NEW JERSEY
SMALL EMPLOYER HEALTH BENEFITS PROGRAM
20 West State Street, 10th floor
CN 325
Trenton, NJ 08625
Fax: (609) 633-2030

ADVISORY BULLETIN
96-SEH-07

To: **SEH Program Members**
From: **The Small Employer Health Benefits Program Board**
Re: **Standard Health Benefits Plans**
Date: **September 30, 1996**

The Small Employer Health Benefits ("SEH") Program Board has become aware, through a variety of channels, that a number of carriers are issuing and renewing "standard" health benefits plans that are inconsistent with the Board's standard forms. This is being done despite the fact that carriers are required to sign a Certification of Compliance (Exhibit BB, Part 1), certifying the use of the standard forms. Some of the inconsistencies are the result of a failure to incorporate adopted amendments to the standard forms, some inconsistencies are the result of carriers modifying the plans in a manner inconsistent with the guidelines set forth in the explanation of brackets, and some inconsistencies appear to be the result of a failure to correctly incorporate the text to issue the standard plans through or in conjunction with a selective contracting arrangement.

This bulletin is intended to clarify the provisions of the standard plans, and to advise carriers that any **nonconforming plans must be brought into compliance with the standard forms immediately.** Carriers may accomplish this by using a compliance and variability rider, as permitted by N.J.A.C. 11:21-4.4 and Exhibit DD, or by issuing new forms. The SEH Board or the New Jersey Department of Banking and Insurance ("DOBI") will perform investigations, including but not limited to, random market conduct surveys to determine compliance with the Board's regulations. If the SEH Board finds that a carrier has issued a nonconforming plan, it may refer the matter to the Enforcement and Consumer Protection Division of the DOBI for enforcement. Please be advised that any carrier issuing nonconforming plans is subject to fines and penalties permitted under law. Pursuant to N.J.S.A. 17B:27A-43, a carrier violating the SEH Act may be liable to a penalty of not less than $2000 and not greater than $5,000 for each violation. Each non-conforming plan issued to a small employer is considered a separate violation.

I. Codification of the Standard Plans and Regulatory Amendments

The Board's standard forms may be found in the Appendix to N.J.A.C. 11:21. Guidance on how the plans are to be structured is set forth at N.J.A.C. 11:21-3. Set forth below are the forms and the corresponding exhibits, and standard riders and corresponding exhibits.

Form	***Exhibit***	***Form***	***Exhibit***
Plan A	A	Plan A Certificate	V
Plan B	B and F	Plan B Certificate	W
Plan C	C and F	Plan C Certificate	W
Plan D	D and F	Plan D Certificate	W
Plan E	E and F	Plan E Certificate	W
HMO Contract	G	HMO Evid. of Coverage	Y
HMO/POS Contract	HH	HMO/POS Evid. of Cov.	II
Plans A - E Explanation of Brackets	K, Part 1	Plans A - E Certificate Explanation of Brackets	X, Part 1
HMO Explanation of Brackets	K, Part 2	HMO Evidence of Coverage Explanation of Brackets	X, Part 2

Rider	***Exhibit***	***Rider***	***Exhibit***
Prescription Drug for Plans B - E: Mail/Card Card Mail	 H, Part 1 H, Part 2 H, Part 3	Prescription Drug for Plans B - E Certificates: Mail/Card Card Mail	 Z, Part 1 Z, Part 2 Z, Part 3
Mental and Nervous Conditions and Substance Abuse for Plans B - E	I	Mental and Nervous Conditions and Substance Abuse for Plans B - E Certificates	Z, Part 4
Prescription Drug for HMO: Mail/Card Card Mail	 J, Part 1 J, Part 2 J, Part 3	Prescription Drug for HMO Evid. of Coverage: Mail/Card Card Mail	 AA, Part 1 AA, Part 2 AA, Part 3

The up-to-date standard forms are available on computer disk. The Board also has its regulations (although not all of the Exhibits in the Appendix) on computer disk. If you would like to receive a copy of the standard forms on disk, or the Board's regulations, please send a check for $10, made payable to the "SEH Program," to the SEH Board at the address above, indicating whether you wish to receive HMO forms or non-HMO forms or both.

Since the adoption of the initial standard health benefits plans in late 1993, the SEH Board has adopted two amendments to the standard forms. These changes should be reflected in the standard forms

now being issued and renewed by carriers. For your reference, set forth below are the *New Jersey Register* cites of the proposed and adopted changes to the standard forms.

Proposal	***Adoption***	***Effective Date***
7/18/94 at 26 N.J.R. 2843	10/3/94 at 26 N.J.R. 4066	9/11/94
8/21/95 at 27 N.J.R. 3051	11/6/95 at 27 N.J.R. 4371	1/1/96

II. Modifications to the Standard Plans; Non-standard Optional Benefit Riders

Modifications to the standard policy forms are permitted only if consistent with the Explanation of Brackets, as set forth in the Appendix to N.J.A.C. 11:21, or if a carrier has filed and received approval of alternative utilization review language pursuant to N.J.A.C. 11:21-4.2**. Carriers may not substitute, remove or add any text to the standard forms except as provided above.** Thus, for example, a carrier may not substitute terms that it believes are synonymous with terms in the standard forms. If you believe that there is a typographical error in either the *New Jersey Administrative Code* or in the computer disks, you should write to the SEH Board at the address or fax number above to receive permission to correct the text. This will help to avoid any misunderstandings and to assist the Board in correcting any errors.

Carriers may file non-standard optional benefit riders to amend the benefits in the standard plans. Riders of increasing value are filed with the SEH Board pursuant to rules set forth at N.J.A.C. 11:21-3.2(d); riders with a benefit decrease or decreases must be filed with the Commissioner for approval. If changes to the standard forms are not consistent with the explanation of brackets, then the change may be accomplished only via an optional benefit rider. Carriers offering optional benefit riders may not incorporate the text of the rider into the standard forms in providing the amended benefits. The standard plans must be offered to small employers both with and without the optional benefit riders. This will help to ensure that consumers may still compare the standard base plans. If a carrier withdraws a rider filing, or if the SEH Board finds an optional benefit rider to be incomplete and not in substantial compliance, the carrier must cease issuing and renewing the rider until the carrier receives notice from the Board that the rider may be issued and renewed.

III. Rate Filings

Before any plan, standard rider, or non-standard rider may be sold in the small employer market, a carrier must file rates for the plan, standard rider, or non-standard rider with the DOBI pursuant to N.J.A.C. 11:21-9.

IV. Plans Sold Through or in Conjunction with a Selective Contracting Arrangement

Carriers offering Plans A through E through or in conjunction with a selective contracting arrangement ("SCA") must have received approval of its SCA from the DOBI prior to offering its SCA plans in the small employer market.

N.J.A.C. 11:21-3.1 and the standard policy forms, particularly the example schedule pages, found in the appendix to N.J.A.C. 11:21, describe the standard benefit designs for plans sold through or in conjunction with an approved SCA. For the purpose of this Bulletin, reference will be made to Preferred Provider Organization (PPO) and Point of Service ("POS") plans. The starting point for either a PPO or a POS plan must be one of the standard plans A, B, C, D or E. Guidelines for Plan A sold through or in conjunction with a selective contracting arrangement are set forth at N.J.A.C. 11:21-3.1(e). Guidelines for Plans B through E sold through or in conjunction with an SCA are set forth at N.J.A.C. 11:21-3.1(d). The

following discussion will be limited to a discussion of PPO or POS plans developed from Plans B through E.

After selecting one of the standard plans as the starting point, the carrier must designate that Plan as being either the network or non-network coverage. The carrier then either builds up or down from the standard plan to create the corresponding network or non-network coverage.

Example 1: -Plan C (Carrier coinsurance 70 percent/ Covered Person 30 Percent) selected
-Designated non-network.
-Building up, the carrier must select the coinsurance of one of the standard plans, here the HMO plan, as the network level of coverage, creating a 100/70 plan.

Example 2: -Plan E (Carrier coinsurance 90 percent/Covered Person 10 percent) selected
-Designated as network.
-Building down, the carrier selects the coinsurance of Plan B as the network level of coverage, creating a 90/60 plan.

A PPO plan may provide for copayments which would apply in lieu of the deductible and coinsurance for any service to which the copayments apply. Using the copayment options available in the standard HMO contract, a carrier selects one or more of the services that would be subject to a copayment when service is supplied by a network provider. Please note that the coinsurance following any copayment must be 100 percent, regardless of the network coinsurance requirement. A POS plan differs from the PPO plan with copayments by including a gatekeeper requirement.

While standard indemnity Plans A through E use a “Coinsurance Cap” (which is not an “out-of-pocket” amount, but rather represents the maximum amount a covered person may be responsible for as a result of his or her coinsurance share), the PPO and POS configurations use a “Coinsurance Charge Limit.” The standard PPO and POS plans specify a non-variable $10,000 Coinsured Charge Limit. All Covered Charges, whether services are obtained from network or non-network providers, accumulate toward the common $10,000 Coinsured Charge Limit. Benefits are payable at 100 percent after the Coinsured Charge Limit has been satisfied.

V. Carrier Suggestions for Modification to the Standard Forms

Carriers and other interested parties are invited to contact the SEH Board at any time with suggested modifications to the standard health benefits forms. The SEH Board intends to conduct periodic reviews of its standard forms to determine whether benefit changes or modifications to the forms are needed. The SEH Board will duly consider all suggested benefit changes and modifications. Of course, the Board is aware of the expense of requiring carriers to modify the forms and will consider the impact of any benefit modifications on the cost of providing those benefits and the administrative cost of modifying the plans.