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DEPARTMENT OF BANKING AND INSURANCE
SMALL EMPLOYER HEALTH BENEFITS PROGRAM
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ADVISORY BULLETIN
17-SEH-04

November 8, 2017

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

From: Ellen DeRosa
Executive Director

Re: Adopted Amendments to Standard Plans B, C, D, HMO and HMO-POS

On September 20, 2017, the Small Employer Health Benefit Program Board (SEH Board) voted to adopt amendments to the standard health benefits plans. The notice of adoption has been filed and will appear in an upcoming *New Jersey Register*. The proposal and adoption are posted on the SEH Board's website.
http://www.state.nj.us/dobi/division_insurance/ihcseh/sehrulesadoptions.htm.

Recognizing that the process of reissuing policy and contract forms is both lengthy and costly the SEH Board determined it appropriate to give Carriers the option to implement the amendments by using the Compliance and Variability Rider set forth at N.J.A.C. 11:21 Appendix Exhibit DD.

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. After Carriers determine which text is appropriate for the plans to be amended the carrier may number or letter the items included on the rider. The SEH Board expects that carriers will work as expeditiously as possible to ensure that all small employer plans issued or renewed on or after January 1, 2018 contain the amended text.

Please contact me with any questions at ellen.derosa@dobi.nj.gov

Compliance and Variability Rider Text for Plans B – E

[The **SCHEDULE OF INSURANCE** is amended to include the following section:
[Outpatient Surgery (facility charges)] Coinsurance Limit: $[500] per [surgery]]
Include only if outpatient surgery or some other service or supply for which coinsurance is required is subject to a limit.

The **DEFINITIONS** section is amended:

- to delete the definitions of E-Visit and Virtual Visit;
- to replace the definitions of Preventive Care, Telemedicine and Triggering Event with the following definitions; and
- to add a definition of Telehealth.

Preventive Care. As used in this Policy preventive care means:

a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the [Covered Person];
b) Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Covered Person];
c) Evidence–informed preventive care and screenings for [Covered Persons] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for [Covered Persons] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, prostate cancer screening, and Nicotine Dependence Treatment.

Telehealth means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117.

Telemedicine means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the physical distance between a Practitioner and a Covered Person, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

Triggering Event means the following dates:

a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government or Carrier.
d) The date an Employee or eligible Dependent demonstrates to the marketplace or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move provided the Employee and/or Dependent demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.
f) The date NJFamilyCare determines an Employee or Dependent who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that determination is made after the open enrollment period or special enrollment period ends.
g) The date an Employee and/or his or her Dependent who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
h) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
i) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
j) The date of a court order that requires coverage for a Dependent.

[The definition of Primary Care Provider in the **POINT OF SERVICE PROVISIONS** is replaced with the following:

Primary Care Provider (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization. A Covered Person may visit the OB/GYN without supervision or coordination from the PCP.]
[Include only for POS plans.]

[The last paragraph of the Primary Care Provider section in the **POINT OF SERVICE PROVISIONS** is replaced with the following:

A Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care [without Referral from the PCP]. The Covered Person must obtain authorization from the PCP for other services.]
[Include only for POS plans.]

[The definition of Primary Care Provider in the **EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS** is replaced with the following:

Primary Care Provider (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply the Covered Person with a list of PCPs who are members of the [XYZ] Provider Organization. A Covered Person may visit the OB/GYN without supervision or coordination from the PCP.]
[Include only for EPO plans that do not require referrals.]

[The last paragraph of the Primary Care Provider section of the **EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS** is replaced with the following:

A Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without Referral from the PCP. The Covered Person must obtain authorization from the PCP for other services.]
[Include only for EPO plans that require referrals.]

[The **COVERED CHARGES** provision is amended to replace the **Practitioner's Charges for Non-Surgical Care and Treatment** section with the following:
We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury.]
[Include only if policies were issued with text addressing telemedicine, e-visits or virtual visits.]

The **COVERED CHARGES** provision is amended to add the following section:

Practitioner's Charges for Telehealth and/or Telemedicine
If a Network Practitioner provides Medically Necessary and Appropriate services through Telehealth and/or Telemedicine that are consistent with the requirements of P.L. 2017, c. 117 We cover such Network Practitioner's charges for services provided through Telehealth and/or Telemedicine.

[The **EXCLUSIONS** provision is amended to replace the telephone consultations exclusion with the following:

Telephone consultations. except as stated in the Practitioner's Charges for Telehealth and/or Telemedicine provision.]
[Include only if policies were issued with the prior exclusion and the carrier wishes to retain the exclusion.].

Compliance and Variability Text for HMO Plans

[The **SCHEDULE OF SERVICES AND SUPPLIES** is amended to include the following section:
[Outpatient Surgery (facility charges)] Coinsurance Limit: $[500] per [surgery]]
Include only if outpatient surgery or some other service or supply for which coinsurance is required is subject to a limit.

The **DEFINITIONS** section is amended:

- to delete the definitions of E-Visit and Virtual Visit;
- to replace the definitions of Preventive Care, Primary Care Provider, Specialist Services, Telemedicine and Triggering Event with the following definitions; and
- to add a definition of Telehealth.

PREVENTIVE CARE. As used in the Contract preventive care means:
a) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the [Member];
b) Immunizations for routine use for [Members] of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Member];
c) Evidence–informed preventive care and screenings for [Members] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Evidence–informed preventive care and screenings for [Members] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; and
e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, prostate cancer screening and Nicotine Dependence Treatment.

PRIMARY CARE PROVIDER (PCP). A [Network] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre and post-natal care, birth and treatment of diseases and hygiene] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; [initiates a [Member]'s [Referral for Specialist Services;]] and is responsible for maintaining continuity of patient care. Primary Care Providers include nurse practitioners/clinical nurse specialists, physician assistants and certified nurse midwives.

SPECIALIST SERVICES. Medical care 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 diseases and hygiene)].

TELEHEALTH. The use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117.

TELEMEDICINE. The delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the physical distance between a Practitioner and a Member, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

TRIGGERING EVENT. The following dates:

a) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
b) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
c) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government or Carrier.
d) The date an Employee or eligible Dependent demonstrates to the marketplace or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
e) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move provided the Employee and/or Dependent demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.
f) The date NJFamilyCare determines an Employee or Dependent who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that determination is made after the open enrollment period or special enrollment period ends.
g) The date an Employee and/or his or her Dependent who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
h) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
i) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
j) The date of a court order that requires coverage for a Dependent.

The **COVERED SERVICES & SUPPLIES** provision is amended to replace item 1 of the **OUTPATIENT SERVICES** section with the following:

Office visits during office hours, and during non-office hours when Medically Necessary and Appropriate. *[Include only if policies were issued with text addressing telemedicine, e-visits or virtual visits.]*

The **COVERED SERVICES & SUPPLIES** provision is amended to add the following new item to the **OUTPATIENT SERVICES** section

Practitioner's Charges for Telehealth and/or Telemedicine. If a Network Practitioner provides Medically Necessary and Appropriate services through Telehealth and/or Telemedicine that are consistent with the requirements of P.L. 2017, c. 117 We cover such Network Practitioner's charges for services provided through Telehealth and/or Telemedicine.

[The **EXCLUSIONS** provision is amended to replace the telephone consultations exclusion with the following:

Telephone consultations. except as stated in the Outpatient Services provision.]

[Include only if policies were issued with the prior exclusion and the carrier wishes to retain the exclusion.].

Compliance and Variability Text for HMO-POS Plans

[The **SCHEDULE OF SERVICES AND SUPPLIES AND COVERED CHARGES** is amended to include the following section:

[Outpatient Surgery (facility charges)] Coinsurance Limit: $[500] per [surgery]]

Include only if outpatient surgery or some other service or supply for which coinsurance is required is subject to a limit.

The **DEFINITIONS** section is amended:

- to delete the definitions of E-Visit and Virtual Visit;
- to replace the definitions of Preventive Care, Primary Care Provider, Specialist Services, Telemedicine and Triggering Event with the following definitions; and
- to add a definition of Telehealth.

PREVENTIVE CARE. As used in the Contract preventive care means:

f) Evidence based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the [Member];
g) Immunizations for routine use for [Members] of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the [Member];
h) Evidence–informed preventive care and screenings for [Members] who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;

i) Evidence–informed preventive care and screenings for [Members] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; and
j) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, prostate cancer screening and Nicotine Dependence Treatment.

PRIMARY CARE PROVIDER (PCP). A [Network] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre and post-natal care, birth and treatment of diseases and hygiene] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; [initiates a [Member]'s [Referral for Specialist Services;]] and is responsible for maintaining continuity of patient care. Primary Care Providers include nurse practitioners/clinical nurse specialists, physician assistants and certified nurse midwives.

SPECIALIST SERVICES. Medical care 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 diseases and hygiene)].

TELEHEALTH. The use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117.

TELEMEDICINE. The delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the physical distance between a Practitioner and a Member, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

TRIGGERING EVENT. The following dates:
k) The date an Employee or Dependent loses eligibility for minimum essential coverage including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.
l) The date an Employee acquires a Dependent or becomes a Dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care.
m) The date an Employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the federal government or Carrier.
n) The date an Employee or eligible Dependent demonstrates to the marketplace or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

o) The date the Employee or Dependent gains access to new qualified health plans as a result of a permanent move provided the Employee and/or Dependent demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.
p) The date NJFamilyCare determines an Employee or Dependent who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that determination is made after the open enrollment period or special enrollment period ends.
q) The date an Employee and/or his or her Dependent who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
r) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare.
s) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan.
t) The date of a court order that requires coverage for a Dependent.

The **COVERED SERVICES & SUPPLIES *APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES*** provision is amended to replace item 1 of the **OUTPATIENT SERVICES** section with the following:
Office visits during office hours, and during non-office hours when Medically Necessary and Appropriate. *[Include only if policies were issued with text addressing telemedicine, e-visits or virtual visits.]*

The **COVERED SERVICES & SUPPLIES *APPLICABLE TO [NETWORK] SERVICES AND SUPPLIES*** provision is amended to add the following new item to the **OUTPATIENT SERVICES** section
Practitioner's Charges for Telehealth and/or Telemedicine. If a Network Practitioner provides Medically Necessary and Appropriate services through Telehealth and/or Telemedicine that are consistent with the requirements of P.L. 2017, c. 117 We cover such Network Practitioner's charges for services provided through Telehealth and/or Telemedicine.

[The **EXCLUSIONS** provision is amended to replace the telephone consultations exclusion with the following:

Telephone consultations. except as stated in the Outpatient Services provision.]

[Include only if policies were issued with the prior exclusion and the carrier wishes to retain the exclusion.].