INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Individual Health Benefits Plans

Proposed Amendments: N.J.A.C. 11:20-1.2, 2.1, 2.5, 2.6, 2.7, 2.9, 2.10, 2.12, 3.1, 3.6, 8.2, 12.4, 12.5, 17.1, 17.2, 17.3, 17.4, 19.3, 23.2, 23.4, 23.5, 24.2, 24.2A, 24.4, and 24.6

Proposed Repeals: N.J.A.C. 11:20-3.5, 12.3, 22, 24.5, and 11:20 Appendix Exhibit L Parts 1 and 2

Authorized By: New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director.

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

Proposed: July 7, 2016

Adopted: September 19, 2016 by the New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director

Filed: as R. 2016 d. ____ **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Effective Date: January 1, 2017

Expiration Date:

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Individual Health Coverage Program Board (IHC Board) held a hearing on August 18, 2016 at 10:00 A.M. at the Department of Banking and Insurance, 11th floor Conference Room, 20 West State Street, Trenton, New Jersey to receive testimony with

respect to the standard health benefits plans, set forth in Exhibits A and B. Ellen DeRosa, Executive Director of the IHC Board, served as hearing officer.

No persons attended the hearing and thus 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 Individual Health Coverage Program Board, P.O. Box 325, Trenton, NJ 08625-0325.

Summary of Public Comments and Agency Responses

The following is a summary of the comments received from the public and the IHC Board's responses. Each comment is identified at the end of the comment by a number that corresponds to the following list:

1. Melinda Martinson, General Counsel, Medical Society of New Jersey
2. Theresa Edelstein, Vice President, New Jersey Hospital Association

1. COMMENT: One commenter expressed concern that the advance notice of the proposal did not mention that the out of network payment benefit and calculation methodology would be part of the proposal and thus the public was deprived of the opportunity to provide input prior to publication of the proposed regulation. (1)

RESPONSE: The Board suspects the commenter's reference to advance notice is referring to Executive Order 2 (EO-2) issued by Governor Christie, which requires agencies to solicit advice and views of knowledgeable persons outside of New Jersey government prior to rulemaking. Since the IHC Board is primarily composed of stakeholders who, but for the Commissioner of Insurance representative, are not government officials in their roles outside of the IHC Board, and because the IHC Board conducts all of its business in public sessions, and

accepts comments from the public without restriction as to topic, the IHC Board does not typically issue a specific advance notice of rules. The situation surrounding this particular proposal was no different. The IHC Board has been discussing changes to the out of network reimbursement methodology for quite a while, and specifically discussed the proposed amendments during multiple open public meetings in 2016, held on May 10, June 14, and June 23. The IHC Board disagrees that the public was deprived of the opportunity to provide input prior to the publication of the proposed regulation.

2. COMMENT: One commenter opposed the repeal of the allowed charge provision and offered multiple reasons for the opposition. The commenter's reasons are summarized in list format below.

a. The Board has studied out of network payment methodology since a Board meeting on July 10, 2012 and during subsequent Board meetings in 2013 contemplated stakeholder engagement and drafted a whitepaper. Key stakeholders were not given the opportunity for early input yet the IHC Board filed a rule proposal that allows carriers to design, calculate and implement out of network benefits.

b. Success with respect to out of network benefits should be measured by the number of individuals who are satisfied with the coverage where a key to the success is transparency. The commenter states that new plans will not be any more transparent to purchasers and carriers will not be successful explaining how out of network benefits are calculated.

c. The commenter states the goal of the proposal is to increase the number of plans sold that include out of network benefits and to increase transparency. To achieve that goal the commenter states that the IHC Board should adopt the Fair Health profile. The commenter states that Fair Health is the successor to Ingenix and notes that when Ingenix succeeded the Health

Insurance Association of America (HIAA) database there was no controversy over the change from HIAA to Ingenix. The commenter believes the IHC Board should have similarly changed from Ingenix to Fair Health and states that if the IHC Board had done so, carriers would not have been required to use outdated data.

d. The commenter notes that other state-regulated plans use Fair Health and referred to the personal injury protection (PIP) regulations and the State Health Benefits Plan.

e. The McCoy v. Healthnet, Inc litigation resulted in a settlement which required the increase of out of network fees by 14.5% to address the "downward fee skewer" of the Ingenix data. The New York Attorney General issued a press release in 2009 regarding manipulation of rates by Ingenix that resulted in the overcharging of patients.

f. New York requires use of Fair Health in connection with the surprise bills legislation and Connecticut requires use of Fair Health with respect to out of network emergency claims. The IHC Board should similarly require use of Fair Health.

g. Using Fair Health will reinvigorate the market because patients and physicians will have transparency with regard to out of network fees.

h. The commenter disagrees with the IHC Board and believes standardization should be a desired goal because consumers want the choice of an out of network provider.

i. The higher premium associated with a plan that has out of network benefit is a "down-payment" for having out of network benefits. Consumers expect the higher premium will result in benefits for a significant or ascertainable portion of the out of network fees.

j. The Affordable Care Act encourages the comparison of insurance products. The proposal is a step backward.

k. The commenter clarified that adopting Fair Health should not necessitate use of the 80th percentile. Carriers could use a lower percentile. (1)

RESPONSE: The IHC Board thanks the commenter for the multi-reasoned comment. The IHC Board's response follows the above list format.

a. The commenter correctly stated the Board previously studied and discussed the out of network payment methodology during various Board meetings. The IHC Board disagrees that stakeholders had no opportunity for early input. All IHC Board discussions of the out of network methodology which began during the fall of 2009 occurred during open public meetings. The minutes for the meetings are posted on the IHC Board's website. From time to time the IHC Board has received requests from stakeholders to speak to the Board. Those requests are always granted. It is accurate that the IHC Board considered holding a specific stakeholder meeting, but ultimately did not. Because Board meetings are open to the public, and the IHC Board provides the public an opportunity to speak at IHC Board meetings, the IHC Board disagrees that key stakeholders did not have an opportunity for early input.

b. The IHC Board disagrees with the commenter that directing carriers to identify the basis to determine allowed charges will not result in more transparency. In fact, the proposed rules do provide transparence. The specific direction set forth in N.J.A.C. 11:20 Appendix Exhibit A states:

"Carrier must specify the method used to determine the allowed charge and explain how a covered person may learn the allowed charge for a service the covered person may receive." Thus, if a carrier elects to use Fair Health, the carrier must identify Fair Health, specify the percentile of Fair Health and include information regarding how the member can find the Fair Health information. Likewise, if a carrier elects to use a specific percentage of CMS data the

carrier must include information regarding where the member can locate the CMS information. For any services not found in the selected database members may request the information from the carrier. Therefore, because all individual plans that include out of network benefits must include specific information about how the carrier determines the allowed charges, the rule proposal achieves the goal of transparency regardless of the methodology chosen by a carrier. The IHC Board notes that carriers currently disclose the basis to determine the allowed charge in large group plans. Carriers define the term "allowed charge" or another similar term, and explain the out of network benefit determination to members. In light of carrier practices with large group plans and the specific disclosure requirements set forth in the proposal, the IHC Board finds there is no reason to expect carriers would not provide necessary and appropriate information to individual consumers.

c. The IHC Board disagrees that the goal of the proposal is to increase the number of plans sold that include out of network benefits. Rather, the goal of the proposal is to allow for an appropriate and meaningful definition of allowed charges with respect to voluntary out of network services. To be meaningful, the database must allow for transparency which was not the case with PHCS. In addition, the commenter draws an incorrect analogy to the change in ownership from HIAA to Ingenix. The IHC Board regulation at N.J.A.C. 11:20-24.5 requires use of the Prevailing Healthcare Charges System (PHCS) profile. That PHCS profile was initially published and available from HIAA. HIAA sold the profile to Ingenix. There was no change in the profile and the IHC Board continued to require the PHCS profile to be used. The change involved only the owner of the profile and the entity from which carriers could purchase the profile. However, the change from PHCS to Fair Health is different because it was not merely a change in ownership of an existing database. There is no newly available PHCS profile

data because new PHCS profile data is no longer developed. The IHC Board's requirement was to use the PHCS profile that was most recently available from Ingenix. If Fair Health had simply replaced Ingenix in making PHCS profile data available the IHC Board would have continued to use PHCS profile data as available from Fair Health. Since that was not the nature of the transaction that occurred, the IHC Board did not automatically transition to require use of Fair Health data.

d. The IHC Board is a State agency with independent rulemaking authority. The IHC Board proposes rules that the IHC Board finds are in the best interest of the Individual Health Coverage Program. The decisions of other State agencies to use Fair Health for specific purposes were based on considerations important to those agencies. The IHC Board was aware of the PIP rules and the State Health Benefit Plan use of Fair Health. Although the IHC Board considered Fair Health data as a potential option, the IHC Board voted to proceed in a different direction for the reasons set forth in the proposal.

e. The IHC Board is aware that the credibility of the PHCS data was challenged by a number of sources and that ongoing use of the PHCS data as was available through Ingenix cannot continue indefinitely. The IHC Board does not agree that discontinuing use of the PHCS profile necessitates adoption of Fair Health as a replacement.

f. The IHC Board appreciates the fact that New York and Connecticut have identified Fair Health as a source of information with respect to very specific circumstances. As explained in the proposal, the allowed charge definition applies exclusively to voluntary out of network charges. In New Jersey, neither surprise bills nor out of network emergency claims are paid using a definition of allowed charge. Thus, the IHC Board disagrees that the decisions made by

New York and Connecticut or the experience of these two States with use of Fair Health have any bearing on the decision process for the IHC Board.

g. The IHC Board agrees that transparency is desired both by patients and providers. The IHC Board does not agree that the only means to achieve transparency is to adopt Fair Health.

h. While the commenter disagrees with the IHC Board that standardization of the means to determine the allowed charge is no longer necessary, the commenter does not explain why standardization of the basis for allowed charges is necessary. The commenter states that consumers want a choice to be able to use an out of network provider. It is unclear how the commenter believes the desire to be able to use an out of network provider translates into a need to standardize how allowed charges are determined for the voluntary use of an out of network provider.

i. The commenter correctly states that the premium for plans with out of network benefits is generally higher than the premium for a network-only plan. The IHC Board disagrees that the higher premium is any sort of "down-payment" toward the out of network charges or that the higher premium paid results in benefits that are a significant portion of the out of network provider's fees. The charges made by an out of network provider do not determine the benefit payable. Rather, the allowed charge determination combined with the cost sharing provisions of the plan determines the benefit payable. The direction given to carriers in the allowed charge definition will ensure that patients have the tools necessary to ascertain the benefit payable for any voluntary out of network service. Whether the benefit paid is a significant portion of the out of network fee will depend on where the provider sets his or her fees.

j. The commenter correctly notes that the Affordable Care Act encourages comparison of insurance products. That comparison involves the essential health benefits and the cost sharing

provisions that are captured with the metal levels. Nothing in the Affordable Care Act addresses the definition of allowed charges with respect to voluntary out of network services. In fact the metal levels which are established according to the actuarial value of each plan are determined based on network benefits only. The existence or lack thereof of out of network benefit is not a factor in the actuarial value of a plan. The IHC Board disagrees that the Affordable Care Act directly or even indirectly requires or encourages the standardization of the basis for allowed charges.

k. The IHC Board thanks the commenter for clarifying that use of Fair Health need not be tied to the 80th percentile. The IHC Board finds that clarification inconsistent with the commenter's support of standardization which the IHC Board understands to mean not just the data base but also the percentile or percentage. The IHC Board does not favor requiring carriers to use Fair Health even if carriers could select the percentile. The IHC Board reminds the commenter that as explained in the proposal carriers offering plans with out of network benefits will define allowed charges and specify not just the selected profile but also the selected percentile.

The IHC Board has considered the various reasons posed by the commenter in opposition to the Board's proposed amendment to repeal N.J.A.C. 11:20-24.5 and amendment to the definition of allowed charge included in the standard plan text. The IHC Board understands the commenter favors the use of Fair Health. The IHC Board notes that carriers selecting a methodology to use to determine allowed charges will consider all available options and may elect to use Fair Health or may elect to use some other profile. For the reasons stated above, the IHC Board is making no change in response to the comment.

3. COMMENT: The commenter objects to changes in the rulemaking process. The commenter believes the Board proposes to shorten the notice provision to twenty days. The commenter gave several reasons for opposing the shorter period. As a major stakeholder the commenter believes advance notice of the proposal should have been provided. The commenter expressed concern that the proposal was published in the *New Jersey Register* on August 15 which was three days prior to the hearing and seven days prior to the end of the comment period. The commenter objects to the presentation of 11:20-24.5 as "Reserved" rather than as repealed and suggests that the repeal of N.J.A.C. 11:20-24.5 lacked transparency. (1)

RESPONSE: As the IHC Board proposed no changes to the rulemaking process the IHC Board is unsure as to why the commenter believes the proposal includes a change to the process. The IHC Board refers the commenter to N.J.S.A. 17B:27A-16.1 which specifies the process whereby the IHC Board may expedite adoption of certain actions, including modification of the IHC Program's health benefits plans and policy forms, if the IHC Board provides a minimum 20-day period during which to comment on the Board's intended action following notice of the intended action in three newspapers of general circulation and to interested parties, with instructions on how to obtain a detailed description of the intended action and the time, place, and manner by which interested parties may present their views regarding the intended action. N.J.S.A. 17B:27A-16.1 has been judicially tested and upheld. See In re N.J. IHC Program's Readoption of N.J.A.C. 11:20-1 et seq., 353 N.J. Super. 494 (App. Div. 2002), aff'd in part and rev'd in part on other grounds, 179 N.J. 570 (2004). The IHC Board used that process but with a 45-day comment period rather than the minimum 20- day period. The response to Comment 1 addresses the commenter's comment regarding advance notice. When the IHC Board uses the process set forth in N.J.S.A. 17B:27A-16.1 the comment period is measured from the date notice

of the proposal is filed, not the date of publication in the *New Jersey Register*. The use of "(Reserved)" is a convention of the Office of Administrative Law. Persons reviewing the proposal were clearly advised of the repeal of N.J.A.C. 11:20-24.5 on the first page of the proposal which states: "Proposed Repeals: N.J.A.C. 11:20-3.5, 12.3, 22, 24.5, and 11:20 Appendix Exhibit L Parts 1 and 2." The IHC Board included extensive discussion of the proposed repeal of N.J.A.C. 11:20-24.5 in the proposal summary. The IHC Board finds the repeal of N.J.A.C. 11:20-24.5 was indeed transparent to persons reading the proposal.

4. COMMENT: One commenter opposed the proposed amendment to N.J.A.C. 11:20-2.5. The commenter believes the IHC Board has five members and a quorum would be three members meaning a majority could be as few as two members. The commenter is concerned that the majority of seats are held by carriers. The commenter suggests that at least one person constituting a quorum must be the State's representative or another non-carrier Director. (2)

RESPONSE: The IHC Board currently has six members, not five. A quorum of the Board requires four members. A majority of votes would require three votes. As a practical matter, while a specific person has been named as the Commissioner's designee, the seat is filled by an alternate when the primary designee is unavailable. The IHC Board recalls no instances in which the Board met without the Commissioner's designee. Thus one of the members constituting a quorum would be the Commissioner's designee. The non-carrier director seats are personally held. The consumer representative currently holding a seat cannot name an alternate when she is unavailable. No change is being made in response to this comment.

5. COMMENT: One commenter opposed the amendments to N.J.A.C. 11:20-2.9(c) because the commenter believes the Board should not determine what information is proprietary and confidential. The commenter believes the State should make such a determination. (2)

RESPONSE: The IHC Board notes that the amendments proposed at N.J.A.C. 11:20-2.9(c) conform the provision to the requirements of the Open Public Records Act set forth in N.J.S.A. 47:1A-1 et seq. Thus the determinations of whether information is proprietary and confidential are governed by State standards. Furthermore, the Open Public Records Act provides that "all government records shall be subject to public access unless exempt from such access by . . . regulation promulgated under the authority of any statute or Executive Order of the Governor . . ." N.J.S.A. 47:1A-1. Because the IHC Board is a State agency with rulemaking authority, it has the discretion to promulgate a rule determining that a type of record is non-public for the purposes of the Open Public Records Act. No change is being made in response to this comment.

6. COMMENT: One commenter opposed the amendment to N.J.A.C. 11:20-17.3 that allows carriers 60 days rather than 45 days following the close of the calendar quarter to file enrollment status reports. In order to align data with nationally reported statistics and to identify trends as quickly as possible the commenter favors retaining the 45-day requirement. (2)

RESPONSE: The IHC Board recognizes the importance of credible data and would like to have that data as quickly as possible. However, following the addition of Federal reporting requirements in the past several years the IHC Board has found the enrollment data submitted within the 45-day period often required revisions. There have been many quarters when enrollment data was not posted on the Board's website shortly after the 45-day period ended because the IHC Board delayed posting until the data was determined accurate. The IHC Board finds the additional time to prepare the reports will enhance the quality of the data thereby reducing the time lag between when the information is received and when the information can be

posted to the website. In other words, the IHC Board anticipates that the data will be posted soon after the 60-day period ends. No change is being made in response to this comment.

7. COMMENT: One commenter partially supports and partially opposes amendments made to N.J.A.C. 11:20-17.4 concerning the contents of the enrollment status report. The commenter supports the elimination of the annual enrollment requirement and the inclusion of enrollment data addressing EPO plans on the quarterly enrollment reports. The commenter opposes the elimination of the previously insured status because that information allows insight into trends and market shifts and the impact of churn between Medicaid and the individual market. The commenter also opposes the elimination of reporting by age, gender and zip code data. The commenter believes the information is valuable to researchers. (2)

RESPONSE: The IHC Board thanks the commenter for supporting some of the amendments. The IHC Board suspects the commenter is not aware that the previously insured data is based on the response to an application question that asks if the applicant had previous coverage. If the response is yes, then the contract is reported as previously insured. If the response is no, then the contract is reported as previously uninsured. If the question has not been answered, the contract is reported as unknown. None of the information the commenter suggested would be useful could be gleaned from knowing the number of persons who self-report that they had or did not have previous coverage. Some applicants did not even answer the question. Carriers reported that some applicants were unsure how to answer the question and applicants may have responded they had previous coverage even though the previous coverage may have been months ago. The inaccuracy of the self-reported information led the IHC Board to conclude that it simply is not credible information. The IHC Board gathers enrollment information for the benefit of the IHC Board as it carries out its responsibilities under the IHC

Act. The IHC Board is pleased when it learns the information is useful not just to the IHC Board but also to other persons who analyze the individual market. As the IHC Board has no need to gather age, gender and zip code information the Board chose to remove it from the reporting requirement. The IHC Board is aware that the Federal government gathers and reports some age, gender and zip code information. Researchers may wish to review the data collected and reported by the Federal government. No change is being made in response to this comment.

8. COMMENT: One commenter expressed concern with the amendment to N.J.A.C. 11:20-24.5 and "the exposure consumers could face from the carrier's ability to arbitrarily determine how the amount will be determined." The commenter notes that consumers could be faced with "financial liability previously unexperienced depending on the methodology adopted by carriers." The commenter believes it is positive that New Jersey has been unique in addressing out of network payments and supports continuing the consumer protection. (2)

RESPONSE: The IHC Board disagrees with the commenter's characterization of the discretion the IHC Board proposed to give carriers regarding defining allowed charges as permitting them "to arbitrarily determine how the amount will be determined." As explained in the proposal, carriers must select a basis to determine allowed charges and that basis must allow for transparency. The basis would be consistently applied to voluntary out of network claims. The IHC Board disagrees that carriers would making arbitrary decisions as they process voluntary out of network claims.

As explained in the proposal, standardization of the basis for allowed charges was meaningful when most plans relied on the definition of allowed charge. The IHC Board agrees the consumer protection the standardization provided was necessary and appropriate at that time. The IHC Board finds that the transparency tools that are available to allow consumers to access

allowed charge information provide the necessary consumer protection in that consumers will be able to make informed decisions regarding the voluntary use of out of network providers. No change is being made in response to this comment.

Summary of Agency Initiated Amendments

Upon adoption, the IHC Board is amending the emergency services provisions of Plans A/50 – D set forth in N.J.A.C. 11:20 Appendix Exhibit A to explain the reason covered persons are required to provide notice to the carrier of the use of emergency services. The change is nonsubstantive, intended only to clarify that calling the carrier within 48 hours, or as soon as reasonably possible, provides the carrier with the information necessary to provide benefits for the emergency at the network level.

Upon adoption, the IHC Board is amending the vision benefit section of the schedule page of Plans A/50 – D set forth in N.J.A.C. 11:20 Appendix Exhibit A to state that the exams, lenses and frames are available per 12-month period rather than per calendar year. This technical change will make the schedule page text consistent with the text in the vision benefit.

Federal Standards Statement

State agencies that propose to adopt or amend State rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. As discussed in the proposal Summary, the proposed amendments and repeals are subject to Federal requirements addressing certain standards for health insurance contracts. The IHC Board does not believe the proposed amendments and repeals exceed the Federal requirements.