INSURANCE

NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Adopted Amendments: N.J.A.C. 11:20 Appendix Exhibits A and B

Proposed: March 17, 2021

Adopted: May 11, 2021, New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director.

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

Filed: _____, 2021 as R. 2021 d. ____ **with non-substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Effective Date: Upon Promulgation

Operative Date: January 1, 2022

Expiration Date:

Summary of Hearing Officer's Recommendations and Agency Responses

The New Jersey Individual Health Coverage Program Board (IHC Board) held a hearing on Wednesday, March 31, 2021 by teleconference in accordance with P.L. 2020, c. 11 to receive testimony with respect to the health benefits plans, set forth in N.J.A.C. 11:20 Appendix 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

Two comments were received from one commenter, the New Jersey Association of Health Plans.

COMMENT: The commenter objected to the amendment to the Payment of Premiums-Grace Period provision that "deletes text that was interpreted as limiting the premium payor to the policyholder. Rather than stating premiums must be paid by "You", where "You" is the term defined to mean the policyholder, the proposed amendments state simply the fact that premiums must be paid. The change clarifies that the Board sanctions third-party payments of premium. Respectfully, we object to this change and to the practice of unlimited third-party payments of premiums." The commenter noted that while Federal antikickback statutes do not apply to the individual health benefits plans, the same rationale should apply to commercial insurance.

RESPONSE: As evidenced by Board meeting minutes, the Board carefully weighed the amendment made to the Payment of Premiums – Grace Period provision before proposing the amendment that made the sentence construction passive and eliminated any reference to the premium payor. Although the existing standard plan text explicitly stated that premiums must be paid by You, where You refers to the policyholder, carriers offering the standard individual plans had been allowing premiums to be paid by parties other than the policyholder. For example, premiums may have been paid by a family member, and carriers are required to accept third-party payments in specific circumstances consistent with 45 C.F.R. 156.1250, which mandates that carriers accept premium payments from (1) a Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act; (2) an Indian tribe, tribal organization or urban Indian organization; and (3) a local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf. Medicaid has had the option under federal law to pay premiums for private insurance since 1973. New Jersey's Medicaid program has elected to pay premiums for some of its recipients for many years.

The Board considered including text in the Payment of Premiums-Grace Period provision to specify the potential payors and determined that such text would not be appropriate in a policy provision. The Board finds that the proposed policy provision does not require carriers to accept all sources of premium payments, and may restrict third party premium payments so long as they comply with applicable state or federal laws concerning third party premium payment. If the Board determines at a later time that it would be beneficial to provide additional guidance regarding third party premium payment, the Board could propose amendments to the Program Compliance subchapter at N.J.A.C. 11:20-24.

No change is being made in response to the comment.

COMMENT: The Commenter noted that to comply with the requirements of P.L 2019, c. 361 the Board proposed amending the contraceptives provision to include language mirroring that of the statute. The Commenter requested confirmation that carriers can exclude certain contraceptive drugs, devices or products so long as coverage is provided for a therapeutic class. The Commenter asked if drugs, devices or products that are excluded because of the coverage of a therapeutic equivalent with cost sharing must be covered and if yes, asked that the schedule clarify the coverage.

RESPONSE: The Board interprets the coverage mandated by P.L. 2019, c. 361 as expressly requiring coverage for the requested contraceptive drug, device or product OR for one or more therapeutic equivalents of the requested drug, device or product. Thus, the mandated coverage permits use of a closed formulary where no coverage under the contraceptive benefit is available for those contraceptive drugs, devices or products for which coverage is provided for a therapeutic equivalent. The closed formulary allowed under P.L. 2019, c. 361 is specific to contraceptives

covered under this mandate. The Board acknowledges the open formulary requirements of N.J.A.C. 11:22-5.9. Therefore, to the extent a contraceptive drug, device or product is excluded under P.L. 2019, c. 361 because a therapeutic equivalent is covered, coverage of the excluded drug would be afforded under the prescription drugs provision. Since Federal law (42 U.S.C. 300gg-13(a)(4)) requires coverage of preventive care, which includes network contraceptives, without cost sharing, the coverage of the contraceptive under the prescription drug provision would be without cost sharing.

On adoption, the Board is amending the specimen schedule page text to include text carriers may include to make it clear that contraceptives as listed on the schedule refers to those included under the contraceptives provision (i.e. those required to be covered by P.L. 2019, c. 361). The prescription drug section of the schedule is amended to include text carriers may include to address the coverage of contraceptives not covered under the contraceptives provision because a therapeutic equivalent is substituted. Whether covered under the contraceptives provision or under the prescription drug provision, contraceptives are covered with no cost sharing. Additionally, the Prescription Drugs provision is amended to include a phrase that explains that contraceptives not covered under the contraceptives provision are covered under the prescription drugs provision.

The text added on adoption is included as variable text to recognize that a carrier may choose to forego the opportunity to substitute a therapeutic equivalent and include coverage for all contraceptives under the contraceptives provision. In such a case the text added on adoption is unnecessary and would not be included.

Agency Initiated Changes

The IHC Board is making no agency initiated changes on adoption.

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, some of the proposed amendments are intended to comply with Federal law, 45 CFR 155.420 and 84 F.R. 28888. The proposed amendments do not exceed the requirements of 45 CFR 155.420 and 84 F.R. 28888. Accordingly, a Federal standards analysis is not required.