



State of New Jersey

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BULLETIN NO. 10-21

TO: ALL INSURANCE COMPANIES, HEALTH SERVICE CORPORATIONS, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, AND HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED TO ISSUE HEALTH BENEFIT PLANS IN NEW JERSEY

FROM: THOMAS B. CONSIDINE, COMMISSIONER

RE: PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT EFFECTIVE BEGINNING SEPTEMBER 23, 2010

The Federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act (Public Law 111-152) (collectively the ACA), requires health benefit plans to meet certain standards upon issuance or renewal on or after September 23, 2010. These were previously described on the Department of Banking and Insurance (the Department) website at http://www.state.nj.us/dobi/division_consumers/insurance/ppaca.html. The Department is issuing this Bulletin to (1) provide template Riders that carriers may choose to use in the large group market and the non-reform individual and small employer markets to describe changes to comply with the ACA; (2) describe the inter-play between the ACA extension of coverage to dependents and continuation under New Jersey law; and (3) provide for the orderly withdrawal from the market of provisions previously approved that do not meet the minimum ACA standards.

Carriers should note that in addition to changes to policies and certificates that may be necessitated by the ACA, there are notice requirements under the ACA with which carriers must comply. These include (1) notice of grandfather status if applicable; (2) notice of the right to reentry for an eligible dependent who previously aged out or was placed on continuation; and (3) notice of the right to reinstatement if coverage was discontinued due to a lifetime limit. Such notice requirements are beyond the scope of this Bulletin, and carriers should

refer to the applicable Federal regulations to ensure that proper notices are provided.

Application of the ACA requirements to standard plans in the New Jersey individual and small employer markets is being handled separately by the Individual Health Coverage Program Board (IHC Board) and the Small Employer Health Benefits Program Board (SEH Board), respectively.

The template contract/certificate/evidence of coverage rider, attached hereto, addresses the following ACA health benefit plan requirements:

- Extension of coverage to dependents;
- Annual and lifetime dollar limits;
- First-dollar coverage of preventive services;
- Limitations on preexisting condition exclusions; and
- Rescissions.

In general, the ACA does not preempt state law unless that state law prevents the application of the Federal requirements. Like the ACA, New Jersey law already prohibits requiring an authorization for emergency services, and New Jersey's requirements for out-of-network emergency services are already above the ACA minimum standards. New Jersey law also already requires access to pediatricians and specialists in obstetrical and gynecological care to serve as primary care physicians. The template therefore does not address these requirements of the ACA because New Jersey health insurance contracts should already conform with these requirements of the ACA.

Extension of Coverage to Dependents

Section 2714 of the Public Health Service Act, as added by the ACA, provides that a health plan that includes dependent coverage must make that coverage available until the attainment of 26 years of age, for plan years beginning on and after September 23, 2010. On May 10, 2010, the United States Departments of Treasury, Labor, and Health and Human Services (the Agencies) promulgated Interim Final Regulations describing the expected eligibility and its application to grandfathered plans. Refer to 34538 Federal Register Vol. 75, No. 116.

Under the Interim Final Regulations, plans and issuers may not condition coverage on whether a child under the age of 26 is a dependent under the Internal Revenue Code or a student. The term "dependent" may only be defined in terms of the relationship between the child and the participant. Specifically, the following factors may not be used for defining "dependent" for purposes of eligibility or continued eligibility for children under age 26: (1) financial dependency; (2) residency; (3) student status; (4) employment; (5) eligibility for other coverage; or (6) any combination of these factors. Grandfathered plans

can deny eligibility to those eligible under a qualifying employer-sponsored health plan (other than the plan of a parent.) Carriers may refer to the Interim Final Regulations to determine which plans are grandfathered plans.

Separate premiums for covered children are not permitted if they are based on age of a child. However, if a plan has a tiered premium structure for single coverage as opposed to single plus a certain number of dependents, the plan is allowed to charge the employee for the appropriate number of dependents as long as it is without regard to age.

New Jersey P.L. 2008, c.38, amending P.L. 2005, c. 375, provides for continuation of coverage for eligible dependents under the age of 31 (DU31.) DU31 differs from the ACA in terms of eligibility, duration, and rating requirements. See Bulletins 06-14 and 09-02 for a description of the New Jersey requirements. An individual who meets the requirements of the ACA described above is covered as a dependent rather than as a DU31 continue under New Jersey law. An individual who does not meet the requirements of the ACA, but does meet the requirements of DU31, should be afforded DU31 continuation. In particular, the following should be noted:

- For group plans grandfathered under the ACA, an individual may be ineligible if that individual is eligible under a qualifying employer-sponsored health plan (other than the plan of a parent.) Under DU31, if the individual is otherwise eligible under New Jersey law (under 31, unmarried/unpartnered, without children, either a resident of New Jersey or a full-time student at an accredited public or private institution of higher education), he or she is eligible for continuation unless *actually* covered by another health benefits plan. An individual under 26 in a grandfathered group plan who is ineligible as a dependent due to eligibility for group coverage is nevertheless eligible for DU31 continuation under New Jersey law.
- Individuals who are no longer eligible due to reaching age 26 who otherwise meet the New Jersey eligibility requirements are eligible for DU31 continuation until age 31.

Carriers may use the attached template rider without submitting to the Department for formal review and filing or approval. Carriers should submit for the Department's formal review and filing or approval their own forms to bring them into compliance by September 23, 2011. In any event, all health plan contracts, certificates and evidences of coverage forms to which the ACA requirements apply must be administered consistently with the requirements of such ACA standards. The filing or approval of any form that includes provisions conflicting with the ACA minimum standards is deemed withdrawn as of September 23, 2011.

Questions regarding this Bulletin may be directed to Neil Sullivan, Assistant Commissioner, Life and Health at 609-292-7272 x50488 or by e-mail at neil.sullivan@dobi.state.nj.us.

August 27, 2010
Date



Thomas B. Considine
Commissioner

inoord/bbPPACA

[COMPANY NAME]
ACA Rider

[Policy/Contract]holder:
Policy No:
Effective Date:

The [Policy/Contract/Certificate/Evidence of Coverage] to which this Rider is attached is amended as described below.

Definitions

The following term is defined in this rider as follows:

“Essential health benefits” has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Dependent Coverage

Any provision of the [Policy/Contract/Certificate/Evidence of Coverage] that indicates that a dependent child’s eligibility for coverage is based on any factor other than the relationship between the child and an individual covered under the [Policy/Contract/Certificate/Evidence of Coverage] for a child under the age of 26 is deleted. Any requirement that such a child be financially dependent on an individual covered under the [Policy/Contract/Certificate/Evidence of Coverage], that the child share a residence with an individual covered under the [Policy/Contract/Certificate/Evidence of Coverage], that the child meet certain student status requirements, that the child be unmarried or not in a Domestic or Civil Union Partnership, [that the child not be eligible for other coverage][– drafting note – delete for grandfathered group plans] or that the child not be employed, is deleted.

[For plan years beginning before January 1, 2014, any requirement that the adult child not be eligible for other coverage, is amended to apply only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent.][Drafting note – include only for grandfathered group plans]

Any provision of the [Policy/Contract/Certificate/Evidence of Coverage] that indicates that the coverage of a dependent child under the age of 26 will terminate when the child marries or enters into a Domestic of Civil Union Partnership, ceases to be financially dependent on an individual covered under the [Policy/Contract/Certificate/Evidence of Coverage], ceases to share a residence with an individual covered under the [Policy/Contract/Certificate/Evidence of Coverage], ceases to be a full-time or part-time student, [is eligible for other coverage][– drafting note – delete for grandfathered group plans] becomes employed full-time or part-time, or reaches age under 26 is deleted.

[For plan years beginning before January 1, 2014, any provision of the contract or certificate that indicates that coverage of the child will cease due to eligibility of the child for other coverage, is revised to provide that termination of coverage will occur only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent. For plan years beginning on or after January 1, 2014, any provision of the contract or certificate that indicates that coverage of the adult child will cease due to eligibility of the adult child for other coverage, is deleted.][Drafting note – include only for grandfathered group plans]

Any dependent child limiting age of less than 26 in the [Policy/Contract/Certificate/Evidence of Coverage] is replaced with the age of 26.

Transitional Rules

Any provision of the [Policy/Contract/Certificate/Evidence of Coverage] that defines or describes which children are eligible for coverage under the [Policy/Contract/Certificate/Evidence of Coverage] is revised to include a child who has not attained the child's 26th birthday irrespective of the child's:

- (1) Financial dependency on an individual covered under the [Policy/Contract/Certificate/Evidence of Coverage];
- (2) Marital or Civil Union/Domestic Partner status;
- (3) Residency with an individual covered under the [Policy/Contract/Certificate/Evidence of Coverage];
- (4) Student status;
- (5) Employment;
- [(6) Eligibility for other coverage; or *[Drafting note – delete in grandfathered group plans]*
- (7)] Satisfaction of any combination of the above factors.

The [Policy/Contract/Certificate/Evidence of Coverage] is amended to provide coverage from the first day of the first policy year occurring on or after September 23, 2010, if a child meets all three of the following:

1. The child was terminated from coverage previously due to failure to satisfy the child definition of the [Policy/Contract/Certificate/Evidence of Coverage] or the child was prohibited from enrolling under the [Policy/Contract/Certificate/Evidence of Coverage] due to failure to meet the child definition in the [Policy/Contract/Certificate/Evidence of Coverage];
2. The child is eligible for coverage based on the terms of this Rider; and
3. The child enrolls during the first 30 days of the first policy year occurring on or after September 23, 2010.

Lifetime Dollar Limits

Any lifetime dollar limit on any essential health benefits in the [Policy/Contract/Certificate/Evidence of Coverage] is deleted.

The [Policy/Contract/Certificate/Evidence of Coverage] is amended to provide that if an individual's coverage under the [Policy/Contract/Certificate/Evidence of Coverage] had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a plan year that begins on or after September 23, 2010, and coverage will begin on the first day of the plan year that begins on or after September 23, 2010.

[Annual Dollar Limits

Any annual dollar limit on any essential health benefits in the [Policy/Contract/Certificate/Evidence of Coverage] is amended to be the greater of (1) the annual dollar limit shown below; and (2) the annual dollar limit described in the [Policy/Contract/Certificate/Evidence of Coverage].

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, \$750,000;
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, \$1,250,000;
- For plan years beginning on or after September 23, 2012, but before September 23, 2014, \$2,000,000;

For plan years beginning on or after September 23, 2014, no limit may apply. *[Drafting Note - This Section May be Omitted for Grandfathered Individual Plans]*

Rescissions

Any provision of the [Policy/Contract/Certificate/Evidence of Coverage] that describes the right of [the insurer] to rescind or void the [Policy/Contract/Certificate/Evidence of Coverage] or to rescind the coverage of an individual under the [Policy/Contract/Certificate/Evidence of Coverage] is amended to permit [the insurer] to rescind or void the entire [Policy/Contract/Certificate/Evidence of Coverage] or the

coverage of an individual only if (1) the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud; or (2) the individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Any provision of the [Policy/Contract/Certificate/Evidence of Coverage] that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

[Preventive Services

In addition to any other preventive benefits described in the [Policy/Contract/Certificate/Evidence of Coverage], [the insurer] shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits [for services received from [participating/network] providers]:

1. Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

[The insurer] shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.] ***[Drafting Note - This Section May be Omitted for Grandfathered Plans]***

Prohibition on Pre-Existing Conditions for Children

Any provision of the [Policy/Contract/Certificate/Evidence of Coverage] described below shall not apply to any child who is under the age of 19:

- (1) Any provision that describes a pre-existing condition exclusion or limitation;
- (2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
- (3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the [Policy/Contract/Certificate/Evidence of Coverage]; and
- (4) Any provision of the [Policy/Contract/Certificate/Evidence of Coverage] that describes possible denial or rejection of coverage due to underwriting.

This rider is part of the [Policy/Contract/Certificate/Evidence of Coverage]. Except as stated above, nothing in this rider changes or affects any other terms of the [Policy/Contract/Certificate/Evidence of Coverage].

Signature of Officer