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ADVISORY BULLETIN
04-SEH-02

August 11, 2004

To: SEH Program Member Carriers and Interested Parties

From: Ellen DeRosa,
Deputy Executive Director

Re: Policy Form Changes Operative October 1, 2004

The New Jersey Small Employer Health Benefits Program Board ("SEH Board") recently adopted a number of changes to the standard health benefits plans, Plans A, B, C, D, E, HMO and HMO/POS. A copy of the adoption text was published in the *New Jersey Register* on March 15, 2004 at 36 N.J.R. 1594(a) and is posted on the Department of Banking and Insurance ("DOBI") web site at: http://www.nj.gov/dobi/reform.htm. The changes are operative for new issues and renewals occurring on or after October 1, 2004.

This Advisory Bulletin includes a spreadsheet that summarizes all the plan changes that affect coverage, specifies the reason each change was made, and identifies the plan or plans affected by the change. Please refer to N.J.A.C. 11:21 and the Appendix Exhibits for the regulatory language associated with each change.

Some of the Board initiated changes to plan specifications represent significant changes to the plans as they have existed for the past ten years. This Advisory Bulletin will discuss the consequence of the changes which may give rise to questions from employers and covered persons. Many of the changes to plan specifications provide significant flexibility to carriers in terms of the cost sharing permitted in the standard plans. As a result, the standard plans issued by one carrier may differ significantly from the standard plans issued by another carrier.

Discussion of Some of the Changes

Pre-Approval

For plans issued or renewed on or after October 1, 2004, the definition of Pre-Approval contained in the standard plans is as follows:

> **Pre-Approval or Pre-Approved** means the [Carrier's] approval using paper or electronic means for specified services and supplies prior to the date charges are incurred. [Carrier] will reduce benefits by 50% with respect to charges for treatment, services and supplies which require Pre-Approval and are not Pre-Approved by [Carrier] provided that benefits would otherwise be payable under this Policy.

For any plan issued or renewed on or after October 1, 2004, carriers ***may*** require pre-approval for speech, cognitive rehabilitation, occupational and physical therapies and/or ***may*** require pre-approval for certain prescription drugs. It will be essential that employers and persons covered under the plans be made aware of the requirement, if any, to secure pre-approval for these services.

For any plan issued or renewed on or after October 1, 2004, carriers ***will*** require pre-approval for the exchange of unused inpatient days for non-biologically based mental illness and substance abuse for additional outpatient visits. Since covered persons were previously able to request an exchange of inpatient days weeks or even months after using the additional visits, it would be helpful to highlight this change in renewal materials.

Emergency Room Copayment

The definition of Copayment in the standard plans has been and will continue to be as follows:

> **Copayment** means a specified dollar amount a Covered Person must pay for specified Covered Charges. **Note**: The Emergency Room Copayment, if applicable, must be paid in addition to the Cash Deductible, any other Copayments, and Coinsurance.

As a result of numerous inquiries from persons who erroneously believed the copayment represented their payment in full for the emergency room services, the standard plans now include text on the schedule page to further explain that the copayment is in addition to the applicable deductible, coinsurance or copayment.

Carriers may impose an emergency room copayment of $50, $75 or $100.

Therapy Services

Coverage for speech, cognitive rehabilitation, occupational and physical therapies in the HMO plan and the network portion of an HMO-POS plan was subject to a 60-day limit per incident of illness or injury. Coverage for speech, cognitive rehabilitation, occupational and physical therapies in an indemnity, PPO or POS plan was subject to a 30-day limit per calendar year, where the limit applied to speech therapy and cognitive rehabilitation therapy, combined, and to occupational therapy and physical therapy, combined.

For ***all*** plans issued or renewed on or after October 1, 2004, coverage for speech therapy and cognitive rehabilitation therapy, combined, will be limited to 30 visits per calendar year and coverage for occupational therapy and physical therapy, combined, will be limited to 30 visits per year. As noted above, this coverage may require carrier pre-approval.

Preventive Care

For plans issued or renewed on or after October 1, 2004, the provision of preventive care in non-HMO plans is as follows:

> [Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment. But [Carrier] limits what [Carrier] pays each Calendar Year to:
> a) $750 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1;
> b) $500 per Covered Person for all other Covered Persons.
>
> These charges are not subject to the Cash Deductible or Coinsurance.

Coverage is also provided for mammography and colorectal cancer screening in other provisions of the standard plans. Covered Persons may choose to have a mammography or colorectal cancer screening and have the charges applied against the $500 benefit per year. If the $500 benefit has already been exhausted, or if the covered person wishes to save the $500 allowance for another preventive service, coverage for a mammography or colorectal cancer screening would be subject to the deductible and coinsurance provisions of the plan.

HMO-Based Plans

HMO-based plans have featured copays of $5, $10, $15, $20 and $30. For plans issued or renewed on or after October 1, 2004, the copays may also be $40 or $50. Additionally, the maternity copay, which is required only for the initial visit may be $25, as it has been for the past ten years, or it may be consistent with the physician visit copay under the plan.

HMO-based plans may feature deductible and coinsurance provided that deductible and coinsurance may not be applied to preventive care. Such plans must include a network maximum out of pocket that cannot exceed $5,000 per year. In addition to N.J.A.C. 11:21, please refer to N.J.A.C. 11:22-5.2 – 5.5 for guidance regarding plans that use deductible and coinsurance.

Cash Deductible

The standard plans have featured deductibles of $250, $500 and $1000, and more recently $2500. For plans issued on or after October 1, 2004, carriers may offer deductibles in any amount from $250 to $5,000. However, in a network-based plan, a network deductible cannot exceed $2500. Refer to N.J.A.C. 11:22-5.3(a)2.

In a network-based plan, carriers may elect to apply a separate deductibles to network and non-network services, or may apply one deductible amount to both network and non-network services.

Maximum Out of Pocket (MOOP)

For the past ten years, the standard plans have featured a coinsurance cap for pure indemnity plans and a coinsured charge limit for PPO and POS and HMO-POS plans. The amount of the coinsurance cap varied based on the standard plan, with Plan D, for example, using a $2,000 coinsurance cap. The amount of the coinsured charge limit was fixed at $10,000, regardless of the plan. The coinsurance cap and coinsured charge limit were terms to define a limit on the covered person's exposure for covered charges.

For plans issued or renewed on or after October 1, 2004, the Maximum Out of Pocket provision *replaces* the coinsurance cap and coinsured charge limit features and will define a limit on the covered person's exposure for covered charges.

For plans issued or renewed on or after October 1, 2004, Maximum Out of Pocket is defined as follows:

> Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Carriers must be guided by N.J.A.C. 11:22-5.4 in setting the dollar amount of the maximum out of pocket.

Carriers may set a maximum out of pocket that applies separately to network and non-network services. Carriers may set a combined maximum out of pocket that applies to both network and non-network services.

Conclusion

As stated above, the full text of the forms adoption, which includes the text of the standard plans, is available on the Department's web site, http://www.nj.gov/dobi/reform.htm. If you are interested in further information regarding any of the changes listed on the chart, or described in the Advisory Bulletin, please consult the regulations and the standard plans.