

NEW JERSEY
INDIVIDUAL HEALTH COVERAGE PROGRAM
and
SMALL EMPLOYER HEALTH BENEFITS PROGRAM

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ADVISORY BULLETIN 97-JOINT-01

Date: July 17, 1997

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

From: Ellen F. DeRosa, Assistant Director

Re: **Implementation of IHC and SEH Policy Form Changes**
Summary of IHC and SEH Policy Form Changes

The Individual Health Coverage Program (IHC) Board and the Small Employer Health Benefits (SEH) Board have adopted modifications to the standard IHC and SEH policy forms. Set forth below is a summary of the adopted modifications. Some of the changes are required as the result of the passage of New Jersey legislation. The changes also include non-benefit modifications and clarifications to the plans. With respect to *new business*, the revised policy forms are effective *September 1, 1997*. With respect to *inforce business*, the revised policy forms, at the option of the carrier, are effective *either September 1, 1997*, for all inforce plans, *or on the first anniversary on or after September 1, 1997*.

After the Boards' adoptions of the policy form amendments, the Legislature passed, and the Governor signed, P.L. 1997, c. 146. The law amends both the IHC and SEH Acts to conform to the requirements of the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is effective on July 1, 1997. The Boards intend to propose modifications to the standard IHC and SEH plans to conform with the requirements of P.L. 1997, c. 146 as quickly as possible. It is hoped that these new modifications will be effective on or about January 1, 1998. **Until such modifications take effect, carriers are advised that they must administratively comply with the requirements of P.L. 1997, c. 146.**

Implementation Options

A. Compliance and Variability Riders

In order to facilitate implementation of the changes, the Boards have given carriers the option of using the *Compliance and Variability Riders* (IHC - N.J.A.C. 11:20-3.3 and Exhibit S; SEH - N.J.A.C. 11:21-4.4 and Exhibit DD). The Rider may be used with both inforce business as well as new business. The Boards have prepared text that Carriers electing the Rider option *must* use; the text of the rider may not be altered. That text is available to Carriers on computer diskette.

B. Incorporate the policy form changes

If a Carrier prefers to use standard plans which *incorporate the policy form changes* for new business and/or inforce business, the Boards have prepared diskettes which contain the text of the standard plans, as revised. Since it is unknown at this time how extensive the text changes to comply with the requirements of P.L. 1997, c. 146 will be, the Boards cannot advise as to whether these future modifications may be accomplished via the Compliance and Variability Rider. Therefore, the Boards advises carriers that elect this option "B" that it is possible that changes to comply with P.L. 1997, c. 146 may require incorporation into the policy forms.

C. Administrative Compliance

The Boards recognize that implementation of policy forms changes can be a time consuming and costly process, and that it may be particularly burdensome to carriers to issue riders or re-issue policies/contracts/certificates in September, and then repeat the process in early 1998 to conform the plans with HIPAA and P.L. 1997, c. 146. Therefore, the Boards are allowing carriers a third option for compliance with the policy form changes that are effective September 1, 1997: *Administrative Compliance*. Carriers that select this option may use the text that was prepared for the Compliance and Variability riders as guidance for the administration of the plans. Carriers opting to administratively comply with these policy forms changes must nevertheless provide written notice to policy and contractholders of the benefit changes contained in the Boards' adoptions coincident with or prior to the issuance or renewal of the plan. Carriers are instructed to use the appropriate Summary of Plan Changes text of this Bulletin as the basis for describing the plan changes to policy and contractholders.

While carriers that elect Administrative Compliance may elect not to revise the standard application and/or enrollment forms to reflect the changes that are effective September 1, 1997, the Boards recognize that P.L. 1997, c. 146 and HIPAA necessitate the collection of some data that is not requested on the application and/or enrollment forms, as adopted effective September 1, 1997. Carriers are advised that they may attach a separate sheet to these standard forms to gather information as required by HIPAA.

Carriers in the individual market will be permitted to modify the schedule page in Plan C in order to meet the requirement of offering the \$2500 deductible plan.

Carriers in the small employer market may not issue dual contracts, as permitted with the promulgation of these forms changes, via administrative compliance.

THE FOLLOWING ARE ONLY SUMMARIES OF THE SUBSTANTIVE POLICY FORM CHANGES. REFER TO THE IHC AND SEH POLICY FORMS FOR SPECIFIC POLICY FORM LANGUAGE AND A COMPLETE EXPLANATION OF ALL THE TERMS AND CONDITIONS OF COVERAGE.

Summary of IHC Changes

(Unless otherwise stated, the changes apply to Plans A-E and HMO.)

A. Changes Which Affect Eligibility

Medicaid

As stated in Advisory Bulletin 96-IHC-02, P.L. 1995, c.291 amended the statutory definition of an "eligible person" such that persons who are residents of New Jersey and who are not eligible for coverage under Medicare or under a group plan are eligible for coverage. Thus, persons who are eligible for Medicaid are eligible to purchase an IHC plan, provided they are otherwise eligible. The modification to the definition was retroactively effective to April 1, 1995. Carriers were advised to administer the standard plans in accordance with the law until such time as the policy forms were modified to reflect the change in eligibility.

Dependent

The definitions of "Child" and "Dependent" have been modified to expand the scope of who may be considered a "Dependent" for purposes of coverage. A Dependent Child includes: a natural child; an adopted child; a step-child; and a Child related to the Policyholder/Covered Person by blood relationship or legal relationship who depends on the policyholder for most of his or her support and maintenance who resides in the Policyholder's/Covered Person's household.

Child Only Coverage

In addition to the mechanisms currently available to cover a child or children, (i.e., Single Coverage or Parent and Child(ren) Coverage) Carriers have the *option* to offer a Child(ren) only type of coverage. Carriers are not required to offer the Child(ren) only type of coverage, but if a Carrier elects to offer the type of coverage, it must be offered with all IHC plans.

B. Changes Which Affect Termination of Coverage

Medicaid

Pursuant to P.L. 1995, c.291, eligibility for Medicaid is not a basis for termination of coverage.

Termination by Request

A Covered Person who wants to replace an existing IHC plan with another IHC plan must notify the existing carrier of the replacement within 30 days after the effective date of the new plan. The existing plan will terminate as of 12:01 a.m. on the effective date of the new plan and the existing carrier must refund the unearned premium. Thus, there should be no duplicative coverage. The allowance for a 30-day overlap of coverage was deleted.

Grace Period Termination - HMO Plan ONLY

HMO carriers have the option to make coverage terminate as of the paid-to-date or as of the end of the grace period.

C. Definition Changes

Accidental Injury (and Accidentally Injured)

The definition of Accidental Injury (Accidentally Injured) was replaced with a definition of Injury (Injured), and all references in the forms to Accidental Injury (Accidentally Injured) have been changed to Injury (Injured). Thus, an injury which is self-inflicted will be covered, subject to the terms of the plan.

Illness (Ill)

The definition was revised to delete the statement that a mental or nervous condition is not an illness.

D. Plan Administration Changes

Grace Period/Continuity of Coverage

While coverage is in force during the grace period, that coverage is not considered to be in force on a premium paying basis. The 30 day permissible "gap" period for continuity is measured from the last date that coverage was in effect on a premium paying basis. Thus, the paid-to-date is used to mark the beginning of the "gap" period.

Reinstatement

A Reinstatement provision, as required by N.J.S.A. 17B:26-7, has been added to the plans.

Pre-Existing Condition Limitation/Continuity

Medicaid is considered valid prior coverage which could entitle a person to a pre-existing conditions credit or waiver.

The pre-existing conditions limitation does not apply to an adopted child, provided the child is enrolled within 30 days.

Dividends - Plans A - E ONLY

Mutual carriers may add a dividends provision to the standard plans.

E. Benefit Changes

Plan A

Plan A will not be available for new business on or after September 1, 1997.

Deductible Options - Plans B - E ONLY

The \$250 deductible option *will not be* available for new business with Plans B, C, and D effective September 1, 1997.

The \$500 deductible option *will not be* available for new business with Plan C, and the \$150 deductible option *will not be* available for new business with Plan E effective September 1, 1997.

A \$2500 deductible option *will be* available with Plan C effective September 1, 1997.

Immunizations and Lead Screening - Plans A - E ONLY

Immunizations and lead screening are covered as part of the primary care services benefit. In addition, immunizations and lead screening are covered as a distinct benefit, with the deductible waived for such services.

Therapy Services - Plans B - E ONLY

The forms were clarified to state that the 30-visit limit per benefit period applies separately to each of the following therapies: physical, occupational, speech, and cognitive rehabilitation.

Therapy Services - HMO Plan ONLY

The text was clarified to state that respiration therapy is covered.

Therapeutic Manipulation - HMO Plan ONLY

A 30 visit per Benefit Period therapeutic manipulation benefit was added to the HMO plan, and the exclusion was deleted.

Reconstructive Surgery

Reconstructive surgery and surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breast is specifically covered, as required by P.L. 1997 c. 75.

Cosmetic Surgery

The limited coverage for cosmetic surgery which was previously described as an exception to the exclusion for cosmetic surgery was added to the description of the surgery benefit.

Mental or Nervous Conditions and Substance Abuse - Plans B - E ONLY

The text describing the benefit for maintenance prescription drugs was clarified. Maintenance prescription drugs as well as the routine office visits to monitor the use of the maintenance prescription drugs are not subject to the internal limits for mental or nervous conditions.

Mental or Nervous Conditions - HMO Plan ONLY

The HMO plan was clarified to state that Partial Hospitalization days are considered as outpatient visits. Each available inpatient day may be exchanged for two outpatient visits or two partial hospitalization days.

Summary of SEH Changes

(Unless otherwise stated, the changes apply to Plans A-E, HMO and HMO-POS.)

A. Plan Administration Changes

Coordination with Medicare (Plans A - E and HMO-POS ONLY)

The Medicare Alternate Deductible feature which created a “benefits less benefits” approach to Medicare coverage has been deleted. The exclusion which would have allowed an exclusion for services or supplies eligible for payment under a federal program has been modified to add Medicare as an exception to the exclusion. The benefits of Medicare eligible persons who are covered under SEH Plans must be determined by application of the Coordination of Benefits provision.

Coordination of Benefits

The definition of what is not a Plan was revised to conform to law.

Participation Requirements

The dependent participation requirement has been eliminated. Participation credit from a spouse’s plan is available only if the spouse’s plan is other than an individual plan. The forms no longer make a distinction between contributory plans and non-contributory plans in terms of participation requirements.

Termination Provisions (Plans A-E and HMO ONLY; HMO-POS already contained this new text.

Grace period termination requires 30 days advance notice. Termination for all other stated reasons requires 60 days advance notice. The termination reasons were expanded to specifically include all reasons permitted by law.

Waiver of Active Work / Non-Confinement Requirements

The plans specifically address the liability of prior and succeeding carriers in plan takeover situations, as required by the New Jersey Discontinuance and Replacement Regulation.

Pre-Existing Conditions Exclusion

The limitation was clarified to specifically state it does not apply to a newborn child.

Pre-Existing Conditions Exclusion (HMO Plan ONLY; already included in other plans)

A complete description of the exclusion and the continuity provision was added to the plan.

Procedures for Compliance with Medically Necessary and Appropriate Treatment / Refusal of Life Sustaining Treatment (HMO Plan and HMO-POS ONLY)

Modified text to more clearly specify the rights of the member.

Medicare as Secondary Payor (HMO Plan ONLY; already contained in other plans)
Added text to describe rules to determine primary/secondary liability with respect to persons who are eligible for Medicare.

Appeals Procedure (HMO-POS Plan ONLY; already included in other managed care plans.)
Added text to allow a carrier to include the text of an appeals procedure as approved by the State of New Jersey.

B. Continuation of Coverage Changes

COBRA

The provisions were modified to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Small Job Protection Act of 1996. Those modifications relate to the disability extension, the definition of a qualified beneficiary, duration of continuations, and Medicare eligibility.

New Jersey Continuation (Plans A-E and HMO ONLY; HMO-POS already contained this new text.

The continuation provision was expanded to specify the responsibilities of the employer with respect to an employee who is eligible for continuation.

C. Definition Changes

Cosmetic Surgery (Plans A-E and HMO ONLY; HMO-POS already contained this new text.

Definition added.

Health Benefits Plan

Definition revised to conform to law.

Illness (Ill)

The definition was revised to delete the statement that a mental or nervous condition is not an illness.

Injury

The definition was revised to delete the requirement that bodily damage must be due to accident. Thus, bodily damage is considered an injury even if not due to accident.

Small Employer (Plans A-E and HMO ONLY; HMO-POS already contained this new text.

Definition revised to conform to law.

Various Definitions (HMO Plan ONLY; already contained in other plans)

Definitions for the following terms were added: Ambulatory Surgical Center; Birthing Center; Covered Employee (replaced HMO plan definition of Subscriber); Extended Care Center; Facility; expanded definition of Prescription Drugs.

D. Benefit / Services and Supplies Changes

Immunizations and Lead Screening (Plans A-E and HMO-POS ONLY)

Immunizations and lead screening are covered as part of the preventive care benefit. In addition, immunizations and lead screening are covered as a distinct benefit, with the deductible waived for such services.

Reconstructive Surgery

Reconstructive surgery and surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breast is specifically covered, as required by P.L. 1997 c. 75.

Cosmetic Surgery

The limited coverage for cosmetic surgery which was previously described as an exception to the exclusion for cosmetic surgery was added to the description of the surgery benefit.

Dental Care and Treatment (HMO Plan ONLY; already contained in other plans)

Specifically described dental care coverage which would previously have been covered, if referred by the PCP.

Treatment for TMJ (HMO Plan ONLY; already contained in other plans)

Specifically described coverage for TMJ which would previously have been covered, if referred by the PCP.

Therapeutic Manipulation (HMO Plan ONLY; already contained in other plans)

Specifically described coverage for therapeutic manipulation which would previously have been covered, if referred by the PCP.

Emergency Care (Plans A - E when issued as PPO or POS plans)

In case of a medical emergency, if a covered person receives care and treatment from a non-network provider, benefits will be paid as if a network provider rendered care and treatment, provided the covered person calls the carrier within 48 hours, or as soon as reasonably possible.

E. Changes to Standard Riders

Prescription Drug (card; card/mail; mail only)

Clarified that drugs provided on an outpatient basis to treat mental or nervous conditions or substance abuse are covered under the rider. Inpatient drugs to treat mental or nervous conditions or substance abuse are covered under the policy/contract and are subject to the internal limits of the policy/contract.

Prescription Drug (mail only)

The mail order option was revised to state that the mail order coverage is in addition to coverage for prescription drugs provided under the policy / contract.

F. Other

Dual Contract (Plans C and D and HMO ONLY)

The standard forms include variable text which would allow an indemnity carrier and an HMO carrier to jointly issue plans to provide a Point of Service Plan.