INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans

Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans

Reproposed Amendments: N.J.A.C. 11:22-5.1 through 5.9

Reproposed 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 2008-414

Submit comments by February 13, 2009 to:

Robert Melillo, Chief
Legislative & Regulatory Affairs
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
FAX: 609-292-0896
Email: LegsRegs@dobi.state.nj.us

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 have submitted 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). 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 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.

The Department proposed amendments and new rules on January 22, 2008 that were intended to address these issues and would directly impact the financial exposure to which persons covered by health benefit plans, including indemnity plans, would be subjected (see 40 N.J.R. 589(a)). Those proposed amendments and new rules are summarized as follows:

The term “Network-Based” was being deleted from the heading of the subchapter because the proposal contained 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” were 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” was being amended to remove the sentence stating that network coinsurance cannot be applied to services or supplies

provided by capitated providers because that language was 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” was being changed to “copayment” for consistency with the remainder of the rules.

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

N.J.A.C. 11:22-5.4, Network coinsurance, was 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,” was 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,” was 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, was being recodified as N.J.A.C. 11:22-5.7 and the section heading amended as "Benefit maximums in health benefit plans." The section was 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 was being further 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, was 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, was being recodified as N.J.A.C. 11:22-5.10, and being amended to revise the cost-sharing requirements. The proposed amendments deleted 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 would be 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 percent 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 permitted 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 percent copayment/coinsurance requirement set forth in the rule.

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

The official comment period for the amendments and new rules proposed on January 22, 2008 and summarized above ended on March 22, 2008. As a result of comments received in response to that proposal, the Department is reproposing the amendments and new rules as modified below.

The Department received comments from the New Jersey Hospital Association; Delta Dental of New Jersey, Inc., the Medical Society of New Jersey, New Jersey Physicians, Harris M. Recht, Horizon Blue Cross Blue Shield of New Jersey, AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey, and the New Jersey Association of Health Plans.

The comments and the Department's responses thereto are summarized as follows:

1. COMMENT: Several of the commenters expressed support for the Department's proposal. Some commenters appreciated the Department's goal of ensuring that consumers are not inappropriately burdened with increasing cost-sharing obligations for their health insurance coverage, and supported the establishment of dollar limits for many services so that the cost-sharing amounts do not render a person's coverage meaningless. One commenter stated that patients/members are entitled to know the "benefit of the bargain" on health insurance contracts; that transparency on costs and cost shifting is appropriate since healthcare is a significant personal expense; and that lower copays and coinsurance may result in enhanced access to care, improved compliance and continuity of care. One commenter cited a study showing that reduced copayments can positively affect adherence to recommended treatment regimens (See Health Affairs, "Cutting Co-payments Yields Increased Adherence to Recommended Treatments" (Jan./Feb. 2008) (abstract available at http://www.content.healthaffairs.org/cgi/content/abstract/27/1/103)). Some commenters also supported the provision that would prohibit plans from restricting the number of services provided by non-network providers to fewer days or visits than allowed for network services.

RESPONSE: The Department thanks the commenters for their support. The Department further thanks the commenter who identified the study that shows that reduced copayments positively affect adherence to recommended treatment regimens, thereby supporting the Department's observation that lower cost sharing enhances access to and continuity of care.

2. COMMENT: Some commenters stated that the proposed rules are a step in the wrong direction. The commenters stated that demand in the marketplace is moving increasingly toward greater cost-sharing in benefit plans. According to the commenters, plan designs with little cost-sharing have insulated consumers from the true cost of health care, which has resulted in increases in inappropriate utilization of health care services. Increased cost-sharing for consumers helps to make plan members stakeholders in purchasing health care and provides an incentive for consumers to seek care from efficient providers and to avoid unneeded care. The commenters stated that the Department indicated (in the proposal Summary) that a reason for the need for maximum amounts on cost-sharing is that a $75.00 copayment for a visit with an $80.00 contract rate provides an illusory benefit. This disregards the value of the health plan's negotiation with providers, which is one of the more valuable benefits of a network-based plan. If the same provider would bill $200.00 in the absence of coverage, the value of the coverage in the Department's example is significant and the resulting combination of low premium and high value should be encouraged, not prohibited.

RESPONSE: The Department does not agree that permitting unlimited cost sharing protects consumers or prevents utilization of unneeded care. Rather, the Department's concern is that increased cost sharing results in underutilization of, or delays in, seeking needed care, resulting in a deterioration of health status for the insured public. Contrary to the commenters' assertion, consumers do not demand increased cost sharing; they want lower premium increases. This can be achieved in

ways other than increased cost sharing, such as increased carrier efficiency, higher medical loss ratios, and alternate definitions of out of network benefits. The Department believes there must be limits on cost sharing and that an absence of regulation in this area is not in the public interest. If the insurance industry believes that the limits proposed are inappropriate, it should suggest alternate limits supported by data. Accordingly, in addition to the other cost sharing limits proposed by the Department in both its original proposal and this reproposal, the Department is adding language to the definition of "network copayment" prohibiting a network copayment from exceeding the contractual fee of the network provider for the service or supply in order to prevent the provision of an illusory benefit. In addition, the Department notes that a consumer who wishes to purchase access to a carrier's negotiated rates with network providers can purchase a discount plan. An insurance plan is not a discount plan and a health benefits plan whose benefits are primarily access to negotiated charges cannot be considered or marketed as insurance. Finally, the Department notes that the commenters did not identify any studies to support their assertions that increased cost sharing reduces utilization of unnecessary care.

3. COMMENT: One commenter stated that the proposal clearly suggests in the Summary that it contains "standards applicable to both network-based and non network-based health benefit plans," but requested that the Department clarify whether the rules apply to all non-network based health plans or only selected plans or benefits. The commenter further questioned whether "non-network based health plans" is

synonymous with and/or encompasses what are commonly referred to as “out of network” plans.

RESPONSE: The Department agrees that the rule should be clarified and has modified the subchapter heading and the purpose and scope section, N.J.A.C. 11:22-5.1, to indicate that the rule applies to both traditional indemnity plans (that is, no network) and network based plans (including those with and without out-of-network benefits).

4. COMMENT: One commenter requested that the Department clarify the meaning of “capitated providers” and other terms used in the proposal.

RESPONSE: The Department agrees and has added definitions of “capitation,” “physician” and “specialist physician” to the rule.

5. COMMENT: One commenter stated that the rule proposal Summary states 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 service.” The commenter questioned whether “cost of service” is the negotiated rate or charges, and whether it varies depending on whether the provider is a network provider or a non-network provider. The commenter requested that the Department define “cost of service.”

RESPONSE: “Cost of service” refers to the covered person’s cost. For an in-network provider, cost of service would be the provider’s negotiated charge. For an out-of-network provider, cost of service would be the provider’s billed charge.

However, the phrase “cost of service” is not used in the text of the rule and the Department does not consider it appropriate to define a term that is not used.

6. COMMENT: One commenter disagreed with the Department’s statements in the proposal’s Social Impact statement that the proposed rules “may increase the marketability” of health plans and that the proposal may result in “increased consumer interest” in health plans. The commenter stated that it believes the opposite would be the result because, the commenter contends, the proposal would cause premium rates to increase.

RESPONSE: The Department disagrees with the commenter’s assumption that high cost sharing plans with associated lower premiums are already issued in New Jersey and that these rules will require the termination of such plans. Since the Department has not approved plans with cost sharing in excess of the proposed maximums, there should be no disruption or termination of in force business.

7. COMMENT: Two commenters addressed the impact of the Department’s proposed rules on employers. The commenters stated that regulations should be promulgated that foster plan designs desired by employers, which would result in an increase in the number of employers providing coverage. The commenters further stated that the proposal’s Economic Impact statement does not address the economic impact on employers, which will be significant. The commenter stated that many employers have opted for benefit plans that currently have greater cost-sharing amounts than those that would be permitted under the proposed rules in order to hold down premiums. If these employers are required to conform their plans to the

proposed rules, they can expect to pay commensurately higher premiums and will be foreclosed from selecting lower cost options unless they opt to eliminate benefits that are not mandated.

RESPONSE: The Department does not believe that having employers provide coverage with cost sharing that is so high that covered persons delay or decline care fosters any public policy. Unregulated cost sharing is not in the public interest. Rather, the debate should focus on what limits on cost sharing are appropriate. As stated above, the contention that the impact of the rules will be to increase premiums and to cause the termination of low cost plans is greatly exaggerated because plans with cost sharing in excess of the levels proposed have not been approved by this Department. Finally, the Department appreciates that employers are looking for lower cost plans, but that does not lead to the conclusion that they seek higher cost sharing.

8. COMMENT: One carrier requested that the scope of the proposed rules be extended to include organized delivery systems (ODSs), either directly by including ODSs in the purpose and scope section or indirectly by applying the rules equally to carriers' "agents" because ODSs assume risk and pay claims just as carriers do. The commenter further stated that many payers utilize selective contracting arrangements (SCAs) that permit preferred provider organizations (PPOs) to remit payment. Although the SCA regulations at N.J.A.C. 11:4-37 contain some standards, they do not specifically address patients' cost-sharing obligations and the proposed rules should also apply to SCAs.

RESPONSE: The rules deal with the design of health benefit, prescription drug and dental plans. Such plans are issued by carriers and the rules apply to carriers. Since ODSs contract with carriers to supply some of the services under the carrier's health benefit plan, their operations do not impact plan design. Similarly, a SCA is a type of plan (that is, one with in-network and out-of-network benefits) and is not an entity. Moreover, the SCA rules state at N.J.A.C. 11:4-37.3(b)6 that the benefit design of plans using SCAs must comply with N.J.A.C. 11:22-5. The rules apply to all health benefits plans, dental plans and prescription drug plans sold by carriers.

9. COMMENT: One commenter stated that the proposed rules' limits on out-of-network cost sharing give more physicians incentive to leave networks. A reduction in in-network physician options results in members paying greater amounts to see out-of-network physicians, driving up the overall cost of care. This leads to premium increases, ultimately lowering the availability and affordability of health coverage. This result is contrary to the stated purposes of the proposed rules.

RESPONSE: The out-of-network cost sharing limits ensure that benefits provided out-of-network are meaningful. The Department does not believe that the limits will provide physicians with an incentive to leave networks. The rules do not require a maximum out-of-pocket limit for out-of-network services, do not regulate out-of-network deductibles, and do not set standards for the determination of the allowable charge for out-of-network services. Thus, the rules provide carriers with flexibility to design a minimal out-of-network benefit, which should maintain the incentive of providers to join and remain in networks. Additionally, if carriers are fearful that

physicians will leave networks, carriers could also consider ameliorating the administrative burdens borne by participating providers and/or increasing compensation rates paid to in-network providers.

10. COMMENT: Three comments concerned the proposed definition of "family network deductible" at N.J.A.C. 11:22-5.2 and the proposed network deductible provisions at N.J.A.C. 11:22-5.3. One commenter noted that the definition would allow a family deductible to be calculated on either an aggregate or a per individual basis, and stated that requiring each individual in a family to contribute a specific amount to the family deductible defeats the purpose of having a family deductible limit. The commenter stated that, in practice, a family member who requires more healthcare services than other members could reach the deductible limit himself or herself. However, the definition would suggest that despite the deductible being reached, the carrier could deny coverage for services until other family members had also accessed enough healthcare services to enable them to reach their individual deductibles under the family plan. The commenter questioned how this serves the best interest of the family or helps control the cost of healthcare services or over-utilization. The commenter also stated that proposed N.J.A.C. 11:22-5.3(a)5, which states that the covered charges that each person in a family can contribute to the family network deductible is limited to the amount of the covered person's individual network deductible, is inconsistent with the proposed definition of "family network deductible," which allows the deductible to be calculated on either an individual or aggregate basis. The commenter recommended that the Department amend the definition to require

that family deductibles be calculated only on an aggregate basis and remove the requirement at N.J.A.C. 11:22-5.3(a)5.

Three commenters stated that the proposed definition of "family network deductible" and N.J.A.C. 11:22-5.3 are inconsistent with a plan design that would qualify for Federal tax advantages as a High Deductible Health Plan for use with a Health Savings Account. Federal law requires that a qualified High Deductible Health Plan have an aggregate family deductible (that is, one where the entire family has to meet the family deductible before any benefits are paid). The proposed rules would require that family coverage plans include deductibles that would apply on the individual level. One of the commenters submitted language from Treasury Notice 2004-2, answering the question what is a "high-deductible health plan" (HDHP). The answer indicates that "[f]or self-only coverage, an HDHP has an annual deductible of at least $1,000 , . . . [and that] for family coverage, an HDHP has an annual deductible of at least $2,000 . . . [.] In the case of family coverage, a plan is an HDHP only if, under the terms of the plan and without regard to which family member or members incur expenses, no amounts are payable from the HDHP until the family has incurred annual covered medical expenses in excess of the minimum annual deductible."

RESPONSE: The Department agrees with the commenters that the definitions are not consistent with Federal high deductible health plans and has modified the definitions of "family network deductible" and "family network out-of-pocket limit" to delete the limitation on the amount any one family member can contribute. The Department has also deleted proposed N.J.A.C. 11:22-5.3(a)5

11. COMMENT: One commenter questioned whether proposed N.J.A.C. 11:22-5.4(a)6, which prohibits a carrier from applying network coinsurance to any service or supply to which network copayment is applied, is inconsistent with the cost-sharing for inpatient hospital services permitted under the Small Employer Health Benefits Program (SEHBP) Plan B and with emergency services under standard SEHBP plans that permit a copayment in addition to deductibles and coinsurance.

RESPONSE: The Department agrees that SEH Plan B will need to be revised following adoption of these rules. No other SEH plans will require revision.

12. COMMENT: Three comments addressed the proposed network copayment requirements at N.J.A.C. 11:22-5.5. One commenter stated that hospitals report that some carriers inappropriately apply inpatient deductible and coinsurance amounts to services provided in an outpatient department of a hospital (such as diagnostic and therapeutic services) that would normally be covered with a copay. Conversely, carriers reimburse the same services performed at freestanding outpatient facilities as “office visits” and only require the patient to pay a nominal copay. Such a practice incorrectly identifies all hospital services as inpatient and inappropriately shifts a larger financial burden on patients for receiving services at a hospital outpatient department, which may be the only location certain services (such as sleep centers) are available. The commenter recommended that the Department include in the list of copayment limits outpatient diagnostic and therapeutic services to ensure that carriers do not require patients to pay at the inpatient deductible or coinsurance level for such services.

RESPONSE: The Department understands the commenters' concern; however, the issue of carriers applying incorrect copayments for outpatient services rendered in a hospital setting is an enforcement issue and beyond the scope of these rules.

13. COMMENT: One commenter stated that policy decisions such as the establishment of maximum cost-sharing are the purview of the Legislature and beyond the authority of the Department. The commenter further stated that maximum copayments are not required to avoid illusory benefit health plans; many plans already exist with higher copayments.

RESPONSE: The comment that the Department does not have authority to set maximum cost sharing ignores the statutes that authorize the Commissioner to disapprove policies and contracts that are unjust, unfair, inequitable, misleading, contrary to law or the public policy of this state and require the Commissioner to establish in regulations standards relating to the review of policies and contracts (see N.J.S.A. 17B:27-49g, 17:48E-13 and 26:2J-8a(3)(a). Further, the commenter's reference to existing plans with higher copayments than those proposed in these rules is unclear since the Department has not approved any policies or contracts containing such copayment levels.

14. COMMENT: One commenter stated that it is unclear whether the same drug copays, which are set forth at proposed N.J.A.C. 11:22-5.5(a)8 and 9, would apply to retail and mail-order pharmacies.

RESPONSE: The same drug copay caps do apply to retail and mail order pharmacies.

15. COMMENT: Some commenters addressed the specific amounts of the maximum copayments set forth at proposed N.J.A.C. 11:22-5.5(a). One commenter recommended that the Department raise the maximum amounts of copayments for emergency room visits and prescription drugs. The commenter stated that as these costs continue to rise, the limitation on the copayments will only result in higher premiums for all insureds. The current demand for affordable health plans indicates that the proposed maximums for the listed items are already at current market levels for a significant portion of the market. Therefore, the commenter recommended that the maximums be raised from $100.00 to $200.00 for emergency room visits, from $25.00 to $50.00 for generic drugs, from $50.00 to $75.00 for preferred drugs and from $75.00 to $100.00 for non-preferred drugs. The commenter added that the maximums for the other categories should also be closely examined in comparison with current offerings so as not to eliminate affordable plans that are being purchased today. The commenter also suggested that the Department establish a timetable to regularly update the copayment maximums to keep pace with inflation.

One commenter stated that a number of the copayment amounts seem high and cited as an example the $500.00 amount for outpatient surgery and inpatient admission per day. The commenter requested that the Department explain the methodology it used to conclude in the proposal Summary that “in setting these maximums, the Department estimated amounts that, excluding deductible, would result in plans providing a 50 percent benefit on average.” The commenter further requested that the Department take another look at how these copayment amounts relate to each other

and how they will work in practice. For example, the $500.00 inpatient admission per day amount is capped at $2,500 and is presumably in addition to other services and services rendered in the course of the admission. This could result in substantial cost shifting and burdens to consumers, possibly in excess of what they would have to pay today under existing policies.

RESPONSE: With respect to adjusting the copay maximums in the rule, the Department invites any party interested in altering the cap amounts to present it with data supporting an adjustment to either increase or reduce them. With respect to the comment regarding the imposition of multiple copays during one admission, the Department notes that only the hospital confinement copay should apply. With respect to the methodology used by the Department to develop these copay caps, the Department notes that the Summary uses the term “estimate” since the Department does not have access to carriers’ network claim data by service type.

16. COMMENT: One commenter stated that proposed N.J.A.C. 11:22-5.5(a)11 would be unworkable. That provision states that for any services and supplies for which the proposed rule does not establish a specific maximum copayment amount, 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. The commenter stated that within a category of services there may be multiple network prices and these may vary with different providers and provider types. Calculating 50 percent or more of the aggregate risk prospectively for purposes of establishing a copayment would not be possible. Another commenter stated that this 50 percent cost-

sharing limitation may still be too high and requested that the Department determine if the percentage should be further reduced or additional safeguards instituted to ensure that the intent of the proposed rule is realized. The commenter stated that it is concerned that carriers will look at the 50 percent cost-sharing as a ceiling, and added that this was one of the main concerns underlying the Department's now withdrawn proposal regarding payment of out-of-network non-hospital provider claims (PRN 2006-405; see 38 N.J.R. 5309(a)). The almost uniform opposition to that proposed rule arose in part as a result of the widespread concern by the provider community that what was perceived by the Department as a floor that would be beneficial to providers would become a ceiling that would further depress the amounts that providers would receive for their services. The commenter added that it is concerned that carriers will simply increase the price of their policies to offset any cost-sharing restrictions and in so doing circumvent the Department's laudable goal -- to ensure that "consumers will be favorably impacted because their cost-sharing amounts will be limited and certain dollar benefit maximums will increase." The commenter further requested that the Department address the issue of carrier pricing. The commenter stated that if the pricing issue is not addressed, this proposal could result in carriers pricing their policies in a manner that would put basic coverage beyond the reach of consumers

RESPONSE: The 50 percent copay cap for network services not specified in the rules is intended to require carriers to provide meaningful benefits for network services for which a copayment is required. With respect to the calculation of the 50 percent cap, when there are multiple network rates for a service the copay does not

have to equal 50 percent but cannot exceed 50 percent of the lowest network rate. Setting a copay so that it would not exceed 50 percent of the lowest network rate ensures that no copay results in a failure to meet the requirement to insure 50 percent of the aggregate risk for the service or supply to which the copay is applied. While the Department understands the commenter's pricing concerns, that issue is beyond the scope of these rules, which address cost sharing. Moreover, rate regulation differs in the various insurance markets (individual, small employer and large employer) and for the various types of carriers (health service corporations, health maintenance organizations and insurance companies).

17. COMMENT: Three commenters addressed the out-of-pocket limits provisions at proposed N.J.A.C. 11:22-5.6 One commenter stated that N.J.A.C. 11:22-5.6(b), which limits the maximum amount that each covered person in a covered family can contribute to the family network out-of-pocket maximum to the amount of the covered person's individual network out-of-pocket limit, should be eliminated on adoption.

Two commenters indicated support for the requirement that carriers track copayments, deductibles and coinsurance to determine when out-of-pocket limits have been met. However, the commenters questioned whether this information will be directly communicated to physicians and other healthcare providers. One commenter suggested that the Department consider options to accomplish that (for example, the first explanation of benefits (EOB) generated after the out-of-pocket limit has been met could specify that the limit has been reached; notifying the primary care physician and

any treating physician; updating the data base containing the patient and plan information to indicate the limit has been reached; informing the insurer's customer service employees that the limit has been reached so physicians can obtain the information by phone). The commenter believes the proposed tracking requirement will not be effective unless a new notice requirement to the treating physicians is provided in a new N.J.A.C. 11:22-5.6(a)4.

One commenter further requested that the Department consider requiring a carrier to be responsible for payment to a provider if the carrier fails to timely and accurately track and make such information available to a provider. Otherwise, as is the case now, the provider finds itself with no recourse even though it rendered services in good faith with the understanding that such services would be reimbursable by the carrier. The commenter expressed its concern that insurance companies will use the tracking requirement as a pretext to impose additional reporting and administrative obligations on providers, thereby increasing provider costs and burdens, as well as to withhold or deny payment to providers.

One commenter questioned whether the reference to "calendar year" at N.J.A.C. 11:22-5.6(a)3 also includes/means contract year.

RESPONSE: The Department agrees with the comment about N.J.A.C. 11:22-5.6(b) and has deleted that provision. The statements concerning the content of EOBs, information available to providers online and other comments regarding tracking of cost sharing are beyond the scope of this proposal, which addresses only limits on cost-sharing. The Department, however, will monitor these issues and consider additional

rulemaking in the future if it determines rules are needed. With respect to the comment on N.J.A.C. 11:22-5.6(a)3, the Department has amended this provision to refer to calendar, contract or policy year.

18. COMMENT: One comment was submitted regarding proposed N.J.A.C. 11:22-5.7, Benefit maximums in health benefit plans. The commenter questioned whether the impermissible "aggregate dollar annual maximums for network services" referred to at N.J.A.C. 11:22-5.7(a)1 means the overall total for all types of services (inpatient, outpatient, professional and ancillary combined) and not necessarily for a particular covered service. By way of example, the commenter asked if a plan would be compliant if it offered benefits for a specific covered service up to an annual dollar maximum such as $1,000. If not, plans will be more likely to include outright exclusions.

The commenter stated that proposed N.J.A.C. 11:22-5.7(b), which requires that internal limits, including, but not limited to, dollar, visit or day limits, be the same for services and supplies delivered by network and out-of-network providers, would not lead to efficiency. By way of example, the commenter stated that in a plan where the out-of-network inpatient day limit is currently $120.00 (while the network inpatient benefit is unlimited), the carrier would need to consider imposing a network inpatient day limit of $120.00. Otherwise, the plan could become significantly more expensive.

RESPONSE: "Aggregate" means total network services. A carrier may impose limits on specific services (other than hospital inpatient and outpatient) provided the limits apply to both in-network and out-of-network providers to ensure that the out-of-

network benefit is meaningful. For example, a plan with unlimited inpatient days in-network and two inpatient days per year out-of-network cannot be considered to offer out-of-network hospital benefits. If a plan is labeled as a point of service or preferred provider organization plan, then the consumer should be free to choose a network or an out-of-network provider for all covered services. Regarding the comment that carriers may need to consider imposing a lower in-network limit in order to comply with this rule, the proposed rule does not determine the limit itself, only that the limit be the same for in-network and out-of-network services. No change to the proposal is being made in response to the comment.

19. COMMENT: One commenter stated that it specifically appreciated the Department's requirement at N.J.A.C. 11:22-5.10(a)1 that the in-network dental benefit provided by a carrier result in "average" cost sharing as applied to "a class of similar services." The commenter stated that it interpreted the proposed rules as establishing a minimum level of coverage for a class of services rather than seeking to control the impact of common dental coverage terms such as "annual maximum benefit amounts" and "lifetime maximum benefit amounts" (most commonly for orthodontic services), as well as frequency limitations and the like. The commenter requested that the Department so state either in the adoption process or by adding a clarifying provision to the proposed rules (for example, adding a subparagraph iv. at N.J.A.C. 11:22-5.10(a)1 stating that paragraph (a)1 does not impact or regulate a carrier's use of annual or lifetime maximum benefit levels for services which are covered). The commenter further appreciated the Department's addition of proposed N.J.A.C. 11:22-5.10(a)2 to

clarify that carriers can protect covered persons by limiting network providers' fee levels for services not covered under the plan without having to include those services in the minimum benefit calculation.

Two commenters stated their belief that N.J.A.C. 11:22-5.10 should not apply to benefits that are provided on a group basis and which specify a dollar ceiling on the amount to be benefited or paid for a specific service. The commenters stated that often dental benefit plans are the result of collective bargaining and, as a result, the plan designs are the end product of an arms-length negotiation and represent an agreement between labor and management on the level of benefits provided in the context of other benefits. The rule proposal could disrupt the balance in benefit payments that has already been struck in such agreements.

RESPONSE: The Department agrees with the comments. The Department has modified reproposed N.J.A.C. 11:22-5.10(a)1i to disregard dollar benefit maximums in determining cost-sharing.

20. COMMENT: Two commenters stated that the January 1, 2009 deadline for policy form compliance with these rules set forth at proposed N.J.A.C. 11:22-5.11 provides insufficient time for the marketplace to replace non-conforming plans with approved plans. The commenters suggested that the Department provide at least an 18-month lead time for implementation.

RESPONSE: The Department believes that 12 months lead time is sufficient but, given the uncertainty as to when the reproposed new and amended rules may be adopted, is extending the effective date to July 1, 2010.

Based on the above-summarized comments received on the proposed amendments to and new rules in N.J.A.C. 11:22-5 originally published on January 22, 2008 at 40 N.J.R. 589(a), the Department is reproposing the amendments and new rules as described in the above responses to the summarized comments. 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 reproposed 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 reproposed amendments and new rules because they limit the cost-sharing amounts carriers may require covered persons to pay and require that health benefit plans include certain minimum annual and lifetime dollar benefits levels. 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 reproposed 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 reproposed amendments and new rules.

Regulatory Flexibility Analysis

These reproposed 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 reproposed 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 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 reproposed amendments and new rules should not require the employment of professional services.

Smart Growth Impact

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

Housing Affordability Impact

The reproposed amendments and new rules will have no impact on housing affordability. The amendments and new rules affect minimum standards for health benefit plans, prescription drug plans and dental plans.

Smart Growth Development Impact

The reproposed amendments and new rules will have no impact on housing production in Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan. The amendments and new rules affect minimum standards for health benefit plans, prescription drug plans and dental plans.

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, PRESCRIPTION DRUG PLANS AND DENTAL PLANS

11:22-5.1 Purpose and scope

(a) This subchapter establishes minimum standards for health benefit plans, prescription drug plans and dental plans **[**that provide coverage only when network providers are used, and for health benefit plans, prescription drug plans and dental plans that provide different levels of coverage depending on whether a network provider or an out-of-network provider is used**]**.

(b) (No change.)

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:

. . .

"Capitation" means a fixed per member, per month payment or percentage of premium payment for which the provider assumes the risk for the cost of contracted services without regard to the type, value or frequency of the services provided.

. . .

"Family network deductible" means the fixed dollar amount of covered charges that 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.

"Family network out-of-pocket limit" means the maximum dollar amount that a 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 copayment shall never exceed the contractual fee of the network provider for the service or supply.**

["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 copayment, 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.**]**

“Physician” means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners or similarly licensed by a comparable agency of the state in which he or she practices.

. . .

“Specialist physician” means a fully licensed physician who:

1. Is a diplomat of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association;

2. Is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college;

3. Is currently admissible to take the examination administered by a specialty board approved by the America Board of Medical Specialties or the Advisory Board of the American Osteopathic Association, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association;

4. Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or

5. Is recognized in the community as a specialist by his or her peers.

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**[**.**]**; **and**

5. 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 physician 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, contract or policy year, except for prescription drugs if, under the terms of the applicable plan, prescription drugs do not accumulate toward the 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 **[**benefits**]** 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**]** **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 limits on out-of-network hospital inpatient and/or outpatient services in health benefit plans are not permitted.

6. 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.

(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 and any dollar benefit maximums 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** Effect 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**]** **July 1, 2010** and may not be made available for new issue or for renewal on or after that date.