each year a report detailing the activities the member undertook during the prior calendar year to market the basic and essential health care services plan. Members may satisfy the requirement by marketing the plan as an HMO plan, a PPO plan, an EPO plan, or as an indemnity plan. The final report required under this section shall be due May 1, 2014.

(b)-(c) (No change.)

SUBCHAPTER 24. PROGRAM COMPLIANCE

11:20-24.1 Purpose and scope

(a) This subchapter sets forth the standards all carriers must meet in offering and issuing standard health benefits plans and standard health benefits plans with riders to eligible persons off the marketplace in New Jersey.

(b) This subchapter sets forth requirements with which carriers must comply in administering standard health benefits plans and standard health benefits plans with riders in New Jersey.

11:20-24.2 Eligibility, issuance, and continued coverage

(a) The policyholder of a standard health benefits plan or a standard health benefits plans with rider shall be a resident, as defined at *N.J.A.C. 11:20-1.2*. A carrier may require reasonable proof of residency. A dependent of the policyholder may be a nonresident of New Jersey, but is not eligible to be covered under the policy if he or she resides outside of the United States.

(b) An eligible person may apply for coverage under a standard health benefits plan or standard health benefits plan with rider during:

1. The initial enrollment period;

2. An annual open enrollment period; or

3. A special enrollment period.

(c) An eligible person may apply for coverage under a catastrophic plan only if:

1. The person is either under 30 years old as of the date the coverage would take effect; or

2. The person has received a certificate of exemption through the marketplace.

(d) After obtaining coverage under a standard health benefits plan or standard health benefits plan with rider, a covered person may elect to retain his or her coverage if he or she later becomes eligible for or covered under Medicare.

(e) After obtaining coverage under a catastrophic plan, a covered person may elect to retain his or her coverage until the effective date of a marketplace redetermination of exemption eligibility that finds the per-

son is no longer eligible for an exemption or until the end of the plan year in which the person attains age 30, whichever occurs first.

(f) A carrier shall issue a standard health benefits plan or standard health benefits plan with rider to any eligible person who requests it and pays the premiums therefor, except that an HMO carrier may refuse to issue coverage to an eligible person that does not live in the carrier's approved service area, and except as provided in N.J.A.C. 11:20-11 and 12.

11:20-24.2A Triggering events that result in special enrollment periods

(a) A special enrollment period begins on the date of the triggering event and continues for 60 days. During this period, an eligible person may apply for coverage for himself or herself and his or her eligible dependents.

(b) The dates listed below are triggering events. A loss of coverage resulting from nonpayment of premium, fraud, or misrepresentation of material fact shall not be a triggering event.

1. The date the eligible person loses ***eligibility for*** minimum essential coverage, or the eligible person's dependent loses ***eligibility for*** minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan (QHP) by the marketplace;

2. The date a dependent child's coverage ends as a result of attaining age 26 whether or not the dependent is eligible for continuing coverage in accordance with Federal or State laws;

3. The date a dependent child's coverage under a parent's group plan ends as a result of attaining age 31;

4. The effective date of a marketplace redetermination of an eligible person's subsidy, including a determination that an eligible person is newly eligible or no longer eligible for a subsidy;

5. The date an eligible person acquires a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care;

6. The date an eligible person who is covered under a standard health benefits plan or standard health benefits plan with rider or group health benefits plan moves out of that plan's service area; *[and]*

7. The date of a marketplace finding that it erroneously permitted or denied an eligible person enrollment in a qualified health plan (QHP)*[.]****; and**

8. The date the eligible person demonstrates to the marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.*

(c) For purposes of 2014 only, enrollment in a non-calendar year standard health benefits plan, standard health benefits plan with rider, basic and essential health care services plan, or basic and essential healthcare service plan with rider creates a limited enrollment period 30 days prior to the date the policy year ends. If an eligible person does not make a selection of new coverage before the policy year ends, the eligible person shall be considered to have experienced a loss of minimum essential coverage, as stated in (b)1 above, as of the date the policy year ends.

(d) The carrier may require proof of the triggering events listed in (b) above.

11:20-24.3 Payment of premium

(a) A carrier may offer a credit card or debit card payment option or an automatic checking withdrawal option to individuals for the monthly or quarterly payment of premiums. In the event that a carrier elects to offer [page=2392] an automatic checking withdrawal option, the carrier shall offer the same option to all individuals.

(b)-(c) (No change.)

11:20-24.4 Effective date of coverage

(a) A carrier, prior to issuing an individual health benefits plan, may require the following:

1. (No change.)

2. Proof of the applicant's residency;

3. If a person is applying during a special enrollment period, evidence of the triggering event;

4. If a person is applying for a catastrophic plan and is not under age 30, a copy of the certificate of exemption from the marketplace; and

5. (No change in text.)

(b) With respect to applications submitted during the initial open enrollment period, the effective date of coverage shall be January 1 if the application is received by December 31, 2013. The effective date will be the first of the following month for applications received January 1, 2014, through March 31, 2014. In addition, carriers may permit effective dates as of the 15th of the month.

(c) With respect to applications submitted during the annual open enrollment period, the effective date of coverage shall be January 1 of the following calendar year.

(d) With respect to applications submitted during the special enrollment period, the effective date of coverage shall be the 1st of the month following the date the carrier receives the application. In addition to the 1st of the month effective date, carriers may permit the effective date to be the 15th of the month following the date the carrier receives the application. However, the effective date of coverage issued following a triggering event of birth, adoption, including placement for adoption, or placement in foster care shall be the date of birth, adoption, or placement for adoption or the date of placement in foster care.

11:20-24.6 Good faith effort to market individual health benefits plans

(a) In order for the Board to determine whether a member that is a small employer carrier as defined in *N.J.S.A. 17B:27A-17* has offered and made a good faith effort to market the standard health benefits plans pursuant to *N.J.S.A. 17B:27A-19a*, every small employer carrier shall submit to the Board, at the address

specified at *N.J.A.C. 11:20-2.1(h)*, on or before May 1 of each year, a report detailing the activities the small employer carrier undertook during the prior calendar year to market at least three of the standard health benefits plans, whether through the marketplace or off the marketplace, or in the case of a Federally qualified HMO, the standard individual HMO plan. If a member offers one or more standard health benefits plans with rider, the member may include information regarding efforts to market the standard health benefits plan with rider in the report.

(b) The report shall include only those marketing activities which were in direct support of the sale of individual health benefits plans whether through the marketplace or off the marketplace during the prior year, even if the effective date of the policy issued as a result of the activities was in the reporting year.

(c) The Board will review the report submitted by each member to determine whether the small employer carrier has demonstrated that it made a good faith effort to market the standard individual health benefits plans including standard health benefits plans with rider, if applicable, and provide written notice of its determination to the member within 45 days of a completed filing.

1. The Board will find that a small employer carrier has marketed in good faith if:

i. The carrier provides evidence that it listed at least three standard individual health benefits plans, or in the case of a Federally qualified HMO, the HMO plan, on the carrier's standard application for individual coverage in the prior calendar year; and

ii. The carrier provides evidence that it has undertaken at least one marketing effort in direct support of the sale of the standard individual health benefits plans or standard health benefits plans with rider during the prior calendar year. Examples of marketing efforts include, but are not limited to: print media such as newspapers and magazines; marketing through licensed producers, where the efforts to encourage the producer to sell the plan can be demonstrated through use of notices, brochures, faxes, or other communications advising the producers of the availability of the plans; or information specific to the standard individual health benefits plans on the carrier's website. Carriers may undertake one or more of these marketing efforts, or may use any other method that is in direct support of the sale of the standard individual health benefits plans.

2. (No change.)

(d) (No change.)