DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans
Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans

Adopted Amendments: N.J.A.C. 11:22-5.1 through 5.9

Adopted New Rules: N.J.A.C. 11:22-5.5 and 5.6

Proposed: December 15, 2008 at 40 N.J.R. 6915(a).

Adopted: July 31, 2009 by Neil N. Jasey, Commissioner, Department of Banking and Insurance.

Filed: July 31, 2009 as R. 2009 d. 265, **with substantive changes** not requiring additional public notice and opportunity for comment (See N.J.A.C. 1:30-6.3).

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

Effective Date: September 8, 2009

Operative Date: September 8, 2010

Expiration Date: April 26, 2011

Summary of Public Comments and Agency Responses:

The Department received comments from the following: the Medical Society of New Jersey (MSNJ); the New Jersey State Nurses Association (NJSNA); the Law Office of Robert Cerrato on behalf of the American Board of Physician Specialists (ABPS) (in the State of New Jersey) and as a board certified physician of ABPS; Delta Dental of New Jersey, Inc. (Delta Dental); AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (AmeriHealth); the American Physical Therapy Association of New Jersey (APTAnj); Aetna; the New Jersey Association of Health Plans (NJAHP); Horizon Blue Cross Blue Shield of New Jersey (Horizon); the New Jersey Hospital Association (NJHA); and Divya Srivastav-Seth.

1. COMMENT: One commenter stated that the proposed definitions for "family network out-of-pocket limit," "individual network out-of-pocket limit" and "individual out-of-network out-of-pocket limit" state that the out-of-pocket limits shall be calculated on a calendar year basis, but that many benefit plans are issued or renewed at different times of the year rather than on a January 1 calendar year basis.

The commenter recommended that the Department revise these definitions to refer to "calendar, contract or policy" years.

RESPONSE: The Department agrees with the commenter and is revising these definitions as suggested by the commenter. This reproposal, made in response to comments on the Department's original proposal of these rules, included proposed revisions to N.J.A.C. 11:22-5.6(a)3 to refer to calendar, contract or policy year, but did not propose the same change in the definitions. The revised definitions clarify the Department's intent and corrects its oversight.

2. COMMENT: One commenter expressed its support for the reproposed definition of "network copayment" that now includes a statement that the copayment shall never exceed the contractual fee of the network providers, and "family network deductible" that eliminates the reference to calculations on an aggregate or individual basis.

RESPONSE: The Department thanks the commenter for its support.

3. COMMENT: Three comments concerned the reproposal's definitions at N.J.A.C. 11:22-5.2. One commenter thanked the Department for clarifying the meaning of "capitated providers" and adding definitions of "capitation," "physician" and "specialist physician." One commenter stated that the proposed definitions of "physician" and "specialist physician" are excessively restrictive. According to the commenter, advanced practice nurses (APNs) (by law, including nurse practitioners and clinical nurse specialists) are recognized by P.L. 1997, c. 192 (the Health Care Quality Act) as health care providers who can be credentialed and directly reimbursed by health care plans. The commenter requested that the Department add a definition of "advanced practice nurse."

One commenter requested that the Department expand the definition of "specialist physician" to include those physicians board certified by the American Board of Physician Specialists (ABPS). According to the commenter, ABPS certified physicians have passed board certification tests as rigorous as those administered by any other accrediting board, practice in 15 specialty areas, and have an excellent record of serving the medical needs of the public. ABPS has certified physicians residing in all 50 states. The commenter stated that excluding ABPS board certified physicians from this definition arbitrarily discriminates against ABPS certified physicians and reduces the number of available in-network

physicians, thereby raising costs because physicians certified by other boards (ABMS, AOA) are given greater financial market power by skewing the supply and demand curve in their favor. As a result, the State will incur greater health costs in terms of Medicaid payments; health insurers will be less able to contain rising costs for physician services and fewer available in-network physicians with higher costs will reduce patient access to care. The commenter added that no state should artificially decide that some certifying boards are more worthy than others. The commenter strongly urged the Department to include the term "the American Board of Physician Specialties" in its definition of "specialist physician."

RESPONSE: The Department agrees that it should have used the term "primary care provider" instead of "primary care physician." The Department is adding a definition of "primary care provider" and revising N.J.A.C. 11:22-5.5(a)2 to refer to a primary care provider office visit and render the rule consistent with the Health Care Quality Act's definition of "primary care provider" at N.J.S.A. 26:2S-2.

Regarding the second comment, the Department notes that in the definition of "specialist physician," paragraph 5 includes any fully licensed physician who is recognized in the community as a specialist by his or her peers. Therefore, physicians who are board certified by the American Board of Physician Specialists are not excluded from the definition. Accordingly, the Department does not believe that the definition requires revision.

4. COMMENT: Four comments concerned reproposed N.J.A.C. 11:22-5.5, Network copayment. One commenter reiterated its comment made in response to the Department's original proposal that some carriers inappropriately apply inpatient deductible and coinsurance amounts to services provided in an outpatient department of a hospital that would normally be covered with a copay. The commenter further stated that, conversely, carriers reimburse the same services performed at freestanding outpatient facilities as "office visits" and only require the patient to pay a nominal copay. According to the commenter, such a practice incorrectly identifies all hospital services as inpatient and inappropriately shifts a larger financial burden to patients receiving services at a hospital outpatient department, which may be the only location certain services (such as sleep centers) are available. The commenter recommended that the Department include at N.J.A.C. 11:22-5.5(a) language stating that outpatient

cost-sharing limits for diagnostic and therapeutic services at hospitals and free-standing facilities must be the same.

One commenter requested that both primary care and specialist advanced practice nurse (APN) office visits be added to the list of maximum network copayment amounts. According to the commenter, APNs are typically reimbursed at 85 percent of the physician's rate. The commenter added that this is the case for both Medicare and Medicaid, which also credential and reimburse APNs as primary care and specialty care providers. State health care plans generally follow the lead of the Federally-based plans regarding APN reimbursement; Horizon-Mercy is an exception and reimburses APNs at 100 percent of the physician's rate.

One commenter questioned how the copayment for preventive services at N.J.A.C. 11:22-5.5(a)1 would apply. By way of example, the commenter stated that preventive services may be performed as part of a primary care visit or part of an OB/GYN visit, and laboratory and radiology services may be ordered pursuant to a preventive examination, although different copayments may apply to each of these.

Two comments addressed N.J.A.C. 11:22-5.5(a)11, which states that "For any other services and supplies, the copayment is to be determined so that the carrier insures 50 percent or more of the aggregate risk for the service or supply to which the copayment is applied." The commenters stated that a copayment is typically applicable to a range of services with differing costs. For example, the specialist copayment applies to services provided by various network specialists – cardiologists, radiologists, surgeons – at various costs. In every instance the applicable copayment may not be 50 percent of cost of the service. One commenter asked if the Department will look at the fifty percent standard "on average" as suggested in its Summary of the reproposal, and if the term "aggregate risk" is intended to capture this "on average" concept.

RESPONSE: Regarding requiring the same copayment for outpatient services provided at a hospital and a free-standing facility, the Department reiterates its original response that the Department understands the commenter's concern, but the issue of carriers applying incorrect copayments for

outpatient services rendered in a hospital setting is an enforcement issue and beyond the scope of these rules.

The Department has addressed the second comment regarding advanced practice nurses by changing the term “primary care physician” to “primary care provider” at N.J.A.C. 11:22-5.5(a)2. The Department notes that the comment discusses the reimbursement that health plans pay to advanced practice nurses, but N.J.A.C. 11:22-5.5 is limited to copayments paid by covered persons and does not address the reimbursement paid by health plans to participating providers.

Regarding the comment concerning the copayment for preventive services at N.J.A.C. 11:22-5.5(a)1, if preventive services are performed during either a primary care provider or specialist physician office visit, the preventive copayment would apply.

Regarding the comments on N.J.A.C. 11:22-5.5(a)11, the Department notes that the reference therein to aggregate risk implies an averaging of the cost of all services to which the copay applies. However, as stated in the proposed definition of “network copayment,” in no event can the copay exceed the contractual fee of the network provider.

5. COMMENT: Three comments concerned reproposed N.J.A.C. 11:22-5.6, which establishes individual network, family network and individual out-of-network out-of-pocket limits. One commenter expressed its support of the addition of this provision in the Department’s original proposal of these rules. The commenter further agreed that the tracking of the accumulation of copayment, deductible and coinsurance payments should be the obligation of the carrier, and that the amounts paid as copayment, coinsurance and deductible should count toward the out-of-pocket limit regardless of the nature of the service rendered. The commenter further reiterated its comment submitted on the Department’s original proposal of these rules suggesting that the Department consider options to make out-of-pocket payment information readily available to treating physicians because a tracking requirement will not have its intended effect unless a new notice requirement to the treating physician is provided.

One commenter stated that the proposed prohibition against requiring covered individuals to report out-of-pocket payments could have the unintended effect of eliminating a number of benefit plan options. By way of example, the commenter stated that it has benefit plans under which pharmacy out-

of-pocket expenses are accumulated against the plan out-of-pocket limit. In some cases, pharmacy expenses may only be effectively tracked if they are "manually" reported to carriers by covered individuals. If carriers are prohibited from requiring individuals to report such information, carriers will be unable to accumulate these expenses against out-of-pocket limits and will be forced to eliminate such benefit plan designs. The commenter added that in circumstances where services are rendered by capitated providers, such providers may not always report copayment, coinsurance and deductible payment information to carriers. In these situations, carriers need to ask covered individuals and/or providers for appropriate information to make sure that out-of-pocket expenses are being tracked accurately.

One commenter supported the Department elimination of N.J.A.C. 11:22-5.6(b) in its reproposal, which referenced the family network deductible.

RESPONSE: The Department thanks the commenter for its support of N.J.A.C. 11:22-5.6. Regarding the comment that the Department consider options for making out-of-pocket payment information readily available to treating physicians, the Department reiterates its response to a similar comment received on the original proposal of these rules. Tracking of cost sharing is beyond the scope of these rules, which address only limits on cost-sharing. However, the Department will monitor this issue and consider additional rulemaking in the future if it determines rules are needed.

Regarding the rules' prohibition against requiring covered individuals to report out-of-pocket payments, the rules do not require that prescription drug cost sharing accumulate to the network out-of-pocket limit. If a carrier elects to allow such accumulation, it should develop an appropriate tracking mechanism that cannot include requiring covered persons to report out-of-pocket payments. With respect to capitated providers, such providers report encounters to the carrier and the carrier should assume that a copay was paid for each encounter. The Department notes that network coinsurance and network copayment do not apply to capitated providers under N.J.A.C. 11:22-5.3(a)5 and 5.4(a)5.

6. COMMENT: Four comments concerned reproposed N.J.A.C. 11:22-5.7, Benefit maximums in health benefit plans. One commenter expressed its support for the Department's proposal prohibiting annual dollar limits on network or non-network hospital services. Two commenters expressed their

concern about the impact of this reproposed section on part-time or temporary workers and college students. According to the commenters, this rule would effectively abolish currently available affordable health insurance options for New Jersey consumers. Specifically, prohibiting a health benefit plan from applying aggregate dollar annual maximums to network services and requiring annual dollar maximums for out-of-network services of at least $1 million or more would uniquely hamper the affordability and accessibility of coverage for students and part-time and temporary workers. Moreover, students are required by New Jersey law to have health insurance coverage, and coverage under many of these plans constitutes "creditable coverage" for purposes of determining whether a person is subject to a pre-existing condition limitation period. Many consumers choose these plans when they are employed on a part-time or temporary basis when they are in between permanent positions. The average member is enrolled for less than six months, and these type plans give them the flexibility they need during that time. For many such workers, a plan with limited benefits is the only affordable option for them and their families. They are not eligible for comprehensive health coverage subsidized by their employers and may be unable or unwilling to pay the high premiums for individual insurance coverage. One of the commenters stated that given nationwide enrollment figures in limited benefit plans, it can attest that consumers find real value in these plans that offer low premiums, access to network providers and coverage for basic health care needs and preventive care with low deductibles. The commenter stated that requiring it to amend its limited benefit plan to comply with these rules is not a viable option, and it estimated that doing so would result in an average premium increase in the range of 500 percent. For a basic medical plan whose premium on average is about $22.00 per week, that takes the plan out of the range of affordability for many consumers. Without these types of policies, many will go uninsured and will be subject to pre-existing condition limitation periods under subsequent plans.

One commenter requested that the Department clarify the meaning of "internal limits" at N.J.A.C. 11:22-5.7(b). The commenter questioned whether that subsection intended to require, for example, that if a carrier currently has a plan with a 365-inpatient-day limit for in-network services and a 70-inpatient-day limit for out-of-network services, the carrier must reduce the in-network patient day limit to 70 days

or increase the out-of-network inpatient day limit to 365 days. The commenter additionally requested that the Department provide some examples that provide guidance on the intent of this subsection.

RESPONSE: The Department thanks the first commenter for its support, but notes that N.J.A.C. 11:22-5.7(a)1 prohibits network hospital inpatient and outpatient aggregated annual dollar maximums. It does not prohibit such maximums on out-of-network services.

With respect to college students, the Department notes that group student plans are excepted from N.J.A.C. 11:22-5.7(a)6. The Department further notes that group student plans use an arsenal of other mechanisms to reduce benefits, including per accident and per sickness dollar caps, requirements to use the student health center, always excess provisions and a host of internal limits. Allowing excessive cost sharing in student plans is particularly problematic since students have little or no means to pay cost sharing charges. Finally, the Department notes that student plans with high cost sharing and multiple benefit limits would not qualify as plans that provide basic hospital coverage as required by New Jersey's Public Higher Education statute at N.J.S.A. 18A:62-15a. Such plans would be inconsistent with the Department's definition of "basic hospital expense coverage" at N.J.A.C. 11:4-16.6(d) as a health insurance policy that provides coverage for a period of not less than 31 days for one period of hospital confinement, including daily room and board at 80 percent coinsurance, and would further be inconsistent with the standards for the Individual Health Coverage Program (IHC) "Basic and Essential" plan established pursuant to N.J.S.A. 17B:27A-4.5 mandating coverage of no less than 90 days hospital room and board subject to a $500.00 copay per confinement. With respect to part-time and temporary employees, there is no reason such individuals should be subject to plans with benefit limits so low as to render the benefits illusory. The Department notes that in the reproposal it invited commenters to suggest alternative limits, but no such suggestions were received.

Regarding the comment seeking clarification of internal limits, the Department notes that a day limit on hospital admissions is an internal limit. However, the Department is declining to adopt N.J.A.C. 11:22-5.7(b) so as to avoid the potential for the provision to be construed as authorizing a reduction in in-network benefits, which would be contrary to the Department's expressed intent to protect a covered person's access to meaningful healthcare benefits.

7. COMMENT: One commenter expressed its appreciation for the Department's effort to provide greater clarity and flexibility with respect to the minimum standard for in-network benefits, especially by addressing cost-sharing based on "average" cost-sharing as applied to "a class of similar services" (N.J.A.C. 11:22-5.10(a)1 and adding N.J.A.C. 11:22-5.10(a)2 to clarify that carriers can protect covered persons by limiting network providers' fee levels for services not covered under the plan without the inclusion of those services in the minimum benefit calculation (thereby giving carriers the opportunity to provide cost savings to their covered persons without requiring the payment of additional dental benefits which would increase the cost of the coverage). The commenter additionally appreciated the Department's clarification in its Response to Comment 19 submitted on the original proposal that the proposed regulation will not control the impact of common dental coverage terms such as annual maximum benefit amounts and lifetime maximum benefit amounts, as well as frequency limitations and the like or apply to benefits which are provided on a group contract basis and which specify a dollar ceiling on the amount to be benefited or paid for a specific service.

RESPONSE: The Department thanks the commenter.

8. COMMENT: One commenter suggested that if these rules are adopted, they apply only to plans issued after the effective date and exclude renewals. Also considering the magnitude of the changes, the commenter further requested that the implementation date be no sooner than 18 months following the date of adoption.

RESPONSE: The Department does not intend to exclude renewals because renewals are not excluded from complying with the requirements of any statute or regulation. Moreover, the Department believes that an implementation date one year after adoption of the rules gives carriers sufficient time to comply. Taking into consideration that these rules may not be adopted by July 1, 2009, the Department is delaying the operative date for one year and revising N.J.A.C. 11:22-5.11 to indicate that non-compliant previously filed forms will be deemed withdrawn one year after the effective date of the rules and may not thereafter be available for new issue or renewal. .

9. COMMENT: Two commenters supported the Department's suggestion made in its responses to the comments submitted on the original proposal that carriers could consider ameliorating the

administrative burdens borne by participating providers and/or increasing compensation rates paid to in-network providers to ensure that the rules do not incentivize providers to leave networks. The commenters additionally acknowledged the flexibility allotted to carriers to modify the design of out-of-network benefits, which is also outlined in the Department's responses to comments on the original proposal. The combined benefit of these recommended improvements to in-network contracts could improve the number of participating providers within the carriers' networks, ultimately increasing access to services for the community.

RESPONSE: The Department thanks the commenter.

10. COMMENT: One commenter stated that the reproposal's Economic Impact Statement does not address the economic impact on employers, which will be significant. The commenter stated that many plan designs currently in force that do not conform to the standards proposed will have to be revised. In responding to comments from the prior proposal, the Department said this concern "is greatly exaggerated because plans with cost sharing in excess of the levels proposed have not been approved by this Department." The commenter stated that this statement disregards the extent to which the new requirements would alter plans that have been approved. The commenter provided the following examples: (1) services that today would be subject to specialist copayments that are not provided by physicians would now be subject to the requirement that the carrier insures "50 percent or more of the aggregate risk for the service or supply to which the copayment is applied." The commenter added that the Department clarifies this in comments to equate to the lowest network rate. Various therapy services may currently be covered with specialist copayments that would not meet this test; (2) many older non-network-based plans include lifetime maxima below the $5 million proposal; (3) many inforce plan designs include different day and visit limits for certain services between in-and-out-of-network; and (4) there is currently no prohibition on coinsurance applying to services for which copayments also apply.

The commenter goes on to say that employers in these plan designs will be forced to conform their plans to the requirements of the regulation upon renewal, and can expect to pay higher premiums. Going forward, employers will be foreclosed from selecting these lower cost options, which will keep the cost of their coverage higher. By imposing fixed cost-sharing maxima, medical inflation can be expected

to further increase the economic burden on employers who will not have the option of sharing these increases with their employees. They may instead opt to eliminate benefits that are not mandated (for example, by excluding services for these non-physician specialists altogether except where required by law).

RESPONSE: Regarding the first comment, the Department explained in its Response to Comment 4 above that the reference to aggregate risk implies an averaging of the cost of all services to which the copay applies and does not require that the copay be 50 percent or less of the contract rate for every service rendered by a network provider. As far as the commenter's second concern that many older non-network-based plans include lifetime maxima below the $5 million proposal, the Department does not believe that there are many older non-network-based plans that are non-compliant given the migration to network based plans. However, the Department acknowledges that such plans, to the extent they exist, will be required to comply on renewal. Regarding different day and visit limits for certain services between in- and out-of-network, the Department has omitted the requirement that internal limits be the same for in-network and out-of-network services. Finally, the Department acknowledges that there is currently no prohibition on multiple forms of cost-sharing being applied to the same in-network services. Consequently, these new rules are being adopted as a necessary consumer protection.

As the Department previously stated in response to a similar comment received on the original proposal regarding higher employer costs, the Department believes there is a level at which low benefit plans provide illusory benefits that mislead consumers and has in these rules attempted to define that level. The Department notes that it invited commenters to suggest alternate benefit and cost sharing limits in the reproposal, but none were offered.

11. COMMENT: Two commenters stated their concern that the reproposed rules seek to limit plan designs with greater cost-sharing, which are the plan designs consumers are demanding. According to the commenters, limiting the flexibility and plan design options available to purchasers would decrease access to affordable health care benefits. The commenters further stated that the proposed limitations on cost-sharing options would serve to further shield consumers from the true cost of health care. As a

result, some aspects of the rules thwart marketplace demand and are a step in the wrong direction. One commenter added that the Department stated that it wanted to make sure benefits were not "illusory" or that they were "meaningful" compared to the cost of the services. According to the commenter, these rules just relate to the payment of benefits under an insurance contract and, unfortunately, do nothing to protect consumers, premium payers, and carriers from abusive charging practices by some out-of-network providers. The commenter stated that it has documentation of many, many cases of abusive charging practices, especially from ambulatory surgical centers. By way of example, the commenter stated that a New Jersey facility charged $181,510 for a service for which the Medicare allowance is $7,805. The commenter questioned how an "illusory benefit" is measured when an out-of-network provider charges 23 times what Medicare would pay.

RESPONSE: The Department understands the problem faced by carriers when out-of-network providers bill excessive charges, but the Department has no authority to control the fees billed by health care providers. The Department notes that restricting the benefits provided for network services would not be an appropriate response to this issue. Rather, the rules as adopted do not prohibit internal limits, including dollar benefit caps, for specific out-of-network services and do not dictate how the allowable charge for all or specific out of network services is calculated. The Department believes that carriers have sufficient flexibility in benefit design to address this problem.

13. COMMENT: One commenter requested clarification regarding how the standards established in the reproposed rules would apply to out-of-network plans, and how these measures would apply in emergency care situations if a patient is given medical care by a non-network provider.

RESPONSE: The reproposed rules do not change the current rules regarding emergency care. The Department does not understand the commenter's reference to out-of-network plans.

Federal Standards Statement

A Federal standards analysis is not required because the Department's adopted amendments and 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 HEALTH BENEFIT PLANS, PRESCRIPTION DRUG PLANS AND DENTAL 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:

"Family network out-of-pocket limit" means the maximum dollar amount that a family shall pay in combination as copayment, deductible and coinsurance for network covered services and supplies in a calendar ***, contract or policy*** year.

"Individual network out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar ***, contract or policy*** year.

"Individual out-of-network out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and coinsurance for out-of-network covered services and supplies in a calendar ***, contract or policy*** year.

Primary care provider" means a participating physician or other health care professional who is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which the services are furnished and who supervises, coordinates and maintains continuity of care for covered persons. Primary care providers include nurse practitioners/clinical nurse specialists, physician assistants and certified nurse midwives who satisfy the requirements of N.J.A.C. 11:24-6.2(c)1 through 3.

11:22-5.5 Network copayment

(a) Network copayments in health benefit plans and stand-alone prescription drug plans may not exceed the following amounts:

1. (No change from proposal.)

2. Primary care ***[**physician**]*** ***<u>provider</u>*** office visit, $50.00;

3. – 11. (No change from proposal.)

11:22-5.7 Benefit maximums in health benefit plans

(a) (No change from proposal.)

[**(b) Internal limits in health benefit plans, including, but not limited to, dollar, visit or day limits imposed on coverage for specific services or supplies, shall be the same for services and supplies delivered by network and out-of-network providers.**]

11:22-5.11 Effect on previously approved forms

Any form that was previously filed with and approved by the Commissioner, but does not meet the requirements of this subchapter, shall be deemed withdrawn as of ***[**July 1, 1010**]*** ***<u>September 8, 2010</u>*** and may not be made available for new issue or for renewal on or after that date.

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