

NEW JERSEY  
**INDIVIDUAL HEALTH COVERAGE PROGRAM**

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**ADVISORY BULLETIN 97-IHC-04**

Date: July 17, 1997

To: IHC Member Carriers That Offer the Standard Health Benefits Plans and All Interested Parties

From: Ellen F. DeRosa, Assistant Director

**Re: Guaranteed Renewability Provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)**

Among other things, Advisory Bulletin 97-IHC-03 reminded Carriers that pursuant to HIPAA, the guaranteed renewability requirements of HIPAA became **effective July 1, 1997**. P.L. 1997, c.146, signed by Governor Whitman on June 30, 1997 and effective July 1, 1997, amended Section 5 of P.L. 1992, c.161 (the IHC Act) to conform with HIPAA by providing that eligibility for Medicare may *not* be used as a basis for termination of coverage under an IHC plan. While a Medicare eligible person continues to be ineligible to apply for an IHC plan, if a person covered under an IHC plan subsequently becomes eligible for Medicare, coverage for such person may *not* be terminated due to Medicare eligibility.

The interim federal regulations offer some guidance concerning how a private plan may operate in conjunction with Medicare: “If permitted by State law, however, policies that are sold to individuals before they attain Medicare eligibility may contain coordination of benefit clauses that exclude payment under the policy to the extent that Medicare pays.” [62 *Fed. Reg.* 16,989 (April 7, 1997)]

Preliminary discussion with a representative of the Health Care Financing Administration (HCFA) indicates that HCFA intends this language to mean that carriers may use a coordination of benefits (COB) provision. In terms of the order of benefit determination, Medicare is the primary plan, and the private plan is the secondary plan.

Ex.:	Physician Visit Charge:	\$120
	Medicare Allowance	\$100 (Provider must accept allowance as payment in full)
	Medicare Payment (@ 80%)	\$ 80
	Covered Person Balance	\$ 20
	Private Plan Payment	<i>lesser</i> of: what plan would have paid had it been primary; and the difference between what Medicare paid and Provider charge, as adjusted for Medicare allowance. (Ex. Of the \$120 charge, the plan may have paid \$85. (Assumes deductible has been met.)
		Applying COB, the plan pays the <i>lesser</i> of: \$85; or (\$100 - \$80), so the plan pays \$20.

(Example based on discussion with HCFA representative)

The standard IHC plans contain a **Conformity with Law** provision, which serves to bring the policy forms into compliance with changes in applicable federal and State law. In addition, the standard IHC plans also contain the following exclusion:

“Services or supplies: eligible for payment under either federal or state programs (except Medicaid) . This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services.”

The IHC Board intends to propose an express coordination of benefits provision for inclusion in the standard IHC plans as quickly as possible. In the meantime, in light of the interim regulations and discussions with HCFA, the IHC Board believes that the Conformity with Law provision and the above-quoted exclusion, taken together, provide a basis for a carrier to apply a coordination of benefits when a covered person who is eligible for Medicare submits a claim under an IHC plan.

N.J.A.C. 11:4-28 is the Group Coordination of Benefits regulation. Department of Banking and Insurance Bulletin 96-17 provides guidance on the operation of the Group Coordination of Benefits regulation. While N.J.A.C. 11:4-28 and Bulletin 96-17 specifically address group coordination of benefits issues, the IHC Board suggests that carriers refer to Bulletin 96-17 for additional guidance concerning the application of coordination of benefits.

If you have any questions, feel free to contact me.