

INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Qualifications of Standard Health benefits Plans as High Deductible Plans
Proposed Amendments: N.J.A.C. 11:20-3.1, 11:20-12.5 and 11:20 Appendix Exhibits C, D and T.

Authorized By: New Jersey Individual Health Coverage Program Board, Wardell Sanders, Executive Director.

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

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

Proposal Number: PRN 2005-

A **public hearing** on the proposed changes to the specimen policy form will be held on April 6, 2005 at 10:30 a.m. at the following location:

11th floor conference room
Mary Roebling Building
20 West State Street
Trenton, NJ

Please call the IHC Board at 609.633.1882 x50302 prior to the hearing date if you wish to be included on the list of speakers.

Submit written comments by April 11, 2005 to:

Ellen DeRosa
Deputy Executive Director
New Jersey Individual Health Coverage Program
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Trenton, New Jersey 08625
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The agency proposal follows:

Summary

Section 1202 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-175, added section 223 to the Internal Revenue Code. The law permits eligible individuals to establish Health Savings Accounts (HSAs) as of January 1, 2004. HSAs are trusts or custodial accounts, owned by individuals, that receive tax-favored contributions that may be accumulated over the years or distributed on a tax-free basis to pay or reimburse qualifying medical expenses. To be eligible to establish a HSA, an individual must be enrolled in a high deductible health plan (HDHP), must not be covered by another HDHP (with certain exceptions for plans providing limited coverage), must not be entitled to Medicare benefits, and may not be claimed as a dependent on another person's tax return.

Under the Internal Revenue Code, a HDHP is defined as a health insurance plan that has an annual deductible of at least \$1,000 and an annual out-of-pocket limit of not more than \$5,100 for individual coverage. For family coverage, a HDHP must have an annual deductible of at least \$2,000 and an annual out-of-pocket limit of not more than \$10,200. Such amounts are subject to cost-of-living adjustments. A HDHP may exempt certain preventive care from the deductible but may not provide benefits in any year for any non-preventive care until the deductible for that year is satisfied. 26 U.S.C. §223(c)(2).

New Jersey law requires that treatment of lead poisoned children be covered in health benefits plans without application of deductible in all plans. See P.L. 1995. c. 316, codified for the individual market at N.J.S.A. 17B:27A-7e(1). Under Federal law, a HDHP may only exempt preventive care from application of deductible. However, Treasury Notice 2004-43, published by the Internal Revenue Service on July 6, 2004, provides that HDHPs that exempt non-preventive care from deductible because of state mandated benefit laws will still be treated as qualifying under section 223(c)(2) and that eligible individuals covered under such plans may

contribute to a HSA through December 31, 2005. States are therefore being provided with a transition period lasting until December 31, 2005 to modify their mandated benefits laws so that a deductible applies to non-preventive care. Accordingly, New Jersey's lead treatment mandate currently is not a bar to the establishment of HSAs but must be modified by January 1, 2006, if HSAs are to continue to be made available after that date.

Currently, none of the standard plans in the individual health coverage (IHC) market qualify as a HDHP, and the IHC law does not permit a carrier to file an optional benefit rider to modify a standard plan. In light of the recent Treasury Notice providing transitional relief as described above, the IHC Board is proposing amendments to the standard plans that will permit them to qualify as HDHPs.

Recognizing that the minimum deductible amount and maximum deductible amount for which tax advantages are available are subject to change each year, the Board is proposing a minimum deductible amount of \$1,200, an amount that slightly exceeds the minimum permitted for 2005 under section 223 of the Internal Revenue Code. The proposed rules provide that at the point when the \$1,200 amount is below the minimum to qualify as a high deductible health plan under section 223 of the Internal Revenue Code, the deductible amount will automatically be adjusted to coincide with the minimum amount. Similarly, the Board is proposing a deductible that is slightly larger than the maximum amount for which an individual or family deduction is currently permitted. These higher amounts will allow a consumer to take full advantage of the permissible tax deduction without carriers possibly having to amend the deductible amount immediately upon an adjustment in January 2006, and will automatically adjust upward when the Internal Revenue Code permits a deduction for an amount greater than \$1,200. To accommodate a consumer who may like a deductible somewhere between the lowest and highest, the Board is proposing a \$2,000 single deductible and \$4,000 other than single deductible. To accommodate

consumers who wish to take full advantage of the permissible tax deduction and who also want to take advantage of the rates associated with a larger deductible, the Board is proposing a \$5,000 single deductible and a \$10,000 other than single deductible. The Board is proposing maximum out of pocket amounts equal to the maximum permitted, and such amounts will automatically increase as the amounts are increased.

The Board proposes to amend N.J.A.C. 11:20-3.1(b) to specify single and other than single deductible amounts and out of pocket amounts that would satisfy the requirements for a HDHP. The Board proposes to amend the Schedule of Benefits page and the Benefit Deductibles, Copayments and Coinsurance provision of Plans C and D, as they appear in Appendix Exhibits C and D of N.J.A.C. 11:20, to address both the dollar amounts of the deductible as well as the method in which the other than single deductible is accumulated, and the calculation of the out of pocket maximum. The Explanation of Brackets, as set forth at Appendix T of N.J.A.C. 11:20, is being amended to accommodate the variable text being added to Plans C and D.

This proposal is similar to PRN-2005-46, published at 37 N.J.R. 415 (a) which the Board did not adopt. The prior proposal featured limited deductible options for use with high deductible health plans. The Board reconsidered its prior decision which would have limited deductibles to the lowest and highest deductible amounts permitted to qualify as a high deductible health plan and determined that such limits were too restrictive and may not have been adequate to respond to consumer requests for plans that would maximize tax advantages for persons in various circumstances. Accordingly, the IHC Board is proposing low, mid-point, and high deductible amounts that bear a relationship to permissible range of amounts for which tax advantages are afforded. In addition, the Board is proposing a higher deductible amount to accommodate consumers who seek tax advantages as well as premium relief afforded by high

deductible amounts. In addition, the IHC Board recognized that prior proposal did not make allowances for persons already covered under individual plans who may wish to purchase a high deductible health plan. Therefore, the current proposal proposes a change to N.J.A.C. 11:20-12.5 such that consumers currently covered under an individual plan will not be barred from purchasing a high deductible health plan. The Board received oral and written comments on that proposal. The comments and the Board's responses are set forth below.

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Individual Health Coverage ("IHC") Program Board held a public hearing on January 18, 2005 to receive oral testimony with respect to proposed amendments to the standard health benefit plans set forth at Appendix Exhibits C and D. Wardell Sanders, the executive director of the IHC Board, served as hearing officer.

One person James Stenger, provided oral testimony on behalf of the National Association of Health Underwriters and the New Jersey Association of Health Underwriters. Mr. Stenger testified in favor of the IHC Board's rule proposal, calling the amendments "excellent public policy." He testified that the Association of Health Underwriters strongly supported creating options for high deductible health plans for use with Health Savings Accounts.

The record of the public hearing may be reviewed by contacting Wardell Sanders, executive director, IHC Board, PO Box 325, Trenton, NJ 08625-0325. The hearing officer made no recommendations to the IHC Board as a result of the oral comments given during the public hearing or as part of a review of the proposal.

Summary of Public Comments and Agency Responses:

Written comments were received from Oxford Health Plans, Inc.

COMMENT 1: The commenter asked if carriers will be required to grandfather the high deductible health plans when new plans are published later in 2005? The commenter noted that if the answer were yes, it would create administrative and operational issues for carriers.

RESPONSE: The commenter correctly notes that the Individual Health Coverage Program Board is working on a comprehensive set of amendments to all of the standard plans. However the Board has not yet proposed the amendments. Adoption of those comprehensive rules will follow a comment period, and the operative date for the changes will be some designated date following the adoption. The amendments to the standard plans are not likely going to be effective until 2006.

Currently, carriers are prohibited by the IHC Board's regulations from offering a high deductible health plan that would qualify for use with a Health Savings Account. The purpose of this proposal was to act to remove that regulatory barrier so that insurance carriers have the option to offer such a plan. The commenter is correct that carriers using the high deductible plans as permitted in this proposal will be required to maintain such plans until the first anniversary on or after the operative date of the plans, as amended. While that may pose some administrative or operational challenges, the Board believes that carriers that wish to make high deductible plans available will be able to administer both the initial plans as well as the amended plans the carrier may elect to make available.

COMMENT 2: The commenter asked if the interim plans provide the "necessary modifications regarding lead screening"? The commenter also asked if the plans published later this year would have the necessary changes to lead treatment.

RESPONSE: New Jersey law requires that treatment of lead poisoned children be covered in health benefits plans without application of deductible in all plans. See P.L. 1995. c. 316, codified for the individual market at N.J.S.A. 17B:27A-7e(1). That State law has not been

repealed or amended, and so all individual health benefits plans must continue to meet that requirement. As noted in PRN-2005-46, Treasury Notice 2004-43, published by the Internal Revenue Service on July 6, 2004, provides that HDHPs that exempt non-preventive care from deductible because of state mandated benefit laws will still be treated as qualifying under section 223(c)(2) and that eligible individuals covered under such plans may contribute to a HSA through December 31, 2005. Thus, modifications to the plans for lead treatment are not necessary for calendar year 2005 in order to qualify for the tax advantages under federal law, nor are the modifications suggested by the commenter permitted at this time under State law.

With respect to the Board's further consideration of amendments to the standard plans, the Board will be required to follow any applicable State laws. If State law continues to require first dollar coverage for lead treatment in all individual health benefits plans, the Board will include such benefits.

If New Jersey law is amended with respect to the coverage required for the treatment of lead poisoned children, all plans would be required to comply with the requirements of the law as of the effective date for any such law. It is possible that would require a carrier to amend both the initial high deductible plan as well as any of the amended plans the carrier elected to offer.

COMMENT 3: The commenter asked who would be able to purchase the high deductible health plan proposed outside of the open enrollment period in the individual market, which currently is October of every year.

RESPONSE: The IHC Board has promulgated rules, set forth at N.J.A. C. 11:20-12.1 through –12.6, which limit the purchase of individual health benefits plans under certain conditions. These rules do not apply to a person without health coverage. For an individual who already has coverage, the restrictions are designed to limit the ability of an individual to purchase a plan of greater actuarial value outside of the October open enrollment period. The existing regulation thus supports limitations on the purchase of a high deductible health plan by a person who has a plan of lesser actuarial value, unless the purchase occurs during the open enrollment period. As result of this comment, the Board is proposing in this proposal a relaxation of the rule to allow a consumer to purchase a high deductible health plan of greater actuarial value within 60 days of the date a carrier makes such plan available. This 60-day period will be in addition to the annual open enrollment period.

COMMENT 4: The commenter asked what would happen if a person switched from one individual health benefits plan to a high deductible health plan as proposed if the person had already incurred medical expenses for 2005? Would a carrier be required to offer a deductible credit? The commenter further inquired as to what credits would be available under the high deductible health plan if a member had a PPO plan with a copayment?

RESPONSE: All of the standard plans provide that a person shall receive credit for any deductible amounts satisfied under previous coverage within the same calendar year that the person starts a new policy, provided there has been no lapse in coverage between the previous coverage and new policy. That same rule will apply to people that purchase coverage under the high deductible health benefits plans. Also, as with any other plan, there is no coinsurance credit from the previous coverage. Similarly, there is no credit for copayments paid under previous coverage.

COMMENT 5: The commenter asked when the high deductible health plan for use with a HSA would be effective. The commenter noted that even assuming a quick effective date, a consumer would not receive the benefit of a twelve-month calendar period.

RESPONSE: Since the Board is using its rulemaking authority specified in N.J.S.A. 17B:27A-16.1, the regulations can be effective as early as the date the Board votes to adopt the proposed changes which can occur after the close of the 20-day comment period. The amendments to the standard plans would thus be available to carriers immediately. Any carrier that wishes to make high deductible plans available could begin to offer them as quickly as the carrier makes the necessary rate filing pursuant to N.J.A.C. 11:20-6, adds the necessary plan option text to the standard HINT application, and prepares the necessary issue documents to be able to issue policy forms with the amended text, along with any marketing materials the carrier may wish to use. How quickly the high deductible plans may become available to consumers will be up to the decisions of the carriers in the individual market. While consumers would not realize the tax advantages of a full year of participation in a high deductible plan and an HSA, there would be tax advantages for the portion of the year during which high deductible plan and HSA would be in effect.

IHC Rulemaking Procedures

The IHC Board proposes these amendments pursuant to the procedures set forth in N.J.S.A. 17B:27A-16.1, which provide a special procedure whereby the IHC Board may adopt certain actions. Pursuant to this procedure, the Board is required to publish notice of its intended action in three newspapers of general circulation, which notice shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views regarding the intended action. Notice of the intended action also is required to be sent to affected trade and professional associations, carriers, and

other interested persons who may request such notice. Concurrently, the Board is required to forward the notice of the intended action to the Office of Administrative Law (OAL) for publication in the New Jersey Register. The Board must provide a minimum 20-day period for all interested persons to submit their written comments on the intended action to the Board.

Pursuant to N.J.S.A. 17B:27A-16.1, the Board may adopt its intended action immediately upon the close of the specified comment period by submitting the adopted action to the OAL. If the Board elects to adopt the action immediately upon the close of the comment period, it shall nevertheless respond to the comments timely submitted within a reasonable period of time thereafter. The Board shall prepare a report for public distribution, and publication by the OAL in the New Jersey Register. The report shall include a list of commenters, their relevant comments, and the Board's responses.

Pursuant to N.J.S.A. 17B:27A-16.1, all actions adopted by the Board are subject to the requirements of this special rulemaking procedure notwithstanding the provisions of the Administrative Procedure Act. As a result, the quarterly calendar requirement set forth at N.J.A.C. 1:30-3.1 is not applicable when the Board uses its special rulemaking procedures.

Please note that the unique provisions of N.J.S.A. 17B:27A-16.1 will result in the publication of this rule proposal in the New Jersey Register after the comment period has concluded.

Social Impact

The proposed amendments may encourage more people to move to high deductible plan options because of the tax saving possibilities, and may encourage some consumers to purchase individual plans that are not currently in the market. Proponents of HSAs believe that the accounts help contain costs by creating financial incentives to avoid inappropriate or over-utilization of services. Opponents of HSAs and high deductible plans believe that cost-shifting

may result in less care or delays in appropriate and needed care that would ultimately result in poorer health outcomes and even higher costs.

Because lower cost sharing plans have not proven to be sustainable in the individual health insurance market, the IHC Board has already promulgated a number of high deductible plan options in order to have plans with more reasonable premiums. The proposed amendments, in effect, simply allow New Jersey consumers that can afford to fund an HSA a tax advantage, perhaps making the coverage more affordable and thus covering more New Jersey residents in this market.

Economic Impact

The IHC Board anticipates that the proposed amendments will have an economic impact on persons eligible for individual coverage who are also eligible for an HSA. The amount contributed to the HSA is not taxed and interest earned thereon is not taxed. Contributions to an HSA can be deducted from a person's income even when a person does not itemize; this is often called an "above-the-line deduction." Currently, an individual deduction of up to \$2,650 and a family deduction of up to \$5,250 are permitted.

The proposed amendments may have an impact on a carrier that chooses to make such a product available. For carriers seeking an exemption from loss assessments, any additional non-group enrollment generated by this plan option will reduce the carrier's assessment liability.

Federal Standards Statement

The standard individual health benefits plans comply with the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191. The standard plans, and the rules describing the standard plans, including these proposed amendments, do not expand upon the requirements set forth in the Federal law.

Jobs Impact

The proposed amendments are not expected to result in the generation or loss of jobs in the State if they were to take effect.

Agriculture Industry Impact

The proposed amendments have no impact on the agriculture industry.

Regulatory Flexibility Analysis

The Board believes that all carriers subject to these rules have in excess of 100 employees or are located outside of the State of New Jersey. Therefore, a regulatory flexibility analysis is not required. However, to the extent that any carrier might be considered a small business under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the following analysis applies.

The proposed amendments are optional. Only carriers wishing to make a HDHP available are required to do so. The changes herein merely provide the appropriate contractual language.

Smart Growth Impact Statement

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

Full text of the proposed amendment to N.J.A.C. 11:20-3.1 and 11:20-12.5 follows (additions indicated in boldface thus; deletion indicated in brackets [thus]):

11:20-3.1 The standard health benefits plans

(a) (No change)

(b) In accordance with [N.J.A.C. 11:20-1.3](#), members that offer individual health benefits plans in this State shall offer standard health benefits Plans A/50, B, C, and D as set forth in Exhibits U, and B through D, respectively, with variable text as specified on the Explanation of Brackets, Exhibit T, in the Appendix.

1. – 2. (No change):

3. Members offering Plans C and D may offer those plans, on a guaranteed issue basis, with **[either or both of]** the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:

i. – ii. (No change)

iii. in the case of single coverage, the greater of: \$1,200; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code Section 223 for the calendar year in which coverage is issued or renewed, per covered person; and in the case of other than single coverage, the greater of: \$2,400; or the lowest deductible amount to qualify as a High Deductible Health Plan under Internal Revenue Code Section 223 for the calendar year in which coverage is issued or renewed, per covered per covered family;

iv. in the case of single coverage, \$2,000, and in the case of other than single coverage, \$4,000;

v. in the case of single coverage, \$2,800 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code Section 223(b)(2)(A) are permitted, per covered person; and in the case of other than single coverage, \$5,600 or the highest deductible amount for the calendar year in which coverage is issued or renewed for which deductions under Internal Revenue Code Section 223(b)(2)(A) are permitted.

vi. in the case of single coverage, \$5,000, and in the case of other than single coverage, \$10,000;

4. (No change)

(c)-(e) no change.

11:20-12.5 Selection of a standard health benefits plan or a basic and essential health care services plan by a person covered by an individual health benefits plan

(a) – (h) no change

(i) A person who is covered under a standard health benefits plan who wishes to purchase a high deductible health plan as permitted by N.J.A.C. 11:20-3.1(b)3 iii, iv or v who would be required by (a) through (h) above to wait until the open enrollment period to replace the existing coverage may purchase a high deductible plan within 60 days of the date such plan is first offered by a carrier.

Date: _____

Wardell Sanders, Executive Director