



State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
INDIVIDUAL HEALTH COVERAGE PROGRAM
PO Box 325
TRENTON, NJ 08625-0325

JON S CORZINE
Governor

TEL (609) 633-1882
FAX (609) 633-2030

DONALD BRYAN
Acting Commissioner

ADVISORY BULLETIN
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To: IHC Program Member Carriers and Interested Parties

From: Ellen DeRosa,
Deputy Executive Director

Re: IHC Policy Form Changes Operative July 1, 2006

The New Jersey Individual Health Coverage Program Board ("IHC Board") recently adopted significant changes to the standard health benefits plans, Plans A/50, B, C, D, HMO and the specimen Basic and Essential Health Care Services Plan ("B&E Plan"). Notice of the adoption text was published in the *New Jersey Register* on January 3, 2006 at 38 N.J.R. 311(a). On February 24, 2006 the Board adopted several additional changes to the standard plans and the specimen B&E Plan. Those additional amendments will be published in the *New Jersey Register* after the date of this Advisory Bulletin. Both the proposals and the adoptions for the changes are posted on the Department of Banking and Insurance ("DOBI") web site at: <http://www.njdobi.org/ihcpage.htm>. The standard plans and the specimen B&E Plan that are posted on the website include all adopted changes to the plans, both those adopted in January as well as those adopted in February, 2006. The changes are operative for new issues and renewals occurring on or after July 1, 2006. **Carriers with inforce individual health benefit plans must re-issue all inforce plans on the first anniversary on or after July 1, 2006.**

This Advisory Bulletin includes a spreadsheet that summarizes all the plan changes that affect coverage and specifies the reason each change was made. Please refer to N.J.A.C. 11:20 and the Appendix Exhibits for the regulatory language associated with each change.

Some of the Board initiated amendments to plan specifications represent significant changes to the plans as they have existed for the past dozen years. This Advisory Bulletin will discuss the consequence of the changes which may give rise to questions from covered persons. Some 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, carriers may offer some new plan designs in addition to the mandated standard

designs. In addition, several carriers have filed riders to offer with the B&E plan, further expanding the options available to a consumer shopping for a health plan.

Discussion of Some of the Changes

Termination of IHC Coverage

The standard plans and the specimen B&E Plan no longer immediately terminate IHC coverage upon a covered person becoming eligible for coverage under a Group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan. If a person who is **already covered** under an IHC plan becomes eligible to be covered under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, the person does **not** lose coverage under the IHC plan. However, eligibility for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan continues to make a person ineligible to **apply** for IHC coverage.

If the person chooses to remain covered under the IHC plan and does not enroll under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, the IHC plan will continue to pay benefits the same as before the person became eligible for the other coverage.

If the person chooses to remain covered under the IHC plan and enrolls under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, the IHC plan will pay benefits as secondary to the group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan. The Coordination of Benefits and Services provision of the IHC plans addresses the coordination.

Pre-Approval

For standard plans issued or renewed on or after July 1, 2006 the definition of Pre-Approval contained in the standard plans is as follows:

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

For any plan issued or renewed on or after July 1, 2006, carriers **may** require pre-approval for speech, cognitive rehabilitation, occupational and physical therapies, **may** require pre-approval for certain prescription drugs, and **may** require pre-approval for therapeutic manipulation. It will be essential that persons covered under the plans be made aware of the requirement, if any, to secure pre-approval for these services. Remember, one carrier may not require it, and another may. Persons changing coverage from one carrier to another should be particularly attentive to the pre-approval requirements under the replacement coverage.

For any plan issued or renewed on or after July 1, 2006, 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, this will be a significant change in terms of the timing for making the request. The exchange of benefits remains available. The change to the plans only serves to limit requests for exchange to those made prospectively.

Emergency Room Copayment

The definition of Copayment in the standard plans has been and continues 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 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.

The dollar amount of the Emergency Room Copayment increased from \$50 to \$100.

Preventive Care

For plans issued or renewed on or after July 1, 2006, the provision of preventive care in non-HMO plans is as follows:

Preventive Care

We cover charges for routine physical examinations including related laboratory tests and x-rays. We also cover charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, lead screening, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment. But We limit what We pay each Calendar Year to:

- a) \$750 per Covered Person for a Dependent child for the first year of life;
- b) \$500 per Covered Person for all other Covered Persons.

These charges are not subject to the Cash Deductible or Coinsurance.

The dollar amount of benefits increased from \$500/\$300 to \$750/\$500 to more adequately cover the costs associated with preventive services. 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 Plans

HMO plans have featured copays of \$10, \$15, \$20 and \$30. For plans issued or renewed on or after July 1, 2006, \$10 and \$20 copayment options have been eliminated, and \$40 or \$50 have been included. Carriers are required to offer the \$15 copayment and may

offer as many of the other options as they wish to make available. Some other copayment related changes include:

- The maternity copay, which is required only for the initial visit may be \$25, as it has been for the past dozen years, or it may be consistent with the physician visit copay under the plan.
- Carriers may require a higher copayment amount for specialist visits than for PCP visits.
- Carriers may require a higher copay for use of the hospital outpatient department than for use of an ambulatory surgical center for outpatient surgery services.

HMO 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. 11:20, 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 \$500, \$1,000, and \$2,500 and allowed deductible options of \$5,000 and \$10,000 as well as MSA and HSA compatible deductible options. For plans issued on or after July 1, 2006, carriers must offer \$1,000 and \$2,500 deductibles with all standard plans, and may offer \$5,000 and \$10,000 as well as HSA compatible deductible options. The \$500 deductible that was available with Plan D has been eliminated. Please note that for a network-based plan, a network deductible cannot exceed \$2,500. 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 dozen years, the standard plans have featured a coinsurance cap for indemnity plans and a coinsured charge limit for PPO 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 financial exposure for covered charges.

For plans issued or renewed on or after July 1, 2006, 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 indemnity plans, the dollar amount of the Maximum Out of Pocket will be consistent with the prior coinsurance cap plus the deductible amount.

For plans, other than HSA compatible plans, issued or renewed on or after July 1, 2006, Maximum Out of Pocket is defined as follows:

Maximum Out of Pocket

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. Except as stated below, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket. Except as stated below, 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.

Exception: Coinsurance paid for covered Prescription Drugs do not count toward the Maximum Out of Pocket. Such coinsurance must continue to be paid even after the Maximum Out of Pocket has been reached.

Please note the above exception as this represents a significant change to the standard indemnity plans. While charges incurred for prescription drugs will accumulate toward the deductible, coinsurance paid for prescription drugs will **not** accumulate toward the Maximum Out of Pocket. This means a person covered under the plan will continue to pay coinsurance for prescription drugs throughout the year. Such a requirement is consistent with the already-existing 50% coverage for prescription drugs under the standard HMO plans which includes no limit on the 50% coinsurance.

For network plans, 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.

When inforce plans are first renewed on or after July 1, 2006, the plans will be issued with a “**Plan Update Rider.**” This rider will ensure that *both* the deductible and the coinsurance satisfied under the plan prior to the renewal into the new plan will be credited to the new plan.

Elimination of Some Options

As noted above, the plans operative July 1, 2006 will no longer feature a \$500 deductible for Plan D or \$10 or \$20 copayments for HMO or PPO plans. Carriers must identify all inforce plans with such options and give appropriate notice of non-renewal pursuant to N.J.A.C. 11:20-18.7.

B&E Plan

All carriers are required to file revisions to their B&E plans consistent with the amendments made to the specimen B&E plan.

Reporting Forms

Carriers are required to file the Certification of Compliance, Exhibit E no later than 45 days following the July 1, 2006 operative date. This Exhibit E replaced former Exhibit Q.

Carriers are required to file the revised Exhibit L parts 1 and 2 beginning with the report filed for third quarter 2006, which is due November 14, 2006.

Period from January 3, 2006 until July 1, 2006

Since the amendments to the standard plans and the specimen B&E plan have a delayed operative date of July 1, 2006, the existing standard plans and specimen B&E Plan remain in effect until June 30, 2006. Similarly, the existing report form, Exhibit Q, Certification of Compliance is due March 1, 2006. The existing Enrollment report, Exhibit L Plat 1 will continue to be filed through the report for second quarter 2006.

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.njdoji.org/ihcpage.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.