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JUSTIN ZIMMERMAN
Acting Commissioner

December 28, 2023

To: IHC Program Member Carriers that Issue Coverage

From: Sandi Kelly
IHC Board Chair

Re: Adopted Amendments to Standard Plans A/50, B, C, D

The Individual Health Coverage Program Board (IHC Board) voted to adopt amendments to the standard health benefits plans on December 12, 2023. The Notice of Adoption was filed with the Office of Administrative Law on December 20, 2023 and is scheduled to appear in an upcoming *New Jersey Register*. The adopted amendments are effective January 1, 2024 and the Operative Date is April 1, 2024 The adoption is available at http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrulesadoptions.htm.

Recognizing that the process of reissuing policy and contract forms is both lengthy and costly the IHC Board determined it appropriate to give Carriers the option to implement the amendments by using the Compliance and Variability Rider set forth at N.J.A.C. 11:20 Appendix Exhibit D.

The text to be included on the Compliance and Variability rider is set forth below. IHC Board expects that carriers will work as expeditiously as possible to ensure that all individual plans issued on or after April 1, 2024 are issued with the rider text attached or with the newly adopted amendments embedded within the plan document. The amendments are effective as of January 1, 2024 and therefore policies issued or renewed January 1 through March 31 will need to be re-issued or amended by the Compliance and Variability rider no later than April 1, 2024.

Please email me with any questions at Sandi_L_Kelly@horizonblue.com

Compliance and Variability Rider Text for Plans A/50 - D

1. The **Policy Index** is amended to delete the section:

Effect of Medicare on an Individual Health Benefits Plan

2. The **DEFINITIONS** section is amended as follows:

a. Item b) in the definition of **Dependent** is deleted and replaced with the following:

b) Dependent child [who is under age 26][through the end of the calendar year in which he or she attains age 26].

b. The definition of **Practitioner** is deleted and replaced with the following:

Practitioner means a person We are required by law to recognize who:
a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b) provides medical services which are within the scope of his or her license or certificate.

For purposes of Applied Behavior Analysis as included in the Diagnosis and Treatment of Autism and Other Developmental Disabilities provision, Practitioner also means a person who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral or as a Board Certified Behavior Analyst.

As used in the Breastfeeding Support provision, Practitioner also means a person who is an International Board Certified Lactation Consultant or a Lactation Counselor as defined in P.L. 2019, c. 343.

As used in the Contraceptives provision, Practitioner also means a pharmacist authorized to furnish self-administered hormonal contraceptives as provided in P.L. 2023, c.2.

3. **Benefits From Other Plans** of the **Health Benefits Insurance** section is deleted and replaced with the following:

Benefits From Other Plans
The benefits We will pay will be affected by a Covered Person's being covered by Medicare. Read the provisions of **Coordination of Benefits and Services** to see how this works.

Impact of the Consolidated Appropriations Act (CAA) on Copayments, Deductible Amounts, and/or Coinsurance, Maximum Out of Pocket Amounts and Balance Billing

Emergency Services

If a Covered Person receives emergency services at a Hospital or independent freestanding emergency department, the Covered Person's liability for services rendered by an out-of-network Provider is limited to the network level copayment, deductible, coinsurance and maximum out-of-pocket. The Covered Person cannot be balance billed for the services.

Except as stated below, the Covered Person's liability for post-stabilization emergency services is also limited to the network level copayment, deductible, coinsurance and maximum out-of-pocket.

Exception: If **all** the following conditions are met, the out-of-network Provider may balance bill for the services:

a) The Covered Person's treating Practitioner determines that the Covered Person's medical condition would allow non-medical or non-emergency transportation to a network Provider located within a reasonable travel distance;
b) The Covered Person's treating Practitioner determines the Covered Person is in a condition to receive notice and provide informed consent; and
c) The out of network Provider provides the Covered Person with written notice as required by the CAA and obtains consent to balance bill.

Non-Emergency Services by Out-of-Network Practitioners at Network Facilities

If a Covered Person receives services at a network Hospital, including Hospital outpatient department, critical access Hospital or an Ambulatory Surgical Center, the Covered Person's liability for the following types of services will be limited to the network level copayment, deductible, coinsurance and maximum out-of-pocket. The Covered Person cannot be balance billed for the services.

a) Services and supplies related to emergency medicine, anesthesiology, pathology, radiology, neonatology
b) Services and supplies provided by assistant surgeons, hospitalists and intensivists Diagnostic services, including radiology and laboratory services
c) Services and supplies provided by an out-of-network Practitioner if there is no network Practitioner who can provide the service or supply at the Facility.

Air Ambulance

If a Covered Person receives covered air ambulance services the Covered Person's liability for such services rendered by an out-of-network air ambulance provider is limited to the network level copayment, deductible, coinsurance and maximum out-of-pocket. The Covered Person cannot be balance billed for the services.

4. The explanation of **Colorectal Cancer Screening Charges** within **Covered Services** of the **Health Benefits Insurance** section is deleted and replaced with the following:

Colorectal Cancer Screening Charges
We cover charges made for colorectal cancer screening in accordance with United States Preventive Services Task Force recommendations.

We will cover the above methods at the frequency in accordance with the most recently published recommendations of the United States Preventive Services Task Force and as determined to be medically necessary by the Covered Person's practitioner in consultation with the Covered Person.

A colonoscopy performed following a positive result on a non-colonoscopy, colorectal cancer screening test recommended by the United States Preventive Services Task Force is not subject to the Cash Deductible or Coinsurance or Copayment.

Please note that colorectal cancer screening is included under the Preventive Care provision.

5. The **Purpose Of This Provision** of the **Coordination Of Benefits And Services** section is deleted and replaced with the following:

Purpose Of This Provision
A Covered Person may be covered under this Policy and subsequently become covered under Medicare or a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan**.** This provision allows Us to coordinate the services and supplies We provide with what Medicare pays. This provision also allows us to coordinate benefits with what a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan pays**.** Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Covered Person is covered.

In the absence of enrollment in other primary coverage, such as Medicare, We will not take that other coverage into account when paying for covered services or supplies. We will not limit or exclude coverage based on eligibility for other coverage. Coordination of benefits occurs only when the Covered Person is enrolled in other coverage.

Please note: The ONLY circumstances in which a person may be covered under both this Policy and under Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan occur when a Covered Person is already covered under this Policy and subsequently becomes eligible for Medicare or coverage

under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan.

6. The term **Plan** of the **Coordination Of Benefits And Services** section is deleted and replaced with the following:

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

For purposes of determining plans with which this plan can coordinate, Plan does not include:

a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the Covered Person, except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

7. The **Primary and Secondary Plan** description of the **Coordination Of Benefits And Services** section is deleted and replaced with the following:

PRIMARY AND SECONDARY PLAN

We consider each plan separately when coordinating payments.

For the purpose of coordinating benefits with this individual policy, Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan is always the Primary Plan and this Policy is always the Secondary Plan. Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan pays or provides services or supplies first, without taking into consideration the existence of this Policy.

This Policy takes into consideration the benefits provided by Medicare or coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan. During each Claim Determination Period, this Policy will pay up to the remaining unpaid allowable expenses, but this Policy will not pay more than it would have paid if it had been the Primary Plan. The method this Policy uses to determine the amount to pay is set forth below in the "**Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

8. The section **Effect Of Medicare on an Individual Health Benefits Plan** is deleted.

9. The second paragraph of **TERMINATION OF DEPENDENT COVERAGE** in the **General Provisions** section is deleted and replaced with the following:

A Dependent's coverage ends at midnight on the date the Dependent is no longer a Dependent, as defined in the Policy However, for a Dependent child who is no longer a dependent due to the attainment of age 26 coverage ends at midnight on the last day of the calendar year in which the Dependent attains age 26. Also, Dependent coverage ends when the Policyholder's coverage ends.