INSURANCE

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Readoption with Amendments: N.J.A.C. 11:21-1 through 3, 4 through 7, 8, 10, 17, 18, 23 and 11:21 Appendix Exhibits A, D, F, G, H, K, N, O, T, V, W, Y, BB Parts 1, 2 and 6, CC, DD, HH, II and KK

Adopted Repeal: N.J.A.C. 11:21-4.3

Proposed: November 18, 2008 (published at 41 N.J.R. 84(a) on January 5, 2009)

Adopted: August 18, 2009 by the New Jersey Small Employer Health Benefits Program Board, Ellen DeRosa, Executive Director.

Filed: August 18, 2009 as R. 2009 d. 278 with substantive and technical changes not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3) and with portions of the proposed amendments to N.J.A.C. 11:21-7.13(a) not adopted at this time, but still pending..

Authority: N.J.S.A. 17B:27A-17 et seq., P.L. 2007, c. 345 and P.L. 2008, c. 38.

Effective Date: August 18, 2009

Operative Date: April 1, 2010 as to the amendments to Appendix Exhibits A, F, G, V, W, Y, HH and II

Expiration Date: August 18, 2014.

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Small Employer Health Benefits (SEH) Program Board held a hearing on Wednesday, December 17, 2008 at 9:30 A.M. at the Department of Banking and Insurance, Conference Room 220, 20 West State Street, Trenton, New Jersey to receive testimony with respect to the proposed amendments to the standard health benefits plans set forth in N.J.A.C. 11:21 as Appendix Exhibits A, F, G, H, N, O, T, V,

W, Y, DD, HH and II. Rosaria Lenox, Program Accountant of the SEH Program Board, served as hearing officer. No testimony was provided during the hearing. The hearing officer made no recommendations regarding the proposed amendments. The hearing record may be reviewed by contacting Ellen DeRosa, Executive Director, New Jersey Small Employer Health Benefits Program Board, P.O. Box 325, Trenton, NJ 08625-0325.

Summary of Public Comments and Agency Responses:

Written comments were received from: The New Jersey Hospital Association; Bayonne Medical Center; CentraState Healthcare System; Chilton Memorial Hospital; Newton Memorial Hospital; Robert Wood Johnson University Hospital Rahway; The Valley Hospital; Warren Hospital; MONOC New Jersey's Hospital Service Corporation; the Medical Society of New Jersey; Lamph, Lipkind, Prupis & Petigrow, with no client referenced; Wolf Block LLP on behalf of the Radiological Society of New Jersey; WolfBlock LLP on behalf of the following clients: the Alliance for Quality Care; the New Jersey Academy of Ophthalmology; the New Jersey Association of Osteopathic Physicians & Surgeons; the New Jersey Interventional Pain Society; the New Jersey State Society of Anesthesiologists and the Orthopaedic Surgeons of New Jersey; WolfBlock LLP on behalf of the New Jersey Association of Ambulatory Surgery Centers; Frank Ruggiero; AmeriHealth Insurance Company; and United Healthcare.

The SEH Board is not adopting all of the amendments that were proposed to N.J.A.C. 11:21-13 Paying Benefits at this time to allow more time to evaluate the impact of such proposed amendments. N.J.A.C. 11:21-13(a) addresses the payment of benefits for

services rendered by a provider who is not subject to a capitated or a negotiated arrangement, that is, a non-network provider. The rule specifies the Prevailing Healthcare Charges System profile for New Jersey as the standard to be used to determine the allowed charge. N.J.A.C. 11:21-7.13 (b) was proposed as new text to address the requirements of P.L. 2007, c. 345. The SEH Board proposed several amendments to N.J.A.C. 11:21-7.13. One amendment was to address the requirements of P.L. 2007, c. 345, and appears as both an introductory clause in subsection (a) and in the entire text of subsection (b). That amendment is being adopted. A second amendment was to replace the term "reasonable and customary" with the new term "allowed charge" in subsection (a), consistent with the amendment proposed in the definition section of the rules, N.J.A.C. 11:21-1.2. That amendment is being adopted. A third amendment to subsection (a) addresses which non-network providers are subject to payment using either allowed charges or actual charges. The rule text at the time of this proposal text limited application of this requirement to providers of medical services and expressly stated that hospital services were to be paid based on actual charges. The SEH Board proposed eliminating the differentiation between medical services and hospital services with the result being that all non-network services would be paid using either allowed charges or actual charges. That amendment is not being adopted at this time in order to allow the SEH Board additional time to evaluate the impact of the proposed amendment. As the SEH Board continues to evaluate the proposed amendment, the text in N.J.A.C. 11:21-7.13(a) regarding payments for non-network medical services and hospital services requires that medical services be paid using either allowed charges or actual charges and

that hospital services be paid based on actual charges, as was the case prior to the SEH Board's proposed amendment.

COMMENT 1: Three commenters contend that "the change from 'reasonable and customary' to 'allowed charge' at 11:21-7.13 is not benign and will have far greater consequences than the SEH board acknowledges." The commenters note that reasonable and customary reflects fair and reasonable reimbursement whereas allowed charge identifies a maximum reimbursement. Additionally, the commenters noted that neither P.L. 2008, c. 38 nor P.L. 2007, c. 345 required the Board to make the change and thus the commenter contends there is no authority for the Board to make the change.

RESPONSE: The SEH Board appreciates that the terms "reasonable and customary" and "allowed charge" have different connotations. The SEH Board disagrees that changing the defined term has consequences given that both reasonable and customary and allowed charge require the use of the PHCS data to determine the amount. Whether the term is called reasonable and customary or it is called allowed charge, the resulting amount is the same and is used to establish the maximum amount the carrier is responsible to pay for a service or supply.

Regarding the authority for the change, the commenters only referenced two of the laws specified under the Authority section of the proposal. The first statute cited is N.J.S.A. 17B:27A-17 et seq which gives the SEH Board not just the authority but the responsibility to establish the standard plans and the benefits contained therein. The standards for reimbursement are inherent in such authority.

COMMENT 2: Four commenters objected to the use of Ingenix data bases as a method of determining reimbursement to providers. The commenters cited examples of

settlements and fines associated with the use of the Ingenix databases and contend the data does not reflect the usual and customary rate of providers and should not be used. The commenters contend that hospitals should be able to bill and be paid the billed charge because carriers have authorized use of a non-network hospital and the commenters further contend non-network hospitals may be chosen because a network hospital may not be available for the services that the patient requires.

RESPONSE: The expectation expressed in these comments, that the benefit is supposed to be the "usual and customary rate" of providers would be addressed by revising the terminology from "reasonable and customary" to "allowed charge," as the SEH Board proposed. The SEH Board is aware of the recent settlements but does not believe that the settlements require carriers to immediately terminate use of the Ingenix databases. Rather, the settlements require development of a new database, after which carriers subject to the settlement agreements have agreed to cease using the Ingenix database and begin using the new one.

Specifically, item 28 of the Assurance of Discontinuance Under Executive Law §63(15) In the Matter of United Health Group Incorporated states the following:

> "The OAG will notify the Company when the New Database is available for use by the Company. Within sixty (60) days of such notification ("the Notification date"), the Company shall cease operating and using the Ingenix databases to determine reimbursement rates and shall further cease making data or rate information from the Ingenix databases available to other health insurers as a tool for determining reimbursement rates, irrespective of any disclaimer by Ingenix. Also within sixty (60) days of the notification date, unless excused by the OAG, the Company shall use the new database in determining reimbursement rates for a period of five years, and shall not own, operate, or fund any other database product that provides data pooled from more than one insurer to other health insurers for determining reimbursement rates."

Thus, the settlement agreement with United Health Group Incorporated neither contemplates nor requires the immediate discontinuance of the use of the Ingenix database.

The SEH Board recognizes that many of the plans available in the small employer market allow members the opportunity to access services from either network or non-network providers. Particularly as regards inpatient hospital care, the carriers require such care to be pre-authorized. Such pre-authorization is intended solely to determine that the person is covered under a plan that covers the requested services and that the services are medically necessary and appropriate. Pre-authorization does not address reimbursement for services and should not be viewed as any type of commitment as to the amount the carrier will pay for the services. With respect to the choice of a non-network provider because a network provider is not available, the SEH Board notes that managed care carriers have procedures in place that would allow a member to request an out of plan exception if the member wishes to use a network provider but none are available. When such an exception is made, members are provided benefits as if the member had accessed a network provider, meaning the member cannot be held liable for balance billing of excess charges. In some instances, this may result in a carrier paying billed charges to assure that the member is held harmless from any amount above the network level cost sharing. However, when a member chooses to use a non-network provider, even when a network provider is available, assuming the member is covered under a plan that provides non-network benefits, the carrier will pay benefits consistent with the non-network provisions of the plan. Such non-network provisions generally require greater cost sharing, and in addition, the allowed charge may be less than the

billed charge resulting in the member being billed for the difference between what the carrier as well as the member paid and the billed charge. When a consumer is considering using a non-network provider, the financial component is one of the factors that should be considered.

No change is being made in response to this comment.

COMMENT 3: Three commenters contend that non-network benefits will be virtually meaningless because consumers will be responsible for a larger portion of the bill that was previously paid by the carrier. The commenters also contend the proposal could result in a fewer number of physicians because the insurance reimbursement will be reduced and noted this was the consequence for Medicaid. The commenters went on to say that if hospital physician charges are affected by the proposal then hospitals might be asked to pay the physicians to provide the hospital services which would be a burden for the hospitals.

RESPONSE: The Department of Banking and Insurance rules governing network and non- network benefits found at NJAC 11:22-5.6 contain protections to assure that non-network benefits are meaningful. The small employer plans are subject to such regulations. The commenters' contention that any benefit less than a benefit equal to the actual charges somehow renders such lesser benefit meaningless fails to recognize the fact that managed care plans with non-network benefits are intended to give consumers the opportunity to choose either a network or a non-network provider. Nowhere is there an express or implied promise that the choice to use non-network benefits will result in no financial exposure. Quite the contrary is the case. The plans expressly advise consumers that there is generally greater out of pocket exposure associated with the use

of non-network providers.   The Board disagrees that this greater cost sharing renders the non-network benefit meaningless.

The SEH Board notes that the manner in which physicians are reimbursed was not proposed for amendment. Non-network physician services have been paid using the 80th percentile of PHCS since 1994. The SEH Board does not agree that continuing to use the same method will result in fewer physicians being available whether as network or a non-network provider. The SEH Board does not believe that a decision physicians made regarding Medicaid reimbursement is in any way related to the manner in which non-network provider charges are covered under the small employer plans. The SEH Board notes that the services of hospital physicians may be covered as network or may be covered as non-network, depending on the plan design. Again, there has been no amendment proposed in this regard, so the SEH Board is unclear how the commenters believe the proposal would somehow result in a change that would be harmful to physicians.

No change is being made in response to this comment.

COMMENT 4: Four commenters requested confirmation that the proposed change from the term "reasonable and customary" to "allowed charge" would not result in a difference in the standard of payment for out of network services.

RESPONSE: The SEH Board confirms that the change in terminology has no effect on payments for out of network services. Both "reasonable and customary" as it appears in the pre-proposal text and "allowed charge" as appears in the proposal text require carriers to use the 80th percentile of the Prevailing Healthcare Charges System or actual charges for non- network services and supplies.

COMMENT 5: Three commenters suggested that in light of recent events relating to the Ingenix Inc. database which indicate the database underestimated the true cost of medical care by up to 28% that it would be appropriate to increase the required reimbursement. The commenters did not state what they believed to be the appropriate increase.

RESPONSE: The SEH Board is aware of recent events regarding the Ingenix, Inc. database. The SEH Board has seen the "Health Care Report The Consumer Reimbursement System is Code Blue" (Report) issued by the State of New York Office of the Attorney General, and suspects the underpayment of 28% the commenter mentioned was taken from such Report. Section IV of the Report identified five CPT Codes for doctor visits that the Attorney General's office evaluated for the period of 2004 through 2007 in specific New York counties which led to the statement in the Report indicating that for ordinary doctor visits the rate is underestimated by up to 28%. The Report acknowledges that regional disparities across the State of New York exist. The SEH Board notes that the settlement agreement with United Health Group Inc. makes no finding on the issue of underpayment. In addition the commenters did not provide any basis for increasing reimbursements or any criteria on which reimbursement adjustments might or should be determined. Considering the information currently available the SEH Board disagrees that the recent events necessitate an increase to the reimbursement.

No change is being made in response to this comment.

COMMENT 6: One commenter requested clarification as to whether emergency services would be covered as non- network and thus subject to an allowed charge payment.

RESPONSE: Emergency care is not covered as a non- network benefit even if the emergency room is non- network assuming the emergency care is to treat an emergency,

as that term is defined in the standard health benefit plans. Emergency care is covered such that the consumer is responsible only for network level cost sharing. Thus the consumer pays whatever the network level of cost sharing is and the carrier pays the amount that is necessary such that the consumer is not billed for more than the network level cost sharing. Please understand that the consumer's liability is only capped at the network level cost sharing to the extent the services were to treat an emergency, as defined in the standard health benefits plans. If emergency care is sought for an illness or injury that is not an emergency, as defined, the care will be covered according to the network or non-network status of the provider.

COMMENT 7: One commenter expressed support for limiting reimbursement for out of network providers. The commenter expressed concern with non- network providers charging exorbitant fees, and waiving patient's cost sharing because the reimbursement received from the carrier is so generous there is no need to collect the deductible and coinsurance. The commenter specifically identified free-standing ambulatory surgical centers as engaging in this practice and noted that such practice has hurt nearby hospitals. The commenter favors limiting non- network fee schedules to something no more generous than in network fee schedules.

RESPONSE: The SEH Board thanks the commenter for support limiting reimbursement for out of network providers. The SEH Board notes that N.J.A.C. 11:22-5.6 precludes calculation of non- network benefits using negotiated fees agreed to for network services.

COMMENT 8: One commenter objected to replacing the term "reasonable and customary" with "allowed charge" because the commenter viewed allowed charge as setting a cap whereas reasonable and customary reflects fair and typical reimbursement.

RESPONSE: The SEH Board disagrees with the commenter's assessment of what the two terms mean. Both the prior definition of reasonable and customary and the proposed definition of allowed charge require the use of the PHCS data to determine the amount. Whether the term is called reasonable and customary or it is called allowed charge, the resulting amount is the same and is used to establish the maximum amount the carrier is responsible to pay for a service or supply.

No change is being made in response to this comment.

COMMENT 9: One commenter believes the definition of allowed charge which refers to the lesser of the negotiated fee or the standard approved by the Board is unnecessary and could lead to confusion such that carriers might conclude the PHCS profile is a cap on reimbursement.

RESPONSE: The two-part definition of allowed charge is necessary to address situations in which there is a negotiated fee and situations in which there is no negotiated fee. To the extent there is a negotiated fee, such fee governs. To the extent there is no negotiated fee, as occurs with non-network providers, the standard approved by the Board governs. Such standard is set forth at N.J.A.C. 11:21-7.13. To the extent a carrier purchases and uses the database, the PHCS data would establish the allowed charge and thus create a "cap" on reimbursement. Failing to include a cap on reimbursement for the use of non-network providers would lead to unlimited reimbursement liability for carriers and result in increased premiums to seek to cover the unlimited reimbursement. Such a result is not desirable.

No change is being made in response to this comment.

COMMENT 10: One commenter opposed the use of the Ingenix database since it has been "discredited as unreliable and not reflective of reasonable, usual, and/or customary rates reimbursed to providers."

RESPONSE: The SEH Board's express definition of Allowed Charge and the text in N.J.A.C. 11:21-7.13 nowhere states or implies that the use of the PHCS profile data will yield an amount that is "reflective of reasonable, usual, and/or customary rates reimbursed to providers." Rather, the provisions indicate that the PHCS amount is to be used to determine the allowed charge. As noted by some commenters and affirmed in the SEH Board's responses, the amount is in effect a cap on reimbursement. The SEH Board appreciates that at some point it may no longer be worthwhile to establish the allowed charge using the Ingenix database but considers continued use of the Ingenix database as a reasonable approach at the present time. No change is being made in response to this comment.

COMMENT 11: One commenter objected to the use of the term allowed charge since it would allow a carrier to assume the allowed charge is a fee schedule and reimburse based on that schedule. The commenter expressed concern with the difference between what is eligible to be reimbursed as contrasted to the amount that would actually be reimbursed.

RESPONSE: The SEH Board directs the commenter to N.J.A.C. 11:21-7.13 which identifies the fee schedule. To the extent a provider is a non-network provider, reimbursement would be based on the 80th percentile of PHCS or actual charges, where actual charges would be used if a carrier did not secure the database for the service.

The difference between what is eligible to be reimbursed and what is actually reimbursed is the result of the application of non-network cost sharing, typically deductible and coinsurance.

No change is being made in response to this comment.

COMMENT 12: One commenter opposed the use of the PHCS profile because the profile is owned by Ingenix Inc, a subsidiary of United Health group and the profile has been the subject of class action cases. The commenter contends the profile yields deflated rates and is concerned there is no means to verify the accuracy of the PHCS data. The commenter would like an unaffiliated organization to compile cost/charge data and make it available.

RESPONSE: The SEH Board is aware of the class action cases and the charges that the values are deflated and that there is no independent verification of the data. The SEH Board has not taken a position in these cases and does not believe it proper to take a position in this response. While it may be appropriate for an unaffiliated party to collect and compile data, such data is not currently available for the SEH Board to consider as an alternative to the continued use of PHCS data. The SEH Board will be open to considering the database that is being developed as a result of the settlement agreements and notes that such database will be developed by an unaffiliated party.

No change is being made in response to this comment.

COMMENT 13: One commenter believes non-network benefits will be rendered meaningless by the proposed regulations and that the proposed regulations have the effect of limiting the amount a provider may charge for a service. The commenter further states that providers will disenroll from networks.

RESPONSE: Although not stated in the comment, the SEH Board assumes the proposed regulations are those set forth at N.J.A.C. 11:21-7.13. First, the SEH Board regulations have required carriers to use the PHCS profile for non-network services since 1994 for all services but hospital. The hospital profile was not available in 1994. All non-hospital providers have been paid using PHCS for 15 years. Plans with non-network benefits continue to be marketed and purchased. The reimbursement has not rendered the non-network benefits meaningless.

The regulation would limit the amount of reimbursement to a provider from the carrier. The regulation in no way limits what the provider charges.

The SEH Board is puzzled that the commenter believes non-network reimbursement would have the effect of encouraging providers to disenroll from networks. If the commenter believes the regulation is not favorable to non-network providers, the Board is unclear why the comment thinks more providers would elect to become non-network by disenrolling from networks.

No change is being made in response to this comment.

COMMENT 14: One commenter opposes the use of the PHCS profile calling it a" debunked data system." The commenter notes that it has been unable to find a statutory requirement for uniformity and thus believes it "nonsensical" to use the Ingenix data base. The commenter noted the economic impact to hospitals of reducing reimbursement and asked that the Board wait until another database has been developed before making a change.

RESPONSE: The SEH Board disagrees with the commenter's characterization of the PHCS database. The SEH Board also disagrees that continuing to reimburse hospitals

based on actual charges is an appropriate measure pending development of another database. As addressed in the response to comment 2 above, the settlement does not require the immediate discontinuance of the use of the Ingenix data base and in fact contemplates that carriers may use the database until a replacement has been developed.

No change is being made in response to this comment.

COMMENT 15: One commenter stated the Ingenix database has been discredited and is being shut down and therefore it should not be relied upon in a regulation. The commenter expressed specific concern to the extent a patient uses ambulance services. The commenter said patients do not know if the ambulance is in network or not and should not be forced to bear high out of pocket costs if the ambulance is non-network. The commenter asks that the regulations not be amended to refer to allowed charge.

RESPONSE: The SEH Board notes that the Ingenix database has not been shut down and data continues to be available. The commenter seems to think a change was proposed with respect to the reimbursement of ambulance services. No change was made in this regard. Non-network ambulance services have been reimbursed using the 80th percentile of PHCS since 1994. Although, it is likely many ambulance services will be in connection with an emergency and would thus not be paid as a non-network benefit. The proposed amendment to use the term “allowed charge” in no way modified the current reimbursement methodology.

No change is being made in response to this comment.

COMMENT 16: One commenter challenged the special rulemaking procedures the SEH Board used when the proposal was filed. The commenter said the SEH Board failed to allow the required 20-day comment period. The commenter also noted the composition

of the small employer board and that the physician seat is vacant and commented that the SEH Board has not done anything to fill such seat.

RESPONSE: The special rulemaking process is clearly summarized in the Board's proposal. The authority for such process is found in N.J.S.A. 17B:27A-51. The Board allowed a 60-day comment period, 40 days greater than required. The comment period is measured not from the date the proposal appears in the New Jersey Register, but from the date notice of the intended action is provided. The SEH Board published notice of the intended action in three newspapers of general circulation, namely the Newark Star Ledger (publication date November 21, 2008), The Trenton Times (publication date November 20, 2008) and the Courier Post (Publication date November 20, 2008). The SEH Board provided notice of the intended action to the Press Corps at the State House on November 18, 2008. The SEH Board gave notice via the website to interested parties, which included not just the summary notice, but the entire text of the proposed readoption with amendments. The website posting was on or about November 20, 2008. The proposal was filed with the Office of Administrative law on November 18, 2009. Additionally, all SEH Board meetings are open public meetings, and the SEH Board's action to proceed with proposal took place during an open public meeting. Minutes for all open public meetings are posted on the website for the benefit of those persons who are interested in the Board's activities but unavailable to attend the Board meetings. The Board's actions are entirely consistent with the requirements of N.J.S.A. 17B:27A-51.

Regarding the composition of the small employer board, the commenter correctly noted that at the time of the proposed readoption there was a vacancy for a physician. This vacancy was filled in May 2009. The small employer Board does not name a

physician representative to the Board. Rather, as stated in N.J.S.A. 17B:27A-29 such public member is appointed by the Governor with the advice and consent of the Senate.

No change is being made in response to this comment.

COMMENT 17: One commenter challenged the use of the Ingenix database because it "estimates the customary rates low, it keeps insurance reimbursements low and shifts more of the cost to the patient." The commenter noted that one of the voting members of the Board is United HealthCare and Ingenix is a subsidiary. The commenter believes the change from reasonable and customary terminology to allowed charge terminology affects how reimbursement is paid.

RESPONSE: As discussed in several prior responses, notably items 2, 10 and 14, the SEH Board disagrees with the commenter's assessment of the reimbursement as determined using the 80th percentile of PHCS. The SEH Board acknowledges that United Healthcare is a member of the SEH Board but notes that the United Healthcare representative has been recused from all discussions and votes regarding use of the PHCS profile and Ingenix.

No change is being made in response to this comment.

COMMENT 18: One commenter opposed the proposed increase in the maximum out of pocket from $5,000 to $7,500. The commenter contends the increase is to raise the profit levels of carriers. The commenter also believes the use of Ingenix data means both physicians and patients will be "ripped off."

RESPONSE: As was clearly identified in the proposal, the increase in the maximum out of pocket to $7,500 is consistent with N.J.A.C. 11: 22-5. Carriers need not increase the maximum out of pocket to $7,500, but such amount is permitted. An action such as

increasing the maximum out of pocket can operate to reduce premium costs, something many small employers seek. The SEH Board believes the commenter misunderstands the $7,500 maximum out of pocket. The $7,500 maximum out of pocket is for use of network services. Thus, there is no balance billing, and the Ingenix fee profile does not apply. The Ingenix fee profile applies only to non-network services.

No change is being made in response to this comment.

COMMENT 19: One commenter opposed using the Federal Medicare rate for prosthetic and orthotic appliances.

RESPONSE: The SEH Board refers the commenter to P.L 2007, c.345 which requires reimbursement using the Federal Medicare reimbursement schedule.

No change is being made in response to this comment.

COMMENT 20: One commenter opposed the change from the term reasonable and customary to allowed charge. The commenter believes the revised definition requires carriers to consider a negotiated charge even if the provider is not subject to a negotiated fee arrangement. The commenter also believes that if the negotiated fee is considered, the reimbursement should be the greater of, not the lesser of the negotiated fee or the allowed charge.

RESPONSE: The SEH Board believes the commenter misunderstood the provision in question. The negotiated fee would apply only in instances where a fee has been negotiated and thus only applies to network providers. Such fee cannot be applied to a non-network provider, unless there is a specific one-case negotiation or the carrier accesses a leased network such as Multi-Plan in which the provider participates. The SEH Board's regulations neither state nor imply that negotiated fees apply to non-

network providers. To the extent a provider is a network provider the payment to the provider of the negotiated amount will be accepted as payment in full and the provider cannot seek any additional amount beyond the applicable deductible, coinsurance or copayment required under the plan

COMMENT 21: One commenter noted the New York Attorney General's investigation of Ingenix and asked that the Board require carriers to pay benefits using actual charges if the Ingenix database cannot be used.

RESPONSE: If the SEH Board cannot use the Ingenix database at some future date the SEH Board will consider the options available at such time and propose an amendment to N.J.A.C. 11:21-7.13. The SEH Board cannot comment today on something that may occur in the future. At this time the SEH Board believes it reasonable to continue to use the Ingenix database. However, the SEH Board is committed to future evaluation of appropriate alternatives that may already exist or will be developed in the future.

COMMENT 22: One commenter asked if N.J.A.C. 11:21-7.5 is correct. Specifically the commenter asked if item 5 is intended to allow participation credit for all spousal coverage, including individual or just group coverage.

RESPONSE: The SEH Board thanks the commenter for noting this error. The commenter is correct. Item 5 is intended to allow credit only for coverage under a spouse's group health benefits plan, consistent with the requirements of N.J.S.A. 17B:27A-24. The Board is proposing an amendment on adoption to address the fact that only spousal group coverage is considered.

COMMENT 23: One commenter asked if the proposal intentionally proposed readoption of Exhibit O without amendment. The participation credit for Medicare, Medicaid and NJ FamilyCare is not addressed in the form.

RESPONSE: The SEH Board thanks the commenter for noting this oversight. On adoption, Exhibit O will be updated consistent with N.J.S.A. 17B:27A-24.

COMMENT 24: One commenter offered some formatting and stylistic changes to the standard plans including stray variable brackets, typographical errors, font sizes, and missing words necessary for proper grammar.

RESPONSE: The SEH Board thanks the commenter for the meticulous review of the forms and has made the appropriate corrections to the text.

COMMENT 25: One commenter asked if the policy and booklet forms will be posted separately on the website and whether they will be available in WORD format.

RESPPONSE: The policy and booklet forms are separate documents. To make it easier for the public to review the proposal, all forms associated with a plan, both the policy and certificate forms were posted together. Upon adoption, the documents will be posted separately and will be available in WORD format as has previously been the case.

COMMENT 26: One commenter asked if the SEH Board ever considered defining civil union and domestic partnership.

RESPONSE: Given that civil union partners and domestic partners are captured under the Dependent definition with specific references to the statutes governing civil union partners and domestic partners, the SEH Board believes it appropriate to rely on the statutory definitions and unnecessary to include them in the plans.

No change is being made in response to this comment.

Summary of Agency Initiated Changes

1. To comply with the requirements of P.L. 2008, c. 126, commonly referred to as "Grace's Law" standard plans B, C, D, E, HMO and HMO-POS are being changed on adoption to include coverage for hearing aids for covered persons age 15 and younger. Such coverage is limited to $1,000 per hearing aid for each hearing-impaired ear every 24 months. The exclusion of coverage for hearing aids is being amended such that this coverage is an exception to the exclusion.

2. The Statement of ERISA Rights as contained in the certificates and evidence of coverage documents for Plans A, B,C,D, E, HMO and HMO-POS identify the Pension and Welfare Benefits Administration. It has come to the Board's attention that the name of this Federal agency has been changed to the Employee Benefit Security Administration. The standard plans are being changed on adoption to include this updated name.

3. The New Jersey Continuation Rights for Over-Age Dependents provision of Plans A, B,C,D, E, HMO and HMO-POS is being changed on adoption such that the provision is consistent with the requirements of P.L. 2008, c. 38 and the advice set forth in Bulletin 09-02 issued by the Department of Banking and Insurance (Department). Bulletin 09-02 provides the Department's guidance regarding the requirements of the provisions of P.L 2008, c. 38 that address the continuation rights available to overage dependents. Such Bulletin advises that there is a continuous opportunity for an eligible overage dependent to enroll and that the dependent need not have been covered on the date he or she reached a limiting age. Therefore, the provision is being amended to eliminate text that would

limit the period for making an election and to state that it is not necessary to have been covered on the date the limiting age was attained.

4. The Board inadvertently neglected to include N.J.A.C. 11:21 Appendix Exhibit BB Part 6 in the proposed readoption with amendments. While it was not proposed for readoption this Exhibit BB Part 6 which captures information on the use of optional benefit riders is necessary to enable the SEH Board to monitor the types of amendments carriers are making to the standard plans via increasing and decreasing riders. The SEH Board is adopting this Appendix Exhibit BB Part 6 without amendment.

Federal Standards Statement

The rules readopted with amendments and repeal comply with the following Federal laws: the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), 29 U.S.C. §§1161 et seq.; the Employee Retirement Security Act of 1974 (ERISA), 29 U.S.C. §§1001 et seq. and implementing regulations at 26 C.F.R. Part 54, 29 CFR Parts 2520 and 2560 and 2590, and 32 CFR Part 220; Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. §1395y(b)(1994) and implementing regulations at 45 CFR Part 411; the Public Health Service Act, 42 U.S.C. §§300gg et seq., (incorporating the Federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191; the Newborns' and Mother's Health Care Protection Act of 1998, Pub.L. 104-204, 110 Stat. 2935 (1996); and the Women's Health and Cancer Rights Act of 1998, Pub.L. 105-277, Title IX, §903, 112 Stat.) and implementing regulations at 45 CFR Parts 145 and 146.

The rules do not expand upon the requirements set forth in these Federal laws. There are no other Federal laws that apply to these rules.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 11:21-1 through 3, 4 through 7, 8, 10, 17, 18, 23 and Appendix Exhibits A, D, F, G, H, N, O, T, V, W, Y, BB Parts 1 and 2, CC, DD,HH, II and KK.

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

§ 11:21-7.5 Participation requirements

(a) A small employer carrier shall require a minimum participation under the small employer's health benefits plan of 75 percent of eligible employees who are not serving under a waiting period as permitted under N.J.A.C. 11:21-7.8(c), except as set forth in (b) below. This participation requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers. A carrier shall count as covered under the small employer's health benefits plan, for the purpose of satisfying employee participation requirements, an eligible employee who:

1. Is covered as an employee or dependent under any fully insured health benefits plan offered by the small employer;

2. Is covered under Medicare;

3. Is covered under Medicaid or NJ FamilyCare;

4. Is covered under another group health benefits plan; or

5. Is covered under a spouse's ***group*** health benefits plan.

. . .

§ 11:21-7.13 Paying benefits

(a) Except as stated in (b) below for prosthetic and orthotic appliances, in paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services, using either the allowed charges or actual charges, and, for hospital services, based on actual charges. Allowed Charge means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, incorporated herein by reference published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

1. The maximum allowed charge shall be based on the 80th percentile of the profile.

2. Carriers shall use the profile effective as of July 1993, and shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

(b) In paying benefits for prosthetic and orthotic appliances as required by P.L. 2007, c. 345, reimbursement shall be at the same rate as reimbursement for such appliances under the Federal Medicare reimbursement schedule, whether the benefits are provided on a network or out-of-network basis. However, if the Carrier’s contract rate with a network provider of orthotic and prosthetic appliances exceeds the Medicare reimbursement rate, the carrier’s contract rate should be paid.