

**INSURANCE  
DEPARTMENT OF BANKING AND INSURANCE  
DIVISION OF INSURANCE**

**Health Benefit Plans  
Minimum Standards for Network-Based Health Benefit Plans  
Basis for Payment of Out-of-Network Non-Hospital Provider Claims**

**Proposed Amendments: N.J.A.C. 11:22-5.2 and 5.6**

Authorized By: Steven M. Goldman, 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 exception to calendar requirement.

Proposal Number: PRN 2006-405

Submit comments by April 2, 2007 to:

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The agency proposal follows:

**Summary**

Large group health insurance companies, health service corporations and health maintenance organizations (carriers) in the commercial health insurance market have traditionally used the Prevailing Healthcare Charges System (PHCS) data, initially developed by the Health Insurance Association of America (HIAA) and now released semi-annually by Ingenix, as the basis for determining benefit amounts for out-of-network non-hospital health care services (as well as for benefits for indemnity plans not using a network). In-network reimbursement is based on contract rates agreed to by carriers and providers. PHCS data is

based on billed charge data submitted by payors who purchase the PHCS data. The data is organized by CPT code (Current Procedural Terminology code) and geozip (the first three digits of the zip code), and displayed by percentiles ranging from the 50th percentile to the 100th percentile. Accordingly, if a carrier pays out-of-network benefits based on the 80th percentile of the PHCS data, the benefit will be the amount that is equal to or greater than the amount billed for 80 percent of procedures with that CPT code in that geographical area. Using a percentile of billed charges ties in with the notion of "reasonable and customary" fees because objective data exists demonstrating that the carrier's allowance is the billed rate for a given proportion of non-hospital providers in a particular area.

It has come to the Department's attention recently that some carriers have been using or proposing to use the Resource Based Relative Value Scale (RBRVS) used by the Centers for Medicare and Medicaid Services (CMS) (that is, the Medicare fee schedule) as the basis for payment of out-of-network non-hospital provider claims. The Medicare fee schedule payment levels are generally lower than those based on PHCS data (for example, the 50th percentile of PHCS roughly corresponds to 175 percent of Medicare, and the 80th percentile of PHCS roughly corresponds to 225 percent of Medicare) and could result in reduced benefit payments to out-of-network non-hospital providers. This, in turn, may result in such out-of-network providers billing the patient in an amount that reflects the larger balance of the total charge that remains due after the lower, medicare fee schedule-based benefit has been calculated. Use of the Medicare fee schedule does, however, provide certain advantages, including that it is made available to the public (the PHCS data is not). This availability would enable covered persons to access the schedule and determine the dollar value of their benefit and the net amount they would owe to the out-of-network non-hospital provider prior to obtaining services.

In considering the totality of the circumstances and balancing the factors discussed herein, the Department has determined that it is reasonable for carriers to use the Medicare fee schedule as a basis for payment of out-of-network non-hospital provider claims provided certain conditions are met. However, because the Medicare fee schedule payment levels are lower than those of the PHCS, under the proposed amendments carriers would be required to pay no less than 150 percent of the RBRVS amount. In addition, because of the cost sharing resulting from the combination of a carrier's use of the Medicare fee schedule and a coinsurance payment, the proposed amendments will require that the member's or covered person's coinsurance percentage could be no greater than 40 percent of the carrier's allowed charge using the Medicare fee schedule (that is, a member's or covered person's coinsurance will be capped at 40 percent). Under the proposed amendments, carriers would also be required to continue to offer at least one health benefit plan that uses the PHCS data as the basis for payment of out-of-network non-hospital provider claims. Carriers may implement these changes upon renewal of existing policies and contracts, and will be required to amend existing policy and contract forms. These proposed amendments to N.J.A.C. 11:22-5.2 and 5.6 set forth the Department's requirements for a carrier's use of the Medicare fee schedule as the basis for payment of out-of-network non-hospital provider claims. The amendments also include definitions of "health care provider" and "hospital" because these amendments apply only to out-of-network non-hospital providers.

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 amendments will have a positive social impact on covered persons in that they would be able to calculate the dollar amount of benefits for out-of-network non-hospital provider services payable under their health benefits plan based on the Medicare fee schedule, and the balance they would be obligated to pay, prior to obtaining services from such providers. Commercial policyholders will also be provided with more options in selecting health benefit plans because these amendments require carriers to offer plans that calculate benefits by using both a charge-based system such as PHCS and the Medicare fee schedule. Overall, by making available to such policyholders health insurance plans with out-of-network non-hospital care provisions that pay a lower level of benefits for such services, these amendments will provide to such policyholders a lower-cost option for healthcare plans with an out-of-network component, thus affording them the opportunity to contain the cost of providing that type of health insurance to their employees.

### **Economic Impact**

These proposed amendments will likely have a negative economic impact on covered persons who opt to use out-of-network non-hospital providers. Because benefits payable under the Medicare fee schedule are lower than those using the PHCS data, covered persons will be responsible for paying more of the difference between non-hospital providers' billed charges and the amount paid to non-hospital providers by carriers paying at least 150 percent of the rates in the Medicare fee schedule. The benefit amounts determined by applying at least 150 percent of the Medicare fee schedule may not reflect actual or "reasonable and customary" non-hospital provider charges as well as the standard PHCS data does. Providers will continue to have the

opportunity to collect from members or covered persons the difference between their billed charges and the amounts carriers pay as benefits under health benefit plans. Depending upon the effectiveness of their collection efforts, non-hospital providers' compensation for services rendered to patients who have opted to go to out-of-network may be reduced because such providers are not always successful in collecting from patients the total difference between their billed charge and the amount paid by carriers. Carriers will be positively impacted because they will pay less by using the 150 percent of the Medicare fee schedule standard as the basis for payment of out-of-network non-hospital provider claims. Use of this alternative fee schedule, however, may subject carriers to certain additional administrative costs, such as programming costs for developing an additional claims payment and related recordkeeping system based on the Medicare fees. Employers and other commercial health insurance policyholders may be positively impacted as premiums may be stabilized if out-of-network costs are reduced.

#### **Federal Standards Statement**

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

#### **Jobs Impact**

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

#### **Agriculture Industry Impact**

The proposed amendments will have no agriculture industry impact.

### **Regulatory Flexibility Analysis**

The proposed amendments 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 proposed amendments would permit carriers to use a different fee schedule to determine out-of-network non-hospital provider fees, and may subject carriers to certain recordkeeping requirements as described in the Economic Impact statement above. However, use of the Medicare fee schedule to determine out-of-network non-hospital provider fees is discretionary, and small business carriers may choose not to use the Medicare fee schedule. Nevertheless, the preconditions for using the Medicare fee schedule that are included in these proposed amendments must be applied consistently to all carriers choosing to use that schedule to ensure that New Jersey consumers are provided adequate fairness and protection. Thus, no exception can be made for small businesses. It is unlikely that carriers would need to incur costs for professional services in order to comply with the requirements of these amendments.

### **Smart Growth Impact**

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

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

## 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:

**“Health care provider” or “provider” means an individual or entity which, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professional licensed pursuant to Title 45 of the Revised Statutes.**

**"Hospital" means a general acute care facility licensed by the Commissioner of Health and Senior Services pursuant to N.J.S.A. 26:2H-1 et seq., including rehabilitation, psychiatric and long-term acute care facilities.**

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

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

**(d) Carriers, including those offering indemnity plans that do not use a network, may calculate benefits for services provided by out-of-network non-hospital providers by using the Resource Based Relative Value Scale (RBRVS) utilized by the Centers for Medicare and Medicaid Services (CMS) provided that:**

**1. The allowance for out-of-network non-hospital provider services shall be no less than 150 percent of the current RBRVS amount;**

**2. The member's or covered person's coinsurance for out-of-network non-hospital provider services shall be no more than 40 percent of the carrier's allowed charge based on the RBRVS amount;**

**3. The basis for the allowance for out-of-network non-hospital provider services shall be described in group contract and certificate forms and issued to groups prior to the effective date of the determination of benefits based on RBRVS for each affected group; and**

**4. The carrier shall also offer at least one plan that calculates benefits for services provided by out-of-network non-hospital providers based on a charge-based system, such as the Prevailing Healthcare Charges System (PHCS).**

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