INSURANCE
NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Readoption with Amendments: N.J.A.C. 11:20-1, 2.1 through 2.16, 3, 6 through 10, 12, 17 through 20 and 22, and 11:20 Appendix Exhibits A through F, J, K, L and Q through V.

Adopted New Rules: N.J.A.C. 11:20-1.6, 2.18, 7.7, 23 and 24.

Adopted Readoption and Recodification with Amendments: N.J.A.C. 11:20 Appendix Exhibits B (formerly Exhibit F), D (formerly Exhibit S) and F (formerly Exhibit V)

Adopted Repeals: N.J.A.C. 11:20-1.5, 9.6, 10.5, 17.5 and 18.9, and N.J.A.C. 11:20, Appendix Exhibits Q, R, S, T, U and V.

Adopted Repeals and New Rules: N.J.A.C. 11:20-1.6, 3.1, 3.2, and 12 and 11:20 Appendix Exhibits A, C and E.

Proposed: August 15, 2005 at 37 N.J.R 2994 (a)

Adopted: December 5, 2005 by the New Jersey Individual Health Coverage Program Board, Wardell Sanders, Executive Director.

Filed: December 7, 2005 as R.2006, d. 15, with substantial and technical changes not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

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

Effective Date: December 7, 2005, Readoption;
January 3, 2006, Amendments, Recodifications, Repeals and New Rules

Operative Date: July 1, 2006 as to the amendments to N.J.A.C. 11:20-2.10, -3.3, 3.4 , -22.4 and the recodification with amendments of Appendix Exhibits B (formerly Exhibit F), D (formerly Exhibit S), and F (formerly Exhibit V); the repeals and new rules at N.J.A.C. 11;20 Appendix Exhibits A, C and E; and the adopted repeals of N.J.A.C. 11;20 Appendix Exhibits B, D, Q, T and U.

Expiration Date: December 7, 2010.

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Individual Health Coverage (IHC) Program Board held a public hearing on September 13, 2005 to receive oral testimony with respect to proposed amendments to the standard health benefit plans set forth at Appendix Exhibits A, B, C, D and F. Ellen DeRosa, the Deputy Executive Director of the IHC Board, served as hearing officer.

No persons provided comments during the hearing.

The record of the public hearing may be reviewed by contacting Ellen DeRosa, Deputy Executive Director, IHC Board, PO Box 325, Trenton, NJ 08625-0325. The hearing officer made no recommendations to the IHC Board as part of a review of the proposal.

Summary of Public Comments and Agency Responses:

Written comments were received from Oxford Health Plans, Inc. and from Windels Marx Lane & Mittendorf, LLP on behalf of Guardian Life Insurance Company of America.

COMMENT 1: One commenter asked for clarification regarding whether the State law regarding mammograms for women age 40 and over applies also to the HMO plan since the Summary only mentioned Plans A/50 - D.

RESPONSE: P.L. 1999 c. 341 applies also to HMO plans. Item 20 of the Outpatient Services provision of the HMO plan Appendix Exhibit B addresses coverage for mammograms.

COMMENT 2: One commenter questioned the discussion of the maximum out of pocket as was provided in the Economic Impact statement, asking for confirmation that the only coinsurance that continues after the maximum out of pocket has been satisfied is coinsurance for prescriptions.

RESPONSE: The Board refers the commenter to the following text as appeared in the Economic Impact statement of the proposal: "As proposed, prescription drug expenses may accumulate toward the satisfaction of the deductible, but do not accumulate toward the satisfaction of the maximum out of pocket, meaning coinsurance continues to be required even after the maximum out of pocket has been reached." The Board confirms that coinsurance continues to be required only for prescription drugs after the maximum out of pocket has been met. However, with respect to plans sold in conjunction with a Health Savings Account, once the maximum out of pocket has been reached, no further coinsurance is required for any services or supplies, including prescription drugs.

COMMENT 3: One commenter questioned whether the definition of "member" in N.J.A.C. 11:20-1.2 was correct with respect to references to NJ FamilyCare and NJ KidCare. The commenter noted that NJ FamilyCare and NJ KidCare are included when discussing the enrollment total, but not when addressing the enrollment calculation.

RESPONSE: The Board proposed amending the definition of "member" to conform to P.L. 2001, c.349 and thus included references to NJ FamilyCare and NJ KidCare as follows (additions in boldface; deletions in brackets): "A member shall not include a carrier whose combined average Medicare **[and]**, Medicaid**, NJ FamilyCare and NJ KidCare** enrollment represents more than 75 percent of its average total enrollment for all health benefits plans or whose combined Medicare **[and]**, Medicaid**, NJ FamilyCare and NJ KidCare** net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare and Medicaid enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum of these enrollment figures, as measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight." The commenter is correct that the last sentence of the definition failed to include NJ Family Care and NJ KidCare. On adoption, the Board is adding NJ FamilyCare and NJ KidCare to the last sentence of the definition of "member." The Board believes this is a non-substantive change, not requiring reproposal since the amendment to add NJ FamilyCare and NJ KidCare corrects an inconsistency in the definition.

COMMENT 4: One commenter suggested that N.J.A.C. 11:20-3.4 is confusing and that the first sentence should end after the citation.

RESPONSE: The notice of proposal published in the New Jersey Register included a period after the N.J.S.A. citation.

COMMENT 5: One commenter supported the name change from husband/wife to address domestic partners, but expressed concern with the use of the new term "two adults," suggesting it could be misconstrued to imply broader coverage. The commenter noted that the policy form text uses the term "single and spouse" and asked that the regulation use the same term.

RESPONSE: The Board notes that the new term "two adults" is used only in the rate filing rules, N.J.A.C. 11:2-6, and the enrollment reporting rules at N.J.A.C. 11:20-17. The Board notes that for purposes of the policy forms which are documents a consumer receives, it was essential to identify the relationship between the adults and thus the forms use the term "single and spouse." For purposes of rate filings and reporting enrollment, the quantity of lives, not the relationship, is critical. Therefore, for rate filing and enrollment reporting, the Board believes "two adults" is the more appropriate term. No change is being made as a result of the comment.

COMMENT 6: One commenter commented that the definition of "Hospice" in the Basic and Essential specimen policy form, Appendix Exhibit F, is not as expansive as the definition included in the HMO plan, set forth in Exhibit B, and suggested that the definition be revised to be consistent with that contained in the HMO plan.

RESPONSE: Hospice care is not a covered service under the Basic and Essential Plan. Therefore, whether a person is terminally ill or terminally injured is of no consequence in terms of a hospice benefit. The Board intentionally removed the references to recognition by state and Federal law from the definition as found in the HMO plan since even if a hospice is recognized, there is no coverage for the service.

COMMENT 7: One commenter suggested that the definition of "Inpatient" in the Basic and Essential specimen policy form, Appendix Exhibit F, be revised to refer to a "person" rather than "you."

RESPONSE: The term "you" in the context of the definition means any covered person, as is explained in the definition of "you." As suggested by the commenter, the Board is revising the definition of "inpatient" on adoption to refer to a "covered person" rather than "you" and therefore the definition will begin with the phrase: "A Covered Person who is…"

COMMENT 8: One commenter questioned why the definition of "Outpatient" in the Basic and Essential specimen policy form, Appendix Exhibit F, refers both to registered bed patient and the defined term "inpatient."

RESPONSE: The definition of "Outpatient" uses the negation of part of the definition and of the defined term for "Inpatient" for clarity and emphasis. The Board does not view such emphasis as being unnecessarily redundant. No change is being made in response to the comment.

COMMENT 9: One commenter suggested that the "Please Note" text under the Child Dependent provision in the Basic and Essential specimen policy form, Appendix Exhibit F, should be clarified such that the third reference to child would mean the child who is eligible to be covered as a dependent.

RESPONSE: The Board believes the note text is clear in explaining that in order for a child of a child to be covered, the child of a child must qualify as a "dependent" as that term is defined in the policy. No change is being made in response to the comment.

COMMENT 10: One commenter identified a typographical error in the second paragraph of the Covered Charges section in the Basic and Essential specimen policy form, Appendix Exhibit F. The word “coverage” should be “covered.”

RESPONSE: The Board thanks the commenter and has made the suggested change.

COMMENT 11: One commenter asked if immunizations and lead screening in the Basic and Essential specimen policy form, Appendix Exhibit F, are subject to the wellness deductible.

RESPONSE: The plan specifications for the basic and essential plan are set forth in P.L. 2001, c. 368. That law specifically references subsection B of section 7 of P.L. 1995, c. 316, which states that no deductible shall be applied for benefits provided pursuant to the section. Coverage for immunizations and lead screening is listed separately from the wellness benefit because it is not intended to be part of the wellness benefit. However, the Board notes that the Wellness text refers to lead screening related to wellness services. On adoption, the Board is deleting the words “lead screening” from the wellness benefit text. Please note that the immunizations and lead screening text does not state that benefits are subject to a deductible. The wellness benefit, which is subject to a deductible, includes text to alert the reader that the wellness benefit is subject to a deductible. The Board believes the text, as amended, is clear that the immunizations and lead screening benefit is separate from the wellness benefit and therefore is not subject to the wellness deductible.

COMMENT 12: One commenter asked if treatment of hemophilia and Wilm's tumor is covered under the in the Basic and Essential specimen policy form, Appendix Exhibit F.

RESPONSE: The Basic and Essential plan provides coverage for some services a patient with hemophilia or Wilm's tumor might require. For example, the plan covers blood and blood plasma and laboratory services on an inpatient basis. P.L. 2001, c. 368 does not specify coverage for hemophilia and Wilm's tumor and therefore such coverage is not specifically included in the Basic and Essential specimen policy form, Appendix Exhibit F.

COMMENT 13: One commenter pointed out that the words "the member" were repeated in the second paragraph of the Provider Payment section of the Basic and Essential specimen policy form, Appendix Exhibit F.

RESPONSE: The Board thanks the commenter and has deleted the duplicate words "the member."

COMMENT 14: One commenter noted a typographical error in item "a" of the Premium Rates Changes text of the Basic and Essential specimen policy form, Appendix Exhibit F.

RESPONSE: The Board thanks the commenter and has changed "de" to "due."

COMMENT 15: One commenter noted that a bracket is missing from the Specialist text of the Copay schedule of the HMO plan, Exhibit B.

RESPONSE: The Board thanks the commenter and has added a close bracket in the Specialist Copay text of the schedule.

COMMENT 16: One commenter questioned why the definition of "outpatient" in the HMO plan, Appendix Exhibit F, refers both to registered bed patient and the defined term "inpatient."

RESPONSE: The definition of "Outpatient" uses the negation of part of the definition and of the defined term for "Inpatient" for clarity and emphasis. The Board does not view such emphasis as being unnecessarily redundant. No change is being made in response to the comment.

COMMENT 17: One commenter asked if the definition of Reasonable and Customary in the HMO Plan, Exhibit B, should be bracketed so it would only be included for a deductible and coinsurance HMO plan.

RESPONSE: The definition of Reasonable and Customary must appear in all HMO plans. Prescription drugs are covered subject to 50 percent coinsurance and the definition is therefore necessary.

COMMENT 18: One commenter noted that the HMO plan, Exhibit B, includes a modality limit per visit for therapeutic manipulation. The commenter asked if a similar limit could be included in the physical therapy benefit.

RESPONSE: The HMO plan limits physical therapy visits to 30 per year. Imposing a modality limit to each of those limited visits would represent a significant decrease in coverage. The Board notes that the commenter did not provide any justification for reducing the physical therapy benefit. Absent appropriate justification for reducing the already limited benefit, the Board declines to make the requested change to the standard HMO plan.

COMMENT 19: One commenter asked why the HMO plan, Exhibit B, contained exclusions for “broken appointments” and “for charges for missed appointments” and asked what is the difference. The commenter asked if Plans A/50 – D should also contain the broken appointments exclusion.

RESPONSE: A broken appointment refers to a scheduled appointment that a patient calls to cancel or break prior to the appointment time. Some offices require that such calls to break an appointment must be made at least certain period of time prior to the scheduled appointment, and failure to call at least that period of time prior to the appointment results in a charge. A missed appointment is one a patient simply fails to keep. Many offices charge patients for missed appointments. The exclusions section of Plans A/50 – D, Appendix Exhibit A, is being amended to include an exclusion for broken appointments.

COMMENT 20: One commenter noted that the current HMO plan contains an exclusion for any therapy not listed. The HMO plan proposed in Exhibit B does not contain such an exclusion. The commenter asked if this was an intentional change.

RESPONSE: The lack of an exclusion for therapy services not listed was intentional. The therapy services that are listed are generally those for which some sort of limit applies or those for which it was important to specifically define the nature of the service. The Board recognizes that there are therapy services that might not be specifically listed, but are medically necessary and appropriate and are not experimental or investigational, and therefore should be covered.

COMMENT 21: One commenter noted the current HMO plan contains an exclusion for gender identity disorders. The commenter asked if this would fall under another exclusion in the HMO plan proposed as Exhibit B.

RESPONSE: The Board refers the commenter to the "Standard Health Benefits Plans" portion of the Summary of the proposal. The second paragraph of that portion of the Summary addressed the Board's conscious decision to develop standard individual plans that are consistent with the standard plans in the small employer market. The discussion of the benefits associated with consistency between individual and small employer plans specifically addressed consistent language for exclusions. Thus, while the existing standard individual plan text specifically excludes coverage for gender identity disorders, the exclusions section in the standard small employer plans does not contain such an exclusion. In keeping with the Board's decision to have consistency between the standard individual and small employer plans, the Board is not amending the individual plan to include an exclusion that is not found in the standard small employer plans.

COMMENT 22: One commenter noted the HMO plan Exhibit B does not include a certificate of need exclusion.

RESPONSE: When a member covered under an HMO plan uses the services of a network provider, the Board believes the member is entitled to coverage for the services or supplies regardless of whether the facility has obtained a certificate of need. The member who uses the services of a network provider in good faith should not be held financially responsible for services and supplies received in the event a provider has failed to obtain a certificate of need.

COMMENT 23: One commenter suggested that the prescription drugs exception text in the maximum out of pocket provision as appears on the schedule and the benefit provision of Plans A/50 – D, Exhibit A, should not refer to copayments since prescription drugs are not covered subject to a copayment.

RESPONSE: The Board agrees with the commenter and has deleted the references to copayment from the prescription drug exception text in the maximum out of pocket provision.

COMMENT 24: One commenter suggested that the reference to Copayment should be deleted from the HSA/MSA schedule pages of Plans C and D, Exhibit A, since neither HSA nor MSA plans use copayments.

RESPONSE: While the sample schedule text includes only deductible and coinsurance features, a carrier could design a plan that might include a copayment.

COMMENT 25: One commenter expressed support for the optional provision in Plans A/50 – D, Exhibit A, to include preapproval for therapeutic manipulation, cognitive rehabilitation, occupational therapy, speech therapy and physical therapy.

RESPONSE: The Board appreciates the commenter's support.

COMMENT 26: One commenter questioned why the definition of "outpatient" in Plans A/50 – D, Exhibit A, refers both to registered bed patient and the defined term "inpatient."

RESPONSE: The definition of "Outpatient" uses the negation of part of the definition and of the defined term for "Inpatient" for clarity and emphasis. The Board does not view such emphasis as being unnecessarily redundant. No change is being made in response to the comment.

COMMENT 27: One commenter asked how prescription drug coverage for HSA/MSA plans will work in Plans C and D, Exhibit A. The commenter asked if the base medical prescription coinsurance will be the same as all other medical services.

RESPONSE: There is nothing in the text to suggest that the coinsurance for prescription drugs is different from the coinsurance for other covered charges. Therefore, the coinsurance for prescription drugs is the same as the coinsurance for all other covered charges.

COMMENT 28: One commenter noted that the Hospital Charges text of Plan B, Exhibit A, includes HSA/MSA text. The commenter said she believed only Plans C and D should permit HSA/MSA text.

RESPONSE: The commenter is correct that only Plans C and D are intended for use with HSAs/MSAs. The text describing the deletion of the emergency room copayment for HSA/MSA products was included in error and is being deleted on adoption. Since no other text in Plan B addresses HSA/MSA provisions, the Board believes persons reviewing the proposal would not have concluded that Plan B could be used with an HSA/MSA.

COMMENT 29: The commenter noted that the hospice benefit in the current forms for Plans A/50 – D include benefits for counseling of family members. The commenter asked if this coverage was deleted intentionally.

RESPONSE: The Board intentionally did not include coverage for family members in the hospice benefit. The hospice benefit is intended for the person covered under the plan. If a family member seeks coverage for counseling services, the family member should review his or her own coverage to determine what benefits may be available.

COMMENT 30: One commenter noted that the Plans A/50 - D, Exhibit A, includes a modality limit per visit for therapeutic manipulation. The commenter asked if a similar limit could be included in the physical therapy benefit.

RESPONSE: Plans A/50 - D limit physical therapy visits to 30 per year. Imposing a modality limit on each of those limited visits would represent a significant decrease in coverage. The Board notes that the commenter did not provide any justification for reducing the physical therapy benefit. Absent appropriate justification for reducing the already limited benefit, the Board declines to make the requested change to standard Plans A/50-D.

COMMENT 31: One commenter noted that the current Plans A/50 - D contain an exclusion for any therapy not listed. Plans A/50 – D, Exhibit A, do not contain such an exclusion. The commenter asked if this was an intentional change.

RESPONSE: The lack of an exclusion for therapy services not listed was intentional. The therapy services that are listed are generally those for which some sort of limit applies or those for which it was important to specifically define the nature of the service. Further, the Board is allowing carriers to apply pre-approval to physical therapy services. The Board recognizes that there are therapy services that might not be specifically listed, but that would be medically necessary and appropriate and would not be experimental or investigational and therefore should be covered.

COMMENT 32: One commenter noted the current Plans A/50 - D contain an exclusion for gender identity disorders. The commenter asked if this would fall under another exclusion in Plans A/50 - D proposed as Exhibit A.

RESPONSE: The Board refers the Commenter to the "Standard Health Benefits Plans" portion of the Summary of the proposal. The second paragraph of that portion of the Summary addressed the Board's conscious decision to develop standard individual plans that are consistent with the standard plans in the small employer market. The discussion of the benefits associated with consistency between individual and small employer plans specifically addressed consistent language for exclusions. Thus, while the existing standard individual plan text specifically excludes coverage for gender identity disorders, the exclusions section in the standard small employer plans does not contain such an exclusion. In keeping with the Board's decision to have consistency between the standard individual and small employer plans, the Board is not amending the individual plan, as proposed, to include an exclusion that is not found in the standard small employer plans.

COMMENT 33: One commenter noted Plans A/50 – D exclude travel to obtain medical treatment. The commenter requested that the exclusion be expanded to exclude treatments, drugs or supplies that may be available in the U.S. but are obtained in another country. The commenter gave an example of a person securing prescription drugs from a Canadian source.

RESPONSE: The commenter did not offer any explanation as to why the requested change should be made. The Board is reluctant to reduce benefits without a specific reason. Therefore, no change is being made in response to this comment.

COMMENT 34: One commenter noted a typographical error in item 8 on page 2 of the Explanation of Brackets. The word “phases” should read “phrases.”

RESPONSE: The Board thanks the commenter and has made the suggested correction.

COMMENT 35: One commenter asked that the Board confirm that the Board has not taken final agency action on the proper loss assessment methodology for any past year assessments (1993 – 2004) in light of In Re New Jersey IHCP, 179 N.J. 570 (2004), and to state its position that there is no reason for any further delay on the issue.

RESPONSE: The comments are beyond the scope of the proposal. The proposed readoption did not address the calculation of loss assessments. The Acting Governor requested that the Department and the IHC Board take additional time "to allow further dialogue in this[the loss assessment rule] important issue...." 37 N.J.R. 2884(a).

Federal Standards Statement

The rules readopted with amendments at N.J.A.C. 11:20 (excluding N.J.A.C. 11:20-2.17 and 11) comply with the Federal Health Insurance Portability and

Accountability Act of 1996, Pub. L. 104-191. The amendments do not expand upon the requirements set forth in Federal law.

The rules readopted with amendments comply with the following federal laws: 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 readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 11:20-1, 2.1 through 2.16, 3, 6 through 10, 12, 17 through 20 and 22, and N.J.A.C. 11:20 Appendix Exhibits A through F, J, K, L and Q through V.

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

11:20-1.2 Definitions

. . .

"Member" means a carrier that issues or has in force health benefits plans in New Jersey. A member shall not include a carrier whose combined average Medicare, Medicaid, NJ FamilyCare and NJ KidCare enrollment represents more than 75 percent of its average total enrollment for all health benefits plans or whose combined Medicare,

Medicaid, NJ FamilyCare and NJ KidCare net earned premium for the two-year calculation period represents more than 75 percent of its total net earned premium for the two-year calculation period. The average Medicare ***[and],*** Medicaid ***NJ FamilyCare and NJ KidCare*** enrollment and average enrollment for all health benefits plans shall be calculated by taking the sum of these enrollment figures, as measured on the last day of each calendar quarter during the two-year calculation period, and dividing by eight.

. . .

11:20-6.3 Informational rate filing requirements

(a) All members issuing standard health benefits plans on a new contract or policy form and the basic and essential health care services plan shall make, prior to issuing any standard health benefits plan, an informational rate filing with the Board, which shall include the following supporting data:

1. – 2. (No change from proposal.)

3. A detailed actuarial memorandum, which shall include the following:

i. – iv. (No change from proposal.)

v. A sample of the notice that will be sent to policyholders to advise them of a rate change, except that such sample notice must only be included with the first rate filing submitted on or after ***[(the effective date of this amendment)]* * January 3, 2006*,** and thereafter, whenever there is a change to the content of the notice previously submitted.

vi. – ix (No change from proposal.)

4. – 5. (No change.)

(b) – (c) (No change from proposal.)