

**SUBCHAPTER 5. MINIMUM STANDARDS FOR HEALTH BENEFIT PLANS,
PRESCRIPTION DRUG PLANS AND DENTAL PLANS
(*effective 09/08/2009)**

11:22-5.1 Purpose and scope

(a) This subchapter establishes minimum standards for health benefit plans, prescription drug plans and dental plans.

(b) This subchapter applies to all insurance companies, health service corporations, medical service corporations, hospital service corporations, dental service corporations, dental plan organizations, prepaid prescription service organizations and health maintenance organizations that deliver or issue for delivery health benefit plans, prescription drug plans or dental plans in this State.

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:

"Brand name drug" means a prescription drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right.

"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.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, dental service corporation, dental plan organization, prepaid prescription service organization or health maintenance organization authorized to issue health benefit plans, dental plans or prescription drug plans in this State.

"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, contract or policy year.

"Formulary" means a list of prescription drugs that are preferred for use in a health benefit plan or prescription drug plan through lower cost sharing (for example, co-payment, coinsurance, deductible or out-of-pocket limits) or other financial incentives (for example, quantity limits or inclusion or exclusion from accumulation toward the out-of-pocket limit). A formulary may have multiple tiers. A plan that provides benefits for all brand name drugs at one level of cost sharing is not considered a formulary for purposes of this subchapter.

"Generic drug" means any prescription drug which is not a brand name drug.

"Health benefit plan" means a hospital and medical expense insurance policy, health service corporation contract, hospital service corporation contract, medical service corporation contract, health maintenance organization subscriber contract, or other plan for medical care delivered or issued for delivery in this State.

1. "Health benefit plan" shall not include one or more, or any combination of, the following:
 - i. Coverage for accident only, disability income insurance;
 - ii. Coverage issued as a supplement to liability insurance, including general liability insurance and automobile liability insurance;
 - iii. Stop loss or excess risk insurance; workers' compensation or similar insurance;
 - iv. Automobile personal injury protection medical expense benefits or medical payment insurance;
 - v. Credit only insurance;
 - vi. Coverage for on-site medical clinics; and
 - vii. Other similar insurance coverage as specified in Federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

2. "Health benefit plan" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance, or are otherwise not an integral part of the plan:
 - i. Limited scope vision benefits;
 - ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
 - iii. Such other similar, limited benefits as are specified in Federal regulations.

3. "Health benefit plan" shall not include hospital confinement indemnity coverage if:

- i. The benefits are provided under a separate policy, certificate or contract of insurance;
 - ii. There is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and
 - iii. Those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.
4. "Health benefit plan" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:
- i. Medicare supplemental health insurance as defined at Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. Sections 1395ss(g)(1));
 - ii. Coverage that is supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section s 1071 et seq.); and
 - iii. Similar supplemental coverage provided to coverage under a group health plan.

"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, contract or policy 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, contract or policy 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 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.

“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.

“Point of service contract” or “POS contract” means a health benefit plan issued by a health maintenance organization or health service corporation that provides covered services and supplies through a network of providers, and pays benefits for covered services and supplies provided by out-of-network providers. The term also includes dual contracts issued pursuant to N.J.A.C. 8:38-14.7, whereby a health maintenance organization contract provides network benefits and an insurance company contract provides out-of-network benefits.

“Preventive care” means services or supplies that are not provided in connection with the treatment of injury or illness. Preventive care includes, but is not limited to: routine physical examinations including related laboratory tests and x-rays, immunizations and vaccines, screening tests, well baby care, well child care and well adult care.

“Primary care provider” means a participating physician or other health care professional who is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which the services are furnished and who supervises, coordinates and maintains continuity of care for covered persons. Primary care providers include nurse practitioners/clinical nurse specialists, physician assistants and certified nurse midwives who satisfy the requirements of N.J.A.C. 11:24-6.2(c)1 through 3.

“Selective contracting arrangement contract” or “SCA policy” means a health benefit plan issued by an insurance company that provides covered services and supplies through a network of providers, and pays benefits for covered services and supplies provided by out-of-network providers.

“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 American 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) 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. The contract or policy 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;
 2. The individual network deductible is no greater than \$2,500;
 3. The individual network deductible is not applied to preventive care;
 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. 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;
 - i. If a carrier offers a contract with an individual network out-of-pocket limit in excess of \$3,000, it shall also offer a contract with an individual network out-of-pocket limit of \$2,500 or less;

2. The network coinsurance level, and the out-of-network coinsurance level (if any), is 50 percent or less;
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.;
4. Network coinsurance 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 provider 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.

11:22-5.7 Benefit maximums in health benefit plans

(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.

11:22-5.8 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. Health club membership;
- ii. Prescription drugs, other than insulin and oral agents for controlling blood sugar as mandated by N.J.S.A. 17:48-6n, 17:48A-7l, 17:48E-35.11, 17B:26-2.11, 17B:27-46.1m and 26:2J-4.11, and medications to treat infertility as mandated by N.J.S.A. 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x and 26:2J-4.23;
- 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. Routine eye care and appliances;
- v. Routine foot care;
- vi. Routine hearing care and appliances;
- vii. Smoking cessation programs; and
- viii. Travel companion benefits.

- (b) All contracts issued by health maintenance organizations and health service corporations, and all SCA policies issued by insurance companies, shall provide the following:

1. That a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is a network provider and the covered person and/or provider has complied with all required preauthorization or notice requirements, shall be limited to

the copayment, deductible and/or coinsurance applicable to network services; and

2. That a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is an out-of-network provider, shall be limited to the copayment, deductible and/or coinsurance applicable to network services.

- (c) Carriers shall not calculate benefits for services provided by out-of-network providers by using negotiated fees agreed to by network providers.

11:22-5.9 Prescription drug benefits

- (a) Health benefit plans and stand-alone prescription drug plans that provide benefits for prescription drugs listed on a formulary may provide higher benefits for formulary drugs than for nonformulary drugs, provided:
 1. The benefit for all tiers of formulary and nonformulary drug coverage shall result in a cost to the covered person of no more than 50 percent of the plan's contracted cost of the drug, after application of any deductibles, for prescription drugs provided by network providers. For prescription drugs provided by out-of-network providers, coinsurance shall not exceed 50 percent.
 2. If a health benefit plan has a separate deductible for prescription drugs, or a stand-alone prescription drug plan has a deductible, such deductible shall not exceed \$250.00 per calendar year for all tiers of formulary drugs and \$250.00 per year for all tiers of nonformulary drugs; and
 3. If a health benefit plan or a stand-alone prescription drug plan has a benefit maximum for prescription drugs, the maximum shall be the same for formulary and nonformulary drugs.
- (b) Health benefit plans and stand-alone prescription drug plans that provide prescription drug benefits through use of a formulary, shall meet the following criteria:
 1. The formulary shall be developed by a pharmacy and therapeutics committee composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee shall consist of at least two-thirds licensed and actively practicing physicians and pharmacists, and shall consist of at least one pharmacist. If the

- carrier contracts with a third party to develop the formulary, the carrier shall be responsible for guaranteeing that the third party complies with all requirements relating to formularies as set forth in this subsection.
2. All drugs in a formulary shall be approved under the Federal Food, Drug and Cosmetic Act, 21 U.S.C. Sections 301 et seq.
 3. The most preferred tier of a formulary, that is, the tier with the lowest cost sharing, shall include more than one drug used to treat each covered disease state where more than one drug is available.
 4. A drug may be excluded from the most preferred tier of a formulary only if, based on the compendia listed in (c)6 below, it does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome of treatment for the specific condition for which the drug is intended over other drugs included in the formulary, and there is a written explanation of the basis for the exclusion that is available to providers and covered persons upon request.
 5. Each health benefit plan utilizing selective contracting arrangements that provides benefits for formulary drugs shall also provide benefits for nonformulary drugs. There shall be no difference in benefit level between formulary and nonformulary drugs obtained from out-of-network providers.
 6. The carrier shall establish an approval process to enable health care providers and covered persons to obtain coverage of nonformulary drugs at the same level as formulary drugs where the prescribing health care provider certifies the medical necessity of the drug.
 - i. A nonformulary drug shall be considered medically necessary if:
 - (1) It is approved under the Federal Food, Drug and Cosmetic Act, 21 U.S.C. Sections 301 et seq.; or its use is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia – Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed professional journal; and
 - (2) The prescribing health care provider states that all formulary drugs used to treat each disease state have been ineffective in the treatment of the covered person’s disease or condition, or all such drugs have

caused or are reasonably expected to cause adverse or harmful reactions in the covered person.

- ii. The approval process for nonformulary drugs shall provide that the carrier respond to the prescribing health care provider by telephone or other telecommunication device within one business day of a request for prior authorization. Failure to respond within one business day shall be deemed an approval of the request. Initial denials shall also be provided to the prescribing health care provider and covered person in writing within five business days of receipt of the request for approval of a nonformulary drug, and shall include the clinical reason for the denial. Such denials are appealable to the Independent Health Care Appeals Program in the Department of Health and Senior Services pursuant to P.L. 1997, c. 192, Section 11.
 - 7. The carrier shall publish and distribute, at least quarterly, either its current formulary or a list of nonformularies to network providers. Such list shall clearly indicate whether the drugs included are formulary or nonformulary. Alternatively, the carrier may annually distribute new formularies or a list of nonformularies, and quarterly updates, to network providers. The current formulary or list of nonformulary drugs shall be provided by the carrier to covered persons upon request.
 - 8. The contract and evidence of coverage form shall disclose the existence of the drug formulary, describe the approval process to obtain coverage of nonformulary drugs as formulary drugs and describe the process to appeal a denial of a request for approval of a nonformulary drug, including the right to appeal to the Independent Health Care Appeals Program in the Department of Health and Senior Services pursuant to P.L. 1997, c. 192, Section 11. The contract and evidence of coverage form shall state that a copy of the formulary will be provided by the carrier to a covered person upon request.
- (c) Health benefit plans and stand-alone prescription drug plans may provide higher benefits for generic drugs than for brand name drugs provided:
- 1. The benefit for both generic and brand name drugs must result in a cost to the covered person of no more than 50 percent of the plan's contracted cost of the medication for prescription drugs obtained from network providers. A deductible, as described in 2. below, does not

need to be considered in calculating the covered person's cost. For prescription drugs provided by out-of-network providers, coinsurance shall not exceed 50 percent.

2. If a health benefit plan has a separate deductible for prescription drugs or a stand-alone prescription drug plan has a deductible, such deductible shall not exceed \$250.00 per calendar year for generic drugs and \$250.00 per calendar year for non-generic drugs.
3. If a health benefit plan or a stand-alone prescription drug plan has a benefit maximum for prescription drugs, the maximum shall be the same for generic and brand name drugs.

11:22-5.10 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. 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.

11:22-5.11 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, 2010 and may not be made available for new issue or for renewal on or after that date.

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