NEW JERSEY
SMALL EMPLOYER HEALTH BENEFITS PROGRAM
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ADVISORY BULLETIN
97-SEH-06

To: **SEH Program Members**
From: **Ellen DeRosa, Assistant Director**
Re: **Model Rider For Plans Issued With A Medical Savings Account**
Date: **June 26, 1997**

This Bulletin is a follow-up to Bulletin 96-SEH-09 which offered assistance to carriers in submitting nonstandard rider filings which increased the deductible under the standard plans. The SEH Board advised SEH Program members that it had attempted to craft the model rider so that the standard plans, as ridered, would be consistent with the requirements of HIPAA with respect to high deductible plans that could be used with an MSA plan design. The SEH Board further advised member carriers that it was the responsibility of the member carrier to make sure that the plans, as ridered, were consistent with federal regulations.

The SEH Board reviewed recently released Revenue Ruling 97-20 issued by the Internal Revenue Service which discusses what constitutes a high deductible plan in the case of family coverage. In light of this new information, the SEH Board issues this to modify Bulletin 96-SEH-09.

As set forth in Bulletin 96-SEH-09, the SEH Board structured the family deductible in the model rider in a manner consistent with general industry practice with respect to the satisfaction of the individual and family deductibles. Rev. Rul. 97-20 however, provides that in the case of family coverage, the high deductible health plan may not provide *any* benefits until the *family* has incurred covered charges which exceed at least $3000 but not more than $4500. Out-of Pocket expenses for family coverage may not exceed $5500. Thus, in the case of family coverage, there is no provision for the satisfaction of an individual deductible.

Accordingly, the SEH Board has revised the model rider. The Department of Banking and Insurance has again indicated that submissions of filings consistent with the attached revised model rider will facilitate prompt review of the filings; filings which depart from the attached revised model will require further review and consideration. The Department further requests that carriers which submit riders which deviate from the attached model rider identify differences from the model rider and briefly explain the reason for the differences.

Again, the SEH Board recommends that carriers provide disclosure to customers concerning the limited availability of MSAs.

Rev. Rul. 97-20 offers a limited period of relief with respect to high deductible plans effective prior to November 1, 1997 that considered the satisfaction of an individual deductible within a plan that provided family coverage. Carriers should refer to Rev. Rul. 97-20 for guidance concerning the duration of this limited period.

Note to Carriers:

Carriers may use the following text, with appropriate variables, as described below, to create an optional benefit rider of decreasing value, to be filed with the Department of Banking and Insurance.

The term *Certificate* is variable since some carriers may use another term to identify the document provided to employees.

References to *Dependent* coverage are variable since some plans may provide employee only coverage.

The *Calendar Year Cash Deductible* shows the least and greatest amounts permitted under HIPAA. Carriers should include the amounts they intend to make available.

The *Emergency Room Copayment* may be deleted at the option of the carrier.

The *Coinsurance* text includes the separate Mental or Nervous Condition percentage that would be used if the plan being amended is Plan D or E.

The *Copayment* definition should be included if the Emergency Room Copayment is not used in the MSA plan.

The names of the provisions in the *Benefit Provision* should reflect the actual text being amended by the rider.

A carrier may elect to adapt this model rider for use with a managed care plan (PPO or POS). Changes similar to those made for an indemnity plan should be made to the PPO or POS schedule page text.

Section: **SCHEDULE OF INSURANCE AND PREMIUM RATES (Policy) and SCHEDULE OF INSURANCE ([Certificate])**
Subsection: **EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS**

The **EMPLOYEE [AND DEPENDENT] HEALTH BENEFITS** subsection of the **SCHEDULE OF INSURANCE AND PREMIUM RATES** of the Policy and **SCHEDULE OF INSURANCE** of the[Certificate] is deleted and replaced with the following:

Calendar Year Cash Deductible

- for Preventive Care NONE
- for immunizations and lead screening for children NONE
- for all other Covered Charges
  - Per Covered Person [$1500 to $2250]
  - [Per Covered Family [$3,000 to $4500]

[Emergency Room Co-Payment (waived if admitted within 24 hours) $50]

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Out of Pocket Maximum has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows: [30%, 20%, or 10%] [**except as stated below]**

[Exception: for Mental and Nervous and Substance Abuse charges 25%]

Out of Pocket Maximum
[Per Covered Person $3000]
[Per Covered Family $5500]

Note**: The Out of Pocket Maximum** cannot be met with Non-Covered Charges.

NOTICE: THE CASH DEDUCTIBLE AND OUT OF POCKET PROVISIONS CONTAINED IN THIS RIDER ARE INTENDED TO PRODUCE A PLAN THAT COULD QUALIFY AS A HIGH DEDUCTIBLE PLAN WHICH MAY BE USED IN CONJUNCTION WITH A MEDICAL SAVINGS ACCOUNT (MSA) PLAN UNDER FEDERAL LAW. HOWEVER, ACTUAL QUALIFICATION OF A PARTICULAR PLAN WILL BE SUBJECT TO FEDERAL REGULATIONS

Daily Room and Board Limits

During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi private room and board rate.

For private room and board accommodations. [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge for the Special Care Unit.

During a Confinement In An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:
a. the centers actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- [Autologous Bone Marrow Transplant and Associated Dose Intensive Chemotherapy for treatment of breast cancer]
- Fertility Services
- Nutritional Counseling

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges
Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits

Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
[• for a Covered Person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person]
• for all [other] Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

Section: DEFINITIONS

[The definition of **Copayment** is deleted and replaced with the following:

> **Co-Payment** means a specified dollar amount a Covered Person must pay for specified Covered Charges.]

The definition of **Non-Covered Charges** is deleted and replaced with the following:

> **Non-Covered Charges** are charges which do not meet this Policy's definition of Covered Charges or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy. Penalties for Non-Compliance as contained in the Utilization Review Features section of the Policy and [Certificate] are also Non-Covered Charges.

[Section: HEALTH BENEFITS INSURANCE
Subsection: BENEFIT PROVISION
The provisions entitled: **The Cash Deductible**, [**Family Deductible Limit**] [**Per Covered Family**] and [**Co-Insurance Cap**] [**Coinsured Charge Limit**] are deleted and replaced with the following:

The Cash Deductible
THIS PROVISION APPLIES *ONLY* IN THE CASE OF EMPLOYEE ONLY COVERAGE
Each Calendar Year, the Covered Person must have Covered Charges that exceed the Per Covered Person Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

Per Covered Family
THIS PROVISION APPLIES *ONLY* IN THE CASE OF COVERAGE FOR AN EMPLOYEE PLUS ONE OR MORE DEPENDENTS

The Per Covered Family Calendar Year Cash Deductible is shown in the Schedule. Once any combination of Covered Persons in a family have incurred Covered Charges equal to the per Covered Family Cash Deductible, the per Covered Family Cash Deductible will have been met for the rest of that Calendar Year.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

Out of Pocket Maximum

The Out of Pocket Maximums "Per Covered Person" and "Per Covered Family" are shown in the Schedule. In the case of *Employee only coverage*, for a Covered Person, the Out of Pocket Maximum is the maximum amount of Covered Charges the Covered Person must pay as Cash Deductible *plus* Coinsurance [*plus* Copayments] during each Calendar year. Once the Per Covered Person Out of Pocket Maximum has been met during a Calendar Year, no further Cash Deductible, [or] Coinsurance [or Copayments] will be required for such Covered Person for the rest of the Calendar Year. In the case of *Employee plus Dependent coverage*, for each Covered Family, the Out of Pocket

Maximum is the maximum amount of Covered Charges the Covered Family must pay as Cash Deductible *plus* Coinsurance [*plus* Copayments] during each Calendar year. Once the Per Covered Family Out of Pocket Maximum has been met during a Calendar Year, no further Cash Deductible, [or] Coinsurance [or Copayments] will be required for such Covered Family for the rest of the Calendar Year.

Section: UTILIZATION REVIEW FEATURES
Subsection: REQUIRED HOSPITAL STAY REVIEW

The last paragraph of the **Penalties for Non-Compliance** provision is deleted and replaced with the following:

Penalties for Non-Compliance
Penalties cannot be used to meet this Policy's or [Certificate's]:
a) Cash Deductible; or
b) Out of Pocket Maximum

Section: UTILIZATION REVIEW FEATURES
Subsection: REQUIRED PRE-SURGICAL REVIEW

The last paragraph of the **Penalties for Non-Compliance** provision is deleted and replaced with the following:

Penalties for Non-Compliance
Penalties cannot be used to meet this Policy's or [Certificate's]:
a) Cash Deductible; or
b) Out of Pocket Maximum