INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

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

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

Proposed: October 7, 2002 at 34 N.J.R. 3485(a).

Adopted: September 26, 2003 by Holly C. Bakke, Commissioner, Department of Banking and Insurance.

Filed: September 29, 2003 as R. 2003 d. 419, **with substantive and tehnical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3)

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

Effective Date: November 3, 2003.

Expiration Date: November 6, 2005.

Summary of Public Comments and Agency Responses:

The Department received comments from the following: New Jersey Hospital Association; Saint Barnabas Health Care System; Carrier Clinic; Oxford Health Plans; Horizon Blue Cross Blue Shield of New Jersey; Health Net of the Northeast, Inc.; New Jersey Association of Health Plans; AmeriHealth HMO, Inc.; and AmeriHealth Insurance Company of New Jersey.

COMMENT: Four commenters expressed their appreciation of the Department's recognition of the value of alternative cost-sharing arrangements in increasing the availability and affordability of health coverage. The commenters indicated that recent sales trends have shown increasing interest on the part of consumers in plans that offer

reduced premium rates while still providing valuable coverage for preventive services and catastrophic medical costs.

RESPONSE: The Department appreciates the commenters' support.

COMMENT: Four commenters expressed concern with the scope of the proposed rules set forth at N.J.A.C. 11:22-5.1(b). One commenter stated that the proposed scope is extraterritorial, and will require a new level of compliance by insurers that offer insurance policies to New Jersey residents, and which are approved by other states but delivered directly or indirectly in New Jersey. As an example, the commenter stated that the proposed scope would impact New Jersey residents working in Pennsylvania or New York, and receiving coverage through their employers. The commenter questioned whether New Jersey would require that such insurers also obtain the approval of Pennsylvania and New York regulators, and stated that such a requirement would be administratively burdensome and costly. The commenter recommended that the proposal apply only to New Jersey licensed insurers as do most other New Jersey insurance regulations.

Three commenters stated that a variety of cost sharing options have historically been available and popular for indemnity and other plan designs that provide coverage out-of-network, but interest in higher cost sharing for HMO plan designs is a fairly recent development. The commenters stated that constraints on cost sharing for HMO plans seems appropriate considering the popular perception that HMO plans provide comprehensive care for individuals who access medical services through the HMO's network, but noted that the proposal goes beyond cost sharing arrangements for HMO

plans. According to the commenters, the proposal would have the effect of eliminating many options for non-HMO plans currently enjoyed by consumers. The commenters questioned why the Department believes that when a network of providers is available under those plans, the cost sharing options of the consumer must be limited.

Two commenters stated that given the complexity of the different cost sharing rules currently allowed by product type, the Department should propose separate cost sharing rules for HMOs, selective contracting arrangements (SCAs) and dually licensed point-of-service (POS) products. The commenters noted that current SCA regulations already allow for more flexible cost sharing standards than the standards for HMOs (for example, in- and out-of-network deductibles), and those rules differ from this proposal (for example, SCA rules require a coinsured charge limit which, when met, prevents a carrier from collecting additional coinsurance, but allows for the collection of copayments). Although this proposal caps the maximum out-of-pocket contribution of members, it is inconsistent with the SCA rules because the out-of-pocket maximum contribution of the member is inclusive of copayments.

RESPONSE: The proposed rules are not extraterritorial, but has the same applicability as all other insurance regulation of health benefit plans. N.J.A.C. 11:22-5.1(b) states that the rules apply to health benefit plans delivered or issued for delivery in New Jersey. Health benefit plan is defined at N.J.A.C. 11:22-5.2 to mean a policy or contract delivered or issued for delivery in New Jersey. Since the definition of “health benefit plan” does not include certificates issued to New Jersey residents under group policies or contracts issued outside of New Jersey, the rules are not extraterritorial.

Moreover, these rules place no limitations on cost sharing options in indemnity plans: they address only those plans that either limit coverage to network providers or that provide different levels of coverage depending on whether a network provider is used (that is, point of service plans issued by health maintenance organizations and selective contracting arrangement plans issued by insurance companies). The Department believes that cost sharing must be regulated in network plans because these plans have historically been offered with modest flat dollar copayments, generally $30.00 or less. Permitting deductible and coinsurance features to be used with network plans subjects covered persons to a much greater dollar level of cost sharing since coinsurance can be as low as 50 percent and deductibles as high as $2,500. A covered person could therefore be required to spend $2,500 on covered services before receiving any benefits, and then still have to pay one half of the cost for covered services. To limit this financial exposure, the Department requires in these rules an out-of-pocket limit of no more than $5,000 per person and $10,000 per family.

Finally, the Department does not agree that different cost sharing should be permitted for HMOs, insurance companies with SCAs and products sold with dual contracts. The SCA rules do not require use of a coinsured charge limit, which is a feature included in the standard small employer health benefit plans, and in fact is more restrictive than these rules in that the coinsurance level is required to be 60 percent or above (see N.J.A.C. 11:4-37.3). These rules allow coinsurance of 50 percent or above. Moreover, products sold by HMOs and insurance companies that require use of

networks are virtually identical and there is no reason to allow different levels of cost sharing based on the legal status of the issuer.

COMMENT: Four comments concerned the proposed definition of "health benefit plan." One commenter stated that the definition indicates that a health benefit plan shall not include one or more, or any combination, of the following: "i. Coverage for prescription drugs; . . ." The commenter questions if this is to be interpreted to mean that prescription drug benefits contained in a policy covering medical hospitalization services are not subject to the proposed rules.

Three commenters stated that in the section of the proposed definition related to hospital confinement indemnity coverage, it is unclear what the impact would be on the coordination of benefits process described in N.J.A.C. 11:4-28.

RESPONSE: The definition of health benefit plan excepts stand alone prescription drug coverage. 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 New Jersey that includes prescription drug coverage is subject to these rules.

The Department does not understand the question relating to hospital confinement indemnity coverage and coordination of benefits. The coordination of benefits rule at N.J.A.C. 11:4-28.2 specifies that a plan may include group hospital indemnity benefit amounts exceeding $150.00 per day and cannot include group hospital indemnity benefits of $150.00 per day or less. This rule states that it is not

applicable to hospital indemnity coverage if the coverage is provided as a separate contract, policy or certificate and the coverage is provided regardless of the provisions of any group health benefit plan of the same plan sponsor. The fact that different rules exclude hospital indemnity coverage under different circumstances is due to the fact that the different rules have different purposes.

COMMENT: Four comments concerned the proposed definition of "network coinsurance" at N.J.A.C. 11:22-5.2, as well as the proposed method of calculating coinsurance as set forth at N.J.A.C. 11:22-5.4(a)3. The commenters indicated that the proposed definition applies the coinsurance to the contractual fee of the network provider. According to the commenters, this approach does not capture the various methodologies used by carriers to compensate providers, which are typically distinguishable between facility and professional providers. Facilities may be paid on a PIP, per case or other negotiated arrangement. Likewise, professional providers may have arrangements other than fee schedule based compensation, including reimbursement based on charges. "Based on charges" could include a percentage discount from charges and, in such situations, the coinsurance and deductible is calculated based on a provider's charges. Consequently, one commenter recommended that the coinsurance be applied to "allowed expense" or "covered expense" which can then be defined to include negotiated arrangements, PIP, per case methodology, contractual fee schedule or other agreed upon compensation methodologies between insurers and providers.

RESPONSE: The Department does not believe that a change is necessary. The definition of network coinsurance refers to a percentage of the contractual fee. The contractual fee may be a fee schedule, a percentage discount from charges, a case rate or other methodology, excluding capitation. The rules do not limit the payment methodologies of network providers.

COMMENT: Three comments stated that although used throughout the proposed subchapter, the term "network copayment" is not defined.

RESPONSE: The Department agrees and has inserted a definition of “network copayment” to mean a specified dollar amount a covered person must pay for covered services and supplies rendered by network providers.

COMMENT: Seven comments concerned the proposed definition of "network out-of-pocket limit." Three commenters stated that to include copayments would be unnecessarily burdensome on carriers. The commenters indicated that most plans provide for collection of the copayment at the provider's office, based upon the copayment level shown on the member's identification card, and it would not be practical for carriers to attempt discontinuance of collection once the out-of-pocket maximum is reached. It would also be administratively burdensome for providers to check on the out-of-pocket status at each office visit, as well as confusing for members. Since copayments tend to be small in comparison to deductibles and coinsurance amounts, excluding copayments from the calculation of out-of-pocket maximum would make the program administrable without adding significant cost to the member.

One comment concerned the following sentence in the definition of "network out-of-pocket limit": "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." The commenter stated that this sentence should be modified to clarify that the copayment, coinsurance and deductible must apply to a service that is covered under the terms of the health benefit plan in order to count toward the network out-of-pocket limit.

Three commenters stated that while the proposed definition is accurate in stating that a covered person has no further obligation to pay for covered services once the out-of-pocket limit has been reached, the definition should specify that the carrier still has an obligation to pay for covered services. Additionally, the commenters are unclear as to the effect of this definition on coordination of benefits.

RESPONSE: The Department appreciates the fact that, presently, copayments tend to be relatively small, and that an out-of-pocket limit based on copayments could present administrative difficulties. However, the Department notes that copayments are getting larger, and that there is no theoretical justification for treating copayments (a flat charge per service) differently than coinsurance (a percentage charge per service) in setting out of pocket limits. Due to the presumed minimal nature of copayments, it is unlikely that anyone would ever exceed the out of pocket limit solely due to copayments. Therefore, a carrier could meet this requirement by: 1) offering to reimburse any copayments for persons exceeding the out-of-pocket limit, and 2)

advising persons who might be approaching the out-of-pocket limit to submit copayments for credit.

With respect to the second comment, it is not necessary to state that copayments, coinsurance and deductibles apply to covered services because cost sharing only applies to covered services. If the service is not covered, the covered person must pay for the service in full. Similarly, it is not necessary to state that a carrier is obligated to pay for covered services without cost sharing once the out-of-pocket maximum is satisfied. If the carrier has no obligation to provide benefits after the out-of-pocket maximum is satisfied, the limit is meaningless. This rule has no effect on the coordination of benefits rule at N.J.A.C. 11:4-28.

COMMENT: One commenter was concerned with the proposed definition of "preventive care." The commenter suggested that the Department clarify that the services or supplies referred to in the definition must also be "covered services" as defined by the benefit plan. The commenter added that the coinsurance and deductible features should also apply to these services.

RESPONSE: The Department does not believe this change is needed since it is axiomatic that benefits are not provided for, and cost sharing is not applied to, services that are not covered by the health benefits plan. The Department notes, however, that wellness, immunizations, PAP smears, mammograms, prostate screening and other preventive benefits are mandated benefits in New Jersey.

COMMENT: One commenter expressed concern with the scope of proposed N.J.A.C. 11:22-5.3 and 5.4, which apply to HMOs that provide "out-of-network benefits

only for emergency and urgent care, . . . [.]" The commenter states that it seems that this provision narrows its scope unnecessarily to exclude HMOs that provide more benefits out-of-network than for emergency and urgent care. The commenter questioned whether the Department had a particular purpose in mind by narrowing this scope. The commenter suggested removing the modifying language or editing the language to read "HMO that provides out-of-network benefits such as emergency and urgent care."

RESPONSE: The language referring to an HMO that provides out-of-network benefits for emergency and urgent care describes the traditional closed panel HMO plan. The phrase “POS contract issued by a health maintenance organization” describes HMO plans that offer out-of-network benefits in addition to those for urgent and emergent care. These two phrases describe all HMO plans available in New Jersey.

COMMENT: Four commenters expressed concern with the individual network out-of-pocket limit of $5,000 proposed at N.J.A.C. 11:22-5.3(a). The commenters stated that in recognition of the need for lower cost coverage options, the New Jersey Legislature recently passed P.L. 2001, c. 268, requiring carriers in the individual market to offer limited benefit plans. The Individual Health Coverage Program Board promulgated regulations permitting carriers to offer plans with $5,000 and $10,000 individual deductibles. High deductible plans are also available for issuance in conjunction with medical savings accounts, with deductibles subject to inflation adjustment. The commenters also stated that, earlier this year, the United States Department of the Treasury issued guidance on the tax treatment of health

reimbursement arrangements, which allow for tax-favored treatment of healthcare reimbursement expenses outside of traditional insured arrangements. According to the commenters, the proposed provision limiting total out-of-pocket network expenses to $5,000 is directly contrary to the public policy behind these initiatives of enabling greater consumer control over health care coverage. Three commenters suggested that the Department provide greater flexibility to offer a higher out-of-pocket maximum, such as $7,500 and $10,000, and permit the out-of-pocket maximum to be increased by amounts available for reimbursement through flexible spending accounts or health reimbursement arrangements. One commenter suggested raising the limit to $10,000.

RESPONSE: Under these rules, a covered person may be subject to a $2,500 network deductible, meaning that no network benefits will be provided until he or she has incurred and paid for $2,500 in network services. After the network deductible has been satisfied, a covered person may be subject to 50 percent network coinsurance, and, therefore, be responsible for one half of the cost of network services. In light of this significant amount of up-front cost sharing, the Department believes that an out-of-pocket limit of no less than $5,000 per person/$10,000 per family is necessary to provide a meaningful level of benefits in plans using these cost sharing devices.

This rule does not preclude the use of high deductible plans. These rules only limit the size of deductibles on network benefits and contain no restriction on deductibles for out-of-network benefits or in traditional indemnity plans.

COMMENT: One commenter expressed concern with proposed N.J.A.C. 11:22-5.3(a)3, which prohibits the application of the individual network deductible to

preventive care. The commenter stated that several "preventive" mandates permit the application of deductibles contrary to this provision, such as colorectal cancer screening, infant screening for hearing loss, mammography examination screenings and diabetic supplies and education. The commenter believes that application of a deductible should be permitted in such cases.

RESPONSE: Use of deductibles of up to $2,500 may discourage covered persons from seeking preventive care since they will be required to pay for such care in full if the deductible has not been satisfied. In order to avoid that result, the Department has determined that such services should be subject to copayment only.

COMMENT: Three commenters expressed concern with the proposed maximum in-network family deductible multiple of two times the individual deductible at N.J.A.C. 11:22-5.3(a)4. Two commenters stated that some carriers currently use out-of-network family deductibles of two, two and one-half or three times the individual deductible, and the proposed multiple may create confusion. The commenters stated that they would rather have the choice, and suggested that the proposed language be replaced with "The in-network family deductible multiple must be less than or equal to the out-of-network family deductible multiple." One commenter stated that the multiplier for the family deductible should be three or four times the individual deductible.

RESPONSE: Individual and family deductibles are not presently permitted on network benefits, only modest copayments. The Department wishes to proceed cautiously in introducing this new cost sharing mechanism because it will require the

covered person to expend substantial amounts of money before receiving any benefits. This rule does not affect deductibles on out-of-network benefits.

COMMENT: One commenter stated that the network coinsurance out-of-pocket limits specified in proposed N.J.A.C. 11:22-5.4(a)1i should be modified to be consistent with increased network deductible limits as suggested by the commenters.

RESPONSE: As stated previously, the use of deductibles and coinsurance on network benefits is a marked change in cost sharing that will significantly increase the amount that covered persons will have to pay for covered services. Because of impact of this change, the Department wishes to proceed cautiously.

COMMENT: Three commenters expressed concern with proposed N.J.A.C. 11:22-5.4(a)3, which requires the network coinsurance obligation of the covered person to be computed by applying the coinsurance percentage to the contractual fee schedule of the provider, not to the billed charges of the provider. The commenters stated that this proposed requirement would unintentionally change how payers currently reimburse providers, as well as calculate applicable coinsurance levels of patients. According to the commenters, because health plans that reimburse providers based on a negotiated rate (such as a per diem, case rate or fee schedule) usually calculate the patient's coinsurance or deductible liability based on that contracted rate, this provision reflects how coinsurance is determined for most services. In fact, contracts between carriers and providers typically include a fee schedule for high volume outpatient services. The commenters further stated, however, that there are situations in which a network provider does not have a contracted rate with a payer, and is reimbursed

based on charges ("based on charges" could include a percentage discount from charges). In such cases, the coinsurance and deductible is calculated based on a provider's charges. For example, most contracts require that certain outpatient services be paid based on charges, such as services used less frequently, or those that fall under a commonly used contract term "all other outpatient services." Because it is not uncommon for carriers' contracts with network providers to include both negotiated rates and charged-based reimbursement, the commenters believe that limiting the calculation of coinsurance to the contractual fee does not reflect current practice and may be unenforceable.

RESPONSE: The intent of N.J.A.C. 11:22-5.4(a)3 is to insure that the coinsurance is applied to the fee set by the contract between the carrier and the network provider, and not the provider's billed charges. If that fee is a reduction from charges, then the coinsurance will be based on those reduced charges. The Department notes that even in traditional indemnity policies, coinsurance is not based on billed charges, but on the reasonable and customary charge for the services provided.

COMMENT: Three commenters expressed concern with proposed N.J.A.C. 11:22-5.5(b), which permits aggregate dollar lifetime benefits maximums for out-of-network services and supplies in a POS contract issued by a health maintenance organization or 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. Two commenters stated that it has been their

experience that very few members ever exceed the lifetime maximum of $1 million, and that the proposed $5 million or greater maximum would prohibit flexibility and increase premiums.

One commenter stated that the proposed maximum should be modified to $500,000 or greater to facilitate the offering of affordable health benefit plans, and that employers desiring to offer a plan with richer out-of-network options can select a higher maximum and/or favorable out-of-network coinsurance and deductible amounts. The commenter also stated that the reference to "per-plan per-carrier basis" should be modified to be "per carrier" for cost containment purposes, and that "carrier" should be defined to indicate that affiliated carriers are not considered separate carriers for purposes of this provision.

RESPONSE: The Department notes that it has not permitted aggregate lifetime maximums in network based contracts and, therefore, does not believe that use of such maximums, restricted to levels of $5 million or higher, will increase cost. The Department notes that a person with a catastrophic injury could easily expend $1 million in medical expenses.

The Department similarly rejects the use of an aggregate lifetime limit on a per carrier basis and of defining carrier to include affiliates. Such a restriction would mean that a person covered by a PPO plan issued by company X who then switches to an indemnity plan issued by company X would have his benefits under the PPO plan charged against the lifetime maximum in the indemnity plan. Further, if the person switched to an HMO plan issued by an affiliate of company X, the benefits paid under

the PPO plan would be charged against his maximum benefits under the HMO plan. The Department considers such a situation unfair to the consumer. The Department notes that the standard Small Employer HMO-POS contract has a $5 million aggregate lifetime maximum per carrier per plan.

COMMENT: Two commenters stated that the proposed list of services and supplies that may be covered only when provided by a network provider at N.J.A.C. 11:22-5.6(a)1 should include infertility/in vitro fertilization benefits, chiropractic benefits, durable medical equipment, home health care services, and skilled nursing facility.

RESPONSE: The Department requires that every service that is covered when rendered by a network provider also be covered when rendered by an out-of-network provider although a lower level of benefits is permitted when the provider is out-of-network. The Department's position is that a POS plan must allow consumers the option to use an out-of-network provider for every covered service, otherwise it is not truly a POS plan but instead a closed panel plan with limited out of network benefits. An exception to the Department's position is that incidental and ancillary benefits are required to be covered only when provided by network providers. The Department notes that infertility and home health services are mandated benefits, and the Department therefore has no authority to restrict those benefits to network providers. Further, none of the benefits mentioned by the commenters are incidental or ancillary.

COMMENT: Five commenters expressed concern with proposed N.J.A.C. 11:22-5.6(b), which requires a covered person's liability for services rendered during a

hospitalization in a network hospital, where the admitting physician is a network provider, to be limited to the copayment, deductible or coinsurance amount applicable to network services. Two commenters suggested revising this provision to read (additions in boldface) "All contracts . . . shall provide that a covered person's liability for **covered** services **that were precertified as provided below** and rendered during a hospitalization in a network hospital . . . [.]" The commenters stated that this revision would specify that only covered services shall be limited to copayment, deductible or coinsurance. Further, unless the service is an emergency, services in a hospital must be precertified.

Three commenters stated that the proposed provision is in direct conflict with P.L. 2001, c. 367, which requires that managed care organizations pay network hospitals the full contractual rate regardless of whether the admitting or treating physician is in-network or out-of-network, and that carriers reimburse hospitals "in accordance with the in-network policies, copayment, coinsurance or deductible requirements." The commenters stated this law surely intended that a patient receiving services in a network hospital be liable for coinsurance or deductibles only at the network rate regardless of whether the admitting or treating physician is a network provider, while the proposed provision would penalize the patient if the admitting physician is non-network and hold the patient responsible for coinsurance and deductibles at a non-network level. The commenters added that the proposed provision may impact a patient's ability to access necessary healthcare services at a network hospital of his or her choice, and could hold a patient liable at the non-network

rate when a patient is admitted through the emergency room by a non-network physician.

RESPONSE: The Department does not believe that any change is needed in response to the first comment because the rule specifies that the covered person has complied with all required preauthorization or notice requirements, which includes precertification.

The Department agrees with the second comment that P.L. 2001, c. 367 (codified as N.J.S.A. 26:2S-6.1) states that when a patient is either admitted to a in-network facility by an out-of-network provider (see N.J.S.A. 26:2S-6.1a(1)), or receives services from an out-of-network provider in an in-network facility and was admitted by an in-network provider (see N.J.S.A. 26:2S-6.1a(2)), the facility is paid by the carrier at the carrier's full contracted rate without any penalty for the patient's selection of an out-of-network provider. N.J.A.C. 11:22-5.6(b) as proposed did not reflect the scenario set forth at N.J.S.A. 26:2S-6.1a(1) where the admitting provider is an out-of-network provider. Accordingly, the Department is revising N.J.A.C. 11:22-5.6(b), consistent with the requirement at N.J.S.A. 26:2S-6.1, to clarify that a covered person's liability when admitted to an in-network facility by either an in-network or out-of-network provider, is the copayment, deductible and/or coinsurance applicable to network facilities.

COMMENT: Three comments concerned proposed N.J.A.C. 11:22-5.7, which requires the immediate withdrawal of previously filed, noncompliant forms. One commenter recommended that the rules provide that the new standards will be implemented at issuance or upon renewal of existing policies. The commenter added

that if the proposed provision is adopted, no insurance policy in place as of the effective date of the rules would be valid, and thus no insurance coverage would be in place, unless the Department reviewed every affected policy for every affected carrier and had approved it by the effective date. The commenter noted that this would be logistically impossible if the final requirements will not be known to carriers until the rules are effective.

Two commenters recommended that the Department revise the proposed provision to read "Any form that was filed with and approved by the Commissioner prior to the effective date of this regulation, but does not meet the requirements of this subchapter, shall not be utilized to market plans that are not compliant with this subchapter. Such forms shall be amended to comply with this regulation and submitted to the Department for approval. Upon Department approval, the new forms shall replace the older forms. Upon policy renewal, or no later than one year from the effective date of this regulation, any group or individual that was previously sold a plan that is not in compliance with this subchapter shall be renewed into plans that are in compliance with said subchapter."

RESPONSE: The first commenter misunderstands the effect of deeming a form withdrawn. Once a form is withdrawn, it can no longer be issued or renewed, but in force business is not affected. Consequently, the Department does not believe that it is necessary to revise N.J.A.C. 11:22-5.7 as suggested by the commenters because the requirements contained in these rules will be applied on a prospective basis only.

Summary of Agency-Initiated Changes:

1. In the definition of “health benefit plan” in N.J.A.C. 11:22-5.2, text is added to subparagraph 1v to clarify that the reference to “Automobile medical payment insurance” therein includes automobile personal injury protection medical expense benefits. The standards for such “PIP” benefits are set forth in N.J.A.C. 11:22-3 and in N.J.S.A. 39:6A-1 et seq. Furthermore, definitions of “health benefit plan” set forth in N.J.S.A. 17B:27A-2 and 17B:27A-17 explicitly exclude PIP coverage.

2. At the end of N.J.A.C. 11:22-5.3(a)1, "network" was inserted before "out-of-pocket limit" for clarity.

3. At N.J.A.C. 11:22-5.3(a)4, "network" was inserted before "deductible" for clarity.

4. At N.J.A.C. 11:22-5.4(a)1i, "network" was inserted before "out-of-pocket limit" for clarity.

5. At N.J.A.C. 11:22-5.6(a)1ii, oral agents for controlling blood sugar has been added as an exception to the services and supplies that may be covered only when provided by a network provider. These supplies were inadvertently included at N.J.A.C. 11:22-5.6(a)1iii in the proposal, which would not require them to be covered when provided by an out-of-network provider. However, they are required by statute to be covered (see P.L. 1995, c. 331, codified as N.J.S.A. 17:48-6n, 17:48A-7l, 17:48E-35.11, 17B:26-2.1l, 17B:27-46.1m and 26:2J-4.11), along with all other diabetes treatment, self-management education, equipment and supplies.

6. At N.J.A.C. 11:22-5.6(a)1ii, the citation to P.L. 2001, c. 236 has been changed to reflect the N.J.S.A. citations.

Federal Standards Statement

A Federal standards analysis is not required because these new rules are not subject to any Federal standards or requirements.

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

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

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:

. . .

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

i. – iv. (No change from proposal.)

v. Automobile ***personal injury protection medical expense benefits or*** medical payment insurance;

vi. – viii. (No change from proposal.)

2. – 4. (No change from proposal.)

"Network copayment" means the specified dollar amount a covered person must pay for covered services and supplies rendered by 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 ***network*** out-of-pocket limit;

2. – 3. (No change from proposal.)

4. The contract contains a family ***network*** deductible no greater than two times the individual ***network*** 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 ***network*** out-of-pocket limit in excess of $3,000, it shall also offer a contract with an individual ***network*** out-of-pocket limit of $2,500 or less.

2. – 4. (No change from proposal.)

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 ***and oral agents for controlling blood sugar*** as mandated by N.J.S.A. 17:48-6n, 17:48A-7l,

17:48E-35.11, 17B:26-2.1l, 17B:27-46.1m and 26:2J-4.11, and medications to treat infertility as mandated by **[**P.L. 2001, c. 236**]** ***N.J.S.A. 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x and 26:2J-4.23****;

[iii. Oral agents for controlling blood sugar;]

Recodify proposed iv. – ix as *iii. – viii.* (No change in text from proposal.)

(b) All contracts issued by health maintenance organizations and health service corporations, and all SCA policies issued by insurance companies, shall provide ***[**that**]*** ***the following:**

1. ***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**]*** ***and/or*** coinsurance applicable to network services ***[**.**]*** ***; and***

2. 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 an out-of-network provider, shall be limited to the copayment, deductible and/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 effective date of this rule),**]*** ***November 3, 2003.*** 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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