(a)

DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH
Health Maintenance Organizations
Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations, and Medical Service Corporations
Proposed Amendments: N.J.A.C. 11:24-1.2 and 11:24A-1.2 and 2.3

Authorized By: Richard J. Badolato, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, and 26:2S-1 et seq.

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

Proposal Number: PRN 2017-230.

Submit comments by November 4, 2017, to:

Denise M. Illes, Chief
Office of Regulatory Affairs
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
E-mail: legsregs@dobi.nj.gov

The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) proposes changes to N.J.A.C. 11:24, which governs health maintenance organizations (HMOs), and N.J.A.C. 11:24A, which implements the provisions of the Health Care Quality Act (HCQA), P.L. 1997, c. 192 (substantially codified at N.J.S.A. 26:2S-1 et seq.). The Department is proposing amendments to the rules to reinforce the existing rights of a covered person to request to receive services from an out-of-network provider, but pay only network level cost sharing when the network associated with the covered person's plan does not contain a qualified, accessible, and available provider to perform the needed service. As used in this Summary, "covered person" means persons who receive benefits or health care services under a health benefits plan. It includes "covered persons" as defined in N.J.A.C. 11:24A-1.2 and "members" as defined in N.J.A.C. 11:24-1.2. The proposed amendments will increase transparency and accountability related to the network adequacy of health benefits plans.

Specifically, this rulemaking includes the following:

N.J.A.C. 11:24-1.2 and 11:24A-1.2, which both contain definitions used in the respective chapters, are proposed to be amended to add a definition of "in-plan exception" in each chapter. Specifically, "in-plan exception" is defined to mean a request by a covered person or provider to obtain services from an out-of-network provider, with the covered person's liability limited to network cost sharing, because the carrier's network does not have providers who are qualified, accessible, and available to perform the medically necessary covered service the covered person requires.

The definition of "adverse benefit determination" is proposed to be amended in both N.J.A.C. 11:24-1.2 and 11:24A-1.2 to specify that the term "adverse benefit determination" specifically includes a denial of a request for an in-plan exception as a type of adverse benefit determination subject to internal and external appeal.

N.J.A.C. 11:24A-2.3, which governs carriers' disclosure requirements to covered persons through a handbook, certificate, or other evidence of coverage designed for covered persons, is proposed to be amended at N.J.A.C. 11:24A-2.3(a)1 to require the disclosure of information concerning the right of a covered person to request to use an out-of-network provider at network cost sharing where the network does not contain a qualified, accessible, and available provider to perform a service. In addition, N.J.A.C. 11:24A-2.3(a)3 is proposed to be amended to specify that the carrier must provide disclosure of information concerning the process a covered person or provider must follow to request to use an out-of-network provider and be responsible only for network cost sharing where the network does not contain a qualified, accessible, and available provider to perform the service.

As a 60-day comment period is provided for this notice of proposal pursuant to N.J.A.C. 1:30-3.3(a)5, this notice is excepted from the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

This rulemaking favorably impacts covered persons in that it reinforces the rights of a covered person regarding the availability of an in-plan exception if the carrier's network does not contain an accessible, available provider with the expertise, skill, and experience to render the medically necessary covered service the covered person requires. Accordingly, the proposed amendments will have a positive social impact on consumers.

This rulemaking will have a neutral social impact on carriers since the opportunity for an in-plan exception is not new, but may be more frequently requested.

This notice of proposal may favorably impact out-of-network providers whose services may be requested through use of the in-plan exception.

Economic Impact

The proposed amendments reinforce current requirements and do not impose a new economic obligation upon carriers.

The services required to comply with the proposed amendments are administrative, including medical management personnel to review requests for in-plan exceptions. These services are currently required to comply with the existing rules and regulated entities should either already maintain such services in-house or contract for same.

Federal Standards Statement

The Federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152, and rules promulgated and guidance issued thereunder (collectively, the Federal law), among a myriad of other things, address adverse benefit determinations and the right to appeal such determinations. This rulemaking specifies that a denied in-plan exception is included in the definition of adverse benefit determination. The Department believes this specificity is supported by the Federal definition and, thus, the rulemaking does not exceed the requirements of Federal law.

Jobs Impact

The Department does not anticipate that this rulemaking will result in the generation or loss of jobs.

The Department invites commenters to submit any data or studies concerning the jobs impact of the proposed amendments together with their comments on other aspects of the rulemaking.

Agriculture Industry Impact

The proposed amendments will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

This proposed amendments, as described in the Summary above, will impose compliance requirements on "small businesses," as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent the proposed amendments apply to small businesses, they will apply to carriers, agents, providers, or arbitration organizations domiciled in this State. The potential costs and the professional services required to comply are set forth in the Economic Impact above. As noted above, the Department believes that the proposed amendments should not have a negative impact on entities subject thereto. The proposed amendments do not provide any differentiation in compliance requirements based on business size. As noted in the Summary above, the proposed amendments clarify the rights of a covered person with respect to adverse benefit determinations and eliminate confusion in regard to the appropriate scope of coverage and course of action when a request for an in-plan exception has been made because the carrier's

network does not contain an accessible, available provider with the expertise, skill, and experience to render the service. These goals do not vary based on business size.

Housing Affordability Impact Analysis

The proposed amendments will not have an impact on housing affordability and they are unlikely to evoke a change in the average costs associated with housing in this State because the proposed amendments relate to HMOs and entities regulated by the HCQA.

Smart Growth Development Impact Analysis

The Department does not expect this rulemaking to evoke a change in the housing production in Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey because this rulemaking deals with the rules addressing HMOs and entities regulated by the HCQA.

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

CHAPTER 24
HEALTH MAINTENANCE ORGANIZATIONS

SUBCHAPTER 1. SCOPE AND DEFINITIONS

11:24-1.2 Definitions

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

"Adverse benefit determination" means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, **denial of a request for an in-plan exception,** as well as a failure to cover an item or service for which benefits are otherwise provided because the HMO determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the HMO has rescinded the coverage.

. . .

"In-plan exception" means a request by a member or provider to obtain medically necessary covered services from an out-of-network provider, with the member's liability limited to network level cost sharing, because the carrier's network does not have providers who are qualified, accessible, and available to perform the medically necessary covered service the member requires.

. . .

CHAPTER 24A
HEALTH CARE QUALITY ACT APPLICATION TO INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS**,** AND MEDICAL SERVICE CORPORATIONS

SUBCHAPTER 1. GENERAL PROVISIONS

11:24A-1.2 Definitions

For the purposes of this chapter, the words and terms set forth below shall have the following meanings, unless the word or term is further defined within a subchapter of this chapter, or the context clearly indicates otherwise:

. . .

"Adverse benefit determination" means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, **denial of a request for an in-plan exception,** as well as a failure to cover an item or service for which benefits are otherwise provided because the carrier determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the carrier has rescinded the coverage.

. . .

"In-plan exception" means a request by a covered person or provider to obtain medically necessary covered services from an out-of-network provider, with the covered person's liability limited to network level cost sharing, because the carrier's network does not have providers who are qualified, accessible, and available to perform the medically necessary covered service the covered person requires.

. . .

SUBCHAPTER 2. PROVISIONS APPLICABLE TO ALL CARRIERS

11:24A-2.3 Disclosure requirements

(a) Carriers shall provide to each subscriber within no more than 30 days following the effective date of coverage, and upon request thereafter, through a handbook, certificate**,** or other evidence of coverage designed for covered persons, information describing the following:

1. The services or benefits therefor to which a covered person is entitled under the policy or contract, including:

i.–ii. (No change.)

iii. A full and clear description of the carrier's policies and procedures governing the provision of emergency and urgent care services or the payment of benefits therefor, including a statement that emergency or urgent care services are not covered, if that is the case; [and]

iv. All dollar, day, visit**,** or procedure limitations applicable to at least those services set forth at (a)1i above, and the method for exchanging inpatient for outpatient services or vice versa, when such exchanges are permitted under the policy or contract; **and**

v. The right to request to use an out-of-network provider at network level cost sharing where the network does not contain a qualified, accessible, and available provider to perform a service.

2. (No change.)

3. Where and in what manner covered services may be obtained.

i. Even in the instance in which the contract or policy is not subject to any network requirements or differentials, carriers shall specify if benefits are payable for certain services only when rendered by a specified class or classes of provider(s); **and**

ii. The process a covered person or provider must follow to request to use an out-of-network provider and be responsible only for network level cost sharing where the network does not contain a qualified, accessible, and available provider to perform the service.

4.-7. (No change.)

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

LABOR AND WORKFORCE DEVELOPMENT

(a)

INCOME SECURITY

2018 Maximum Weekly Benefit Rates
2018 Taxable Wage Base Under the Unemployment Compensation Law
2018 Contribution Rate of Governmental Entities and Instrumentalities
2018 Base Week
2018 Alternative Earnings Test
Proposed Amendments: N.J.A.C. 12:15-1.2, 1.3, 1.4, 1.5, and 1.6

Authorized By: Aaron R. Fichtner, Ph.D., Commissioner, Department of Labor and Workforce Development.

Authority: N.J.S.A. 34:1-5, 34:1-20, 34:1A-3(e), 43:21-3(c), 43:21-4(e), 43:21-7(b)(3), 43:21-7.3(e), 43:21-19(t), 43:21-27, 43:21-40, and 43:21-41.