NEW JERSEY
INDIVIDUAL HEALTH COVERAGE PROGRAM
and
SMALL EMPLOYER HEALTH BENEFITS PROGRAM
20 West State Street, 10th Floor
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ADVISORY BULLETIN 97-JOINT-02

Date: November 3, 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: **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. These changes are in addition to the changes adopted in July 1997, which were effective September 1, 1997. Refer to Advisory Bulletin 97-JOINT-01 for a summary of the changes which were effective September 1, 1997. Set forth below is a summary of the adopted modifications. Most of the changes are required as the result of the passage of P.L. 1997, c. 146 and the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). With respect to ***new business***, the revised policy forms are effective ***January 1, 1998.*** With respect to ***inforce business***, the revised policy forms, at the option of the carrier, are effective *either* ***January 1, 1998***, for all inforce plans, *or* on the ***first anniversary on or after January 1, 1998.***

As stated in Bulletins 97-IHC-05 and 97-SEH-09, however, the Boards will allow carriers to implement the policy forms changes prior to January 1, 1998. The Boards again remind carriers that the Compliance and Variability Riders may ***not*** be used to implement these forms changes.

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.)

1. Changes which Affect Eligibility for Coverage

Eligible Person means a person who is a Resident who is not eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, Church Plan, or Part A or Part B of Title XVIII of the federal Social Security Act (Medicare.)

Federally Defined Eligible Individual means an Eligible Person:

a) for whom, as of the date on which he or she seeks coverage under the plan, the aggregate of the periods of Creditable Coverage is 18 or more months;
b) whose most recent prior Creditable Coverage was under a Group Health Plan, Governmental Plan, Church Plan, or health insurance coverage offered in connection with any such plan;
c) who is not eligible for coverage under a Group Health Plan, Part A or Part B of Title XVIII of the federal Social Security Act (Medicare), or a State plan under Title XIX of the federal Social Security Act (Medicaid) or any successor program and who does not have another Health Benefits Plan, or hospital or medical service plan;
d) with respect to whom the most recent coverage within the period of aggregate Creditable Coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;
e) who, if offered the option of continuation coverage under a COBRA continuation provision or similar State continuation option, elected that continued coverage; and
f) who has elected continuation coverage described in item "e" above, and has exhausted that continuation coverage.

The "Federally Defined Eligible Individual" is thus an Eligible Person who satisfies very specific criteria, and can be considered as a "subset" group of individuals under the definition of an Eligible Person. As discussed in the section addressing Pre-Existing Conditions and Continuity of Coverage, the "Federally Defined Eligible Individual" is entitled to more favorable treatment than a person who does not satisfy this criteria.

Resident means a person:

a) whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the Calendar Year; or
b) in the case of a person who has moved to New Jersey less than six months before applying for coverage, who intends to be present in New Jersey for at least six months of the Calendar Year.

The forms only require that the primary insured be a resident. That is, persons covered as a dependent spouse or a dependent child need not be a resident.

2. Changes which Affect Termination of Coverage

Eligibility for Medicare
While a person is eligible for Medicare is *not eligible* to purchase coverage under an IHC plan, the coverage of a person who is already covered under an IHC plan and then first becomes eligible for coverage under Medicare *may not be terminated due to eligibility for Medicare.* As discussed in the Coordination of Benefits (COB) section of this Bulletin, the standard plans, as adopted, contain a COB provision so there will not be duplicative coverage.

Fraud or Intentional Misrepresentation of Fact
Carriers have the option to elect, for all plans, to either rescind coverage back to the effective date, or to terminate coverage immediately.

3. Changes Which Affect Pre-Existing Conditions and Continuity of Coverage

Creditable Coverage
The forms contain a definition of Creditable Coverage which is consistent with the definition contained in HIPAA. This definition is very broad, and expands the scope of coverage which entitles a person to Pre-Existing Conditions credit or waiver. For example, Creditable Coverage includes individual and group plans, whether insured, or self-funded, Medicare, Medicaid, and CHAMPUS. Please refer to HIPAA or the standard plans for a complete definition.

Continuity of Coverage for all Eligible Persons
The permissible "gap" period which is measured from the date prior coverage ends until the date the new IHC coverage begins has been expanded from 30 days to *31 days*. Thus, if an Eligible Person was covered under Creditable Coverage which ends no more than 31 days prior to the effective date of the new IHC coverage, the person is eligible for Pre-Existing Conditions credit, or waiver, as appropriate.

Special Provision for Federally Defined Eligible Individuals
The Pre-Existing Conditions Limitation does *not* apply to a Federally Defined Eligible Individual, provided he or she applies for coverage within *63 days* of termination of the prior coverage.

4. Change Which Addresses Coexistence of an IHC Plan and Medicare

Coordination of Benefits (COB)
As stated in the Termination section of this Bulletin, eligibility for Medicare is *not* a basis for termination of an IHC plan. If a person who has coverage under an IHC plan becomes eligible for coverage under Medicare, whether due to age, disability, or end stage renal disease, elects to retain coverage under the IHC plan, the COB provision will apply. Under the COB rules, Medicare is the primary payor and the IHC plan is the secondary payor. The COB provision included in the IHC plans allows coordination against a Medicare benefit for which the person is eligible. Thus, if a person covered

under an IHC plan becomes eligible for Medicare, but for some reason fails to sign up for Medicare, the IHC carrier may coordinate against the Medicare benefit the person would have received had he or she enrolled for Medicare. It is important that consumers understand that the IHC plan will not replace Medicare coverage for which they are eligible.

5. Changes Which Affect Benefits

Coverage for Hospitalization following Mastectomy
To comply with P.L. 1997, c. 149, the forms provide the required hospital coverage following a mastectomy.

Prescription Drug Coverage (Plans B - E Only)
The Prescription Drug covered charge was clarified to state that prescription drugs needed to treat a mental or nervous condition or substance abuse are covered under the Mental or Nervous Conditions and Substance Abuse covered charge, and are not covered under the Prescriptions Drug covered charge. An exception is made for maintenance prescription drugs, which are eligible for coverage under the Prescription Drugs covered charge.

6. Terminology Changes

Benefit Period ⇒ Calendar Year
The forms contained a definition of Benefit Period, and used this term throughout the text. Since the term, as defined, was the same as a calendar year, the term Calendar Year has been substituted throughout the forms.

Primary Care Services ⇒ Preventive Care (Plans A - E Only)
In order to clarify the nature of the services eligible for the limited first dollar coverage, the amended forms refer to Preventive Care rather than Primary Care Services.

7. Delivery System Changes (Plans B - E Only)

New variable text has been added to the standard plans to allow carriers to issue Plans B - E as PPO plans and Plans C - E as POS plans. This new text was patterned after the PPO and POS options that existed in the small employer standard plans.

8. Application Changes

The standard application was revised primarily to capture data required for administration of the standard plans in conformance with HIPAA.

Summary of SEH Changes

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

1. Changes which Affect Eligibility for Coverage

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of *at least two but not more than 50 eligible Employees* on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the Plan Year, and the majority of the Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

Health Status-Related Factor means any of the following factors: health status; medical condition, including both physical and mental Illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

Coverage may not be denied to an eligible person on the basis of a Health Status-Related Factor. Two significant consequences of this prohibition appear in the Employee Eligibility and Dependent Eligibility sections of the standard plans:

Active Work Requirement

The standard plans allow carriers to elect to either eliminate the active work requirement in its entirety, or to use modified text which precludes application of the active work requirement when the reason an eligible employee is not actively at work is due to a Health Status-Related Factor.

Non-Confinement Requirement

The non-confinement requirement that applied to eligible dependents has been eliminated from the standard plans. Thus, a dependent who is hospital confined on the date coverage is supposed to take effect will not be subject to a deferred effective date.

Exceptions to Late Enrollee Status

An employee and his or her Dependents will not be considered Late Enrollees provided they waived coverage under the plan because they were covered under another plan and the coverage under that other plan ends due to one of the following *events*:

a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;

d) divorce or legal separation;
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or
g) termination of the other plan's coverage.

If an Employee initially waived coverage under a plan because he or she had coverage under a *COBRA continuation* provision and the Employee requests coverage under the plan within 30 days of the date the COBRA continuation ended, the employee will not be considered a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

An Employee and any Dependents will not be considered Late Enrollees if the Employee is employed by an employer which offers *multiple Health Benefits Plans* and the Employee elects a different plan during the open enrollment period.

An Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under the plan for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under the plan within 30 days of the *marriage, birth, adoption or placement for adoption* of a Newly Acquired Dependent.

2. Changes Which Affect Termination of Coverage (HMO and HMO-POS Plans Only)

Termination of the Contract - Renewal Privilege
The following have been added as termination events:

- there is no eligible Employee who resides, lives, or works in the HMO carrier's approved Service Area, but only if coverage is terminated uniformly, without regard to any Health Status-Related Factor relating to any Member; or
- the Small Employer no longer has any enrollee in connection with the plan who lives, resides, or works in the HMO carrier's Service Area and the HMO would deny enrollment with respect to such plan, as permitted by law.

3. Changes While Affect Pre-Existing Conditions

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the *Enrollment Date*.

The carrier does not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the *Enrollment Date*. This 180-day period may be reduced by the length of time the person was covered under any Creditable Coverage if, without application of

any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming covered.

This limitation does not affect benefits for other unrelated conditions, or pregnancy, or birth defects in a covered Dependent child. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Carriers must waive this limitation for a person's Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the person immediately before the person's coverage under the plan started.

Enrollment Date means, with respect to a Covered Person, the Effective Date or, if earlier, the first day of any applicable waiting period.

Thus, carriers may no longer apply a prudent person approach in determining conditions which are pre-existing. Further, the satisfaction of the pre-existing condition period is measured from the Enrollment Date which, if a plan has a Waiting Period, is the first day of the Waiting Period.

Creditable Coverage
The forms contain a definition of Creditable Coverage which is consistent with the definition contained in HIPAA. This definition is very broad. For example, Creditable Coverage includes individual and group plans, whether insured, or self-funded, Medicare, Medicaid, and CHAMPUS. Please refer to HIPAA or the standard plans for a complete definition.

Continuity of Coverage
The forms contain variable text which would be used by carriers that elect to use the alternate method of counting Creditable Coverage. The alternate method permits carriers to determine the amount of Creditable Coverage based on a category or categories of benefits, as described in federal regulations.

4. Changes Which Affect Benefits

Coverage for Hospitalization following Mastectomy
To comply with P.L. 1997, c. 149, the forms provide the required hospital coverage following a mastectomy.

Prescription Drug Coverage (HMO and HMO-POS Network Coverage Only)
The HMO Plan and the network coverage of the HMO-POS Plan include variable text which would allow a carrier to impose specified dispensing limits with respect to prescription drug coverage. A prescription or refill will not include a prescription or refill that is more than: the greater of a 30-day supply or 100 unit doses for each prescription or refill; or the amount usually prescribed by the Participating Provider.

Maximum Lifetime Benefit (HMO-POS Plan Only)
The out-of-network coverage under the HMO-POS plan has been revised to impose a $5,000,000 per person lifetime maximum benefit.

5. Changes Which Affect Administration

New Jersey Continuation
The forms have been revised to state that if an employee who is continuing coverage under the New Jersey Continuation provision acquires a dependent, he or she may add that newly acquired dependent to the plan.

Medicare as Secondary Payor (MSP)
As required by the Balanced Budget Act of 1997, the MSP provision as applicable to persons who are eligible for Medicare due to End Stage Renal Disease has been revised to extend the period during which the employer plan is primary from 18 months to 30 months.

Application and Enrollment Forms
A number of changes were made to the application, certification, enrollment and waiver forms primarily to capture data required for administration of the standard plans in conformance with HIPAA.

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IMPORTANT NOTICE TO CARRIERS

November 3, 1997

We have just discovered that the computer used to duplicate the policy forms disks sent to carriers was infected with the "WM.WAZZU.A" virus. Thus, there is a chance that the policy forms disks we provided to carriers may have been infected with this virus.

We used the Norton AntiVirus version 4.0 software to scan for and repair the virus. An earlier version of this software did not detect this "WM.WAZZU.A" virus, so it appears to be a fairly recent virus. Thus, if you have not already scanned the disks you received from the IHC and/or SEH Programs, you should use a relatively recent software program to scan the disks. If you are not able to successfully repair any infected disks, please contact us to request replacement disks.

We regret the inconvenience this virus may have caused you, and have already taken precautions to ensure we do not risk spreading viruses in the future.

To request replacement disks, please complete the following, and FAX it to Diane Rustay at 609-633-2030.

Name: _____

Carrier: _____

Mailing Address: _____

_____

Check which disks should be sent:

_____ IHC Indemnity _____ SEH Indemnity

_____ IHC HMO _____ SEH HMO