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ADVISORY BULLETIN
99-SEH-03

March 17, 1999

To: SEH Program Member Carriers
From: Ellen F. DeRosa, Deputy Executive Director
Re: Model Rider to Create High Deductible Plans that Could Be Issued With a Medical Savings Account

This Advisory Bulletin is a follow-up to Advisory Bulletin 97-SEH-06 that offered assistance to carriers in submitting optional benefit riders that are intended to increase the deductible amounts available under the standard health benefit plans such that the plans could be used in conjunction with a Medical Savings Account.

The SEH Board received a copy of Revenue Procedure 98-61, issued by the Federal Internal Revenue Service. Among other things, this Procedure specified the inflation-adjusted deductible amounts that must be contained in a high deductible plan for tax year 1999 in order for the plan to qualify for use with a Medical Savings Account. The deductible and out-of-pocket maximum amounts are scheduled to be adjusted annually, with guidance on the amount of the adjustments being released in December of the year prior to the date the inflation-adjusted amounts are to be effective. The model rider that was included with Advisory Bulletin 97-SEH-06 included variable text that contained specific dollar amounts of the deductibles and out-of-pocket maximums. To the extent that carriers filed optional benefit riders that specified exact dollar amounts for the deductible and out-of-pocket maximum, the riders will need to be re-filed to address the inflation-adjusted amounts. Since the amounts will change each year, it is suggested that narrative text, discussing the inflation-adjusted amounts, be included on the rider. The model rider attached to this Advisory Bulletin provides sample text that could be used to accomplish the annual inflation-adjustments.

The model rider that was included with Advisory Bulletin 97-SEH-06 replaced the schedule page in its entirety. The SEH Board proposed and adopted changes to the coverage for mental or nervous conditions or substance abuse that were effective September 1, 1998. To the extent that carriers filed optional benefit riders that similarly replaced the schedule page in its entirety, the previously filed riders would require revision to address the current level of coverage for the treatment of mental or nervous conditions or substance abuse.

Carriers may use the following text, with appropriate variables, as described below, to create an optional benefit rider of decreasing value to be filed, for approval, with the Department of Banking and Insurance.

Explanation of variable text

- The term C*ertificate* may be replaced with the term the carrier uses to identify the document provided to employees.
- References to *Dependent* coverage may be omitted in plans that provide employee only coverage.
- In addition to the narrative to discuss the *inflation-adjusted amounts*, carriers may elect to include text that would specify the exact dollar amount for the current tax year, and update that amount annually.
- The *Emergency Room Copayment* may be deleted, at the option of the carrier.
- If amending Plans D or E, the rider would need to include the specific coinsurance percentage for coverage of *mental or nervous conditions or substance abuse*.
- The definition of *Copayment* should be included in the rider *if* the carrier elects to delete the Emergency Room Copayment.
- The names of the provisions in the *Benefit Provision* should be consistent with the actual text being amended by the rider.
- Carriers that wish to use this type of rider with a plan issued through or in conjunction with a *selective contracting arrangement* should adapt the model rider accordingly.

Sample Rider Text

Section: SCHEDULE OF INSURANCE ANDPREMIUM RATES (Policy) and SCHEDULE OF INSURANCE ([Certificate])
Subsection: EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS

The **EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS** subsection of the **SCHEDULE OF INSURANCE ANDPREMIUM RATES** of the policy and the **SCHEDULE OF INSURANCE** of the [Certificate] is deleted and replaced with the following:

Calendar Year Cash Deductible

for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[$Inflation-adjusted deductible amount for the current tax year; for tax year [1999,] the amount is [$1550 to $2300]]
[Per Covered Family	[$Inflation-adjusted deductible amount for the current tax year; for tax year [1999,] the amount is [$3050 to $4600]]

[Emergency Room Copayment
(waived if admitted within 24 hours) $50]

Coinsurance
Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Coinsurance requirement once the Out-of-Pocket Maximum has been reached. The Policy's Coinsurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for the Policy is as follows:	[30%, 20%, or 10%] [**except as stated below**]
[Exception: for Mental or Nervous and Substance Abuse charges	25%]

Out-of-Pocket Maximum

[Per Covered Person	[$Inflation-adjusted amount for the current tax year; for tax year [1999,] the amount is [$3050]]
[Per Covered Family	[$Inflation-adjusted amount for the current tax year; for tax year [1999,] the amount is [$5600]]

Note: The **Out-of-Pocket Maximum cannot** be met with **Non-Covered Charges.**

NOTICE: THE CASH DEDUCTIBLE AND OUT-OF-POCKET PROVISIONS CONTAINED IN THIS RIDER ARE INTENDED PRODUCE A PLAN THAT COULD QUALIFY AS A HIGH DEDUCTIBLE PLAN THAT MAY BE USED IN

CONJUNCTION WITH A MEDICAL SAVINGS ACCOUNT (MSA) PLAN UNDER FEDERAL LAW. HOWEVER, ACTUAL QUALIFICATION OF A PARTICULAR PLAN WLL BE SUBJECT TO FEDERAL REGULATIONS.

Daily Room and Board Limits

• **During a Period of Hospital Confinement**
For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

• **During a Confinement in an Extended Care Center or Rehabilitation Center**
[Carrier] will cover the lesser of:
a) the center's actual daily room and board charge; or
b) 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- •[Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar	

Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits

Charges for Preventive Care per Calendar Year as follows:
(Not subject to Cash Deductible or Coinsurance)

[for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person

Charges for all treatment of Mental or Nervous Conditions and Substance Abuse, per Calendar Year

Inpatient Confinement	30 days *
Outpatient Care	20 visits

* Unused Inpatient days may be exchanged, for additional Outpatient visits, where each inpatient day may be exchanged for 2 outpatient visits.

Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

Section: DEFINITIONS

[The definition of **Copayment** is deleted and replaced with the following:

> **Copayment** means a specified dollar amount a Covered Person must pay for Covered Charges.]

The definition of **Non-Covered Charges** is deleted and replaced with the following:

> **Non-Covered Charges** are charges which do not meet the Policy's definition of Covered Charges or which exceed any of the benefit limits shown in the Policy or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Policy. Penalties for non-compliance as contained in the Utilization Review Features section of the Policy and [Certificate] are also Non-Covered Charges.

Section: HEALTH BENEFITS INSURANCE
Subsection: BENEFIT PROVISION
Th provisions entitled: the **Cash Deductible**, [**Family Deductible Limit**] [**Per Covered Family**] and [**Coinsurance Cap**] [**Coinsured Charge Limit**] are deleted and replaced with the following:

The Cash Deductible
THIS PROVISION APPLIES *ONLY* IN THE CASE OF EMPLOYEE ONLY COVERGE
Each Calendar Year, the Covered Person must have Covered Charges that exceed the Per Person Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred incurred by the Covered Person while insured by the Policy can be used to meet the Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But, all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

Per Covered Family
THIS PROVISION APPLIES *ONLY* IN THE CASE OF COVERGE FOR AN EMPLOYEE PLUS ONE OR MORE DEPENDENTS
The per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once any combination of Covered Persons in a family have incurred Covered Charges equal to the per Covered Family Cash Deductible, the per Covered Family Cash Deductible will have been met for the rest of that Calendar Year.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by a member of that Covered Family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But, all charges must be incurred while the

member of that that Covered Family is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum "Per Covered Person" and "Per Covered family" are shown in the Schedule.

In the case of *Employee only coverage*, for a Covered Person, the Out-of-Pocket Maximum is the maximum amount of Covered Charges the Covered Person must pay as Cash Deductible *plus* Coinsurance [*plus* Copayments] during each Calendar Year. Once the Per Covered Person Out-of-Pocket maximum has been met during a Calendar Year, no further Cash Deductible, [or] Coinsurance [or Copayments] will be required for such Covered Person for the rest of the Calendar Year.

In the case of *Employee plus Dependent coverage*, for each Covered Family, the Out-of-Pocket Maximum is the maximum amount of Covered Charges the Covered Family must pay as Cash Deductible *plus* Coinsurance [*plus* Copayments] during each Calendar Year. Once the Per Covered Family Out-of-Pocket maximum has been met during a Calendar Year, no further Cash Deductible, [or] Coinsurance [or Copayments] will be required for such Covered Family for the rest of the Calendar Year.

Section: UTILIZATION REVIEW FEATURES
Subsection: REQUIRED HOSPITAL STAY REVIEW
The last paragraph of the **Penalties for Non-Compliance** provision is deleted and replaced with the following:

> **Penalties for Non-Compliance**
> Penalties cannot be used to meet the Policy's or [Certificate's]:
> a) Cash Deductible; or
> b) Out-of-Pocket Maximum.

Section: UTILIZATION REVIEW FEATURES
Subsection: REQUIRED PRE-SURGICAL REVIEW
The last paragraph of the **Penalties for Non-Compliance** provision is deleted and replaced with the following:

> **Penalties for Non-Compliance**
> Penalties cannot be used to meet the Policy's or [Certificate's]:
> c) Cash Deductible; or
> d) Out-of-Pocket Maximum.