INSURANCE

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Adopted Amendments: N.J.A.C. 11:21-7.13

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

Adopted: November 24, 2009 by the New Jersey Small Employer Health Benefits Program Board, Ellen DeRosa, Executive Director.

Filed: November 24, 2009 as R. 2009 d.

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

Effective Date: December 20, 2009

Operative Date: December 20, 2009

Expiration Date: August 18, 2014.

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.

The SEH Board proposed an amendment to N.J.A.C. 11:21-7.13(a) Paying Benefits as part of the proposed readoption with amendments of N.J.A.C. 11:21. The SEH Board filed the readoption with amendments of 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 on August 18, 2009, specifically excluding the amendments proposed to N.J.A.C. 11:21-7.13(a) 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. The proposed 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 the proposal 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 was not adopted on August 18, 2009 in order to allow the SEH Board additional time to evaluate the impact of the proposed amendment. During the period of further consideration, 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.

The SEH Board has determined that the adoption of the amendments proposed at subsection (a) is appropriate and is proceeding with the adoption of the amendments proposed November 18, 2008 (published at 41 N.J.R. 84(a) on January 5, 2009). The following information affirmed that the SEH Board's proposed amendments are both appropriate and necessary.

- Enrollment in small employer health benefits plans continues to decrease. Total persons covered under small employer plans has decreased from 870,344 in 3Q08 to 850,615 in 4Q08 to 829,412 in 1Q09 to 820,442 as of 2Q09. Thus, over the most recent four quarters, enrollment has dropped by 49,902 lives.
- Premiums in the small employer market continue to increase. As required by law, the Department of Banking and Insurance collects data to produce a premium comparison survey, with the most recent survey data requested in 2008 with rates for effective dates in 2009. As stated in the report,

> "The report compares the premium shown for 2009 to the premium shown in the 2008 survey, and calculates the percentage increase. This percentage increase is only indicative for the plans of coverage shown, and for the particular sample group specified. The percentage increase shown in this report is for the standard plans, and may be different than the average percentage increase for all plans. The percentage increase may also be different for groups with different age/gender or family structure compositions."

The survey provides information for three counties, Bergen, Middlesex and Camden. For Bergen County, the increases range from a low of 6.5% to a high of 23.1%. For Camden County the increases range from 6.6% to 26.1%. For Middlesex County the

increases range from 2.3% to 23.1%. The increases reflected in the premium comparison survey are significantly lower than the increases that have lead employers to contact the SEH Board to ask for explanations of the increases. Employers experiencing the low end of the increases are not generally calling. Employers with increases far exceeding the upper range reflected on the survey, with increases in excess of 30%, are calling. As rates continue to increase employers make decisions as to whether to continue to offer health coverage.

- The cost for care at one non-network hospital is two to five times greater than that at other hospitals. For example, one hospital billed a daily room and board charge of $18,000 as compared to $3,200 for another hospital.

The SEH Board appreciates that enrollment in the small employer market is sensitive to the economy and that decreases in enrollment due to loss of jobs likely account for some of the nearly 50,000 life decrease in enrollment. The SEH Board has long recognized that the small employer market is very price-sensitive. Escalating costs force employers to look to make plan changes to reduce the cost of coverage and/or require greater contributions from the employees. The alternative is that employers may drop coverage entirely.

The SEH Board defined an allowed charge to establish a standard for payment within the standard health benefits plans. That standard of payment is intended to ensure that plans pay comparable amounts for the same service. If a billed charge for a non-network hospital can vary as dramatically as indicated above the objective of defining an allowed charge is severely compromised. By using the 80th percentile of the PHCS data to determine the allowed charge, the room and board charge for non-network hospitals

within the same geo-zip would be consistent and thus preserve standardization as required by N.J.S.A. 17B:27A-19.

COMMENT 1: One commenter opposed the proposed deletion of the requirement that non-network hospital providers be reimbursed based on actual charges. The commenter notes that while the proposed language still mentions actual charges, the commenter is concerned that carriers will think they are no longer allowed to reimburse based on actual charges.

RESPONSE: The SEH Board proposed the following: "pay covered charges for [medical] services, [on a reasonable and customary] using either the allowed charges or actual charges." The SEH Board believes the requirement to use either allowed charges or actual charges is clear.

No change is being made in response to this comment.

COMMENT 2: One commenter opposed the elimination of the requirement to pay hospitals actual charges. The commenter contends that using allowed charges is effectively setting a cap on reimbursement. The commenter noted that hospitals are already facing extraordinary fiscal challenges. The commenter contends that actual charges paid for non-network hospitals was a bargaining tool when negotiating with third party payers. The commenter further states that using the reduced reimbursement methodology would have a negative financial impact on patients who use non-network hospitals and on the hospitals that must treat regardless of the patient's ability to pay.

RESPONSE: The SEH Board appreciates the commenter's concern that hospitals may receive less reimbursement for hospital stays of patients covered under small employer plans. However, with enrollment in small employer plans at less than 900,000 lives, the

SEH Board doubts the majority of the patients a hospital treats are covered under small employer health benefits plans and thus questions how the impact of the change could be significant. Further, of those covered under small employer plans, many are covered under HMO plans that would not allow use of a non-network provider. If the small employer plans begin to provide reimbursement to non-network hospitals using a fee profile, which the SEH Board agrees would set a cap on the reimbursement, the practice would be no different than the practice currently employed by carriers selling coverage in the large group market and by self funded plans. The SEH Board believes it is proper to limit the payments to non-network providers to an amount that is less than actual charges.

As far as a bargaining tool is involved, the SEH Board believes the volume of patients covered under small employer plans that have non-network benefits for any given hospital would not be significant enough to effect bargaining with third party carriers.

The SEH Board agrees that a consumer who chooses to use non-network services will generally have greater financial exposure. This is true for hospital services as it is true for non-hospital services. The cost is part of the information a patient needs to carefully weigh before electing to use a non-network provider. The SEH Board notes that if a patient is covered under a plan the patient would be admitted to the hospital as an insured patient. However, the SEH Board is unclear why the commenter believes greater financial exposure of the member that results from choosing to use a non-network hospital would necessarily lead to a negative financial consequence to the hospital.

COMMENT 3: One commenter claimed the SEH Board's proposal is "clearly capricious." The commenter noted the authority for changing the hospital reimbursement

methodology to move away from actual charges is found in neither P.L. 2008, c. 38 nor P.L. 2007, c.345. The commenter noted hospitals are different from other providers in that hospitals are required to provide services for free.

RESPONSE: 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.

The commenter's remark regarding hospitals providing services for free is curious given the fact that when a consumer is covered under a small employer plan the consumer would not seek services for free. If the commenter is suggesting that carriers who market coverage in the small employer market must somehow make up for a shortfall that occurs due to "free services," the SEH Board disagrees the burden should be borne by small employers.

No change is being made in response to this comment.

COMMENT 4: One commenter contends that paying non-network hospitals using allowed charges rather than actual charges will limit their ability to negotiate with managed care companies since the fee schedule will be a ceiling on non-network reimbursement.

RESPONSE: The SEH Board believes the volume of patients covered under small employer plans for any given hospital, given that there are fewer than 900,000 lives state-wide, would not be significant enough to affect bargaining with third party carriers.

Further of those less than 900,000 lives, not all persons have plans that allow access to non-network providers.

No change is being made in response to this comment.

Federal Standards Statement

There are no Federal rules governing the standard for determining an allowed charge. Therefore the adopted amendment does not impose a requirement that exceeds Federal law.

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

§ 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 services using either the allowed charges or 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.