

NEW JERSEY
INDIVIDUAL HEALTH COVERAGE PROGRAM

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ADVISORY BULLETIN
03-IHC-01

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To: IHC Program Members and Interested Parties

From: Wardell Sanders, Executive Director

Re: HIPAA Alternative Mechanism Compliance

Section 2744(b)(1)(C) of Title XXVII of the Public Health Service (PHS) Act requires that, every three years, each State provide the Federal government with information necessary to review its "alternative mechanism," the term under the PHS Act for a mechanism designed to serve the health insurance needs of federally defined eligible individuals.¹ As part of its recent review of New Jersey's filing under this law, the Centers for Medicare and Medicaid Services (CMS) of the federal Department of Health and Human Services has asked that New Jersey regulators address the following two issues.

Definition of creditable coverage. The definition of "creditable coverage" in the Individual Health Coverage Reform Act, ("IHC Act") at N.J.S.A. 17B:27A-2 is nearly identical to the definition of "creditable coverage" under federal regulations set forth at 45 C.F.R. 146.113. However, while the federal regulation includes in its list of types of

¹ "Federally defined eligible individual" means an eligible person: (1) for whom, as of the date on which the individual seeks coverage under P.L.1992, c. 161 (C.17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months; (2) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan; (3) who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.) or any successor program, and who does not have another health benefits plan, or hospital or medical service plan; (4) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; (5) who, if offered the option of continuation coverage under the COBRA continuation provision or a similar State program, elected that coverage; and (6) who has elected continuation coverage described in (5) above and has exhausted that continuation coverage. N.J.S.A. 17B:27A-2.

creditable coverage both "a state health benefits risk pool" and "a health plan offered under title 5 U.S.C. Chapter 89" (referring to the Federal Employees Health Benefits Program), New Jersey law does not list those types of coverage but does include "a state health plan offered under chapter 89 of Title 5, United States Code." Since there is no state plan offered through Federal Employees Health Benefits Program, and because of the preemption provisions in HIPAA, the IHC Board believes that IHC member carriers must consider all of the types of coverages listed in 45 C.F.R 146.113 as creditable coverage, including both "a state health benefits risk pool" and "a health plan offered under title 5 U.S.C. Please be advised that the New Jersey Individual Health Coverage Program Board intends to amend its regulations to reflect this change.

Screening for federally defined eligible individuals. Individual market carriers are reminded that they must have a process in place to identify the people who meet the definition of a federally defined eligible individual in order to prevent an inappropriate imposition of a pre-existing condition exclusion on that person. The current standard application/enrollment form in New Jersey, which is set forth at N.J.A.C. 11:22-3, Appendix Exhibit 1, does not ask the applicant to identify whether the person is a federally defined eligible individual. Nevertheless, a carrier is under an affirmative obligation to inquire and determine whether a person is a federally defined eligible individual if it intends to impose a preexisting condition limitation on that person. Failure to provide a federally defined eligible individual with the protections afforded under State and Federal law may result in the imposition of penalties as permitted under applicable law.

In making its determination as to whether a person is a federally defined eligible individual, the carrier will need to determine the answers to the following questions:

- (1) Did the individual, as of the date on which he or she sought individual coverage in New Jersey, have continuous coverage for a period of 18 or more months with no break in coverage of more than 63 days?
- (2) Was the individual's most recent prior creditable coverage under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan?
- (3) Is the individual eligible for coverage under a group health plan, Part A or Part B of Medicare (42 U.S.C. § 1395 et seq.), or Medicaid or any successor program?
- (4) Does the individual have other health coverage?
- (5) Was the individual's last coverage terminated because he or she committed fraud or did not pay premiums?
- (6) If the individual had the opportunity to continue his or her prior coverage under COBRA or a similar State program, did the individual remain covered for the entire period that the continuation coverage was available to him or her?

If an individual is considered a "federally defined eligible individual," then the "pre-existing condition" waiting period requirement will not apply, provided there has been no more than a 63-day lapse in coverage between the date the prior "creditable coverage" ends and the date the individual applies for individual coverage.

This bulletin can also be found at the Department of Banking and Insurance web site at:
www.njdobi.org