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DEPARTMENT OF BANKING AND INSURANCE DIVISION OF INSURANCE

Health Benefit Plans

Proposed Readoption with Amendments: N.J.A.C. 11:22

Proposed Repeal: N.J.A.C. 11:22-5.7

Authorized By: Marlene Caride, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17:48H-32, 17B:27B-25, 17B:30-13.1, 17B:30-23 et seq., 17B:30-55, 17B:30-56, and 26:1A-36.11 and 36.12.

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

Proposal Number: PRN 2018-102.

Submit comments by January 4, 2019, to:

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The agency proposal follows:

Summary

In accordance with N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 11:22 were scheduled to expire on September 21, 2018. In accordance with N.J.S.A. 52:14B-5.1.c(2), the filing of this notice of rules proposed for readoption with amendments and repeal with the Office of Administrative Law extended the expiration date by 180 days to March 20, 2019. The rules in this chapter were promulgated to implement the statutes applicable to Health Benefits Plans, including prompt payment of claims, health wellness promotion plans, electronic receipt and transmission of health care claims, and organized delivery systems. The rules provide guidance to the insurance industry and protect consumers by requiring the provision of vital information and establishing useful standards concerning health insurance.

The Department of Banking and Insurance (Department) reviewed the chapter and determined that, except as provided herein, the rules are necessary, reasonable, adequate, efficient, and responsive for the purpose for which they were originally promulgated. Accordingly, the Department is proposing to readopt the chapter with amendments and a repeal.

Subchapter 1, Prompt payment of claims, was promulgated to implement N.J.S.A. 17B:30-26 through 34, which sets forth standards for the payment of claims relating to health benefits plans and dental plans, as well as claim submission requirements. This subchapter addresses internal appeals, external appeals, alternative dispute resolution, and sets forth the minimum requirements for an Explanation of Benefits.

Subchapter 2, Health wellness promotion plans, governs provisions of a health wellness promotion program, and establishes that health benefits plans delivered, issued, executed, or renewed in this State are required to offer certain screening tests and counseling to covered persons.

Subchapter 3, Electronic receipt and transmission of health care claims, was promulgated to implement N.J.S.A. 17B:30-23 et seq., P.L. 1999, c. 154 (the Health Information Electronic Data Interchange Technology Act ("HINT" or "Act"). This subchapter establishes timetables for the electronic receipt and transmission of health care claim information, including, but not limited to, eligibility, premium payments, reports of injury, enrollment, disenrollment, and other health care claims transactions in accordance with the standards developed by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (HIPAA) for the electronic administration of health care benefits.

Subchapter 4, Organized delivery systems, sets forth the filing requirements for an entity to be licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 through 35.

Subchapter 5, Minimum standards for health benefit plans, prescription drug plans, and dental plans, establishes minimum standards for those plans. The Department is proposing to amend N.J.A.C. 11:22-5.3(a)1 to address the 2010 Federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended (ACA) and the Federal rules promulgated thereunder, that require that health benefits plans issued in the individual and small employer markets satisfy specific actuarial value (AV) standards (also see Department Bulletin No. 18-09). The Federal Government makes annual adjustments to the actuarial value calculator. These AV calculator adjustments cause plans that satisfied the requirements of certain actuarial metal tiers (that is, bronze, silver, gold, and platinum) in one policy year to no longer qualify in the following policy year without changes (also known as uniform modifications) to the plan design. For 2019, greater consumer cost-sharing is required in order for plans to qualify under the AV calculator. For 2019, the ACA maximum out-of-pocket (MOOP) exceeds New Jersey's MOOP for individuals of $7,500 as currently provided in N.J.A.C. 11:22-5.3 and 5.4.

The Department has determined that the Federal changes to the AV calculator, and the associated increase in the ACA MOOP, have impacted the ability of carriers to have their plans fit within the metal tiers without significant plan design changes that will likely require increases in upfront cost sharing for policyholders—such as increased co-payments and increased deductibles, or an increase to the MOOP that functions as a cap on cost-sharing. The Department proposes to amend the MOOP, such that the network MOOP does not exceed the maximum annual limit on cost sharing provided under 45 CFR 156.130. However, the Department is concerned that the Federal MOOP may at some point become excessive, and, thus, the proposed amendments also provide that the Commissioner may issue an order to freeze the MOOP at the maximum annual limit on cost sharing provided under 45 CFR 156.130 as established the previous year. These proposed amendments are necessary to ensure the continued availability of reasonable and meaningful health benefits plans for consumers.

N.J.A.C. 11:22-5.3(a)2 is proposed to be amended to provide that the individual network "per covered person" annual deductible is no greater than $2,500, except as stated for bronze and catastrophic plans.

The Department is proposing to add new N.J.A.C. 11:22-5.3(a)3 that permits a bronze plan available in the individual health coverage or small employer health benefits markets to include a network per covered person annual deductible up to $3,000. The Department notes that this proposed amendment was necessitated by Federal AV calculator adjustments. See also Department Bulletin No. 15-04.

The Department is proposing to add new N.J.A.C. 11:22-5.3(a)4 that addresses the deductible for catastrophic plans offered in the individual health coverage market consistent with the requirements of 45 CFR 156.130(a)(2). Specifically, for such catastrophic plans, the per covered person annual deductible shall equal the greatest permissible maximum out-of-pocket as defined in 45 CFR 156.130(a)(2), except that the deductible shall be waived for three physician visits per calendar year and shall not apply to preventive health services.

N.J.A.C. 11:22-5.4 is proposed to be amended to align this provision with the proposed amendments to N.J.A.C. 11:22-5.3(a)1 described above. N.J.A.C. 11:22-5.7 is proposed for repeal because the ACA prohibits lifetime limits whether they are in- or out-of-network.

Subchapter 6, Exclusions and preauthorization requirements, specifies standards for war and other exclusions and preauthorization requirements in health benefits plans.

Subchapter 7, Carrier/provider joint negotiation agreements, provides for joint negotiations regarding non-fee-related matters, fees, and fee-related matters by physicians and dentists with carriers. This subchapter establishes standards and procedures for carriers to report to the Department certain information concerning the number of a carrier's covered lives and the impact of provider negotiations.

Subchapter 8, Health insurance identification cards, establishes standards and criteria regarding information contained on health insurance identification cards issued by carriers authorized to issue health benefits plans in this State.

Subchapter 9, Maternity installment payments, was promulgated to implement P.L. 2009, c. 113 by establishing a process whereby, if requested by a licensed obstetrical provider, a health insurance carrier shall reimburse a New Jersey licensed obstetrical provider in installments for maternity services rendered by the provider during the term of a covered person's pregnancy.

The Department believes that the readoption of these rules with the amendments and repeal described above will continue to provide a regulatory framework by which the Department may ensure that the prompt payment of claims; health wellness promotion plans; electronic receipt and transmission of health care claims; organized delivery systems; minimum standards for health benefits plans, prescription drug plans and dental plans; exclusions and preauthorization requirements; health insurance identification cards; and maternity installment payments are operating in compliance with applicable statutory requirements. The Department notes, however, that additional amendments will likely be forthcoming in light of the recently enacted P.L. 2018, c. 32.

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

Social Impact

The rules proposed for readoption with amendments and repeal address several areas of concern to consumers and provides significant consumer protections. The rules regarding prompt payment of claims continue to have a positive impact on the public and the healthcare community by requiring claims to be paid quickly and fostering the efficient and fair resolution of disputes. The health wellness promotion plan rules continue to have a positive social impact because they require carriers to make health wellness promotion benefits available to their insureds. These services and tests can detect serious illness at an early stage and serve to encourage covered persons to make choices that promote better health. Additionally, the minimum standards rules for network-based health benefits plans benefit consumers because they increase the availability and affordability of health benefits plans affected by these rules. The health insurance identification card rules enable providers to more readily obtain information concerning their patients' health benefits plan coverage, therefore, facilitating the claim submission and payment process.

The industry also relies on the presence and effectiveness of these rules in their operations. For example, the health benefits plan carrier/provider joint negotiation agreement rules require carriers to report to the Department quarterly the number of covered lives enrolled in certain health benefits plans, and to report annually the impact of provider negotiations conducted pursuant to N.J.S.A. 52:17B-196 et seq., Joint Bargaining by Physicians and Dentists with Carriers.

The minimum standards for health benefits plans, prescription drug plans, and dental plans rules also have a favorable impact on carriers, providers, and consumers. These rules assist in the marketability of the plans affected by the rules; continue to permit providers to expand their practices due to the increased availability of the plans; and increase consumer access to, and the affordability of, these plans.

Since the rules proposed for readoption with amendments and a repeal align the Department rules with the requirements of the ACA, which carriers are already following pursuant to Federal statutes and rules, there is no new social impact associated with these rules proposed for readoption with amendments and a repeal.

Economic Impact

The failure to readopt this chapter would require the insurance industry to perform many significant statutory functions without guidance from the Department because that guidance would expire. This would impose significant costs on the marketplace because current compliance requirements would not be readily available to the industry; in fact, they would cease to exist. The industry has invested a great amount of time and resources to operate in compliance with the Department's current procedures, which benefits both insurers and the general public.

If, on the other hand, the chapter is readopted with the proposed amendments and a repeal, insurers and other regulated entities will be required to incur only minimal costs associated with continued compliance with the requirements set forth in this chapter. These costs are associated with services and tests to detect serious illness at an early stage, maintaining the electronic receipt and transmission of health care claims, issuing health insurance identification cards that contain information that is uniform throughout the industry and ensuring that the Department is provided with quarterly reports and informational filings.

The Department's prompt payment of claims rules continues to have a positive economic impact on providers, insureds, and covered persons under health benefit plans by requiring their claims to be paid within the statutory time frames and by clearly defining what constitutes a clean claim.

While, as described above, insurers are required to continue to incur the costs to continue compliance with this chapter, these costs are minimal and are outweighed by the protections afforded to consumers, the benefits obtained by health care providers, and the guidance provided to the insurance industry.

The Department notes that the rules proposed for readoption with amendments and a repeal aligns the rules with the requirements of the ACA. There is no new economic impact associated with aligning the rules with the requirements of the ACA because carriers are already following the rules as promulgated on the Federal level.

Federal Standards Statement

The rules proposed for readoption with amendments and a repeal comply with the Federal Patient Protection and Affordable Care Act, Pub. Law 111-148, as amended and supplemented by the Health Care and Reconciliation Act, Pub. Law 111-152. The rules proposed for readoption with amendments and a repeal do not exceed the requirements of the Federal Patient Protection and Affordable Care Act or the Health Care Reconciliation Act. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not anticipate that the rules proposed for readoption with amendments and a repeal 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 rules proposed for readoption with amendments and a repeal together with their comments on other aspects of the rules proposed for readoption with amendments and a repeal.

Agricultural Industry Impact

The rules proposed for readoption with amendments and a repeal will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

Few, if any, carriers regulated by the rules in this chapter are "small businesses" as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Recordkeeping, reporting, and compliance requirements will continue to be imposed by this chapter, which include the filing of enrollment/change request forms, and application/change request forms at Subchapter 3, organized delivery systems forms and application requirements at Subchapter 4, and reporting requirements related to carrier/provider joint negotiation agreements at Subchapter 7. The Department has determined that all such compliance, recordkeeping, and reporting requirements continue to be reasonable and necessary for the purpose for which they were originally proposed. The rules proposed for readoption with amendments and a repeal continue to apply to all carriers without regard to size, since they implement statutory provisions and/or regulatory policies that provide significant consumer protections and effective regulatory oversight of carriers. Consequently, the rules proposed for readoption with amendments and a repeal do not allow for exceptions based upon business size. The Department is unaware of any provisions of the rules that are excessively onerous to "small businesses" or unnecessary. The Department notes, however, that the rules proposed for readoption with amendments and a repeal impose no new recordkeeping, reporting, or other compliance requirements.

Future annual costs of compliance with these rules proposed for readoption with amendments and a repeal are not expected to differ from current annual costs. The Department does not anticipate that professional services will be necessary for continued compliance with these rules. To the extent the use of professional services is necessary, these costs will vary with individual professional services and the need of the carrier.

Housing Affordability Impact Analysis

The rules proposed for readoption with amendments and a repeal will have no impact on the affordability of housing in New Jersey and are unlikely to evoke a change in the average costs associated with housing because the rules proposed for readoption with amendments and a repeal concern health benefit plans.

Smart Growth Development Impact Analysis

The rules proposed for readoption with amendments and a repeal will have no impact on smart growth and there is an extreme unlikelihood that the rules proposed for readoption with amendments and a repeal would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey because the rules proposed for readoption with amendments and repeal concern health benefit plans.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:22.

Full text of the proposed amendments and repeal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 5. MINIMUM STANDARDS FOR HEALTH BENEFIT**S** PLANS, PRESCRIPTION DRUG PLANS**,** AND DENTAL PLANS

11:22-5.3 Network deductible

(a) 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] **an** SCA policy providing hospital and medical coverage issued by an insurance company, provided that:

1. [The contract or policy contains an individual network out-of-pocket limit that is no greater than $7,500, and] **Effective with contracts or policies effective on or after January 1, 2019, health carriers shall use an individual network out-of-pocket limit that is no greater than the maximum annual limitation on cost sharing provided under 45 CFR 156-130 and** a family network out-of-pocket limit that is no greater than two times the individual network out-of-pocket limit**, unless the Commissioner issues an Order within 45 days of the issuance of final Federal rules governing benefits and payment parameters to freeze the out-of-pocket limit at the prior policy year maximum**;

2. The individual network **per covered person annual** deductible is no greater than $2,500**, except as stated in (a)3 and 4 below**;

3. For a network-based bronze contract or policy available in the individual health coverage or small employer health benefits markets, meaning a plan with a 60 percent actuarial value, the network per covered person annual deductible shall not exceed $3,000;

4. For a contract or policy to be offered as a catastrophic contract or policy in the individual health coverage market, the per covered person annual deductible shall equal the greatest permissible maximum out-of-pocket as defined in 45 CFR 156.130(a)(2), except the deductible shall be waived for three physician visits per calendar year and shall not apply to preventive health services;

Recodify existing 3.-5. as **5.-7.** (No change in text.)

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] **an** SCA policy providing hospital and medical coverage issued by an insurance company, provided that:

1. The contract [contains an individual network out-of-pocket limit that is no greater than $7,500, and a family network out-of-pocket limit that is no greater than two times the individual network out-of-pocket limit] **or policy complies with the requirements set forth in N.J.A.C. 11:22-5.3(a)1**;

i. (No change.)

2.-6. (No change.)

11:22-5.7 [Benefit maximums in health benefit plans] **(Reserved)**

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

1. Aggregate dollar lifetime 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 health benefit plan.

2. Aggregate dollar lifetime maximums for out-of-network services and supplies are permitted in a 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.]

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF ELECTRICAL CONTRACTORS
Notice of Pre-Proposal
Power Over the Ethernet
Pre-Proposed Amendment: N.J.A.C. 13:31-4.1

Authorized By: Philameana Tucker, Executive Director, Board of Examiners of Electrical Contractors.

Authority: N.J.S.A. 45:5A-6 and 18.

Pre-Proposal Number: PPR 2018-002.

Take notice that the State Board of Electrical Contractors (Board) is soliciting comments regarding rules, or an exemption therefrom, for power over the Ethernet (POE).

On October 14, 2016, the Board received a petition for rulemaking from Custom Electronic Design & Installation Association (CEDIA), requesting that the Board amend its rule governing the limited telecommunications wiring exemption. The petitioner proposed that the Board amend N.J.A.C. 13:31-4.1 to add a new exemption for the design, installation, integration, erection, repair, maintenance, or alteration of products that transport voice, video, audio, and data signals in residential premises. During the Board's deliberative process, the petitioner raised questions concerning the ability of technology integrators, in accordance with the limited telecommunications wiring exemption, to install POE.

On May 9, 2018, the Board determined to deny CEDIA's petition for rulemaking (see 50 N.J.R. 1454(b)). The Board noted that, pursuant to N.J.A.C. 13:31-4.1, POE does not meet the requirements of the telecommunications wiring exemption. Therefore, an electrical contractor licensee is required to install a device or wires to power the device. As part of its denial, the Board also noted that there may be merit in initiating a rulemaking with respect to POE and that it intended to seek further input