INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans
Minimum Standards for Network-Based Health Benefit Plans

Proposed Amendments: N.J.A.C. 11:22-5.2 through 5.9

Proposed New Rules: N.J.A.C. 11:22-5.5 and 5.6

Authorized By: Steven M. Goldman, Commissioner, Department of Banking and Insurance.

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

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2008-16

Submit comments by March 22, 2008 to:

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The agency proposal follows:

Summary

In an effort to increase the availability and affordability of health coverage, on October 7, 2002, the Department of Banking and Insurance (Department) proposed new rules at N.J.A.C. 11:22-5, Minimum Standards for Network-Based Health Benefit Plans, that would permit health insurance carriers (that is, insurance companies, health service corporations, hospital service corporations, medical service corporations and health maintenance organizations authorized to issue health benefit plans in this State) issuing network-based health benefit plans to use coinsurance and deductibles on services other than preventive care as cost-sharing methods for

network benefits (see 34 N.J.R. 3485(a)). The Department adopted those rules on November 3, 2003 (see 35 N.J.R. 5116(a)). The rules placed limits on the amounts or percentages of network deductibles and network coinsurance, prescribed maximum out-of-pocket limits carriers may use, and also addressed aggregate dollar lifetime benefits maximums and out-of-network coverage.

As the Department noted when adopting the rules, the new cost-sharing methods authorized by the rules permitted carriers to sell plans that included greater cost-sharing for network services, which was a departure from prior practice. Because of its concern with the potential impact on covered persons' ability to access healthcare, the Department noted its intention to proceed cautiously in introducing the new methods. Since 2003, when the new cost-sharing rules were adopted, the Department has monitored carriers' policy form and contract submissions. This monitoring has disclosed that some carriers are submitting policy forms and contracts with multiple and extensive cost-sharing provisions that render the benefits under the policy or contract illusory. For example, since the adoption of N.J.A.C. 11:22-5, some carriers have submitted policy forms and contracts to the Department that provide for excessive cost sharing, such as requiring a $75.00 copayment for a primary care physician visit with a contract rate of $80.00, subjecting network services to multiple forms of cost sharing (for example, applying deductible, copayment and coinsurance to the same non-preventive network service) and/or the use of low dollar caps to restrict benefits.

HMOs are statutorily required to provide basic comprehensive benefits (see N.J.S.A. 26:2J-2f) and the Department is concerned that providing services subject to significant cost sharing is not consistent with the statutory mandate to furnish basic comprehensive services. Accordingly, the Department has determined that, in order for the benefit to be meaningful a

health benefit plan may include cost-sharing provisions, excluding deductible, of no greater than 50 percent of the cost of the service. These proposed amendments and new rules are intended to address these issues, which directly impact the financial exposure to which persons covered by health benefit plans are subjected. The following are the proposed amendments and new rules.

The term "Network-Based" is being deleted from the heading of the subchapter because this proposal contains standards applicable to both network-based and non network-based health benefit plans.

At N.J.A.C. 11:22-5.2, the definitions of "network deductible" and "network out-of-pocket limit" are being deleted and replaced with new definitions of "individual network deductible," "family network deductible," "individual network out-of-pocket limit," "individual out-of-network out-of-pocket limit," and "family network out-of-pocket limit." The definition of "network coinsurance" is being amended to remove the sentence stating that network coinsurance cannot be applied to services or supplies provided by capitated providers because that language is being relocated to N.J.A.C. 11:22-5.3(a)6, and to insert "network" before deductible and out-of-pocket limit for clarity. The term "co-payment" in the definition of "network co-payment" is being changed to "copayment" for consistency with the remainder of the rules.

N.J.A.C. 11:22-5.3, Network deductible, is being amended to remove the term "individual" appearing before "network deductible" because the proposed rule refers to both family and individual network deductibles. The amendments also limit the amount that can be contributed to the family network deductible by each covered person in a family and prohibit application of a network deductible to services or supplies provided by capitated providers.

N.J.A.C. 11:22-5.4, Network coinsurance, is being amended to add a provision prohibiting application of network coinsurance to services or supplies provided by capitated providers or to any service or supply to which network copayment is applied.

A new section, "Network copayment," is being added as N.J.A.C. 11:22-5.5. The section contains network copayment dollar maximums for various types of services and supplies provided in health benefit plans and stand-alone prescription drug plans. In setting these maximums, the Department estimated amounts that, excluding deductible, would result in the plans providing a 50 percent benefit on average. This section also prohibits the application of network copayment to any service or supply to which network coinsurance is applied.

A new section, "Out-of-pocket limits," is being added as N.J.A.C. 11:22-5.6, which applies to individual network, family network and individual out-of-network out-of-pocket limits. The section makes carriers responsible for tracking copayments, deductibles and coinsurance to determine when the out-of-pocket limit has been met and, when met, releases all covered persons from any further copayment, deductible and coinsurance obligations for the remainder of the calendar year, except for prescription drugs under a plan where prescription drugs do not accumulate toward the out-of-pocket limit. Other than the cost sharing associated with prescription drug coverage (where the coverage for prescription drugs does not accumulate towards the out-of-pocket limit), this section prohibits carriers from excluding any amounts paid as copayment, coinsurance or deductible toward the out-of-pocket limit. This section also limits the maximum amount that can be allocated toward the family network out-of-pocket limit for services provided to each covered person in a family.

Current N.J.A.C. 11:22-5.5, Aggregate dollar lifetime benefits maximums, is being recodified as N.J.A.C. 11:22-5.7 and renamed as Benefit maximums in health benefit plans. The

section is being amended to expand the current prohibition on placing aggregate dollar lifetime benefit maximums for network services and supplies only in certain types of contracts. The amended provision would prohibit aggregate dollar lifetime and annual dollar maximums for network services and supplies, as well as hospital inpatient and/or outpatient annual dollar maximums, in all health benefit plans. The section is further being amended to limit aggregate dollar lifetime maximums and annual dollar maximums in health benefit plans that are not network-based, and to limit annual dollar maximums for out-of-network services and in health benefit plans that are not network-based. Additionally, annual dollar maximums on out-of-network hospital inpatient and/or outpatient services are not permitted. Internal limits on coverage for services and supplies, such as dollar, visit or day limits must be the same for services and supplies delivered by network and out-of-network providers.

N.J.A.C. 11:22-5.6, Network and out-of-network coverage, is being recodified as N.J.A.C. 11:22-5.8. That section currently permits routine dental examinations to be covered only when provided by a network provider, and is being amended to change routine dental examinations to dental services and supplies, other than services and supplies for injury to sound natural teeth, bony impacted teeth and as required by P.L. 1999, c. 49.

N.J.A.C. 11:22-5.8, Dental benefits, is being recodified as N.J.A.C. 11:22-5.10, and is being amended to revise the cost-sharing requirements. The proposed amendments delete the requirements that 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 that for services rendered by out-of-network providers, coinsurance shall not exceed 75 percent. These current requirements are being replaced with the requirement that the in-network benefit provided by the carrier shall

result in average cost sharing, through coinsurance or copayments, of no more than 75% of the carrier's contracted cost of that service or for the cost of a class of similar services. Further, an aggregate deductible for all services may be disregarded in determining the cost-sharing, but a per service deductible shall be considered a copayment; a scheduled in-network benefit shall be considered a benefit with a copayment equal to the difference between the contracted rate and the scheduled benefit; and a carrier shall not use the cost of periodic examinations in determining the average cost sharing requirement. The amendments also permit a carrier that does not provide an in-network benefit for a particular service to allow the subscriber to receive the service by paying to the provider the carrier's in-network contracted rate, but those services are not taken into consideration for purposes of meeting the maximum 75% copayment/coinsurance requirement set forth in the rule.

N.J.A.C. 11:22-5.9, Effects on previously approved forms, is being recodified as N.J.A.C. 11:22-5.11, and is being amended to require all noncompliant previously filed and approved forms to be withdrawn as of January 1, 2009.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

These proposed amendments and new rules should have a favorable impact on carriers, providers and consumers. Carriers should be favorably impacted because the revised cost-sharing limits and benefit maximums may increase the marketability of the plans affected by these amendments and new rules. Providers should be favorably impacted because the proposed amendments and new rules may further expand their practices due to increased consumer interest

in the plans. Consumers will be favorably impacted because their coverage will not include cost sharing at levels that are so high as to render the coverage illusory. Consumers will also be more aware of the benefits they are entitled to receive under their health plans, the annual and lifetime limits on those benefits, and the cost-sharing amounts they are required to pay.

Economic Impact

Carriers may be unfavorably impacted by these proposed amendments and new rules because they limit the cost-sharing amounts carriers may require covered persons to pay and require that certain minimum annual and lifetime dollar benefits are paid. Carriers may incur certain additional recordkeeping and administrative expenses related to compliance with these amendments and new rules (for example, carriers are being required to track the accumulation of copayment, deductible and coinsurance to identify when a covered person's out-of-pocket limit has been satisfied, and carriers may need to provide notice to providers and/or covered persons of the revised cost-sharing amounts and annual and lifetime dollar benefits). Providers may be favorably impacted if these revised cost-sharing and benefit levels result in an increase in patients and additional fees. Consumers will be favorably impacted because their cost-sharing amounts will be limited and certain dollar benefit maximums will increase.

Federal Standards Statement

A Federal standards analysis is not required because the Department's proposed amendments and new rules are not subject to any Federal standards or requirements.

Jobs Impact

The Department does not anticipate that the proposed amendments and new rules will result in the generation or loss of jobs.

Agriculture Industry Impact

Pursuant to N.J.S.A. 4:1C-10.3, the Right to Farm Act, and N.J.S.A. 52:14B-4(a)(2) of the Administrative Procedure Act, the Department does not expect any agriculture industry impact from the proposed amendments and new rules.

Regulatory Flexibility Analysis

These proposed amendments and new rules may apply to some carriers that constitute "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments and new rules limit the cost-sharing amounts covered persons can be required to pay, and require that covered persons receive minimum annual and lifetime dollar benefits under their network-based health benefit plans. While carriers will not experience any additional reporting requirements in complying with the amendments and proposed new rules, carriers may experience additional recordkeeping and administrative costs as described in the Economic Impact statement above. Nevertheless, the standards set forth in these amendments and new rules must be applied consistently to all carriers offering the types of health benefit plans described in these rules. Covered persons under all network-based health benefit plans are entitled to experience the benefit levels and cost-sharing limits contained in these amendments and new rules, and no exception can be made for small businesses.

Compliance with the proposed amendments and new rules should not require the employment of professional services.

Smart Growth Impact

The proposed amendments and new rules will have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

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

SUBCHAPTER 5. MINIMUM STANDARDS FOR [NETWORK-BASED] HEALTH BENEFIT PLANS

11:22-5.2 Definitions

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

. . .

"Family network deductible" means the fixed dollar amount of covered charges that two or more covered persons in a family shall pay to network providers before the health benefits plan provides members of the covered family with coverage for services or supplies rendered by network providers. The family network deductible may be calculated on either an aggregate or a per individual basis.

"Family network out-of-pocket limit" means the maximum dollar amount that two or more persons in a covered family shall pay in combination as copayment, deductible and coinsurance for network covered services and supplies in a calendar year.

. . .

"Individual network deductible" means the fixed dollar amount of covered charges that a covered person shall pay to network providers before the health benefit plan provides the covered person with coverage for services or supplies rendered by network providers.

"Individual network out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar year.

"Individual out-of-network out-of-pocket limit" means the maximum dollar amount that a covered person shall pay as copayment, deductible and coinsurance for out-of-network covered services and supplies in a calendar year.

"Network coinsurance" means the percentage of the contractual fee of the network provider for covered services and supplies specified in the contract between the provider and the carrier that must be paid by the covered person, under the health benefit plan, subject to **network** deductible and **network** out-of-pocket limit. **[**Network coinsurance cannot be applied to services or supplies provided by capitated providers.**]**

"Network **[**co-payment**]** **copayment**" means the specified dollar amount a covered person must pay for covered services and supplies rendered by network providers under the health benefit plan.

["Network deductible" means the fixed dollar amount that a covered person or family must pay to network providers before the health benefit plan provides the covered person with coverage for services or supplies rendered by network providers. A network deductible shall not be applied to services or supplies provided by capitated providers.

"Network out-of-pocket limit" means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar year. All amounts paid as copayment, coinsurance and deductible shall count toward the out-of-pocket maximum, and shall not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason. A carrier may, however, elect to exclude from the network out-of-pocket limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefits plan or as a rider. Once the network out-of-pocket limit has been reached, the covered person has no further obligation to pay any amounts as copayments, coinsurance or deductible for services and supplies provided by network providers (other than for prescription drugs, if prescription drugs do not accumulate toward the out-of-pocket limit) for the remainder of the calendar year.**]**

. . .

11:22-5.3 Network deductible

(a) **[**An individual**]** **A** network deductible is permitted in a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or health service corporation, and in a SCA policy providing hospital and medical coverage issued by an insurance company, provided that:

1. – 2. (No change.)

3. The individual network deductible is not applied to preventive care; **[**and**]**

4. The contract contains a family network deductible no greater than two times the individual network deductible**[**.**]****;**

5 The covered charges that each covered person in a family can contribute to the family network deductible is limited to the amount of the covered person's individual network deductible; and

6. The network deductible shall not be applied to services or supplies provided by capitated providers.

11:22-5.4 Network coinsurance

(a) Network coinsurance is permitted in a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or health service corporation, and in a SCA policy providing hospital and medical coverage issued by an insurance company, provided that:

1. - 2. (No change.)

3. The network coinsurance obligation of the covered person is computed by applying the coinsurance percentage to the contractual fee schedule of the provider, not to the billed charges of the provider;**[**and**]**

4. Network coinsurance **[**cannot**]** **shall not** be applied to preventive care**[**.**];**

5. Network coinsurance shall not be applied to services or supplies provided by capitated providers; and

6. Network coinsurance shall not be applied to any service or supply to which network copayment is applied.

11:22-5.5 Network copayment

(a) Network copayments in health benefit plans and stand-alone prescription drug plans may not exceed the following amounts:

1. Preventive services, $30.00;

2. Primary care physician office visit, $50.00;

3. Specialist office visit, $75.00;

4. Emergency room visit, $100.00;

5. Outpatient surgery, $500.00;

6. Inpatient admission, $500.00 per day up to a maximum of $ 2,500 per admission;

7. Magnetic resonance imaging, computerized axial tomography and positron emission tomography, $100.00;

8. Generic drug, $25.00 per 30-day supply;

9. Preferred drug, $50.00 per 30-day supply;

10. Non-preferred drug, $75.00 per 30-day supply; and

11. For any other services and supplies, the copayment is to be determined so that the carrier insures 50 percent or more of the aggregate risk for the service or supply to which the copayment is applied.

(b) Network copayment shall not be applied to any service or supply to which network coinsurance is applied.

11:22-5.6 Out-of-pocket limits

(a) The following shall apply to individual network, family network and individual out-of-network out-of-pocket limits:

1. Carriers shall track the accumulation of copayment, deductible and coinsurance payments to identify when the out-of-pocket limit has been satisfied, and shall not require covered persons to report payment of copayments, coinsurance or deductible for inclusion in the out-of-pocket limit;

2. All amounts paid as copayment, coinsurance and deductible shall count toward the out-of-pocket limit, and shall not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason, except carriers may, provided the terms of the health benefit plan so state, elect to exclude from the out-of-pocket limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefit plan or as a rider; and

3. When the out-of-pocket limit has been reached, the covered person, or the covered members of the family in the case of a family network out-of-pocket limit, shall have no further obligation to pay any amounts as copayment, coinsurance or deductible for services and supplies provided by providers for the remainder of the calendar year, except for prescription drugs if, under the terms of the applicable plan, prescription drugs do not accumulate toward the out-of-pocket limit.

(b) The maximum amount that each covered person in a covered family can contribute to the family network out-of-pocket limit shall be the amount of the covered person's individual network out-of-pocket limit.

11:22-[5.5]**5.7** [Aggregate dollar lifetime benefits]**Benefit** maximums **in health benefit plans**

(a) The following limitations on dollar maximums shall apply:

[(a)]**1.** Aggregate dollar lifetime [benefit] maximums **for network services and supplies, aggregate dollar annual maximums for network services and supplies, and hospital inpatient and/or outpatient aggregate annual dollar maximums** for network services and supplies are not permitted in [a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or a health service corporation, or in a SCA policy issued by an insurance company] **a health benefit plan**.

[(b)]**2.** Aggregate dollar lifetime [benefits] maximums for out-of-network services and supplies are permitted in a [POS contract issued by a health maintenance organization or a health service corporation, or in a SCA policy issued by an insurance company] **health benefit plan**, only if such maximums are in the amount of $5 million or greater and are imposed on a per-plan per-carrier basis.

3. Aggregate dollar lifetime maximums are permitted in health benefit plans that are not network-based only if such maximums are in the amount of $5 million or greater and are imposed on a per-plan per-carrier basis.

4. Annual dollar maximums for out-of-network services in a network-based health benefit plan are permitted only if such maximums are in the amount of $1 million or greater.

5. Annual dollar maximums are permitted in health benefit plans that are not network-based only if such maximum is in the amount of $1 million or greater, except that health benefit plans that qualify as group student health insurance as defined at

N.J.A.C. 11:4-13.2 or that are supplemental to another health benefit plan may have annual dollar benefit maximums lower than $1 million.

6. Annual dollar limits on out-of-network hospital inpatient and/or outpatient services in health benefit plans are not permitted.

(b) Internal limits in health benefit plans, including, but not limited to, dollar, visit or day limits imposed on coverage for specific services or supplies, shall be the same for services and supplies delivered by network and out-of-network providers.

11:22-**[**5**.**6**]5.8** Network and out-of-network coverage

(a) POS contracts issued by health maintenance organizations and health service corporations, and SCA policies issued by insurance companies, shall provide coverage for covered services and supplies regardless of whether rendered by a network or an out-of-network provider, with the following exceptions:

1. The following services and supplies may be covered only when provided by a network provider, and are not required to be covered when provided by an out-of-network provider:

i. – ii. (No change.)

[iii. Routine dental examinations;**]**

iii. Dental services and supplies, other than services and supplies for injury to sound natural teeth, bony impacted teeth and as required by P.L. 1999, c. 49;

iv.- viii. (No change).

(b) - (c) (No change.)

11:22-[5. 7]**5.9** (No change in text.)

11:22-[5. 8] **5.10** Dental benefits

(a) The following standards apply to health benefit plans and stand-alone dental plans that provide benefits for dental services only when rendered by network providers, and plans that provide benefits for dental services rendered by both network and out-of-network providers:

[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.]

1. The in-network benefit provided by the carrier shall result in average cost sharing, through coinsurance or copayments, of no more than 75 percent of the carrier's contracted cost of that service or for the cost of a class of similar services.

i. An aggregate deductible for all services may be disregarded in determining the cost-sharing, but a per service deductible shall be considered a copayment.

ii. A scheduled in-network benefit shall be considered a benefit with a copayment equal to the difference between the contracted rate and the scheduled benefit.

iii. A carrier shall not use the cost of periodic examinations in determining the average cost sharing requirement.

2. A carrier that provides no in-network benefit for a service may allow the subscriber to receive that service by having the subscriber pay to the provider the

carrier's in-network contracted rate. In such cases, the services are not considered to be covered services for purposes of meeting the maximum 75 percent copayment/coinsurance requirement.

11:22-**[**5.9**]5.11** Effects on previously approved forms

Any form that was previously filed with and approved by the Commissioner, but does not meet the requirements of this subchapter, shall be deemed withdrawn as of **[**July 1, 2006**]** **January 1, 2009** and may not be made available for new issue or for renewal on or after that date.

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