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DEPARTMENT OF BANKING AND INSURANCE
INDIVIDUAL HEALTH COVERAGE PROGRAM
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ADVISORY BULLETIN
08-IHC-04

December 30, 2008

To: IHC Program Member Carriers that Issue Coverage
IHC Program Interested Parties

From: Ellen DeRosa
Executive Director

Re: Adopted Amendments to the Standard Individual Health Benefits Plans

The Individual Health Coverage Program Board proposed amendments to the standard plans to comply with the requirements of P.L. 2007 regarding coverage for prosthetics and orthotics and, c. 345, P.L. 2001, c. 295 regarding revised guidelines for colorectal cancer screening. Additionally, the IHC Board re-named the term previously called Reasonable and Customary to Allowed Charge. The Notice of Adoption will be published in an upcoming *New Jersey Register*. Both the proposal and the adoption are posted on the following website:

http://www.state.nj.us/dobi/division_insurance/ihcseh/ihrulesadoptions.htm

Since the proposed amendments to the standard plans affect only specific sections of the policy forms, carriers will be given the option to implement the forms changes by using the Compliance and Variability Rider set forth at N.J.A.C. 11:20 Appendix Exhibit D or by incorporating the change into the standard plans. The text to be included on the Compliance and Variability rider by those carriers that choose that option is set forth below. In either case, whether using the Compliance and Variability Rider, or reissuing the standard plans to include the amendments, carriers must begin the process of issuing riders or reissuing plans no later than the first renewal occurring on or after April 1, 2009.

Carriers issuing the Basic and Essential Healthcare Services Plan may re-file such plan or may use the Compliance and Variability Rider as discussed below.

Please also note that included in the proposal and adoption is a new form carriers must complete each year to identify the standard health benefits plans being sold. In accordance with N.J.A.C. 11:20-3.1(e) each carrier shall file the Identification of Standard Plans set forth as Appendix Exhibit H, no later than July 1, 2009 and an amended Identification of Standard Plans within 60 days of any change in the plans being offered by the carrier.

Compliance and Variability Rider Text For A/50-D

A. The Policy is amended to provide coverage for **Prosthetic Appliances and Orthotic Appliances**. The following provisions are affected by the inclusion of this additional coverage:

- i) The list of services for which Pre-Approval is required as appearing in the Schedule is amended to delete prosthetic devices.
- ii) The **Definitions** section is amended to include definitions of Orthotic Appliance and Prosthetic Appliance.
 - (a) **Orthotic Appliance** means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.
 - (b) **Prosthetic Appliance** means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.
- iii) The **Definitions** section is amended to delete the definition of Routine FootCare and replace it with the following definition.

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychia, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, and supportive devices for the foot.

- iv) The **Covered Charges** section is amended to include the following provision

Orthotic or Prosthetic Appliances

We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Covered Person's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Policy.

- v) The **Covered Charges with Special Limitations** section is amended to delete the Prosthetic Devices provision.

B. The Policy is amended to replace Reasonable and Customary terminology with Allowed Charge terminology.

- i) The Definition section is amended to delete the definition of Reasonable and Customary Charge and add a definition of Allowed Charge, as follows.

Allowed Charge means an amount that is not more than the [lesser of:
• the] allowance for the service or supply as determined by Us based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will decide a standard for what is considered an Allowed Charge under this Policy. For charges that are not determined by a negotiated fee schedule, the Covered Person may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.

- ii) Throughout the Policy, all references, except in the definition of Surgery, to Reasonable and Customary are deleted and replaced with Allowed Charges. In the definition of Surgery, Reasonable and Customary is replaced with reasonable and customary.

- iii) In the Coordination of Benefits and Services section the acronym R&C is replaced with AC

C. The Colorectal Cancer Screening provision of the **Covered Charges** section is deleted and replaced with the following

Colorectal Cancer Screening Charges

We cover charges made for colorectal cancer screening provided to a Covered Person age 50 or over and to younger Covered Persons who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Covered Person's Practitioner in consultation with the Covered Person regarding methods to use, We will cover charges for:

- a) Annual gFOBt (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
- b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
- c) Stool DNA (sDNA) test with high sensitivity for cancer
- d) flexible sigmoidoscopy,
- e) colonoscopy;
- f) contrast barium enema;
- g) Computed Tomography (CT) Colonography
- h) any combination of the services listed in items a – g above; or
- i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will cover the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the Covered Person's practitioner in consultation with the Covered Person.

High risk for colorectal cancer means a Covered Person has:

- a) A family history of: familial adenomatous polyposis, hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
- b) Chronic inflammatory bowel disease; or
- c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a Covered Person may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Covered Person has exhausted the available annual Preventive Care benefit, or elects not to use any available Preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.

Compliance and Variability Rider Text For the HMO Plan

A. The Contract is amended to provide coverage for **Prosthetic Appliances and Orthotic Appliances**. The following provisions are affected by the inclusion of this additional coverage:

- i) The **Definitions** section is amended to include definitions of Orthotic Appliance and Prosthetic Appliance.
 - (a) **Orthotic Appliance** means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.
 - (b) **Prosthetic Appliance** means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.
- ii) The **Definitions** section is amended to delete the definition of Routine FootCare and replace it with the following definition.

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychia, onychocryptosis, tyloids or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, and supportive devices for the foot.

- iii) Item 8 of the Outpatient Services section of the Covered Services and Supplies provision is deleted and replaced with the following:

8 Orthotic or Prosthetic Appliances We cover charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the [Member's] Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any Network licensed orthotist or prosthetist or any certified pedorthist.

Coverage for the appliances will be provided to the same extent as other charges under the Contract.

B. The Contract is amended to replace Reasonable and Customary terminology with Allowed Charge terminology.

i. The Definition section is amended to delete the definition of Reasonable and Customary Charge and add a definition of Allowed Charge, as follows.

[ALLOWED CHARGE. An amount that is not more than the [lesser of:
• the] allowance for the service or supply as determined by Us based on a standard approved by the Board[; or
[• the negotiated fee schedule.]

The Board will decide a standard for what is considered an Allowed Charge under this Contract. For charges that are not determined by a negotiated fee schedule, the [Member] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Allowed Charge.]

ii. Throughout the Contract, all references to Reasonable and Customary are deleted and replaced with Allowed Charges.

iii. In the Coordination of Benefits and Services section the acronym R&C is replaced with AC

C. Item 18 of the Outpatient Services section of the Covered Services and Supplies provision is deleted and replaced with the following

18. Colorectal Cancer Screening We provide coverage for colorectal cancer screening provided to a Member age 50 or over and to younger [Members] who are considered to be high risk for colorectal cancer. Coverage will be provided, subject to all the terms of this Contract, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the [Member's] Practitioner in consultation with the [Member] regarding methods to use, We will cover:

- a) Annual gFOBt (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
- b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
- c) Stool DNA (sDNA) test with high sensitivity for cancer
- d) flexible sigmoidoscopy,

- e) colonoscopy;
- f) contrast barium enema;
- g) Computed Tomography (CT) Colonography
- h) any combination of the services listed in items a – g above; or
- i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

We will provide coverage for the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the [Member's] practitioner in consultation with the [Member].

High risk for colorectal cancer means a [Member] has:

- a) A family history of: familial adenomatous polyposis, hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
- b) Chronic inflammatory bowel disease; or
- c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

D. The definitions of Specialist Doctor and Specialist Services are deleted and replaced with the following:

SPECIALIST DOCTOR. A fully licensed physician who:

- a) Is a diplomat of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association;
- b) Is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college;
- c) 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;
- d) 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
- e) Is recognized in the community as a specialist by his or her peers.

SPECIALIST SERVICES. Medical care provided by a Specialist Doctor in specialties other than family practice, general practice, internal medicine [or pediatrics][or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females)].

Specimen Text for the Basic and Essential Health Care Services Plan (B&E Plan)

Please note the B&E Plan is not subject to the prosthetics and orthotics mandate nor does the plan cover colorectal cancer screenings. Therefore, the amendments made to the standard plans to comply with law were not similarly included in the specimen B&E Plan. The definition of Reasonable and Customary as included in the specimen B&E plan was amended to use the Allowed Charge term, consistent with the amendment made to the standard plans.

Carriers with inforce B&E plans that would like to revise the terminology to be consistent with that used in the standard plans and specimen B&E plan may use the Compliance and Variability rider to accomplish the amendment. Carriers should use the text from item B above as shown for Plans A/50-D or HMO, as appropriate.