INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Selective Contracting Arrangements of Insurers; Minimum Standards for Network-Based Health Benefit Plans

Adopted Amendments: N.J.A.C. 11:4-37.2, 37.3, 37.4, and 37.6, and 11:22-5
Adopted Repeals: N.J.A.C. 11:4-37.5 and 37.7
Adopted New Rules: N.J.A.C. 11:22-5.7 and 5.8

Proposed: December 5, 2005 at 37 N.J.R. 4510(a).

Adopted: April 18, 2006 by Steven M. Goldman, Commissioner, Department of Banking and Insurance

Filed: April 20, 2006 as R. 2006 d.189, with a technical change not requiring additional public notice and comment (See N.J.A.C. 1:30-6.3)

Authority: N.J.S.A. 17:1-8.1, 15e, 17B:27A-54, 26:2J-42 and 26:2J-43.

Effective Date: May 15, 2006

Expiration Date: March 14, 2011, N.J.A.C. 11:4
April 26, 2011, N.J.A.C. 11:22

Summary of Public Comments and Agency Responses:

The Department received comments from Delta Dental of New Jersey, Inc. and the New Jersey Dental Association.

COMMENT: One commenter expressed concern with proposed language at both N.J.A.C. 11:4-37.3(b)7 and 11:22-5.6(c) that would prohibit carriers from calculating benefits for services provided by out-of-network providers by using negotiated fees agreed to by network providers. The commenter stated that it believed the Department's intent in proposing this language was to prohibit carriers from deeming the fee levels they negotiate with their network providers to be reasonable and customary fee levels; rather, they are fee levels

that the carrier agrees to pay and the provider agrees to accept as full payment. To avoid misinterpretation, the commenter suggested the Department add language that would make an exception regarding the proposed prohibition for policies and contracts specifically providing for use of such negotiated fees as either the benefit or the basis for calculating the benefit. According to the commenter, this additional language would enable carriers to issue a negotiated fee schedule and provide, for example, that both in and out-of-network benefits would be based on that same schedule.

RESPONSE: The Department disagrees with the commenter's proposed language change, which would have the effect of establishing network contracted rates as a standard for reasonable and appropriate rates for an out-of-network provider. The Department's proposed rules would not prohibit a carrier from issuing a contract with scheduled benefits (that is, a stated dollar amount of coverage for a specified service) for both in and out-of-network. If a carrier were to negotiate rates with its network providers based on such a schedule, the out-of-network benefits would not be based on the network contract rates but on the schedule of benefits in the contract of coverage. Similarly, if a carrier were to pay out-of-network providers based on a percentage of a charge based system, such as Ingenix's Prevailing Healthcare Charges System (PHCS), the fact that in-network providers would be paid based on a percentage of that same system would not violate this rule. Calculation of the out-of-network compensation would be based on something other than the in-network contract rate.

COMMENT: Both commenters expressed concern with the proposed new requirement at N.J.A.C. 11:22-5.8 regarding dental benefits. This provision requires that:

> 1. For services rendered by network providers, the plan shall provide benefits that result in a cost to the covered person of no more than 75 percent of the plan's contracted cost of the covered services, after application of any deductibles; and
>
> 2. For services rendered by out-of-network providers, coinsurance shall not exceed 75 percent.

One commenter requested clarification of the proposed language. The second commenter requested that the Department consider amending the proposed language as follows since dental plans frequently have deductibles for both in and out-of-network services and also have annual maximum benefits (additions in boldface):

> 2. For services rendered by out-of-network providers, coinsurance shall not exceed 75 percent <u>of the actual charge for the service after application of any deductibles.</u>
>
> <u>3. Subsections (1) and (2) do not apply to any services to the extent benefits are not available because of the application of an annual and/or lifetime maximum benefit provision</u>.

The commenter stated that this additional language would clarify that deductibles are applicable whether in or out of network, that the out-of-network limitation applies to the actual charge imposed by the out-of-network

provider, and that these standards apply only to the extent benefits have not been exhausted by virtue of either an annual or lifetime benefit payment maximum.

RESPONSE: The Department does not believe that either clarification of the proposed language, nor additional language, is necessary. All rules such as N.J.A.C. 11:22-5.8 that place limits on coinsurance or similar percentages are meant to be read in the context of policy deductibles and maximum benefit limits (that is, that coinsurance is applied after the deductible and subject to any policy maximums); therefore, the Department does not believe that additional explanatory language needs to be included in this particular rule provision.

Federal Standards Statement

A Federal standards analysis is not required because these adopted amendments, repeals and new rules are not subject to any Federal standards or requirements.

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

11:22-5.7 Prescription drug benefits

(a) – (b) (No change from proposal.)

[(b)**]*** ***(c)*** Health benefit plans and stand-alone prescription drug plans may provide higher benefits for generic drugs than for brand name drugs provided:

1. – 3. (No change from proposal.)

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