



## State of New Jersey

DEPARTMENT OF BANKING AND INSURANCE  
INDIVIDUAL HEALTH COVERAGE PROGRAM  
PO BOX 325  
TRENTON, NJ 08625-0325

CHRIS CHRISTIE  
*Governor*

RICHARD J. BADOLATO  
*Commissioner*

KIM GUADAGNO  
*Lt. Governor*

TEL (609) 633-1882  
FAX (609) 633-2030

PETER L. HARTT  
*Director*

### ADVISORY BULLETIN 16-IHC-01

October 20, 2016

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

From: Ellen DeRosa  
Executive Director

**Re: Adopted Amendments to Standard Plans A/50, B, C, D and HMO**

On July 7, 2016 the Individual Health Coverage Program Board (IHC Board) issued a rule proposal proposing amendments to the standard plans A/50, B, C, D and HMO. The IHC Board used the special rulemaking process set forth at N.J.S.A. 17B:27A-16.1 which allows for a comment period of at least 20 days after which the IHC Board may adopt the amendments. The IHC Board allowed a 45-day period. At its meeting on September 13, 2016 the IHC Board voted to adopt the amendments and at its meeting on October 11, 2016 discussed the permissible use of the Compliance and Variability Rider to address the amendments. The notice of adoption has been filed and will appear in an upcoming *New Jersey Register*. The proposal and the adoption may be found on the following website:

[http://www.state.nj.us/dobi/division\\_insurance/ihcseh/ihcrulesadoptions.htm](http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrulesadoptions.htm)

Recognizing that the process of reissuing policy and contract forms is both lengthy and costly the IHC Board determined it appropriate to give Carriers the option to implement the amendments to enforce policies and contracts by using the Compliance and Variability Rider set forth at N.J.A.C. 11:20 Appendix Exhibit D. Additionally, the IHC Board appreciates the lead time necessary for carriers to update issue systems for new business and will thus allow carriers to issue the 2016 forms with the Compliance and Variability Rider to new policyholders and new contractholders until March 1, 2017. By March 1, 2017, the IHC Board expects carriers will issue 2017 policies and contracts without the use of the Rider.

The text to be included on the Compliance and Variability rider is set forth below. Please note that Carriers must carefully review the text to determine which variable text should be included for each of the policies or contracts to be amended. Refer to the *Note to carriers* for guidance regarding items that may or may not be appropriate to include.

Please do not use the text for the compliance and variability rider as a comprehensive list of the amendments to the standard plans. The rider text picks up revisions that impact eligibility and benefits. The text does not pick up the more cosmetic amendments.

Please contact me with any questions at [ellen.derosa@dobi.nj.gov](mailto:ellen.derosa@dobi.nj.gov)

## **Text for Compliance and Variability Rider Plans A/50 – D**

A. The DEFINITIONS section is amended as follows:

[1. The definition of “Allowed Charge” is deleted and replaced with the following:

**Allowed Charge** means an amount that is not more than the negotiated fee schedule.]  
*Note to carriers: The above item is variable text. Include if appropriate. Adjust numbering accordingly.*

2. The definition of “Developmental Disability or Developmentally Disabled” is deleted and replaced with the following:

**Developmental Disability or Developmentally Disabled** means a severe, chronic disability that:

- a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
- b) is manifested before the Covered Person attains age 26;
- c) is likely to continue indefinitely;
- d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
- e) reflects the Covered Person’s need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of, lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable intellectual disability, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

3. The definition of “Joint Commission” is deleted and replaced with the following definition:

**The Joint Commission** means the entity that evaluates and accredits or certifies health care organizations or programs.

4. The definition of “Preventive Care” is amended to add prostate cancer screening as an example of preventive care.

5. A definition of “Primary Care Provider” is added. All references in the Policy to “Primary Care Physician” are deleted and replaced with “Primary Care Provider.”

**Primary Care Provider (PCP)** means a Practitioner who is a Network provider 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.

6. The definition of “Skilled Nursing Care” is deleted and replaced with the following:

**Skilled Nursing Care** means services which are more intensive than Custodial Care, are provided by a Nurse, and require the technical skills and professional training of a Nurse.

[7. The definition of “Telemedicine” is deleted and replaced with the following:

**Telemedicine** means [a telephone][or] [an audiovisual] consultation between a [Network] Provider that has contracted with [Carrier] to offer telemedicine services and a Covered Person.]

*Note to carriers: The above item is variable text. Include if appropriate. Adjust numbering accordingly.*

B. The second paragraph of the CONTINUATION OF CARE provision is deleted and replaced with the following paragraphs:

We shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated health care professional and in certain cases of active treatment for up to 90 days, as described below.

In case of a Covered Person in active treatment for a health condition for which the Provider attests that discontinuing care by the Provider would worsen the Covered Person’s condition or interfere with anticipated outcomes, coverage of the terminated Provider shall continue for the duration of the treatment, or up to 90 days, whichever occurs first.

[C. The Prescription Drugs provision of the COVERED CHARGES section is amended to include the following additional text:

Specialty Pharmaceuticals Split Fill Program: Select Specialty Drugs will be eligible for a split fill when a new prescription that will be filled at a specialty pharmacy is prescribed. Under the split fill program an initial prescription will be dispensed in two separate amounts. The first shipment will be for a 15-day supply. The [Covered Person] will be contacted prior to dispensing the second 15-day supply in order to evaluate necessary clinical intervention due to medication side effects that may require a dose modification or discontinuation of the medication. The split-fill process will continue for the first 90 days the [Covered Person] takes the medication. The [Covered Person’s] cost share (Copayment) amounts will be prorated to align with the quantity dispensed with each fill. If the [Covered Person] does not wish to have a split fill of the medication, he or she may decline participation in the program.

For those [Covered Persons] the Specialty Pharmacy will ship the full prescription amount and charge the [Covered Person] the cost share for the medication dispensed. Alternatively, the [Covered Person] may obtain the medication at a retail pharmacy.]

*Note to carriers: The above item is variable text. Include if appropriate. Adjust numbering accordingly*

D. The Dental Care and Treatment provision of the COVERED CHARGES WITH SPECIAL LIMITATIONS section of the Policy is deleted and replaced with the following:

**Dental Care and Treatment**

This Dental Care and Treatment provision applies to all Covered Persons.

We cover:

- a) the diagnosis and treatment of oral tumors and cysts; and
- b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

- a) the Injury was not caused, directly or indirectly by biting or chewing; and
- b) all treatment is finished within 6 months of the later of:
  - 1. the date of the Injury; or
  - 2. the effective date of the [Covered Person's] coverage under this Policy.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

E. The EXCLUSIONS section of the Policy is amended to delete the following exclusion:

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

F. The RENEWAL PRIVILEGE TERMINATION provision of the GENERAL PROVISIONS section is amended as follows:

- 1. The first paragraph is deleted and replaced with the following:

All periods of insurance hereunder will begin at 12:01 a.m. and end at midnight Eastern Standard Time.

- 2. The fourth paragraph is deleted and replaced with the following:

During or at End of Grace Period - Failure to Pay Premiums: If any premium is not paid by the end of its grace period, the Policy will end as described in the Grace Period provision.

Termination by Request - If You want to replace this Policy with another individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of midnight on the day before the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that

the Policy be terminated at the end of any period for which premiums have been paid. Then the Policy will end on the date requested.

3. Item d of the last paragraph is deleted and replaced with the following:

d) You become covered under another individual Health Benefits Plan; (Coverage will end at midnight on the day before the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)

G. The second paragraph of the TERMINATION OF DEPENDENT COVERAGE provision of the GENERAL PROVISIONS section is deleted and replaced with the following:

A Dependent's coverage ends at midnight on the date the Dependent is no longer a Dependent, as defined in the Policy However, for a Dependent child who is no longer a dependent due to the attainment of age 26 coverage ends at midnight on the last day of the month in which the Dependent attains age 26.

[H. The Payment of Claims provision of the CLAIMS PROVISIONS section is amended to add the following text:

[Carrier] uses reimbursement policy guidelines that were developed through evaluation and validation of standard billing practices as indicated in the most recent edition of the Current Procedural Terminology (CPT) as generally applicable to claims processing or as recognized and utilized by Medicare. [Carrier] applies these reimbursement policy guidelines to determine which charges or portions of charges submitted by the Facility or the Practitioner are Covered Charges under the terms of the Policy.]

*Note to carriers: The above item is variable text. Include if appropriate. Adjust numbering accordingly*

I. Include language taglines as required by 45 C.F.R. 155.205(c)(2)(iii)(A)

## Text for Compliance and Variability Rider HMO Plans

A. The DEFINITIONS section is amended as follows:

[1. The definition of “Allowed Charge” is deleted and replaced with the following:

**ALLOWED CHARGE.** An amount that is not more than the negotiated fee schedule.

*Note to carriers: The above item is variable text. Include if appropriate. Adjust numbering accordingly.*

2. The definition of “Developmental Disability or Developmentally Disabled” is deleted and replaced with the following:

**Developmental Disability or Developmentally Disabled** means a severe, chronic disability that:

- a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
- b) is manifested before the Member attains age 26;
- c) is likely to continue indefinitely;
- d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
- e) reflects the Member’s need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of, lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable intellectual disability, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

3. The definition of “Joint Commission” is deleted and replaced with the following definition:

**THE JOINT COMMISSION.** The entity that evaluates and accredits or certifies health care organizations or programs.

4. The definition of “Preventive Care” is amended to add prostate cancer screening as an example of preventive care.

5. The definition of “Skilled Nursing Care” is deleted and replaced with the following:

**SKILLED NURSING CARE.** Services which are more intensive than Custodial Care, are provided by a Nurse, and require the technical skills and professional training of a Nurse.

[6. The definition of “Telemedicine” is deleted and replaced with the following:

**TELEMEDICINE.** [A telephone][or] [an] [An] audiovisual] consultation between a [Network] Provider that has contracted with [Carrier] to offer telemedicine services and a Covered Person.]

*Note to carriers: The above item is variable text. Include if appropriate. Adjust numbering accordingly.*

B. The second paragraph of the CONTINUATION OF CARE provision is deleted and replaced with the following paragraphs:

We shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Member to continue treatment with the terminated health care professional and in certain cases of active treatment for up to 90 days, as described below.

In case of a Member in active treatment for a health condition for which the Provider attests that discontinuing care by the Provider would worsen the Member's condition or interfere with anticipated outcomes, coverage of the terminated Provider shall continue for the duration of the treatment, or up to 90 days, whichever occurs first.

[C. The Prescription Drugs provision of the OUTPATIENT SERVICES section is amended to include the following additional text:

Specialty Pharmaceuticals Split Fill Program: Select Specialty Drugs will be eligible for a split fill when a new prescription that will be filled at a specialty pharmacy is prescribed. Under the split fill program an initial prescription will be dispensed in two separate amounts. The first shipment will be for a 15-day supply. The [Member] will be contacted prior to dispensing the second 15-day supply in order to evaluate necessary clinical intervention due to medication side effects that may require a dose modification or discontinuation of the medication. The split-fill process will continue for the first 90 days the [Member] takes the medication. The [Member's] cost share (Copayment) amounts will be prorated to align with the quantity dispensed with each fill. If the [Member] does not wish to have a split fill of the medication, he or she may decline participation in the program. For those [Members] the Specialty Pharmacy will ship the full prescription amount and charge the [Member] the cost share for the medication dispensed. Alternatively, the [Member] may obtain the medication at a retail pharmacy.]

*Note to carriers: The above item is variable text. Include if appropriate. Adjust numbering accordingly*

D. The Dental Care and Treatment provision of the COVERED SERVICES & SUPPLIES section of the Contract is deleted and replaced with the following:

**Dental Care and Treatment**

This Dental Care and Treatment provision applies to all Members.

We cover:

- a) the diagnosis and treatment of oral tumors and cysts; and

b) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

- a) the Injury was not caused, directly or indirectly by biting or chewing; and
- b) all treatment is finished within 6 months of the later of:
  1. the date of the Injury; or
  2. the effective date of the [Member's] coverage under this Contract.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

E. The NON-COVERED SERVICES AND SUPPLIES section of the Contract is amended to delete the following exclusion:

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

F. The RENEWAL PRIVILEGE TERMINATION provision of the GENERAL PROVISIONS section is amended as follows:

1. The first paragraph is deleted and replaced with the following:

All Contract Years and Contract Months will be calculated from the Effective Date. All periods of insurance hereunder will begin at 12:01 a.m. and end at midnight Eastern Standard Time.

2. The fourth paragraph is deleted and replaced with the following:

During or at End of Grace Period - Failure to Pay Premiums: If any premium is not paid by the end of its grace period, the Contract will end as described in the Grace Period provision.  
Termination by Request - If You want to replace this Contract with another individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Contract will end at midnight on the day before the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Contract and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Contract be terminated at the end of any period for which premiums have been paid. Then the Contract will end on the date requested.

3. Item d of the last paragraph is deleted and replaced with the following:

d) You become covered under another individual Health Benefits Plan; (Coverage will end at midnight on the day before the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)

G. The second paragraph of the TERMINATION OF DEPENDENT COVERAGE provision of the GENERAL PROVISIONS section is deleted and replaced with the following:



A Dependent's coverage ends at midnight on the date the Dependent is no longer a Dependent, as defined in the Contract. However, for a Dependent child who is no longer a dependent due to the attainment of age 26 coverage ends at midnight on the last day of the month in which the Dependent attains age 26.

H. Include language taglines as required by 45 C.F.R. 155.205(c)(2)(iii)(A)