

**INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE**

**Health Benefit Plans
Health Insurance Identification Cards**

Adopted New Rules: N.J.A.C. 11:22-8

Proposed: November 17, 2008 at 40 N.J.R. 6527(a).

Adopted: October 2, 2009 by Neil N. Jasey, Commissioner, Department of Banking and Insurance.

Filed: October 8, 2009 as R. 2009, d. 333, **with substantive changes** not requiring additional public notice and opportunity for comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15(e), 17B:27B-25 and 17B:30-56.

Effective Date: November 2, 2009

Operative Date: July 1, 2010

Expiration Date: April 26, 2011

Summary of Public Comments and Agency Responses:

The Department received comments from the following: the Workgroup for Electronic Data Interchange (WEDI); the Council for Affordable Quality Healthcare (CAQH); Thomas Edison State College; William F. Megna, Esq. on behalf of Integrity Health LLC; Horizon Blue Cross Blue Shield of New Jersey; UnitedHealth Group; Enumeron LLC; the New Jersey Association of Health Plans; the New Jersey Academy of Family Physicians; the Independent Insurance Agents of New Jersey; the Medical Society of New Jersey; the New Jersey Hospital Association; the Raritan Bay Medical Center; AMERIGROUP New Jersey, Inc.; D. Scott Alenick, MD; the New Jersey State Nurses Association; Marcie Case; and Lampf, Lipkind, Prupis & Petigrow.

1. COMMENT: Several commenters expressed their support for the Department's proposed rules, which would standardize the format of, and information contained on, health insurance ID cards. According to the commenters, these standards will enable providers to ascertain eligibility and benefit information and will improve the billing and payment process.

RESPONSE: The Department thanks the commenters for their support.

2. COMMENT: Several commenters stated that they believe that all New Jersey stakeholders – carriers, providers and patients – would be better served if the Department took into consideration national efforts towards standardization of the exchange of information. According to the commenters, while well intentioned, the proposed rules will divert resources from that important goal and the costs required by this rule proposal are significant. As a result, the commenters urged the Department to not move forward with this proposal, and rather to enter into a dialogue with key stakeholders, with consideration of these national efforts.

One of the commenters outlined the following key observations that the Department should consider prior to any final healthcare information exchange rule:

(1) Consider existing standards and national initiatives. The Council for Affordable Quality Healthcare's (CAQH) CORE (the Committee on Operating Rules for Information) initiative, which has been endorsed by providers, vendors and health plans, is serving as one facilitator in helping to drive the voluntary implementation of consistent and robust administrative data exchange. CORE participants, including the Federal government and health plans, represent approximately 75 percent of the commercially insured nationwide. Provider organizations, many with state chapters in New Jersey, have endorsed CORE. Also, many vendors already operating in New Jersey are CORE-certified. Finally, approximately 85 percent of the commercially insured lives in New Jersey are served by health plans that are CORE participants and/or CORE-certified (for example, Aetna, CIGNA, Health Net, Horizon and United Healthcare). Many of the same organizations participating in CORE also contribute to the

healthcare administration streamlining efforts of the Workgroup for Electronic Data Interchange (WEDI).

(2) Build upon existing momentum and extensive coordination and collaboration that are already occurring. The commenter stated that improving electronic access to health care information is a complex issue with technology, social and economic impacts. To be successfully implemented, it requires careful, coordinated work and the involvement of technical expertise. New Jersey should consider and take advantage of the mature health care technology environment that exists today. For example, in 2009 CORE Phase III rules are addressing standard health ID cards requirements. In 2008, the Healthcare Administrative Simplification Coalition (HASC), a national effort led by provider groups, began considering how to publicly support both CORE's and WEDI's efforts. It is the commenter's opinion that the Department should consider these and other initiatives prior to finalizing any health ID card standardization rule.

(3) Support existing standards because they were designed with social impact in mind, including patient privacy. Guidelines for health ID cards were promulgated by WEDI in 2007 and are gaining national acceptance. Under the WEDI structure, these guidelines were created by a multi-stakeholder body after exhaustive research, including review by all stakeholder types. Some key principles behind this industry effort are not in the Department's proposed rules: (i) using ID cards as an access key rather than to provide information storage as proposed by the Department; (ii) other states, regional efforts and provider-driven recommendations regarding health ID cards have thoroughly reviewed this WEDI standard and are moving in the direction of supporting its adoption; (iii) other groups have called for the widespread use of machine-readable patient ID cards using the WEDI Health ID Card Implementation Guidelines; and (iv) the health ID card is just one way to access data. The proposed rules would eliminate the opportunity for health plans to utilize other forms of delivering eligibility and other information that are just as good as, if not better than, what has been proposed by the Department

One commenter stated that the healthcare industry as a whole is currently making great strides in simplifying the administration of health care and reducing impediments and that anticipated upcoming national healthcare reform legislation clearly will go a long way in meeting this goal. The commenter believes that it would be prudent to delay any individual state efforts in this area at least for the next six months to a year to give the federal government the chance to enact this legislation. The commenter added that careful consideration must be given to the potential burden state-specific solutions that differ or run counter to national efforts will impose on the national effort.

RESPONSE: The import of these rules is misunderstood by the commenters. As the Department stated in the proposal Summary, the purpose of these rules is to require that all carriers and third party administrators issue health insurance identification cards that contain certain basic information about the patient's health benefits plan so that health care providers can properly bill and/or receive payment for services and supplies provided to their patients that are covered by the plans. These rules are not related to electronic health records or the exchange of electronic information and are not contrary to any federal requirements. The rules do not impact CORE or WEDI, as they do not deal with using health insurance identification cards to access data. To clarify its intent, the Department is changing the definition of "card" to delete "or other technology that functions like a card" in N.J.A.C. 11:22- 8.2 and is eliminating that part of N.J.A.C. 11:22- 8.3(c) which references embedded information on the card available through magnetic stripe or smart card, and other electronic technology.

3. COMMENT: A few commenters urged the Department to incorporate into its proposed rules the WEDI Health Identification Card Implementation Guide by reference, stating that the WEDI Guide and the proposed rules are complementary. (For informational purposes, Section 1.1 of the WEDI Guide states that "The intent of this implementation guide is to enable automated and interoperable identification using standardized health identification cards. The guide standardizes present practice and brings uniformity of information, appearance, and

technology to the over 100 million cards now issued by health care providers, health plans, government programs, and others. A card serves as an access key to obtain information and initiate transactions. It is used by a consumer to convey identification to providers or others. A card may convey patient identifiers to providers. It may convey insurance identifiers for multiple benefits involving different administrators on a single card. It may combine bank and health ID cards.”)

The commenters stated that while the Department’s proposed rules specify what information is required on the card, they do not specify placement, coding, or data format of the information. Incorporating the WEDI Guide will add specificity for placement, coding and data format of both human-readable and machine-readable information. Incorporation of the WEDI Guide will align New Jersey with developments in the rest of the nation. National uniformity will make it more likely that New Jersey providers will implement the card in their systems. And it will make it easier for national health plans, clearinghouses, and processors doing business in New Jersey.

RESPONSE: The proposed rules do not address how the data is presented on the health insurance identification card and the Department does not believe that it is appropriate to do so. The rules are limited to requiring the display of certain basic data on the card. They do not deal with the electronic exchange of health data.

4. COMMENT: Two commenters stated that the proposed rules’ Economic Impact statement indicates that providers will be favorably impacted by the proposed rules “because they will have the information they need to more efficiently navigate the claims submission and payment process on behalf of their patients.” The commenters do not believe that such cost savings are likely to materialize. According to the commenters, giving providers the “information they need” is dependent on many factors (for example, the ID card is only useful if the data it is trying to access is available, and the patient must present an up-to-date ID card at the time of service). Placing written benefits information on a health ID card does not address the

fundamental issue of how patient eligibility information can be exchanged electronically across the various systems that may be involved in the administration of health care.

Two commenters stated that many of the providers, vendors and health plans conducting business in New Jersey operate in the tri-state area and/or in many other states across the country. If every regional effort and/or state developed unique approaches, the cost to providers, plans and vendors to adhere to separate requirements would be significant. Moreover, the goal to have uniform health care data available will not be achievable.

RESPONSE: As stated above, these rules do not deal with the electronic exchange of health information. They merely require that certain basic data be included on a health insurance identification card. As the Department stated in the Summary of the proposal of these rules, some carriers are currently issuing ID cards that do not contain essential information required by health care providers to properly bill and/or receive payment for services and supplies covered by the plans provided to their patients. Although the Department recognizes that uniform national standards are preferred, it does not believe that it is appropriate to defer action in the hope that Federal standards will be adopted on health insurance identification cards. If and when such standards are adopted, the Department will comply. The Department also notes that several states currently have laws addressing the data elements that must appear on health insurance identification cards.

5. COMMENT: Two comments concerned the proposed definition of “card,” “health insurance identification card” or “identification card,” which defines the term as “a card or other technology that functions like a card issued by a health benefit plan to a subscriber or member and containing information related to the member’s identity and health benefits plan.” The commenters questioned what is meant by the phrase “other technology that functions like a card[.]”

RESPONSE: The Department used this language to address concerns that technology may be developed in the future to convey the required information in other forms. As stated in a Response appearing above, the Department has eliminated this reference to avoid confusion.

6. COMMENT: Five comments concerned the proposed definition of “health benefit plan.” Two of the commenters questioned whether the term includes pharmacy only plans. Two commenters stated that the proposed definition is unusually complex and inconsistent with the definition used in other Department regulations, such as the HMO regulations at N.J.A.C. 11:24 or the prompt pay regulations at N.J.A.C. 11:22-1. The commenters suggested revising the definition of “health benefits plan” to mean “a benefits plan which pays hospital and medical expense benefits or provides hospital and medical services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and Medicare Advantage contracts to the extent not otherwise prohibited by Federal law. For the purposes of this chapter, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, Civilian Health and Medical Program for the Uniformed Services, CHAMPUS supplement coverage, coverage arising out of a workers’ compensation or similar law, automobile medical payment insurance, personal injury protection insurance or hospital confinement indemnity coverage.” The commenter stated that if the Department chooses to retain its proposed definition, that it clarify the last exclusion referencing hospital confinement indemnity coverage because, as drafted, it appears that a benefit plan covering maternity and delivery services would be excluded from having to comply with the proposed rules. The commenters further stated that they believe any healthcare coverage written under a policy in New Jersey must be subject to the proposed rules.

Two commenters stated that the definition should expressly exclude discount card programs.

RESPONSE: The Department used the definition of health benefits plan that appears in the Individual Health Coverage Act at N.J.S.A. 17B:27A-2. The definition of health benefit plan does not include pharmacy only plans because such plans do not cover hospital and medical expense benefits. Moreover, the Department has already adopted a rule on pharmacy identification cards that appears at N.J.A.C. 11:4-55. Hospital confinement indemnity coverage cannot be expense incurred under N.J.A.C. 11:4-42.5 (i). Therefore, policies covering maternity and delivery expenses, which are expense-incurred policies, are not hospital confinement indemnity coverage and are not excluded from the definition of health benefit plan. Finally, discount card programs are not insurance but are merely a list of providers willing to offer reductions in billed fees and therefore are not subject to regulation by this Department.

7. COMMENT: Several comments concerned the information the proposed rules require to be included on health benefit plan ID cards. One commenter stated that N.J.A.C. 11:22-8.3(b)1 should be amended to read (additions in boldface) “the name of the carrier issuing the health benefit plan or the third party administrator . . . **and its authorized logo.**” According to the commenter, plans can have similar names and the logo helps differentiate between them and ensure accuracy by registration staff. More important, contracts between payers and providers often indicate that only patients presenting an ID card containing the carrier’s logo are eligible for the discounted managed care rate.

One commenter recommended the inclusion of the ISO Standard U.S. Healthcare Identifier in addition to the name to identify the carrier. According to the commenter, this number is critical for both manual and automated use, and to not have it is like a charge card not having a number to identify the bank. The present lack of a standard plan or administrator identifier on an ID card is the principal reason why providers photocopy health cards while merchants merely swipe a charge card or can so easily obtain accurate information over the telephone. Without a standard plan or administrator number, a health ID card today is inefficient and a source of significant error both when presented and when information is obtained pre-

admission from a patient over the phone. The WEDI Guide specifies that an ISO standard U.S. healthcare identifier for the health plan or administrator shall be included to identify the issuer of the card. The commenter suggested modifying the proposed provision to read (additions in boldface) “The name **and standard identifier** of the carrier issuing the health benefit plan or the name **and standard identifier** of the third party administrator administering the health benefit plan.”

RESPONSE: There is no requirement that health benefit plans have a logo and the Department sees no reason to mandate that logos be included on health insurance identification cards. While ISOs would provide a universal method to identify such entities as an individual (consumer), a healthcare provider, a healthcare organization, a payer, or others (clearinghouses, vendors, products, etc.), there is still no industry-wide consensus, or Federal mandate, on their use and obtaining a standard identifier would involve a lengthy process. As stated in its proposal, the Department’s intent in proposing these rules was to ensure that certain essential information be included on health insurance ID cards that will address health care providers’ immediate claims payment concerns. However, should Federal action result in the creation of a national standard for an ISO, to foster uniformity with such a national standard the Department would be amenable to revisiting the inclusion of ISOs on health insurance identification cards in the future.

8. COMMENT: Four comments concerned the requirement at N.J.A.C. 11:22-8.3(b)2 that ID cards contain the name of the contract holder. Two commenters stated that the ID card should also include the name of the subscriber for whom the policy is written. The commenters stated that often a payer’s eligibility system requires a provider to look up the insurance policy under the policy holder or “subscriber’s” name.

Two commenters stated that including the name of the contract holder is duplicative and unnecessary. One of the commenters stated that the group number is more specific, and will

ultimately be more helpful, since a company could have several different groups and accessing coverage information via the group number is the only accurate method of determining an individual's coverage. One commenter stated that the group name is irrelevant for the stated purpose of allowing providers "to properly bill and/or receive payment."

RESPONSE: The Department agrees that it is not necessary for the card to contain the name of the contract holder and that including the group number on the card is more helpful. Therefore, the Department is omitting the requirement that the card contain the name of the contract holder. The Department intended to provide carriers with the flexibility to either issue one card that shows the names of the subscriber (that is, the employee) and his or her covered dependents, or to issue separate cards for the subscriber and each covered dependent that show only the name of the subscriber and each covered dependent. It is unclear to the Department why the commenter believes the subscriber's name should appear on a card issued to a dependent.

9. COMMENT: Five comments concerned the requirement at proposed N.J.A.C. 11:22-8.3(b)3 that ID cards indicate whether the plan is insured or self-funded. One commenter stated that this up-front knowledge will be extremely helpful to physicians and their staff to help identify what regulations apply and what remedies are available with respect to claims processing and claims appeals, and that the information will help family physicians to more effectively manage the administrative aspects of providing health care services to patients.

One of the commenters stated that it believed that the proposal is not able to direct self-funded plans as to what information must be contained on their ID cards because such a rule would be pre-empted by ERISA. However, if the proposed rule were to apply to self-funded ERISA plans, it should be noted that national employers generally prefer that all their employees around the country have the same card. If New Jersey has a different standard that could make it less attractive for an employer to have its plan administered in New Jersey, it would harm health insurers in New Jersey and drive that business to other states.

Two of the commenters stated that there should be some flexibility as to how a carrier may signify on an ID card whether the coverage is insured or self-funded (for example, some carriers identify on the card “Underwritten” (for fully-insured) or “Administered” (for self-insured)).

One commenter stated that the WEDI Guide permits almost any additional information besides what it specifies to be included on the ID card. In addition to needing this information in relation to required appeals processes as stated by the Department in its proposal, an additional reason may be to advise the provider as to the entity to which the provider is extending credit. The commenter suggested that the proposed rule might be specific on the wording and placement of the wording to indicate self-insured versus insured. If the Department would like to include this indication in machine-readable data, a qualifier code could be added to Section 4.2 of the WEDI Guide and sufficient space exists for inclusion of this code on the magnetic stripe.

Two commenters were concerned with the sale of discount cards or “membership” in PPOs to uninsured patients. The ID card issued to such persons indicates that the patient will receive services at the discounted managed care rates that hospitals and physicians have negotiated through their contracts with carriers, and often includes the name of the carrier whose rates will be accessed. When the card is presented at a hospital, it appears to be a regular insurance card, but in reality the patient is a self-pay patient. The result is that a patient may be responsible for only the contracted rate. When patients are aware that they have purchased a discount card they are likely pleased that their bill reflects a reduction off the provider’s charges, but patients who believe they purchased health insurance are unlikely prepared to pay out-of-pocket for the services they received. The commenter believes that clearer standards should be established for indicating whether the ID card represents an insured or self-funded plan, and that the Department should require carriers to indicate the type of coverage by using the specific words “insured” or “self-funded.”

RESPONSE: With respect to the ERISA pre-emption comment, the argument is not persuasive because the rules are directed at entities licensed by this Department and meet the test enunciated in *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003) (that is, the rules are directed toward entities engaged in insurance and substantially affect the risk pooling arrangement). Moreover, the Department notes that several other jurisdictions require that health insurance identification cards indicate whether the plan is insured or self-funded, including Texas, 28 Tex. Admin. Code § 21.2820; Florida, Fla. Stat. ch. 627.657; and Colorado, Colo. Rev. Stat. § 10-16-135.

The rules allow flexibility as to how a plan is described as either insured or self-funded and does not prohibit the use of terms such as “underwritten” or “administered.” The Department does not believe it is appropriate to mandate the text that is required for this description or where it should appear on the card. Finally, the Department reiterates that discount plans are not insurance but instead are a list of providers willing to accept less than their billed rates. Such plans are not regulated by this Department.

10. COMMENT: One commenter stated that the requirement at proposed N.J.A.C. 11:22-8.3(b)4 that ID cards contain the primary insured's name should be expanded to include the names of all insureds.

RESPONSE: The Department is aware that some carriers provide a separate identification card to each covered person (that is, to the employee, the spouse and to each child), while other carriers list all covered persons on the identification card. The Department sees no reason to mandate one approach over the other.

11. COMMENT: Two comments concerned the requirement at proposed N.J.A.C. 11:22-8.3(b)5 that ID cards contain the insured's identification number, the contract number and the policy or group number, if applicable. The commenters stated that this is problematic for Medicaid and NJ FamilyCare business since it does not make sense for the Medicaid contract number to be on the card. If the Department feels compelled to require public programs to

comply with these rules, those programs should be exempt from this ID card requirement and be required only to include the plan member ID number on the card because that is the number needed to process claims.

Three commenters suggested that Medicaid and NJ FamilyCare plans be exempt from the requirements of these proposed rules because the Department of Human Services (DHS) regulates those programs and has promulgated rules regarding the DHS managed care contract. Those rules include requirements regarding the information to be included on ID cards and DHS prior review and approval of ID cards.

RESPONSE: The rules do not apply to Medicaid and NJ FamilyCare and N.J.A.C. 11:22-8.1(b) is being revised to so clarify.

12. COMMENT: Four comments concerned the requirement at proposed N.J.A.C. 11:22-8.3(b)6 that ID cards contain the effective date of the insured's coverage. Two of the commenters stated that if this requirement ties back to the need to update the card, then carriers would have to issue a new card every year (as the coverage is renewed) even if nothing else has changed in the policy. There would otherwise be no need to issue a new ID card. This requirement could confuse members because they might see a new date that is later than their original eligibility date. This could also generate confusion about the eligibility date for providers because they may see the eligibility date and think that they do not need to check to determine if the member is still eligible. Further, all of this information is readily available through Internet access.

Two of the commenters stated that the cards should include the effective dates of the cards themselves or the policy renewal date, rather than the effective date of coverage only, to make it easy for both the provider and consumer to identify whether a card has expired and may contain old or inaccurate information.

RESPONSE: The information the Department intended to be shown on the card is the date that the coverage for the employee/subscriber, not the group, first became effective; such

information will not change with each policy year. The Department's intent in including this information was to assist providers in determining such issues as an individual patient's eligibility due to a pre-existing condition, etc. However, for the reasons discussed in Comment and Response 14 below, upon adoption the Department is deleting the requirement to include information regarding pre-existing conditions on health insurance identification cards.

Consequently, the primary reason for requiring the inclusion of an eligibility date on the cards no longer applies and there remains no need to include the covered individual's eligibility date on the cards.

13. COMMENT: Four comments concerned the requirement at proposed N.J.A.C. 11:22-8.3(b)7 that ID cards contain the beginning and ending dates of any pre-existing exclusion period. One of the commenters stated that over the last several years, identification of pre-existing exclusions has become a significant problem with claims processing for family physicians in New Jersey. According to the commenter, without this information on the ID card, a physician will provide services without knowledge of a pre-existing exclusion period and submit the claim to the carrier. After several requests for additional information in support of the claim by the carrier, the claim is ultimately denied. The physician's only option is to directly bill the patient, at which point collection is unlikely given the passage of time. The commenter stated that these multiple layers of administrative processes could be avoided if the pre-existing exclusion period were readily accessible or identified on the patient's ID card.

Two of the commenters indicated that this proposed requirement would be problematic for several reasons:

(1) the actual pre-existing condition exclusion period is frequently not known with certainty in the time period for which issuance of the ID card is required. Certificates of creditable coverage (COCC), which would reduce or eliminate pre-existing condition periods, are commonly not received by the carrier until some time after the initial enrollment. Printing an

ID card based on the information available at enrollment and replacing it when the COCC is received would create confusion for providers and members.

(2) knowing the actual pre-existing condition period, even if accurate, is of limited value to the provider. Without knowing the plan's definition of a pre-existing condition and the member's complete medical background, the provider could not make a coverage determination. Providers who request authorizations for service receive information about pre-existing condition exclusions, including how they apply to the specific member for the specific service, which is far preferable to relying on an ID card.

(3) Most ID cards are printed with the information for the subscriber, and do not include dependent-level information. Depending upon prior coverage, different periods may apply. Printing separate ID cards for subscribers and members would increase the cost of producing cards exponentially without adding meaningful information value. Members are notified at the inception of coverage what their pre-existing condition period is, and they are urged to send in any COCC that could be credited against it.

(4) Showing the pre-existing condition period on the ID card may lead to the deferral of necessary care.

(5) Some members may object to this type of information being accessible by others, and may argue that it is a HIPAA violation.

The commenters recommended that this requirement be removed from the rules. One commenter recommended limiting the requirement to a statement indicating the maximum amount of time that a pre-existing condition exclusion may be applied under law, and noted that this exclusion would not apply to Medicaid/FamilyCare plans.

One commenter stated that the WEDI Guide permits information on a pre-existing condition exclusion, but does not specify it.

RESPONSE: The Department agrees that information on whether a pre-existing condition exclusion applies may not be available on the date the health insurance identification

card is issued if the COCCs were not included with the application and enrollment materials, and is therefore deleting this paragraph. The Department also agrees that different pre-existing condition periods may apply to dependents. While knowing whether a pre-existing condition period exists might be of some value to providers, the Department agrees with some of the commenters that issuing an ID card that contains accurate or complete pre-existing condition information appears to be impracticable. The Department does not agree that an ID card containing a pre-existing condition exclusion period would violate HIPAA because the dates of the exclusion period are not personal health information protected by HIPAA and the cards would not indicate the nature of any such pre-existing condition(s).

14. COMMENT: Several comments concerned the requirement at proposed N.J.A.C. 11:22-8.3(b)8 that ID cards contain the name of the primary care provider (PCP) for each covered person where selection of a primary care provider is required. Two of the commenters were opposed to this requirement. One of the commenters stated that members identify their PCP when they enroll for coverage and the PCPs are notified monthly who is on their panel. Requiring that ID cards also include this information would be burdensome and outdated as PCPs are changed. Further, ID cards that include member-level information would require an amount of information that would be prohibitive based on available space, or require the issuance of member-level cards adding millions of dollars to healthcare expenses without adding commensurate value. One commenter stated that this information is available through the carrier's web portal.

One commenter stated that without the ID card identifying the PCP, there is no way for the physician's office to know at the time of service that the selection of a PCP by the patient is required or whether that particular physician has been properly identified as the PCP by the patient. As a result, family physicians often provide services to a patient and submit a claim that is ultimately denied, in which case the physician's only option for payment is to directly bill the patient.

One commenter stated that Section 5.1(2) of the WEDI Guide addresses identification of the primary care provider on the ID card as discretionary. The Department's proposed rule would require the information, which is not inconsistent with the Guide. The Guide does not specify how to indicate that the plan requires a primary care provider as gatekeeper, and perhaps that would be a good thing to add to the WEDI Guide in the future. The commenter suggested that the proposed rule be specific about when a primary care provider is required as gatekeeper.

One commenter stated that the proposed rule restricts its use of the term primary care providers to physicians, but that State law permits other types of providers to be primary care providers (for example, the HMO law permits carriers to credential advanced practice nurses (APNs) as primary care providers). The commenter requested that the rule be modified to reflect this fact.

RESPONSE: The Department agrees that the term "primary care physician" should be "primary care provider" and is making this change throughout the rule. The Department believes that identification of the PCP on the health insurance identification card, either by name or other identifier, is necessary so that PCPs can be aware when they initially see a patient as to whether or not they have been selected as the PCP by the patient. The Department notes that the requirement to include the name of the PCP on the health insurance identification card is required in other jurisdictions including Georgia (see Ga. Code Ann. § 33-24-57.1).

The Department disagrees with the comment that each member identifies his or her PCP when enrolling for coverage and the PCPs are notified monthly who is on their panel. Such monthly notification is not mandated, may not apply to PCPs who are not capitated and does not confirm the PCP selection on the date of the PCP encounter.

The Department further disagrees that including the PCP on ID cards would be burdensome and outdated as PCPs are changed. With one exception, all carriers currently authorized to offer health insurance or health benefit plans in New Jersey include PCP

information on their ID cards. The Department also notes that the commenter provided no information regarding how frequently PCPs are changed. Regarding the comment that ID cards that include member-level information would be prohibitive because of the lack of space on the card and would add millions of dollars to healthcare costs without adding commensurate value, the Department notes that carriers currently issue ID cards that contain both subscriber and dependent information and PCP selections for all. Finally, to require physicians to access carriers' websites to confirm the identity of PCPs for every office visit would be overly burdensome to physicians.

15. COMMENT: Four comments concerned the requirement at proposed N.J.A.C. 11:22-8.3(b)9 that ID cards contain a phone number or electronic address for authorization and admission certifications, if required. One commenter stated that the ID card must include fax numbers, phone numbers and an electronic address regardless of whether the provider is in-network or out-of-network.

Two commenters stated that the ID card should include the name of the entity responsible for medical management if this function is outsourced to an organized delivery system or other company by the carrier. Also, P.L. 2005, c. 352, the Health Claims Authorization, Processing and Payment Act (HCAPPA) requires carriers to provide written authorization or denial in response to a provider's request, and providers often submit an authorization request in writing so they can document the time and nature of the request. Therefore, inclusion of a phone number alone on the ID card would not ensure compliance with these requirements. The commenters recommended revising the requirement to state (additions in boldface) "A phone number **and** electronic address for the authorization, admission certifications, and **other medical management certifications and the name of the entity responsible for medical management.**" The commenters indicated that the phrase "medical management certifications" will clarify that precertifications (commonly used for outpatient

services) and concurrent reviews (during an inpatient stay) are medical management actions that will be available by accessing the contact information on the ID card.

RESPONSE: Including separate telephone, fax and electronic addresses for each entity that performs authorization, admission certifications and other medical management certifications would not be practical as the identification card has limited space and carriers may contract with multiple vendors for management of various services such as radiology, chiropractic services, mental health, etc. It is sufficient to show one general phone number or electronic address for all authorization and admission certifications that can be used to direct the covered person or provider accordingly.

16. COMMENT: Four comments concerned the requirement at proposed N.J.A.C. 11:22-8.3(b)10 that ID cards contain in-network cost sharing information, including amounts applicable to primary care provider visits, specialist visits, emergency room visits and hospital stays. Two of the commenters stated that the requirement should be amended to be more explicit with respect to the patient's cost-sharing, as well as benefit levels. Specifically, the Department should require carriers to list the plan's copay, coinsurance and deductible amounts for the network services listed in the proposal, and include the plan's annual or lifetime benefit maximum (dollar amount or number of visit limits). According to the commenters, this information will help providers determine prior to providing a service whether a patient will be held financially responsible by the carrier, and will help consumers to determine whether the services may be denied because the maximum benefit has been reached.

One of the commenters stated that the trend has been for more differentiated cost-sharing elements, even for in-network services. The proposal may require very detailed and extensive information for some plan designs, which would affect the readability of the card. Another commenter stated that certain facility information would require additional information about pre-authorization, which would make including it on the card far more complicated. Including deductible and coinsurance information can also be challenging because it gets to be

very detailed. This type of information could also be confusing if the plan is a health savings account (HSA) or health reimbursement account (HRA), especially if the member is in a “doughnut hole.” The commenter added that this information is available either on the member website or in the Summary of Benefits, which should be resources for the member. The commenter recommended that this requirement be limited to physician and specialist co-pays.

RESPONSE: With respect to the first comment, requiring the health insurance identification card to include information as to annual and lifetime benefits maximums and other benefit restrictions is not practical because of the limited space available on the identification card. Regarding the comments that argue that showing the in-network cost sharing is burdensome and would affect the card’s readability, the Department notes that the cost sharing information to be shown on the card is limited to in-network cost sharing for primary care provider visits, specialist visit, emergency room visits and hospital stays. The Department believes that this limited amount of information will not be burdensome to carriers and will not affect the card’s readability.

17. COMMENT: Two commenters stated that additional information should be required to appear on ID cards. One commenter stated that the card should state whether or not a referral is needed. One commenter stated that because many times provider reimbursement depends on the type of plan in which the patient is enrolled, the provider needs to know the type of plan (that is, a small employer plan (SEH), a large employer plan (LEH), an individual plan (IHC) or a state health benefits plan (SHBP)), the out-of-network cost sharing information and whether the issuer of the card is the carrier or a third-party administrator (TPA).

Two commenters stated that there is a large amount of information that the proposed rules are requiring to be on ID cards, which presents a problem with respect to readability. One commenter stated that since the size of the card cannot be increased, the way to fit the information on the card is to reduce the font size. The amount of information required, together with the requirement to reissue cards every time the information changes, increases the

administrative costs. Repeatedly printing and mailing cards to millions of members adds to health care costs.

RESPONSE: The health insurance identification card has limited space and therefore can only show a small amount of data. There would not be enough room on the card to show referral requirements, plan type, out-of-network cost sharing and license status of the carrier or issuer. In addition, referral requirements can vary depending on the service being provided, the plan terms and whether the provider is in or out of network. The Department does not believe that the seven remaining elements that are now required to be shown on the card are excessive or economically burdensome to carriers.

18. COMMENT: Six comments concerned proposed N.J.A.C. 11:22-8.3(c), which states that the ID card “must present information in a readily identifiable manner, or the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.”

One commenter stated that the rule appears to permit the information to be made available electronically, but that proposed N.J.A.C. 11:22-8.3(b) requires that information “appear” on all ID cards. Two of the commenters requested clarification as to whether the requirement permits the information to be made available electronically instead of being printed on the ID card, and that if the information is made available electronically, that new cards not be required to be issued whenever the information changes. One commenter suggested revising the requirement to state that “The identification card must present the information in a readily identifiable manner or the information may be provided through electronic technology.”

Two commenters understood proposed N.J.A.C. 11:22-8.3(c) to mean that a card must have either magnetic stripe or be a smart card, and after this requirement is met it would permit other technology in addition. The commenters stated that if some cards have one technology and other cards have another technology, providers would be required to invest in multiple ways to read the cards. The commenters noted that the WEDI ID card and CORE have already

addressed these issues. Some of the commenters suggested that a single standard be used to read the ID cards. One of the commenters noted that the large health plans who have adopted the WEDI Guide have chosen Track 3 Magnetic Stripe because it is expected the market will make it the de facto implementation standard in the country. It is not enough to specify the technology, but it is necessary to specify the data content, coding and format as well; incorporation of the WEDI Guide into the proposed rule accomplishes that. Track 3 Magnetic Stripe has a capacity of 82 alphanumeric characters and does not have the capacity to include all of the data listed in the Department's proposed N.J.A.C. 11:22-8.3(b). According to the commenter, provider systems currently do not have the capability to process all this information, so there is no immediate problem with not having it in machine-readable form. If included on the card, it would be ignored for quite a number of years. In the longer term, the best system design is to obtain the most current information from the plan's or administrator's systems using enhanced eligibility inquiry/response transactions. This is the design approach embodied in CAQH/CORE Operating Rules certification. The commenter further stated that the proposed provision would allow information to be encoded in the machine-readable data on the card, but not be readable by a person. The WEDI Guide requires all machine-readable information to also be human-readable, but not vice versa, for the following reasons: (1) during transition to machine-readability, many providers may not have the technology to read the card; (2) the proposed rule does not mandate that providers install machine-readability and those that do not would then not be able to obtain all the card's information; and (3) providers very often obtain essential information prior to admission or appointment from a patient over the telephone where machine-readability is inoperative.

One commenter expressed concern that the rule provision that permits the information to be provided "through other electronic technology" may be interpreted to mean that the data may be made available on the carrier's website, resulting in the ID card containing only a web address that the provider must access to obtain the patient's information. According to the

commenter, carriers' websites are frequently subject to system delays, failures or other data inaccuracies that render this mechanism unreliable to serve as the sole provider of benefit information.

Some of the commenters suggested that the Department consider establishing standards for card readability purposes, including a font style and minimum point size. Also, some providers have reported difficulties reading cards that are imprinted in such a way that the raised text on one side of the card causes printing on the reverse side to fall into the valleys of the raised text. As a result, phone numbers and other salient information become unreadable. One commenter stated that all cards should only be allowed to be printed in black and white, with no shades of gray permitted because gray does not copy on a Xerox machine rendering the information printed on them unreadable. The commenter believes that carriers intentionally do this to make properly transcribing the information more difficult so that claims can be denied.

A few of the commenters stated that the proposed rule should be amended to state that if the carrier chooses to provide information in any way other than printed directly on the ID card, the carrier or third-party administrator bear the financial cost of supplying the health care provider with the ability to read the information. One commenter suggested adding the following language: "The carrier or third party administrator shall provide physicians with the hardware and/or software or other means required to read the health insurance identification card when information is embedded on the card and available through magnetic stripe or smart card or through other electronic technology."

RESPONSE: As stated above, the Department has eliminated the reference to magnetic stripe, smart card and other electronic technology because such technology is not presently available and it is the Department's intent that the required information be contained on the card itself. The Department does not believe that it is necessary to establish font style, minimum point size or other readability standards for the information appearing on the card because the purpose of the rules is to have the cards contain sufficient information for providers

to properly bill and/or receive payment for services and supplies covered by the plans provided to their patients. Moreover, proposed N.J.A.C. 11:22-8.3(c) states that the ID card must present the information in a readily identifiable manner.

19. COMMENT: One commenter stated that ID cards often carry multiple logos, so the proposed rules must specify in which order payers should be held financially responsible. According to the commenter, if a carrier has contracted with one or more preferred provider organizations (PPOs), then each plan's logo must be represented on the card and the rules must specify which PPO takes precedence. When carriers contract with multiple networks for a single market, this opens the door for cherry picking because the carrier can determine which PPOs the hospital has a contract with and then select the PPO with the lowest rate through which to process the claim. Specifying in these rules that the first PPO listed on the card is the one that must process the claim is the only way to mitigate cherry-picking. If a provider does not contract with the first PPO represented on the card, then the second PPO can be considered, and so on.

RESPONSE: Requiring carriers to display on the card the preferred provider organizations from which they lease networks to supplement their network would require excessive information to be displayed as carriers may have contracts with multiple preferred provider organizations. Moreover, providers should already be aware of the preferred provider organizations with whom they have contracted and what those contracts state.

20. COMMENT: Two comments concerned proposed N.J.A.C. 11:22-8.4(a), which sets forth the time limits within which carriers must issue ID cards. One commenter stated that requiring replacement of nonconforming cards on renewal would be unnecessarily expensive. The commenter suggested that since employers typically change plan designs every few years, necessitating the replacement of cards, the rules require replacement cards to be issued as plans change, with a requirement that all cards be replaced within a three-to-four year timeframe.

One comment concerned the proposed requirement that new cards be issued after a change in any information required by these rules to be included on the card. The commenter stated that since there are so many specific pieces of information that are being required to be included on the card, there will be changes fairly regularly. As a result, cards would need to be re-issued often, which would add administrative burden and expense. The commenter added that while these rules as proposed will add administrative costs, there is the conflicting interest in the State and elsewhere that carriers reduce administrative costs (P.L. 2008, c. 38 -- which expands NJ Family Care, establishes a mandate for the health care coverage of children, and makes various reforms to the individual and small employer markets and certain dependent coverage -- among other things, caps administrative expenses). Accordingly, the commenter recommended that the provision requiring plans to re-issue cards every time there is a change be removed or modified to significantly reduce the triggers for re-issuance, especially when information is available electronically.

RESPONSE: Identification cards are required to be re-issued only if the information on the card changes, and the only two items on the card that would be subject to change are the name of the primary care provider and the cost-sharing information. The commenters submitted no data to the Department as to how often this information would be likely to change or any attendant administrative costs in issuing new cards. On the other hand, to allow cards with this outdated information to continue to be used would hinder the ability of health care providers to properly bill and/or receive payment for the services and supplies delivered to their patients. As stated in the proposal's Economic Impact statement, the Department anticipates that the cost savings realized through the increased efficiency with which providers' claims will be processed due to the additional and uniform information being included on the ID cards will exceed carriers' costs in including the data on the cards.

21. COMMENT: One commenter stated that too often a provider contacts the carrier listed on an ID card to verify eligibility and receives assurance from the carrier that the patient is

covered under the plan and that the carrier authorizes the requested services, only to learn later that the carrier provided false information (for example, the member dropped coverage or exhausted his or her benefits under the plan). According to the commenter, carriers will say that their systems are sometimes not up to date because employers can take up to 60 days to inform them of a change in a plan member's status. The commenter believes that these are issues that must be resolved between the carrier and employer. Providers who render a service in good faith and rely on the information contained both on the ID card and directly from the carrier upon eligibility verification should not be asked to forego reimbursement or incur a bad debt because the plan member does not pay the bill. The commenter stated that carriers must assume responsibility for the information not only contained on the ID card, but also provided over the telephone or via their websites in response to a provider's eligibility verification request. Accordingly, the commenter stated that the rules must include an enforcement provision; that carriers must be held financially responsible for the services they authorize; and that a card that is in effect but contains incorrect information must not be grounds for retroactively adjusting a member's eligibility status after eligibility was originally verified using the carrier's approved verification mechanisms.

RESPONSE: The Department notes that this comment is beyond the scope of the proposal as these rules do not address a carrier's reversal of a verification of eligibility or an authorization of services.

22. COMMENT: One commenter stated that because the proposed rules are an effort to make it easier for providers and members to quickly identify correct information about coverage, the commenter recommended that the rule include a provision making it an act of fraud for an individual to knowingly present a card when coverage has lapsed.

RESPONSE: The comment is beyond the scope of the proposal as these rules do not address misuse of identification cards.

23. COMMENT: Four comments concerned the rules' proposed January 1, 2010 operative date. Three of the commenters stated that the proposed date does not permit enough time for redesign, retooling and retesting of ID card issue systems, and suggested a date at least 18 months after adoption of the rules. One commenter stated that the proposed operative date allows all parties the time needed to meet the rules' requirements.

RESPONSE: The Department agrees with the three commenters requesting a revised operative date. However, because many of the ID card requirements initially proposed have been omitted, the Department does not believe a delayed operative date of 18 months is necessary. Accordingly, the Department is delaying the operative date until July 1, 2010.

Federal Standards Statement

A Federal standards analysis is not required because the Department's adopted 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]***):

11:22-8.1 Purpose and scope

- (a) (No change from the proposal.)
- (b) This subchapter shall apply to all insurance companies, health service corporations, hospital service corporations, medical service corporations and health maintenance organizations authorized to issue health benefit plans in this State and to all third party administrators licensed or registered in this State. ***The subchapter shall not apply to Medicaid and NJ Family Care coverage.**

11:22-8.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

“Card,” “health insurance identification card” or “identification card” means a card ***[or other technology that functions like a card]*** issued by a health benefit plan to a subscriber or member and containing information related to the member’s identity and health benefits plan.

11:22-8.3 Requirement to issue identification cards

(a) (No change from proposal.)

(b) The following information shall appear on all health benefit plan identification cards:

1. (No change from proposal.)

[2. The name of the contract holder;]

Recodified proposed 3. – 5. as ***2.4.*** (No change in text from proposal.)

***[6. The date upon which the insured’s coverage became effective;**

7. The beginning and ending dates of any pre-existing exclusion period;]*

[8] *5 The name of the primary care ***[physician]*** ***provider*** for each covered person where selection of a primary care ***[physician]***

provider is required;

[9] *6. (No change in text from proposal.)

[10] *7* In-network cost sharing information, including amounts applicable to primary care *[physician]* *provider* visits, specialist visits, emergency room visits and hospital stays.

(c) The identification card must present the information in a readily identifiable manner *, or the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology]*.

11:22-8.6 Operative date

This subchapter shall become operative on *[January]* *July* 1, 2010.

inoregs/bbNOAIDCards