

NEW JERSEY  
**INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD**

20 West State Street, 10th floor  
CN 325  
Trenton, NJ 08625

**BULLETIN 94-03**

TO: Carriers Participating in the Individual Health Coverage Program  
FROM: Kevin O'Leary, Executive Director, IHC Program  
RE: 1) Effective Date of Revised Policy Forms, A, B, C, D, E and HMO  
2) "Lapse in Coverage" and Preexisting Conditions  
3) Treatment of Prior Coverage by Medicaid  
DATE: December 16, 1994

**I. EFFECTIVE DATE OF NEW POLICY FORMS**

The IHC Board, in response to concerns raised by several carriers offering individual health benefits plans in New Jersey, has decided to allow carriers to begin offering the revised policy forms as late as March 1, 1995. Carriers may, however, begin using the revised forms as early as January 1, 1995, as had been proposed originally. The Board understands the administrative difficulties involved in changing policy forms and marketing materials on short notice and believes the additional two months should provide ample time to accommodate the various revisions to the forms.

All policyholders who receive coverage under the current standard or alternative policy forms, including any issued between January 1, 1995 and February 28, 1995, must be converted to the revised forms on the first anniversary date of their coverage that occurs after the carrier begins using the revised forms. A hard copy of the final revisions to the policy forms adopted by the Board will be faxed to you early next week. Any carrier that would like to obtain a computer disk containing the complete revised policy forms may request one, in writing, from the IHC Board. If you specify the software you prefer (i.e., WordPerfect, Word, etc.) we will do our best to meet your request.

**II. IMPOSITION OF PREEXISTING CONDITION LIMITATIONS**

At least one carrier has expressed confusion over what should be considered a "lapse" in coverage, with respect to imposition of a preexisting condition limitation on a policyholder. As you are no doubt aware, a carrier may impose a limitation of no more than 12 months on coverage for preexisting conditions, except that the limitation shall not apply to an individual who has, under a prior group or individual health benefits plan, with no intervening lapse in coverage, been treated or diagnosed by a doctor for a condition under that plan or satisfied a 12-month preexisting condition limitation.

Since the beginning of the IHC Program, “an intervening lapse in coverage” has been considered to be a gap of no more than 30 days between the termination of prior coverage and the effective date of the new coverage. See comments and responses to IHC Rules, 25 N.J.R. 4182 (September 7, 1993). That principle has also been expressed and widely disseminated in the IHC Buyers’ Guide (page 15), and has been followed by most carriers in the market. However, recent questions about this principle, and traumatic results of imposing preexisting condition limitations in situations when applicants, acting in good faith, have allowed a brief lapse between health benefits plans only to find their new coverage will not cover a preexisting condition for the first 12 months, the IHC Board has decided to memorialize the “30-day lapse” in its rules. In the meantime, the Board advises all carriers that they should not impose preexisting condition limitations on policyholders who have, under a prior group or individual health benefits plan, with no intervening lapse in coverage greater than 30 days, been treated or diagnosed by a doctor for a condition under that plan or satisfied a 12-month preexisting condition limitation. You will receive a rule proposal to this effect in the coming weeks.

### **III. TREATMENT OF PRIOR MEDICAID COVERAGE**

At its meeting on December 16, 1994, the IHC Board resolved that it would seek a legislative amendment to the Individual Health Insurance Reform Act, N.J.S.A. 17B:27A-2 et seq., to require carriers to recognize Medicaid coverage as a prior health benefits plan in terms of waiving the imposition of a preexisting condition exclusion. The Board believes that a statutory change is necessary because Medicaid coverage is currently excluded from the definition of “health benefits plan.” N.J.S.A. 17B:27A-2. While the Board seeks a statutory change, it requests that carriers recognize Medicaid as valid prior coverage.

If you have any questions about this bulletin, please call me at (609)984-2425.

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<b>ADVISORY BULLETIN 96-IHC-01</b>
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TO:           **Carriers That Received Exemptions From Assessment in Calendar Years 1993 And 1994**  
FROM:       Kevin O'Leary, IHC Program Executive Director  
RE:          **Request For Information About Conversion Contracts, Due 3-4-96**  
DATE:       February 23, 1996

The Individual Health Coverage Program Board is in the process of a final reconciliation of the 1993 and 1994 assessments for reimbursable losses. This process will take into account final decisions of administrative and civil court appeals of the assessments, as well as the results of an independent audit of the losses of Blue Cross and Blue Shield of New Jersey, the primary recipient of reimbursement.

In an appeal of the 1993 assessment, filed by HIP Health Plan of New Jersey, the IHC Board determined that a carrier that filed for an exemption from assessments for reimbursable losses could count toward its market goal, or "minimum number of non-group persons," conversion contracts issued prior to August 1, 1993 as long as the contracts met the following criteria:

- there was no medical underwriting, at the time of issuance, of the group contract from which the conversions were made; and
- the group conversion contracts were open enrolled, meaning that there was no medical underwriting of persons at the time of conversion; and
- the conversion contracts were community rated or modified community rated.

If you did not list such contracts when you reported your minimum number of non-group persons for calendar years 1993 and 1994, please revise your report, in accordance with N.J.A.C. 11:20-9.5(b), **and submit it to the IHC Board by March 4, 1996.** Your reporting such conversions can only result in lowering your assessment liability. Since this information is essential to accurately recalculating the assessments for 1993 and 1994, which must be approved by the Board at its March meeting, late reports will not be accepted. You may fax responses to the number listed above, but send the original certified report by regular mail for the Board's records. Please call if you need clarification of this notice.

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**ADVISORY BULLETIN 96-IHC-02**

TO: Carrier Members of the New Jersey Individual Health Coverage Program  
FROM: Kevin O'Leary, IHC Program Executive Director  
DATE: March 14, 1996

**1995 Assessment: Notice of 1995 Reimbursable Net Paid Losses**

Pursuant to N.J.A.C. 11:20-2.17(d)(1), the Individual Health Coverage Program Board is required to notify carriers subject to assessment of the total 1995 reimbursable net paid losses for carriers in the individual health insurance market in New Jersey. Accordingly, the following carriers have filed for reimbursement of 1995 net paid losses:

Blue Cross and Blue Shield of New Jersey	\$ 45,041,000
Sanus Health Plan of NJ	\$ 204,371
Time Insurance Company	\$ <u>27,236,629</u>
<b>Total Net Paid Losses=</b>	<b>\$ 72,482,000</b>

The IHC Board, on March 12, 1996, authorized the accounting firm of Deloitte & Touche to commence an independent audit of these carriers' losses.

In accordance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20-2.17, the IHC Board will assess carrier members for their proportionate shares of the total net paid losses on the basis of information submitted on carriers' 1995 Market Share and Net Paid Loss Reports ("Exhibit K"), which should have been filed with the IHC Board on or before March 1, 1996.

You will receive an estimate of your share of reimbursable losses sometime after April 1, 1996, once the 1995 premium data from all carriers has been compiled. If you have not filed an Exhibit K or non-member certification, on behalf of all affiliated carriers reporting accident and health premium on an annual statement filed with the Commissioner, please do so immediately, or the assessment share will be based on the total accident and health premium reported.



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**ADVISORY BULLETIN 97-IHC-02**

TO: Carrier Members of the New Jersey Individual Health Coverage Program  
FROM: Kevin O'Leary, IHC Program Executive Director  
DATE: March 14, 1996  
**RE: Assessment: Notice of 1996 Reimbursable Net Paid Losses**

Pursuant to N.J.A.C. 11:20-2.17(d)(1), the Individual Health Coverage Program Board is required to notify all carriers subject to assessment for a share of the 1996 reimbursable net paid losses for the individual health insurance market in New Jersey. Accordingly, you are advised that the following carriers have sought reimbursement of 1996 net paid losses, subject to independent audit:

<b>Carrier</b>	<b>Reimbursement Sought</b>
Manhattan National Life	\$ 2,248,563
Metropolitan Life Ins. Co.	\$ 3,147,868
National Casualty	\$ 7,518,727
Protective Life Ins.	\$ 1,415,834
Time Ins. Co.	\$ 14,643,953
TMG Life Ins. Co.	\$ 1,413,529
Travelers Ins. Co.	\$ 1,081,086
Washington National	\$ 7,405,325
<b>Total Net Paid Losses</b>	<b>\$ 38,874,885</b>

In accordance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20-2.17, the IHC Board will assess carrier members for their proportionate shares of the total net paid losses on the basis of information submitted on carriers' 1996 Market Share and Net Paid Loss Reports ("Exhibit K"), which should have been filed on or before March 1, 1997.

You will receive an estimate of your share of reimbursable losses and minimum enrollment share on or about April 1, 1997, once the 1996 premium data from all carriers has been compiled. If you have not filed an Exhibit K or non-member certification with the Board on behalf of all affiliated carriers that reported accident and health premium on an annual statement filed with the Commissioner of Banking and Insurance, please do so immediately, or your IHC Program assessment share will be based on the total accident and health premium reported on your annual statement. Thank you.