INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Individual Health Benefits Plans

Adopted Amendments: N.J.A.C. 11:20-1.2, 12.4, 24.2A, 24.4 and N.J.A.C. 11:20 Appendix Exhibits A and B

Authorized By: New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director.

Authority: N.J.S.A. 17B:27A-2 et seq.

Proposed: August 17, 2017

Adopted: October 10, 2017 by the New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director

Filed: as R. 2017 d. ____ **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Effective Date:

Operative Date: January 1, 2018

Expiration Date:

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Individual Health Coverage Program Board (IHC Board) held a hearing on Thursday, August 31, 2017 at 9:00 A.M. at the Department of Banking and Insurance, 11th floor Conference Room, 20 West State Street, Trenton, New Jersey to receive testimony with respect to the proposed amendments to the standard health benefits plans, set forth in Exhibits A and

B of the Appendix to N.J.A.C. 11:20. Ellen DeRosa, Executive Director of the IHC Board, served as hearing officer.

No persons came to the hearing. The hearing officer made no recommendations regarding the proposed amendments. The hearing record may be reviewed by contacting Ellen DeRosa, Executive Director, New Jersey Individual Health Coverage Program Board, P.O. Box 325, Trenton, NJ 08625-0325.

Summary of Public Comments and Agency Responses:

The IHC Board accepted comments on the proposal through September 6, 2017 and received no comments.

Summary of Agency-Initiated Changes

Upon further review of the requirements of 45 CFR 155.420(d), the IHC Board noted that the triggering event associated with an NJ FamilyCare determination of ineligibility applies only if that determination is made after the open enrollment period or special enrollment period ends. On adoption, the IHC Board is amending item 7 of N.J.A.C. 11:20-1.2 and item 7 of N.J.A.C. 11:20-24.2A(b) as well as item g in the triggering event definition in N.J.A.C. 11:20 Appendix Exhibits A and B to include the qualification that the determination is made after the open enrollment period or special enrollment period ends.

The IHC Board noted that although the proposal summary described a number of amendments to the list of triggering events in N.J.A.C. 11:20-1.2 and N.J.A.C. 11:20-24.2A(b) as well as the definition of triggering event as it appears in Appendix Exhibits A and B, the revisions were not consistently made in the Appendix Exhibits. On adoption the IHC Board is

correcting the triggering event definitions in N.J.A.C. 11:20 Appendix Exhibits A and B as follows:

a) The missing word “carrier” is added to item j.

b) The term “dependent” replaces the term “eligible person” in item k. (Exhibit B only)

c) The reference to “state regulatory agency” is added to item l.

The IHC Board noted that although the proposal summary stated that the definition of virtual visit was being deleted, it was inadvertently retained in N.J.A.C. 11:20 Appendix Exhibit B. The definition is being deleted upon adoption.

The IHC Board determined that the following amendments to N.J.A.C. 11:20 Appendix Exhibits A and B are necessary to better align with the requirements of P.L. 2017, c. 117:

The specification of telemedicine and telehealth is not specifically illustrated on the schedule pages. Since telemedicine and telehealth are alternate means for a network practitioner to provide services, the cost sharing shown on the schedule for the applicable practitioner services applies to the telehealth or telemedicine services and it is unnecessary to include specific cost sharing for telemedicine or telehealth services. However, if a carrier elects to apply different cost sharing for certain telemedicine or telehealth services, such as those provided through a telemedicine or telehealth vendor, where the different cost sharing is less than or equal to the cost sharing for an in-person visit, the carrier may specifically list those telemedicine and telehealth services on the schedule with the applicable cost sharing requirement.

The variable brackets around the definitions of telehealth and telemedicine have been removed. The IHC Board determined that the definitions must always be included to address situations in which network practitioners provide services via telemedicine or telehealth.

The variable brackets for the telehealth and telemedicine provision have been removed and the text has been clarified to explain that telehealth and telemedicine are covered charges if a network practitioner provides medically necessary services using telehealth or telemedicine. The IHC Board recognizes that network practitioners may or may not provide services using telehealth or telemedicine. To the extent a covered person uses a network practitioner that does provide services using telehealth or telemedicine consistent with the requirements of P.L. 2017, c. 117, the telehealth or telemedicine visit is covered.

The variable brackets in the telephone consultations exclusion have been adjusted so the exclusion is either used or not used, and if it is used, there is an exception for telehealth and telemedicine.

On adoption, the IHC Board is making necessary typographical and grammatical corrections.

Federal Standards Analysis

State agencies that propose to adopt or amend State rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. As discussed in the Summary above, some of the proposed amendments are intended to comply with Federal law, 45 CFR 155.420(d), 45 CFR 147.104 and 45 CFR 155.410. The proposed amendments do not exceed the requirements of 45 CFR 155.420(d), 45 CFR

147.104 or 45 CFR 155.410. Consequently, the IHC Board does not believe a Federal standards analysis is required.

§ 11:20-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

. . .

"Triggering event" means an event that results in an individual becoming eligible for a special enrollment period. Triggering events are:

1-6 (No change)

7. The date NJFamilyCare determines an applicant whose application was submitted during the open enrollment period or during a special enrollment period is ineligible **if that determination is made after the open enrollment period or special enrollment period ends**.

8 - 12. (No change)

§ 11:20-24.2A Triggering events that result in special enrollment periods

(a) (No change).

(b) The dates listed below are triggering events. A loss of coverage resulting from nonpayment of premium, fraud, or misrepresentation of material fact shall not be a triggering event.

1 - 6 (No change)

7. The date NJFamilyCare determines an applicant whose application was submitted during the open enrollment period or during a special enrollment period is ineligible **if that determination is made after the open enrollment period or special enrollment period ends;**

8 – 12 (No change)

(c) (No change)