

NEW JERSEY
**INDIVIDUAL HEALTH COVERAGE PROGRAM &
SMALL EMPLOYER HEALTH BENEFITS PROGRAM**

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ADVISORY BULLETIN

97-Joint-03

To: IHC and SEH Carriers and Interested Parties
From: The IHC and SEH Program Boards
**Re: Amendments to The Individual Health Care Reform Act &
The Small Employer Health Benefits Act**
Date: November 24, 1997

The New Jersey Legislature passed, and the Governor signed, two laws P.L. 1997, c. 146, and P.L.1997, c.192, that, in part, amend the Individual Health Coverage Reform Act, N.J.S.A. 17B:27A-2 et seq., and the law commonly referred to as the Small Employer Health Benefits Act, N.J.S.A. 17B:27A-17 et seq. The purpose of this bulletin is to give carriers, agents, small employers, and consumers of individual health benefits coverage an overview of these recent changes in the law as they relate to the individual and small employer markets.

Many of the amendments to the law will require the New Jersey Individual Health Coverage (IHC) Program Board, the New Jersey Small Employer Health Benefits Coverage ("SEH") Program Board, the Department of Banking and Insurance ("DOBI"), and the Department of Health and Senior Services ("DOHSS") to promulgate new regulations or modify existing regulations, a process that will take place during the coming months. This bulletin is intended to provide guidance in the meantime for issues regarding the individual and small employer markets, though it should not be a substitute for a review of the laws themselves. Included in the regulatory changes are amendments to the standard individual and small employer health benefits plans. Both the IHC and SEH Boards have already adopted amendments to the standard forms which carriers will be required to use for new issues and renewals occurring on or after January 1, 1998, but may be used prior to January 1, 1998.

P.L.1997, c.146 made many changes to the laws governing the individual and small employer markets to conform those markets with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, or "HIPAA." In addition, P.L.1997, c.146 maintained the current system of modified community rating in the small employer market, and made some other changes to the individual market. P.L.1997, c.146 was effective on July 1, 1997.

P.L.1997, c.192, also known as the Health Care Quality Act (“HCQA”), primarily regulates the conduct between carriers and providers. There are, however, sections which have a direct impact on the individual and small employer markets. That law is effective February 3, 1998.

<p>P.L.1997, c.146 Effective July 1, 1997</p>
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I. AMENDMENTS TO THE INDIVIDUAL MARKET

A. *Definition Changes*

P.L.1997, c.146 modifies the following definitions: “carrier,” “eligible person,” “health benefits plan,” “individual health benefits plan,” and “net earned premium.”

In addition, the amendments include the addition of the following definitions: “church plan,” “creditable coverage,” “federally defined eligible individual,” “governmental plan,” “group health plan,” “health status-related factor,” “medical care,” “non-group person life year,” “plan sponsor,” “resident,” “two-year calculation period.”

The significance of these additions and modifications are discussed in various sections of this bulletin.

(P.L.1997, c.146, section 1 amending N.J.S.A. 17B:27A-2)

B. *Guaranteed Issuance and Exceptions*

Although the amendments introduce the concept of a “federally defined eligible individual,” the importance of that term is significant only for purposes of determining whether or not a preexisting condition limitation will be applicable to a covered person and has no bearing on eligibility for an individual health benefits plan. The eligibility requirements for the individual market have not been altered significantly. A person is eligible for individual health benefits coverage so long as he or she is a resident of New Jersey, and not eligible for or covered under a group health benefits plan, group health plan, governmental plan, church plan, or Medicare. A “resident” means a person whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the calendar year. However, if a person has moved to New Jersey less than six months before applying for individual coverage, such a person is a resident if he or she intends to be present in New Jersey for at least six months of the calendar year.

P.L.1997, c.146 amended certain exceptions to the guaranteed issuance requirement in the individual market. The exceptions include:

- Health maintenance organizations (“HMOs”) are not required to offer coverage to an individual if that individual does not live, reside, or work within that HMO’s approved service area.
- HMOs will not be required to offer coverage or accept any new enrollees if they do not have the capacity to deliver services to additional enrollees.
- Carriers are not required to offer coverage or accept applications if the Commissioner of DOBI determines that the carrier does not have the financial reserves necessary to underwrite additional coverage.

(P.L.1997, c.146, sections 1 and 5 amending N.J.S.A. 17B:27A-2 and -8)

C. Guaranteed Renewability and Exceptions

All standard individual health benefits plans are guaranteed renewable at the option of the policy or contractholder. The amendments modified the existing exceptions to this requirement and added others. Specifically, the law provides that a carrier may *terminate* a plan if:

- the policy or contract holder has failed to pay premiums in accordance with the terms of the policy or if the carrier has not received timely payments; and
- the policy or contract holder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.

The amendments also provide that a carrier may *nonrenew* a health benefits plan only under the following circumstances:

- The covered person is no longer a resident of New Jersey.
- The covered person becomes eligible for a group health benefits plan, a group health plan, a governmental plan or a church plan, as those terms are defined under the law as amended.
- The carrier receives approval from the IHC Board to nonrenew a particular type of health benefits plan in accordance with rules adopted by the IHC Board. The amendments also set forth certain notice requirements. Please refer to the amendments to the IHC Act and the IHC Board’s regulations, when adopted, for guidance on notice to covered persons.¹
- The carrier receives approval from the IHC Board to withdraw completely from the individual market. Again, the law and applicable regulations set forth certain notice requirements to advise policy or contract holders of the nonrenewal.² Carriers that file for market withdrawal are prohibited from re-entry into the individual health benefits market for a five-year period.

¹ The Board has proposed regulations that set forth the requirements for plan withdrawal and which will be codified at N.J.A.C. 11:20-18.

² The same proposed regulations noted in footnote 1 above also address the requirements for market withdrawal.

- In the case of an HMO, such a carrier will not be required to renew coverage to an individual who no longer resides, lives, or works in the service area of the HMO.

P.L.1997, c.146 did not affect carriers' ability to nonrenew coverage where the IHC Board has cancelled a specific health benefits plan.

As a result of the amendments, a carrier may not cancel or nonrenew coverage to persons covered by an individual health benefits plan who become eligible for or covered under Medicare after becoming covered by an individual health benefits plan. Benefits under a standard individual health benefits plan would, however, be subject to a coordination of benefits where Medicare is the primary payor. The IHC Board has developed modifications to the standard health benefits plans that set forth the requirements for the coordination of benefits in the event that an individual who is covered under an individual plan retains that coverage after becoming eligible for Medicare.

(P.L.1997, c.146, sections 1 and 3 amending N.J.S.A. 17B:27A-2 and -6)

D. Preexisting Conditions Limitations and Credit for Prior Coverage

Neither HIPAA nor P.L.1997, c.146 amended the definition of a "preexisting condition" as it applies to the individual market. The definition provides for a six-month "look-back" period to examine whether a condition had manifested itself in such a manner that would cause an ordinarily prudent person to seek advice, care or treatment, or for which advice, diagnosis, care or treatment was recommended or received. The definition also provides that pregnancy is a preexisting condition. If a preexisting condition limitation applies, the limitation may last no longer than twelve months.

P.L.1997, c.146 introduces the concept of "creditable coverage," a defined term which includes most types of health coverage including individual health benefits plans, group health benefits plans including self-funded plans, and governmental sponsored plans including Medicare and Medicaid. A preexisting condition may not apply to an eligible person who has had "creditable coverage" with no intervening lapse in coverage of more than 31 days or if the person had satisfied a 12-month limitation under the prior plan. In addition to expanding the types of coverage which entitle a person to preexisting condition credit or waiver, the amendment to this provision extended the permissible lapse in coverage by one day to capture those persons that had a lapse in coverage during a month with 31 days. Persons who also meet the definition of a "federally defined eligible person" may not be subject to a preexisting condition limitation if such persons apply for coverage within 63 days of termination of his or her prior group coverage. In effect, an eligible individual who also meet the definition of a "federal defined eligible person," is permitted a longer permissible lapse in coverage. A federally defined eligible person is an eligible individual under State law with 18 months or more of creditable coverage, the most recent of which must have been a group health plan, governmental plan, or church plan, and has exhausted all federal and state continuation coverage.

(P.L.1997, c.146, sections 1 and 4 amending N.J.S.A. 17B:27A-2 and -7)

E. Assessment for Reimbursable Losses

P.L.1997, c.146 amends the assessment mechanism for the sharing of program losses among the members. The key changes to the assessment mechanism for reimbursement of losses include:

- A shift in the assessment from a one-year calculation period to a two-year calculation period, the first of which shall begin January 1, 1997 and end December 31, 1998.
- An increase in the loss ratio which a carrier must experience during the two-year calculation period such that reimbursement may not be sought unless a carrier's paid losses exceeds 115 percent of earned premium. The amendments removed the reasonable administrative expenses provision from the calculation of reimbursable losses.
- A change in the enrollment target to measure "person life years." Carriers filing for an exemption must agree to cover a minimum number of non-group person life years on an open enrollment, community rated basis. Thus, enrollment for the purpose of an exemption will no longer be measured based solely on the number of non-group persons enrolled as of December 31, but will rather be calculated based on enrollment during the entire calculation period.
- Pursuant to regulations to be proposed by the IHC Board, carriers must determine the number of non-group person life years it has covered by adding the number of non-group persons covered on the last day of each calendar quarter of the two-year calculation period, taking into account the limitations that exist on counting Medicaid recipients and Medicare cost and risk lives. That total is then divided by eight.
- The removal of the provision which provided that no carrier shall be liable for an assessment which exceeds 35 percent of the aggregate net paid losses of all carriers.

Please note that while the Senate Health Committee Statement to Senate Committee Substitute for Senate, No. 2192 refers to use of "incurred claims" as the basis for the reimbursement formula, the law still refers to "paid claims." The IHC Board believes that the Committee Statement is inaccurate.

(P.L.1997, c.146, sections 1 and 6 amending N.J.S.A. 17B:27A-2 and -12)

F. Hospital and Medical Service Corporation Plans

The definition of "carrier" in the IHC Act did not previously include hospital and medical service corporation entities. The amendments to the IHC Act modify the definition of "carrier" to include hospital and medical service corporations. Pre-reform plans issued by such entities are not subject to the requirements of the IHC Act except to the extent such plans are guaranteed renewable. Individual health benefits plans issued by hospital and medical service corporations after August 1, 1993 are subject to most of the features of reform in the individual market including guaranteed issuance, guaranteed renewability, loss ratio requirements, and limitations on preexisting conditions, but are not subject to the assessment mechanism.

(P.L.1997, c.146, sections 1, 2, and 6 amending N.J.S.A. 17B:27A-2, -3 and -12)

G. Miscellaneous Amendments

References to “the effective date of this [the IHC] act” were changed to August 1, 1993 to reflect the date carriers first issued the standard health benefits plans.

(P.L.1997, c.146, sections 2 and amending N.J.S.A. 17B:27A-3)

II. AMENDMENTS TO THE SMALL EMPLOYER MARKET

A. Definition Changes

P.L.1997, c.146 modifies the following definitions: “carrier,” “community rating,” “eligible person,” “health benefits plan,” “late enrollee,” “net earned premium,” “small employer,” and “stop loss or excess risk.”

In addition, the amendments include the addition of the following definitions: “church plan,” “creditable coverage” (this term, in effect, replaces the term “qualifying previous coverage”), “enrollment date,” “governmental plan,” “group health plan,” “health status-related factor,” “medical care,” “plan sponsor,” and “preexisting condition exclusion” (the amendments also delete the definition of “preexisting condition”).

(P.L.1997, c.146, section 7 amending N.J.S.A. 17B:27A-17)

B. Modified Community Rating

P.L.1997, c.146 makes the current system of modified community rating permanent. Modified community rating allows the highest rates charged to small employers to be no greater than 200 percent of the rate charged to the lowest rated small employer. The permissible rating factors continue to be limited to age, gender, and geographic location of the employer and the family status of the employees.

(P.L.1997, c.146, sections 7 and 11 amending N.J.S.A. 17B:27A-17 and -25)

C. Guaranteed Issuance and Exceptions

As noted above, P.L.1997, c.146 modifies the definition of “small employer.” A small employer is now defined as a group of two to 50 employees. The measurement of the size of the group has changed as well. An employer group must be engaged in business and is measured by determining the average number of eligible employees in the preceding calendar year. As was previously the case, a majority of the employees of the group must be employed in New Jersey. The law also provides that all persons treated as a single employer under “subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. section 414) shall be treated as one employer.” In the case of an employer that was not in business the previous calendar year, the size of the group is determined by the number

of eligible employees that it reasonably expected the employer will employ on business days in the current calendar year. New employer entities that are shown to have purposefully misrepresented the expected number of eligible employees shall be considered to have committed fraud. The law no longer excludes a State, county or municipal body, agency, board or department from the definition of a small employer.

(P.L.1997, c.146, section 7 amending N.J.S.A. 17B:27A-17)

The standard small employer health benefits plans had required that an employee must be actively at work on the effective date in order for coverage to take effect. HIPAA, however, prohibits discrimination against individual participants and beneficiaries based on a health status-related factor. The SEH Board has interpreted this provision in HIPAA to prohibit an “actively at work” requirement that would be based on a health status-related factor. As a result, it is the SEH Board’s understanding of the impact of HIPAA on the small employer market that carriers may no longer apply an actively at work requirement if the eligible employee excluded from coverage is not actively at work due to a health status-related factor. Amendments to the standard policy forms give carriers the option of eliminating the actively at work requirement entirely or to limit its application to those eligible employees not actively at work for other than a “health status-related factor.”

(HIPAA, section 2702)

D. Guaranteed Renewability and Exceptions

All standard small employer health benefits plans are guaranteed renewable at the option of the policy or contractholder. The amendments modified the existing exceptions to this requirement and added others. Specifically, the law provides that a carrier may *discontinue* a plan if:

- the policy or contract holder has failed to pay premiums in accordance with the terms of the policy or contract if the carrier has not received timely payments; or
- the policy or contract holder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.

The amendments also provide that a carrier may *nonrenew* a small employer health benefits plan only under the following circumstances:

- the small employer has not met the carrier’s minimum participation requirements;
- the small employer has not met the carrier’s minimum contribution requirements;
- the small employer carrier has filed to cease doing business in the small employer market;
- in the case of plans issued through an association or a trust of employers, an employer ceases to maintain its membership in the trust or association, but only if coverage is terminated uniformly without regard to an health status-related factor of any covered person;
- the small employer carrier has ceased to offer and renew a particular type of plan option or if the SEH Board discontinues a standard health benefits plan;
- the small employer no longer has any enrollee in the small employer’s plan that lives, resides, or works in the service area of the HMO carrier; and

- the small employer no longer meets the definition of “small employer” under the law.

(P.L.1997, c.146, sections 7 and 10 amending N.J.S.A. 17B:27A-17 and -23)

E. Preexisting Conditions Limitations and Prior Credit

P.L.1997, c.146 adds the definition of a “preexisting condition exclusion” and amends the consequences of a preexisting condition limitation. Preexisting condition limitations are still limited to groups of two to five eligible employees and to late enrollees, and the limitation period may not exceed 180 days following the enrollment date of coverage. However, the amendments provide that pregnancy may no longer be considered a preexisting condition. The amendments also remove the “prudent person” concept, and thus limit the application of a preexisting condition limitation to situations where the condition was manifested during the six months immediately preceding the “enrollment date” and for which medical advice, diagnosis, care, or treatment was recommended or received during those six months. The enrollment date is the date of enrollment of the person in the health benefits plan or, if earlier, the first day of the waiting period for such enrollment.

P.L.1997, c.146 replaces the definition of “qualifying previous coverage” with “creditable coverage,” a defined term which includes most types of health coverage including individual health benefits plans, group health benefits plans including self-funded plans, and governmental sponsored plans including Medicare and Medicaid. To those persons who may be subject to a preexisting condition limitation as a late enrollee or part of a group of two to five employees, a carrier must provide credit for the prior “creditable coverage” if that prior coverage ended not more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under the new plan. Carriers may provide credit in one of two ways: (1) without regard to the specific benefits covered in the prior plan; or (2) based on the coverage of benefits within certain classes or categories of benefits specified by federal regulation. Carriers that select that second option, must provide credit with respect to any class of benefits contained in the previous plan, and must comply with all federal notice requirements.

(P.L.1997, c.146, sections 7 and 9 amending N.J.S.A. 17B:27A-17 and -22)

F. Stop Loss Coverage

P.L.1997, c.146 amends the definition of “stop loss” or “excess risk insurance” by reducing the minimum permissible per person attachment point or retention from \$25,000 per covered person per plan year to \$20,000.

(P.L.1997, c.146, section 7 amending N.J.S.A. 17B:27A-17)

G. Loss Ratio Requirements

P.L.1997, c.146 amends the loss ratio requirements by permitting carriers to aggregate their losses in the standard policy forms and in all non-standard policy forms, rather than require the loss ratios for each policy form be calculated separately.

(P.L.1997, c.146, section 11 amending N.J.S.A. 17B:27A-25)

H. Medical Savings Accounts

P.L.1997, c.146 requires the SEH Board to ensure that the means exists for a carrier to offer high deductible health benefits plan options that would qualify under HIPAA for use with tax-deductible medical savings accounts. Pursuant to N.J.S.A. 17B:27A-19i, any carrier may file with the Department of Banking and Insurance a nonstandard optional benefit rider of decreasing value amending the benefits in the standard plans, and thus provides carriers with a means to offer high deductible plan options.

(P.L.1997, c.146, section 13 amending N.J.S.A. 17B:27A-33)

I. Miscellaneous Amendments

P.L.1997, c.146 repeals N.J.S.A. 17B:27A-23.1 which required notification to small employers of ineligibility for small employer plan within 60 days prior to the termination of the policy or contract.

(P.L.1997, c.146, section 28 amending N.J.S.A. 17B:27A-23.1)

P.L.1997, c.192
Effective February 3, 1998

The Health Care Quality Act, enacted on August 7, 1997, generally addresses patient protections under managed health care plans and the rules governing the carrier and provider relationship. The HCQA is effective on February 3, 1998.

The law provides that no “health benefits plan” may be issued or renewed on or after February 3, 1997 unless the plan meets all applicable requirements of that law and any regulations adopted pursuant to that law. Both the IHC and SEH Boards are reviewing the HCQA to determine whether the Act will require any modifications to either the standard IHC plans or the standard SEH plans, or either Programs’ regulations.

(P.L.1997, c.192, sections 23 and 24; N.J.S.A. 17B:27A-7.3 and -19.5)

One of the key provisions in the HCQA is a requirement that certain managed care plans offer a point of service plan with both in-network and out-network benefits to all “contract holders.” The term “contract holder” is a defined term which refers to an employer or organization. The HCQA outlines various requirements for such POS plan designs.

(P.L.1997, c.192, section 10)

Carriers must file information with the Commissioner of the DOHSS which includes basic identification data as well as a description of the internal patient appeals process available to covered persons to contest a denial, reduction or termination of benefits.

(P.L.1997, c.192 section 3)

Carriers must provide written disclosure to subscribers of the terms and conditions of coverage including covered services and benefits, restrictions or limitations, financial responsibility, prior authorization requirements, where and how to access services, changes in covered services, appeal information, and the procedure to initiate an appeal through the Independent Health Care Appeals Program. Carriers must provide a current provider directory and give prompt notice of termination or withdrawal of a person’s PCP. The financial incentives between the carrier and providers must be disclosed along with other provider data.

(P.L.1997, c.192, sections 4 and 5)

A licensed physician must serve as a medical director of managed care plans or plans that use utilization management features. The Act sets forth standards for the medical director.

(P.L.1997, c.192, section 6)

The HCQA establishes an Independent Health Care Appeals Program. The purpose of the Program is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person.

(P.L.1997, c.192, section 11)

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