INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Small Employer Health Benefit Plans

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

Proposed Repeals: N.J.A.C. 11:21-2.13, 2.17, 7.13, 8, 10.2, and 17.4 and 11:21 Appendix Exhibits BB Part 6 and KK

Authorized By: New Jersey Small Employer Health Benefits Program Board of Directors (Ellen DeRosa, Executive Director).

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

Proposed: July 7, 2016.

Adopted: October 12, 2016 by the New Jersey Small Employer Health Benefits 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

Operative Date: January 1, 2017

Expiration Date:

Summary of Hearing Officer's Recommendations and Agency Responses:

The New Jersey Small Employer Health Benefits Program Board (SEH Board) held a hearing on August 18, 2016 at 9:00 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 F, G, W, Y, HH and II of

the Appendix to N.J.A.C. 11:21. Ellen DeRosa, Executive Director of the SEH Board, served as hearing officer.

Joan Fusco representing Savoy Associates and Matthew Greller representing Teladoc, Inc. attended the hearing and requested the opportunity to offer testimony.

Joan Fusco stated she submitted written comments on July 8, 2016 and asked when she would receive responses to the comments. E. DeRosa explained that all written comments will be summarized and responses will be included in the notice of adoption that will be filed after the close of the comment period. Ms. Fusco said she had no comments other than those that were previously submitted in writing.

Matt Greller said Teladoc would be submitting written comments to address two main issues. First, pending legislation defines telemedicine in a manner that provides for technology neutrality and thus would contemplate technology yet to be developed. Teladoc favors a definition of telemedicine such as the one included in proposed legislation, A. 1464 and S. 291. He said the definition included in the SEH Board's proposal would forestall later technological developments. M. Greller said Teladoc is concerned that the standard plan text illustrates cost sharing for telemedicine visits as a fixed dollar amount. Teladoc recommends replacing the fixed dollar amount with a formula that would reflect price increases or decreases and offered to work with the SEH Board in the development of a formula.

No additional persons requested the opportunity to offer testimony 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:

The SEH Board accepted written comments on the proposal through August 22, 2016. The following is a summary of the comments received from the public and the SEH Board's responses. Each comment is identified at the end of the comment by a number that corresponds to the following list:

1. Michelle Scott, General Counsel, FAIR Health
2. Nicholas Peterson, Horizon Blue Cross Blue Shield of New Jersey
3. Melinda Martinson, General Counsel, Medical Society of New Jersey
4. Theresa Edelstein, Vice President, New Jersey Hospital Association
5. Joan Fusco, Director, Research & Education, Savoy Associates
6. Claudia Tucker, Vice President, Teladoc

1. COMMENT: Although the commenter states that the comment letter "does not address the substance of the proposed amendments" the commenter wished to "correct erroneous information" in the proposal summary and alleged misinformation the commenter states was given to New Jersey government officials. The commenter disagrees with the explanation in the proposal that "states that since 2010, when Ingenix ceased producing charge benchmarks for healthcare services, there has been no source of information about charges." The commenter explained that upon cessation of the production of Ingenix benchmarks FAIR Health issued benchmark modules "which were expressly intended to supplant the prior benchmarks offered by Ingenix." The commenter notes that DOBI was well-informed about FAIR Health and cites the PIP regulation as evidence. The commenter further states that in 2014 FAIR Health advised DOBI of concerns with the use of 2010 rates to determine benefits. (1)

RESPONSE: As part of the discussion of the proposed repeal of N.J.A.C. 11:21-7.13 the proposal provides some information regarding PHCS and states: "As a result of legal action in

New York, the PHCS data base was eliminated in 2010. No updated data has been produced since that time. As required by rule, small employer carriers that already had the 2010 data have continued to process voluntary out-of-network claims using 2010 data. Carriers that did not exist in 2010 have no ability to access the 2010 PHCS data and, thus, have not been able to offer plans with out-of-network benefits, impeding employer choice and potentially skewing market competition." As the entire paragraph concerns PHCS the SEH Board suspects the commenter read the second sentence out of context to draw the erroneous conclusion expressed in the comments. The SEH Board finds that the proposal correctly explained that no updated PHCS data has been produced since 2010.

The SEH Board is aware of FAIR Health and understands that FAIR Health began producing benchmark data to coincide with the timeframes in which updated PHCS data ceased to be available. The SEH Board also understands that the PIP regulations which rely on FAIR Health benchmark information were proposed and adopted by the Department of Banking and Insurance which is a different State agency from the SEH Board, which proposed the notice of readoption with amendments. No change was requested and no change is being made in response to this comment.

2. COMMENT: A commenter stated that America's Health Insurance Plans (AHIP) published a study that was presented to state government officials and expressed concern with information included in the study. (1)

RESPONSE: The SEH Board did not consider the study in the rulemaking. No change was requested and no change is being made in response to this comment.

3. COMMENT: A commenter stated that while the proposed regulation at N.J.A.C. 11:21-7.7A(c) states the effective date of coverage selected during a special enrollment period

following the loss of minimum essential coverage will be the day after the loss of coverage the policy form text states the effective date is the first of the month following the receipt of the enrollment form. Similarly, the regulation states the effective date of coverage selected during a special enrollment period for coverage required by a court order will be the date specified in the order, yet the policy form text states the effective date is the first of the month following the receipt of the enrollment form. The commenter requested that the inconsistency be reconciled. (2)

RESPONSE: The SEH Board thanks the commenter for noting the inconsistency with respect to the loss of minimum essential coverage and upon adoption is adding the following text to the Special Enrollment Rules provision of the policy forms. "If the triggering event is loss of minimum essential coverage the effective date may be as early as the day after the loss of minimum essential coverage." The SEH Board notes that Enrollment Requirement provision of the Dependent Coverage section already states that "Coverage will take effect as of the date required pursuant to a court order." Thus no change is necessary with respect to that part of the comment.

4. COMMENT: One commenter observed that the definition of Dependent contained in the policy forms explains that legal spouse is limited to spouses of a marriage as marriage is defined with respect to the provisions of the policy regarding Medicare Eligibility by reason of Age and by Medicare Eligibility by Reason of Disability. The definition in N.J.A.C. 11:21-1.2 does not include that same information. The commenter requested that the regulation be amended to align with the definition in the policy forms. (2)

RESPONSE: The SEH Board thanks the commenter for noting this inconsistency. On adoption the SEH Board is amending the definition of Dependent in N.J.A.C. 11:21-1.2 to include text that is included in the policy form definition.

5. 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. (3)

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. The SEH Board is aware that the Department of Banking and Insurance (Department) provided advance notice with respect to a proposal that would amend various provisions of the small employer regulations that are governed by the Department rather than the SEH Board. Since the SEH Board is primarily composed of stakeholders who, but for the Commissioner of Insurance representative, are not government officials in their roles outside of the SEH Board, and because the SEH Board conducts all of its business in public sessions, and accepts comments from the public without restriction as to topic, the SEH Board does not typically issue a specific advance notice of rules. The situation surrounding this particular proposal was no different. The SEH 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 April 20, May 18 and May 25. The SEH Board disagrees that the public was deprived of the opportunity to provide input prior to the publication of the proposed regulation.

6. 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 many times during the past three years and drafted a whitepaper. Key stakeholders were not given the opportunity for early input yet the SEH 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 small employers whose employees 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 SEH 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 SEH Board should have similarly changed from Ingenix to Fair Health and states that if the SEH 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 SEH 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 SEH Board and believes standardization should be a desired goal because consumers want the choice of an out of network provider. Physicians and patients "do not accept the erosion of patients' right to their choice of physician through carrier designed closed and narrow networks and opaque benefit design. They embrace patients' right to transparent benefits."

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 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. (3)

RESPONSE: The SEH Board thanks the commenter for the multi-reasoned comment. The SEH 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 SEH Board disagrees that stakeholders had no opportunity for early input. All SEH Board discussions of the out of network methodology occurred during open public meetings. The minutes for the meetings are posted on the SEH Board's website. Because Board meetings are open to the public, and the SEH Board provides the public an opportunity to speak at SEH Board meetings, the SEH Board disagrees that key stakeholders did not have an opportunity for early input.

b. The SEH 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. As an example, the specific direction set forth in N.J.A.C. 11:21 Appendix Exhibit F 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 covered person 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 covered person can locate the CMS information. For any services not found in the selected database covered persons may request the information from the carrier. Therefore, because all small employer 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 SEH 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 covered persons. In light of carrier practices with large group plans and the specific disclosure requirements set forth in the proposal, the SEH Board finds there is no reason to expect carriers would not provide necessary and appropriate information to consumers covered under small employer plans with out of network benefits.

c. The SEH 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 SEH Board regulation at N.J.A.C. 11:21-7.13 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 SEH 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; the PHCS was abolished, not transferred to a new proprietor as was the case when HIAA sold the profile to Ingenix. There is no newly available PHCS profile data because new PHCS profile data is no longer developed. The SEH 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 SEH 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 SEH Board did not automatically transition to require use of Fair Health data.

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

e. The SEH 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 SEH Board does not agree that discontinuing use of the PHCS profile necessitates adoption of Fair Health as a replacement.

f. The SEH 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 SEH 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 SEH Board.

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

h. While the commenter disagrees with the SEH 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 given the use of "closed and narrow networks and opaque benefit design" associated with network providers. 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. The SEH Board notes that carriers offer plans with out of network benefits in the large group market and designs in the large group market are not and have never been standardized.

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 SEH 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. 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 SEH Board disagrees that the Affordable Care Act directly or even indirectly requires or encourages the standardization of the basis for allowed charges.

k. The SEH Board thanks the commenter for clarifying that use of Fair Health need not be tied to the 80th percentile. The SEH Board finds that clarification inconsistent with the commenter's support of standardization which the SEH Board understands to mean not just the data base but also the percentile or percentage. The SEH Board does not favor requiring carriers to use Fair Health even if carriers could select the percentile.

The SEH Board has considered the various reasons the commenter opposes the Board's proposed amendment to repeal N.J.A.C. 11:21-7.13 and amendment to the definition of allowed charge included in the standard plan text. The SEH Board understands the commenter favors the use of Fair Health. The SEH 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 SEH Board is making no change in response to the comment.

7. COMMENT: One commenter opposes the change to the dependent age limit from 31 to age 26. The commenter states that the Legislature intended for dependents to be covered until their 31st birthday. (3)

RESPONSE: The SEH Board notes that the proposal does not change existing rules concerning the dependent age limit. The provisions that address over-age coverage are in the policy forms, under "New Jersey Continuation Rights for Over-Age Dependents." Under both

the current forms and the proposed readoption, the forms state: "If a Dependent Child is over the age 26 limiting age for dependent coverage and: a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age 26; or b) the Dependent child has proof of prior creditable coverage or receipt of benefits, he or she may elect to be covered under the Employer's plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below."

The SEH Board refers the commenter to N.J.S.A. 17B:27A-19.16. The coverage of dependents until age 31 creates an opportunity for coverage to continue beyond the dependent limiting age of 26 for dependents who meet the definition of dependent in N.J.S.A. 17B:27A-19.16. Thus, the SEH Act's provision stating that a dependent is someone who is 30 years of age or younger, N.J.S.A. 17B:27A-19.16(a)1, is one of several criteria that define a "dependent" for the purpose of N.J.S.A. 17B:27A-19.16. Coverage until age 31 means a dependent who loses coverage due to attainment of the age 26 limiting age has the opportunity to elect to continue the coverage until the age of 31 provided the conditions set forth in N.J.S.A. 17B:27A-19.16 are satisfied. No change is being made in response to this comment.

8. COMMENT: The commenter objects to changes in the rulemaking process. The commenter believes the SEH 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 11:21-7.13 as "Reserved" rather than as repealed and suggests that the repeal of N.J.A.C. 11:21-7.13 lacked transparency. (3)

RESPONSE: As the SEH Board proposed no changes to the rulemaking process the SEH Board is unsure as to why the commenter believes the proposal includes a change to the process. Pursuant to N.J.S.A. 17B:27A-51, the SEH Board may expedite adoption of certain actions, including modification of the SEH Program's health benefits plans and policy forms, if the SEH Board provides interested parties a minimum 20-day period during which to comment on the Board's intended action following notice of it in three newspapers of general circulation, with instructions for obtaining a detailed description of the proposed action and the manner for submitting comments to the Board. Concurrently, the SEH Board must forward notice of the proposed action to the Office of Administrative Law (OAL) for publication in the New Jersey Register (note, however, that the comment period runs from the date the notice of the proposed action is submitted to the newspapers and OAL, not from the date of publication of the notice in the New Jersey Register.) The SEH Board is also required to send notice of the intended action to affected trade and professional associations, carriers, and other interested persons who may request such notice. In addition, for intended modifications to the health benefits plans, the SEH Board must allow for testimony to be presented at a public hearing prior to adopting any such modifications. The SEH Board notes that the special rulemaking process specified in N.J.S.A. 17B:27A-51 is the same as the special rulemaking process specified in N.J.S.A. 17B:27A-16.1 which is contained in the Individual Health Coverage Program Act. The SEH Board further notes that 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 SEH Board used the process set forth in N.J.S.A. 17B:27A-51 but with a 45-day comment period rather than the minimum 20- day period. The response to Comment 5 addresses the commenter's comment regarding

advance notice. When the SEH Board uses the process set forth in N.J.S.A. 17B:27A-51 the comment period is measured from the date notice of the proposal is filed, not the date of publication in in the *New Jersey Register*. The use of "(Reserved)" is an editorial code depiction convention of the Office of Administrative Law. Persons reviewing the proposal were clearly advised of the repeal of N.J.A.C. 11:21-7.13 on the first page of the proposal which states: "Proposed Repeals: N.J.A.C. 11:21-2.13, 7.13, 8, 17.4 and 11:21 Appendix Exhibits BB Part 6, and KK." The SEH Board included extensive discussion of the proposed repeal of N.J.A.C. 11:21-7.13 in the proposal summary. The SEH Board finds the repeal of N.J.A.C. 11:21-7.13 was indeed transparent to persons reading the proposal.

8. COMMENT: One commenter opposes the amendments proposed to N.J.A.C. 11:21-2.11(c) because the commenter believes the SEH Board should not determine what information is proprietary and confidential. The commenter believes the State should make such a determination. (4)

RESPONSE: The SEH Board notes that the amendments proposed at N.J.A.C. 11:21-2.11(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 SEH 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.

9. COMMENT: One commenter opposes the elimination of N.J.A.C. 11:21-2.13 regarding penalties, adjustments and dispute resolutions. The commenter believes the text should be retained as a "motivator to ensure reporting errors are kept to a minimum." (4)

RESPONSE: As explained in the proposal, the SEH Board determined N.J.A.C. 11:21-2.13 is not necessary. The SEH Board disagrees that the provision would have any effect on whether reporting errors are made. The SEH Board has good working relationships with the carriers participating in the small employer market and has found carriers are cooperative. A "motivator" is unnecessary. No change is being made in response to this comment.

10. COMMENT: One commenter expressed concern with the amendment to N.J.A.C. 11:21-7.13 and "the exposure consumers could face from the carrier's ability to arbitrarily determine how the amount will be determined." Because knowing the basis for determining the allowed charge does not ensure it is appropriate, the commenter notes that consumers could be faced with "financial liability previously unexperienced depending on the methodology adopted by carriers." The commenter supports not only the transparency provided in the proposal but also consistency among carriers. (4)

RESPONSE: The SEH Board disagrees with the commenter's characterization of the discretion the SEH 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 SEH Board disagrees that carriers would making arbitrary decisions as they process voluntary out of network claims. Whether the database a carrier elects to use is "appropriate" is a subjective determination and although the commenter believes the rate the carrier allows must

be the appropriate rate, the commenter did not explain how the commenter believes appropriateness should be evaluated. Certainly each carrier will select the database the carrier finds appropriate.

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 SEH Board agrees the consumer protection the standardization provided was necessary and appropriate at that time. The SEH 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. Although the SEH Board requires carriers to use standard plans the carriers create many unique plan designs using those standard plans. Small employers appreciate the ability to choose from among myriad plan designs. The SEH Board is not aware of employers complaining that there is no consistency among plans. Just as cost sharing amounts, delivery system, tiering and referral requirements are determined by the carriers (within certain parameters established by Federal and State law), the SEH Board leaves the determination of the basis for allowed charges to the carriers. The SEH Board disagrees with the commenter that consistency with respect to out of network benefits is necessary. No change is being made in response to this comment.

11. COMMENT: One commenter asked that the waiver form set forth as Appendix Exhibit T be amended to remove the requirement to include a social security number. The commenter states the information is not needed or used. (5)

RESPONSE: The SEH Board thanks the commenter for the suggestion. The SEH Board agrees a social security number is not necessary information to require of an employee who is

waiving coverage. On adoption the SEH Board is amending Appendix Exhibit T to remove the social security number.

12. COMMENT: One commenter noted that the proposal summary states that owners cannot be covered if they are the only people covered. The commenter states that if there are employees waiving coverage owners have been permitted to buy small employer plans in the past. (5)

RESPONSE: As the SEH Board explained in the proposal, the SEH Board sought to better align New Jersey's rules with Federal law. The SEH Board refers the commenter to the proposal discussion that addresses one of the regulations implementing the Employee Retirement Income Security Act of 1974 (commonly known as "ERISA") at 29 CFR 2510.3-3. That regulation establishes that a group only exists if there are employees covered under the plan, and specifies that an individual and his or her spouse, and partners in a partnership are not considered employees for this purpose if the business is wholly owned by one or both of the spouse(s) or by the partners. To emphasize the requirements of the regulation the proposal specifically noted that while it is possible for owners to be covered under a group plan, if the owners are the only people covered, the plan is not a group health plan. The commenter did not request a change and no change is being made in response to the comment.

13. COMMENT: One commenter stated that the proposal summary incorrectly states two percent shareholders in an S-corporation are not employees. The commenter said the text should have stated "greater than" two percent shareholders are not employees. (5)

RESPONSE: 26 CFR 54.4980H-1 (a) (15) defines employee as follows: "Employee. The term employee means an individual who is an employee under the common-law standard. See § 31.3401(c)-1(b). For purposes of this paragraph (a)(15), a leased employee (as defined in

section 414(n)(2) [26 USCS § 414(n)(2)]), a sole proprietor, a partner in a partnership, a 2-percent S corporation shareholder, or a worker described in section 3508 [26 USCS § 3508] is not an employee." The SEH Board finds the proposal summary was correct in stating two percent shareholders in an S-corporation are not employees.

The SEH Board notes, however, that while the proposal summary was correct the proposed definition of employee in N.J.A.C. 11:21-2.1 incorrectly states "more than" a two-percent shareholder in a Subchapter S corporation. On adoption the SEH Board is correcting the definition of employee to explain that a two percent shareholder in a Subchapter S corporation is not an employee.

14. COMMENT: One commenter disagreed with the proposal summary that indicates the counting method to determine small employer v. large employer has a bearing on COBRA and MSP because those Federal laws require specific counting methodologies. (5)

RESPONSE: The SEH Board suspects the commenter misunderstood text in the proposal summary that states: "it becomes problematic for carriers in trying to determine how to address continuation requirements under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), Federal Medicare as Secondary Payor requirements and other Federal laws." The SEH Board neither states nor implies that the employee counting methodology used for these federal laws is the same as the methodology used to determine whether an employer is a small employer or a large employer. Rather the SEH Board referred to other Federal laws because these laws define employee according to the Federal standards with which the SEH Board is aligning the small employer rules. No change is being made in response to this comment.

15. COMMENT: One commenter supports the continued definition of employee eligibility that requires employees to work at least 25 hours per week. The commenter notes that increasing the requirement to 30 hours would have resulted in the loss of coverage for employees working between 25 and 29 hours per week. (5)

RESPONSE: The SEH Board thanks the commenter for the supportive comment.

16. COMMENT: One commenter supports the proposal to discontinue use of PHCS and require carriers to specifically identify the standard for the determination of allowed charges within the definition of allowed charges contained in the standard plans. (5)

RESPONSE: The SEH Board thanks the commenter for the supportive comment.

17. COMMENT: One commenter supports the clarification in the proposal that an individual and spouse, if at least one of them owns the business, cannot be considered an employee. (5)

RESPONSE: The SEH Board thanks the commenter for the supportive comment.

18. COMMENT: One commenter thanks the SEH Board for explaining how the text of the dental care and treatment provision could have the effect of excluding coverage of a pre-existing condition. (5)

RESPONSE: The SEH Board thanks the commenter for the supportive comment.

19. COMMENT: One commenter requested that the definition of telemedicine included in the standards plans be replaced with a definition that closely corresponds with the definition found in pending legislation A. 1464 and S. 291. The commenter states that a technology-neutral definition would be consistent with the model policy developed by the Federation of State Medical Boards. The commenter emphasized that telemedicine is a tool, not a new specialty or practice. The commenter suggested amendments to the definition found in pending legislation

A. 1464 and S. 291, and the amended definition should be included in the standard plans. A brief version of this comment was provided during the hearing by Matt Greller. (6)

RESPONSE: The following response addresses both the testimony offered during the hearing as well as the written comment. The SEH Board thanks the commenter for the information regarding A. 1464 and S. 291 as well as the background information regarding Teladoc and the tool of telemedicine. The SEH Board will monitor activity with the pending legislation and will consider changes to the definition of telemedicine that may be required by any enacted legislation. The SEH Board does not favor amending the regulations to comply with the requirements of legislation until the legislation has been enacted. No change is being made in response to this comment.

20. COMMENT: One commenter suggested that cost sharing for telemedicine visits should utilize a formula to calculate the amount rather than setting the cost sharing at a fixed dollar amount. The commenter offered to assist with the development of the formula. A similar comment was provided during the hearing by Matt Greller. (6)

RESPONSE: The following response addresses both the testimony offered during the hearing as well as the written comment. The SEH Board notes that the cost sharing illustrated in the standard plan text specifies a maximum copayment of $50. Thus the cost sharing for telemedicine is not fixed at $50 and could be an amount less than $50. The SEH Board notes the $50 limit was selected because $50 is the greatest copayment permitted by N.J.A.C. 11:22-5.5(a)2 for a primary care visit. The SEH Board expects that the cost sharing a carrier applies to telemedicine would not exceed the cost sharing the carrier applies to a primary care visit. Although the commenter recommended use of a formula, instead of offering any information regarding how a formula might operate, the commenter offered to assist with development. The

SEH Board cannot comment on the merits of a formula that has yet to be outlined or developed. No change is being made in response to this comment.

Summary of Agency Initiated Amendments

Upon adoption, the SEH Board is amending the emergency services provisions in the standard plans 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 SEH Board is amending the vision benefit section of the schedule page of the standard plans to state that the exams, lenses are 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.

Upon adoption the SEH Board is amending the definition of "Employee" to more closely align with the definition in N.J.A.C. 11:21-1.2 and the explanation of the term employee as provided in the proposal summary. This technical change will make the definition of employee as it appears in N.J.A.C. 11:21-1.2 and the policy forms consistent.

Upon adoption, the SEH Board is amending N.J.A.C. 11:21-10.3(a) on adoption to delay the due date for the filing of the Market Share Report until April 1. The SEH Board expects that delaying the due date from March 1 until April 1 will provide carriers with additional time to validate the premium information contained in the report. Upon adoption, the SEH Board is amending the market Share Report set forth in Appendix Exhibit CC to specify the April 1 due date. Since the Market Share Report is an administrative form that provides data the SEH Board

requires to calculate the carrier assessment the delay in the filing due date will not adversely impact any interested party.

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. The rules proposed for readoption with amendments are subject to Federal requirements addressing certain standards for health insurance contracts, as noted in the Summary above. The SEH Board does not believe the rules proposed for readoption with amendments exceed the Federal requirements.

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

SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

...

"Dependent" means the spouse or child of a full-time employee subject to applicable terms of the employee's health benefits plan. For purposes of dependent eligibility only, the reference to "spouse" includes a civil union partner pursuant to P.L. 2006, c. 103, and same sex relationships

recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage, except that spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended**, and the provisions of the policy or contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability**. At the option of the small employer, "spouse" includes a domestic partner pursuant to P.L. 2003, c.246.

...

"Employee" means an individual who is an employee under the common law standard as described in 26 CFR 31.3401(c)-1. For purposes of determining whether an employer is a small employer, employee excludes an individual and his or her spouse when the business is owned by the individual or by the individual and his or her spouse, a sole proprietor, a partner in a partnership, and [more than] a two percent shareholder in a Subchapter S corporation as well as immediate family members of such individuals. Employee also excludes a leased employee.

SUBCHAPTER 10. THE MARKET SHARE REPORT

...

11:21-10.3 Filing of the Market Share Report

(a) Every member of the SEH Program shall file the Market Share Report set forth as Exhibit CC in the Appendix to this chapter, incorporated herein by reference, on or before [March 1] **April 1**. Every member shall complete Parts A, B, C and D of the Market Share Report.