INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans
Minimum Standards for Network-Based Health Benefit Plans

Proposed New Rules: N.J.A.C. 11:22-5

Authorized by: Holly C. Bakke, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B:27A-54, 26:2J-42 and 26:2J-43.

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

Proposal Number: PRN 2002-358.

Submit comments by December 6, 2002 to:

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The agency proposal follows:

Summary

To increase the availability and affordability of health coverage, some carriers issuing network-based health benefit plans have requested that the Department of Banking and Insurance (Department) permit them to use coinsurance and deductibles, rather than copayments, as cost-sharing methods for network benefits. The Department is proposing these new rules to permit the use of such cost-sharing methods, with certain limits. These rules establish minimum standards regarding the use of coinsurance and deductibles for both network and out-of-network benefits

provided by network-based health benefit plans. The rules also permit carriers to offer certain nonmandated benefits on a network basis only. The proposed new rules include the following provisions:

N.J.A.C. 11:22-5.1 contains the purpose and scope.

N.J.A.C. 11:22-5.2 contains definitions of terms used throughout the rules.

N.J.A.C. 11:22-5.3 contains standards for the use of network deductibles.

N.J.A.C. 11:22-5.4 contains standards for the use of network coinsurance.

N.J.A.C. 11:22-5.5 contains standards for the use of aggregate dollar lifetime benefits maximums.

N.J.A.C. 11:22-5.6 requires that point of service (POS) contracts issued by health maintenance organizations (HMOs) and health service corporations, and selective contracting arrangement (SCA) policies issued by insurance companies, provide coverage for covered services and supplies regardless of whether rendered by a network or out-of-network provider, with certain exceptions. The exceptions are generally ancillary benefits such as payment for a spouse to accompany the covered person for treatment. This section also establishes a covered person's liability in instances where he or she obtains services during a hospitalization in a network hospital to which he or she was admitted by a network provider, and the covered person complied with all other preauthorization and notice requirements.

N.J.A.C. 11:22-5.7 states the effect of these new rules on previously-approved forms.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

These proposed new rules should have a favorable impact on carriers, providers and consumers. Carriers will be favorably impacted because the marketability of the plans affected by these rules will increase. Providers should be favorably impacted because they may expand their practices due to the increased availability of the plans. Consumers should be favorably impacted by these proposed new rules because there will be increased availability and affordability of health benefit plans affected by the rules.

Economic Impact

Carriers will experience a favorable economic impact from these proposed new rules because there will be greater cost sharing by covered persons under the health benefit plans affected by the rules. However, carriers may incur greater expenses in processing claims for network services because deductibles and coinsurance will have to be applied in adjudicating such claims. Additionally, carriers may incur expenses in producing marketing materials to explain the new plan design. Providers may be favorably impacted if they experience an increase in patients because they will collect additional fees. Persons covered under these health benefit plans will be favorably impacted because greater cost sharing generally results in lower premiums. However, covered persons who actually receive medical care under these plans will experience greater out-of-pocket costs.

Federal Standards Statement

A Federal standards analysis is not required because the Department's proposed new rules are not subject to any Federal standards or requirements.

Jobs Impact

The Department does not anticipate that the proposed new rules will result in the generation or loss of jobs.

Agriculture Industry Impact

Pursuant to N.J.S.A. 4:1C-10.3, the Right to Farm Act, and N.J.S.A. 52:14B-4(a)(2) of the Administrative Procedure Act, the Department does not expect any agriculture industry impact from the proposed new rules.

Regulatory Flexibility Analysis

These proposed new rules may apply to some carriers that constitute "small businesses" as that term is defined in the Regulatory Flexibility Act at N.J.S.A. 52:14B-16 et seq. The new rules permit carriers that offer certain types of health benefit plans to use coinsurance and deductibles rather than copayments for network benefits, and to offer certain nonmandated benefits on a network basis only. Carriers that intend to offer these features may experience additional recordkeeping or other administrative costs that are related to compliance with these rules. Nevertheless, the standards set forth in these rules must be applied consistently to all carriers choosing to offer the types of health benefit plans described in the rules, and no exception can be made for small businesses. Compliance with the proposed rules should not require the employment of professional services.

Smart Growth Impact

The proposed new rules will have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

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

SUBCHAPTER 5. MINIMUM STANDARDS FOR NETWORK- BASED HEALTH BENEFIT PLANS

11:22-5.1 Purpose and scope

(a) This subchapter establishes minimum standards for health benefit plans that provide coverage only when network providers are used, and for health benefit plans that provide different levels of coverage depending on whether a network provider or an out-of-network provider is used.

(b) This subchapter applies to all insurance companies, health service corporations, medical service corporations, hospital service corporations, and health maintenance organizations that deliver or issue for delivery health benefit plans in this State.

11:22-5.2 Definitions

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

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefit plans in this State.

"Health benefit plan" means a hospital and medical expense insurance policy, health service corporation contract, hospital service corporation contract, medical

service corporation contract, health maintenance organization subscriber contract, or other plan for medical care delivered or issued for delivery in this State.

1. "Health benefit plan" shall not include one or more, or any combination of, the following:

i. Coverage for prescription drugs;

ii. Coverage for accident only, disability income insurance;

iii. Coverage issued as a supplement to liability insurance, including general liability insurance and automobile liability insurance;

iv. Stop loss or excess risk insurance; workers' compensation or similar insurance;

v. Automobile medical payment insurance;

vi. Credit only insurance;

vii. Coverage for on-site medical clinics; and

viii. Other similar insurance coverage as specified in Federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

2. "Health benefit plan" 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:

i. Limited scope dental, drug or vision benefits;

ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

iii. Such other similar, limited benefits as are specified in Federal regulations.

3. "Health benefit plan" shall not include hospital confinement indemnity coverage if:

i. The benefits are provided under a separate policy, certificate or contract of insurance;

ii. There is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and

iii. 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.

4. "Health benefit plan" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

i. Medicare supplemental health insurance as defined at §1882(g)(1) of the Federal Social Security Act (42 U.S.C. §1395ss(g)(1));

ii. Coverage that is supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §§1071 et seq.); and

iii. Similar supplemental coverage provided to coverage under a group health plan.

"Network coinsurance" means the percentage of the contractual fee of the network provider for covered services and supplies specified in the contract between the provider and the carrier that must be paid by the covered person, subject to

deductible and out-of-pocket limit. Network coinsurance cannot be applied to services or supplies provided by capitated providers.

"Network deductible" means the fixed dollar amount that a covered person or family must pay to network providers before the health benefit plan provides the covered person with coverage for services or supplies rendered by network providers. A network deductible shall not be applied to services or supplies provided by capitated providers.

"Network out-of-pocket limit" means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar year. All amounts paid as copayment, coinsurance and deductible shall count toward the out-of-pocket maximum, and shall not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason. Once the network out-of-pocket limit has been reached, the covered person has no further obligation to pay any amounts as copayment, coinsurance or deductible for services and supplies provided by network providers for the remainder of the calendar year.

"Point of service contract" or "POS contract" means a health benefit plan issued by a health maintenance organization or health service corporation that provides covered services and supplies through a network of providers, and pays benefits for covered services and supplies provided by out-of-network providers. The term also includes dual contracts issued pursuant to N.J.A.C. 8:38-14.7, whereby a health maintenance organization contract provides network benefits and an insurance company contract provides out-of-network benefits.

"Preventive care" means services or supplies that are not provided in connection with the treatment of injury or illness. Preventive care includes, but is not limited to: routine physical examinations including related laboratory tests and x-rays, immunizations and vaccines, screening tests, well baby care, well child care and well adult care.

"Selective contracting arrangement contract" or "SCA policy" means a health benefit plan issued by an insurance company that provides covered services and supplies through a network of providers, and pays benefits for covered services and supplies provided by out-of-network providers.

11:22-5.3 Network deductible

(a) An individual network deductible is permitted in a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or health service corporation, and in a SCA policy issued by an insurance company, provided that:

1. The contract or policy contains an individual network out-of-pocket limit that is no greater than $5,000, and a family network out-of-pocket limit that is no greater than two times the individual out-of-pocket limit;

2. The individual network deductible is no greater than $2,500;

3. The individual network deductible is not applied to preventive care; and

4. The contract contains a family deductible no greater than two times the individual deductible.

11:22-5.4 Network coinsurance

(a) Network coinsurance is permitted in a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or health service corporation, and in a SCA policy issued by an insurance company, provided that:

1. The contract contains an individual network out-of-pocket limit that is no greater than $5,000, and a family network out-of-pocket limit that is no greater than two times the individual network out-of-pocket limit;

i. If a carrier offers a contract with an individual out-of-pocket limit in excess of $3,000, it shall also offer a contract with an individual out-of-pocket limit of $2,500 or less;

2. The network coinsurance level, and the out-of-network coinsurance level (if any), is 50 percent or less;

3. The network coinsurance obligation of the covered person is computed by applying the coinsurance percentage to the contractual fee schedule of the provider, not to the billed charges of the provider; and

4. Network coinsurance cannot be applied to preventive care.

11:22-5.5 Aggregate dollar lifetime benefits maximums

(a) Aggregate dollar lifetime benefits maximums for network services and supplies are not permitted in a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or health service corporation, or in a SCA policy issued by an insurance company.

(b) Aggregate dollar lifetime benefits maximums for out-of-network services and supplies are permitted in a POS contract issued by a health maintenance organization or a health service corporation, or in a SCA policy issued by an insurance company, only if such maximums are in the amount of $5 million or greater and are imposed on a per-plan per-carrier basis.

11:22-5.6 Network and out-of-network coverage

(a) POS contracts issued by health maintenance organizations and health service corporations, and SCA policies issued by insurance companies, shall provide coverage for covered services and supplies regardless of whether rendered by a network or an out-of-network provider, with the following exceptions:

1. The following services and supplies may be covered only when provided by a network provider, and are not required to be covered when provided by an out-of-network provider:

i. Health club membership.

ii. Prescription drugs, other than insulin as mandated by N.J.S.A. 17:48-6n, 17:48A-7*l*, 17:48E-35.11, 17B:26-2.1*l*, 17B:27-46.1m and

26:2J-4.11, and medications to treat infertility as mandated by P.L. 2001, c. 236;

iii. Oral agents for controlling blood sugar;

iv. Routine dental examinations;

v. Routine eye care and appliances;

vi. Routine foot care;

vii. Routine hearing care and appliances;

viii. Smoking cessation programs; and

ix. Travel companion benefits.

(b) All contracts issued by health maintenance organizations and health service corporations, and all SCA policies issued by insurance companies, shall provide that a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is a network provider and the covered person and/or provider has complied with all required preauthorization or notice requirements, shall be limited to the copayment, deductible or coinsurance applicable to network services.

11:22-5.7 Effect on previously-approved forms

Any form that was filed with and approved by the Commissioner prior to (the

effecive date of this rule), but does not meet the requirements of this subchapter, shall be deemed withdrawn immediately and may not be made available for sale or use.

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