INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Medicare Supplement--Under 50 Coverage

Proposed Amendments: N.J.A.C. 11:4-23A.2, 23A.6 and 23A.12

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance

Authority: N.J.S.A. 17:1-8.1, 17:1-15e and 17B:26A-14a.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2003-121

Submit comments by August 15, 2003 to:

Douglas A. Wheeler, Assistant Commissioner
Legislative and Regulatory Affairs
Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
Email: LegsRegs@dobi.state.nj.us

The agency proposal follows:

Summary

On August 16, 1995, P.L. 1995, c. 229 (the "Act") (codified at N.J.S.A. 17B:26A-12 to 17) was enacted. Its purpose was to provide Medical Supplement Standard Plan C coverage to persons under 50 years of age who are entitled to Medicare benefits due to disability.

The Department of Insurance adopted rules implementing the Act (effective April 15, 1996) and thereby created a mechanism (the "Under 50

Plan") to provide this coverage at N.J.A.C. 11:4-23A. Pursuant to statute and rule, the Under 50 Plan is administered by the Governing Board of the Under 50 Medicare Supplement Program (the "Board"), consisting of representatives of carriers subject to the Act, as well as public representatives.

Since the passage of the Act and the implementing rules, there have been a series of changes in Federal law that have affected Medicare benefits. (See the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"); the Balanced Budget Act of 1997 ("BBA"); the Medicare, Medicaid, State Health Insurance Program Balanced Budget Refinement Act of 1999 ("BBRA"); and the Medicare, Medicaid, State Health Insurance Program Benefits Improvement Act of 2000 ("BIPA").) These changes have benefited consumers by improving the availability, portability and continuity of health coverage. They also established new standards relating to the guarantee issue period for Medicare supplement insurance policies for individuals eligible for Medicare by reason of age in various circumstances.

The proposed amendments to N.J.A.C. 11:4-23A.2, 23A.6 and 23A.12 codify amendments to the Program's Plan of Operation that were approved by the Commissioner on June 19, 2002. Although the Under 50 Plan in New Jersey is not subject to the Federal laws cited above, the Board has amended its Plan of Operation so that it will provide coverage in a manner consistent with the 65 and over Medicare Supplement Program in accordance with recent changes in federal law.

These Federal standards are consistent with the legislative objectives of the Act and the Department considers them appropriate to apply to individuals eligible for Medicare by reason of disability. Therefore, the Department proposes to amend its rules applicable to Medicare Supplement coverage for those under 50 years of age to incorporate these Federal standards.

The Commissioner now proposes to amend rules governing the Under 50 Medicare Supplement Program to reflect the Board's suggestions.

The definition section at N.J.A.C. 11:4-23A.2 is proposed for amendment. The section is amended to define "continuous period of creditable coverage" to mean a period in which there was no break in coverage longer than 63 days. It would establish detailed definitions of "creditable coverage" and amend the definition of "health benefits plan" that are consistent with the definitions of those terms in Federal law. It would establish a detailed definition of "excepted benefits," for coverage not included in creditable coverage. Finally, a definition is added of "pre-existing condition" as a condition for which treatment was recommended or given by a physician during the six months before the effective date of the Medicare Supplement plan, again in order to be consistent with the federal law.

N.J.A.C. 11:4-23A.6(a) is amended to extend the guarantee issue period (i.e. the period in which an application for coverage must be accepted without medical underwriting) beyond six months of enrollment in Medicare Part B in certain situations including where there has been a retroactive determination of Medicare eligibility, where the individual loses creditable coverage, where an

individual loses coverage under an employee welfare benefit plan, where an individual's COBRA coverage terminates, where an individual's coverage under Medicare + Choice and other types of Medicare managed plans terminates for certain reasons, where an individual's coverage under a Medicare Supplement policy is involuntarily terminated, where an individual's coverage under a Medicare Supplement policy ends because of the issuer's misconduct and where an individual enrolled in a Medicare Supplement policy switches to a Medicare + Choice or other Medicare managed care plan and terminates coverage during the trial period. If applications are filed within the guarantee issue period as extended in the above described situations, the Under 50 Plan shall not deny or condition the issuance or renewal of coverage, nor discriminate in the pricing of coverage because of the health status, claims experience, receipt of health care or medical condition of an applicant.

The amendments to N.J.S.A. 11:4-23A.6(b) specify that in certain situations the preexisting condition exclusion in the Under 50 Plan shall be reduced by the amount of continuous creditable coverage of an applicant.

The new subsection at N.J.A.C. 11:4-23A.6(c) specifies the effective date of coverage of applicants to the Under 50 Plan.

N.J.A.C. 11:4-23A.12 is amended by "housekeeping" changes that reflect the merger of the Department of Insurance and of the Department of Banking into the Department of Banking and Insurance and the correct mailing address for appeals to the Commissioner.

A 60-day comment period is provided for this notice of proposal and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The proposed amendments will have a beneficial social impact. Consumers will benefit from expanded provision of access to Medicare Supplement Plan C to persons under the age of 50 who, because of disability, become eligible for Medicare. Allowing credit for time spent under prior coverage in satisfying the Under 50 Plan preexisting condition exclusion may enable some eligible persons to obtain benefits for such conditions sooner. This also conforms to the approach contained in Federal law for persons 65 and over.

Economic Impact

As every insurer or HMO providing health benefits in this State shares in any net losses of the Under 50 Plan, these carriers will be responsible for sharing in any additional costs related to complying with the proposed amendments and enabling some eligible persons to obtain benefits sooner. However, it is unlikely that they will experience a significant adverse economic impact.

Consumers who are eligible for coverage in the Under 50 Program should experience a favorable economic impact. The new provision whereby a

consumer's creditable coverage is applied against the preexisting condition exclusion will provide an economic benefit to those consumers covered by the Under 50 Plan who have claims that would have been excluded under the preexisting condition exclusion. Moreover, the expanded guarantee issue periods will make it easier for certain persons to obtain coverage from the Under 50 Plan.

Federal Standards Statement

Federal standards exist regarding Medicare Supplement Plans (see 42 U.S.C. 1395ss et seq.) but they do not apply to the New Jersey Under 50 Plan. The Board has revised its Plan of Operation so that the Under 50 Plan will continue to operate consistently with the Federal standards for over 65 Medicare Supplement Plans. The proposed amendments would apply the same standards that are applicable to individuals eligible for Medicare by reason of age under Federal law to individuals eligible for Medicare by reason of disability under State law. The Board's recommendations do not exceed those Federal standards; therefore, no further federal analysis is required.

Jobs Impact

The proposed amendments will not cause any jobs to be generated or lost. The Department invites interested parties to submit any data or studies concerning the job impact of the proposed amendment.

Agriculture Industry Impact

The proposed amendments will not have any agriculture industry impact

Regulatory Flexibility Statement

These proposed amendments are unlikely to affect any small business as that term is defined in the Regulatory Flexibility Act at N.J.S.A. 52:14B-16 et seq. The current contracting carrier that provides Under 50 Plan coverage has a full-time work force in excess of 100 people. Accordingly, a regulatory flexibility analysis is not required.

Smart Growth Impact

The proposed amendments have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Full text of the proposal follows (additions indicated in boldface and underlined **thus**; deletions indicated in brackets [thus]:

11:4-23A.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

...

"Commissioner" means the Commissioner of the Department of **Banking and** Insurance.

“Continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

…

"**Creditable coverage” means coverage of the individual, other than coverage of excepted benefits, provided under any of the following: a group health plan; health insurance coverage; Title XIX of the Social Security Act (Medicaid), other than the coverage consisting solely of benefits under section 1928 (42 U.S.C. § 1396s); Chapter 55 of Title 10 United States Code (CHAMPUS)(10 U.S.C. §§ 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a State health benefits risk pool; a health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program)(5 U.S.C. §§ 8901 et seq.); a public health benefit plan as defined in 45 C.F.R. 146.113(a)(1)(ix); and a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504 (e)).**

“Excepted benefits” means coverage for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; worker’s compensation or similar insurance; automobile medical payment

insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits. When provided under a separate policy, certificate or contract of insurance or, when otherwise not an integral part of the plan, excepted benefits include: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or such other similar, limited benefits as are specified in federal regulations. When offered as independent, non-coordinated benefits, excepted benefits include: hospital indemnity or other fixed indemnity insurance; and coverage for specified diseases or illnesses. When offered as a separate policy, contract, certificate or contract of insurance, excepted benefits include: Medicare supplement health insurance as defined under section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(s)(1); coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (10 U.S.C. 1071 et seq.); and similar supplemental coverage provided under a group health plan.

…

"Health benefits plan" [means a hospital and medical expense insurance policy, hospital service corporation contract, medical service corporation contract or health service corporation contract delivered or issued for delivery in this State, or a health maintenance organization subscriber contract

delivered or issued for delivery in this State.] **shall have the meaning set forth at N.J.S.A. 17B:27A-2.**

...

11:4-23A.6 Open enrollment

(a) The Under 50 Plan shall not deny or condition the issuance or renewal, nor discriminate in the pricing of coverage because of the health status, claims experience, receipt of health care or medical condition of an applicant if the application for coverage is submitted [during the six-month period beginning with the first month in which] **under the circumstances and within the timeframes specified below:**

1. When an individual is [enrolled] **eligible** for benefits under Medicare Part B**,** [or if the application is submitted within six months of the approval of a plan of operation pursuant to this subchapter, whichever is later.] **and the application is submitted during the six-month period beginning with the first month in which the individual is enrolled for benefits under Medicare Part B;**

2. Where there is a retroactive determination of Medicare eligibility, and the application is submitted during the six-month period beginning with the month in which the retroactive determination is made;

3. Where an individual is no longer eligible under a plan that is considered creditable coverage or such a plan terminates or ceases

to provide benefits, and the application is submitted within 63 days of the applicant losing creditable coverage;

4. Where an individual was enrolled under an employee welfare benefit plan that provided health benefits that supplement Medicare benefits and that plan terminates or ceases to provide all Medicare supplemental health benefits, or the plan is primary or secondary to Medicare and the plan terminates, ceases to provide all health benefits to the individual, or the individual leaves the plan, and the application is submitted within 63 days from the date the individual receives a notice of termination or a claim denial due to termination, or within 63 days after the health coverage ends;

5. Where an individual elects COBRA coverage and chooses to terminate his COBRA coverage before the maximum coverage period is reached, or the COBRA coverage period is exhausted, and the application is submitted within 63 days of the date on which the COBRA coverage terminated;

6. Where an individual who is enrolled in a Medicare + Choice plan, Medicare managed care plan, Medicare private-fee-for-service plan, Medicare risk or cost contract, a plan offered by a similar organization operating under demonstration project authority, a health care prepayment plan or a Medicare SELECT plan, and his or her enrollment ends for reasons specified in (a)6iii below, such an

individual's application shall be subject to the following requirements:

i. In connection with an involuntary termination, an application shall be submitted during the period beginning on the date the individual receives a notice of termination and ending 63 days after the date their coverage is terminated.

ii. In connection with a voluntary termination, the application shall be submitted during the period beginning 60 days before the disenrollment effective date and ending 63 days after the disenrollment effective date.

iii. The reasons for termination of enrollment that will trigger the applicability of this paragraph are:

(1) The organization's or plan's certification under Part C of Medicare has been terminated or will be terminated;

(2) The plan is leaving the Medicare program;

(3) The organization has discontinued providing the plan or will be discontinuing the plan in the area where the enrollee resides;

(4) The demonstration project has ended;

(5) The enrollee moves out of the service area;

(6) The individual demonstrates that the organization substantially violated a material provision

of the policy (with respect to the individual), such as failure to provide covered care on a timely basis or adhere to quality standards; or

(7) The organization, agent or other entity acting in the organization's behalf materially misrepresented the policy provisions in marketing.

7. Where an individual is enrolled under a Medicare Supplement policy and the enrollment ceases due to the bankruptcy or insolvency of the issuer, or to other involuntary termination of the coverage under the policy, and the application is submitted during the time period beginning on the earlier of the date the individual receives a notice of termination, bankruptcy or insolvency or other such similar notice, if any, and the date on which their prior coverage terminated and ending 63 days after the prior coverage is terminated.

8. Where an individual is enrolled under a Medicare Supplement policy and enrollment ends because the issuer substantially violated a material provision of the policy, or because the issuer, its agent, or another entity acting on the issuer's behalf materially misrepresented the policy provisions in marketing the policy, and the application is submitted during the period beginning on the disenrollment effective date and ending 63 days after the disenrollment effective date. However, if in such a situation the

termination is voluntary, the period shall begin 60 days before the disenrollment effective date and end 63 days after the disenrollment effective date.

9. Where an individual is enrolled under a Medicare supplement policy, including the Under 50 Plan, terminates enrollment, and subsequently enrolls, for the first time, in a Medicare + Choice plan, a Medicare managed care plan, a Medicare private-fee-for-service plan, a Medicare risk or cost contract, a plan offered by a similar organization operating under demonstration project authority, a health care prepayment plan, or a Medicare SELECT plan, and thereafter terminates enrollment within the trial period, and the application is submitted during the period beginning 60 days before the disenrollment effective date and ending 63 days after the disenrollment effective date. For the purposes of this subsection, the trial period is whichever of the following that occurs first: 12 months of continuous enrollment in any one plan of the types listed above, or 24 months of continuous enrollment in any two or more plans of the types listed above.

(b) Nothing in (a) above shall be construed to prohibit the exclusion of benefits during the first three months, based on a preexisting condition for which the insured received treatment or was otherwise diagnosed during the six months before the policy or contract became effective**, except that:**

1. The pre-existing condition exclusion shall not apply to individuals who submit an application under the circumstances and in the time periods referenced in (a)4, 6, 7, 8 or 9 above; and

2. The pre-existing condition exclusion shall be reduced by the amount of time the applicant had a continuous period of creditable coverage, if he or she submits an application under the circumstances and during the time periods referenced in (a)2, 3 and 5 above.

(c) The effective date of coverage by the Under 50 Plan is the first day of the month following the date an applicant enrolls in the Under 50 Plan and makes a premium payment.

11:4-23A.12 Assessment relief requests

(a) - (d) (No change.)

(e) All requests for relief or other information required pursuant to this section shall be filed with the Department at the following address:

Under 50 Plan**--Request for Relief**

[Request for Relief**]**

New Jersey Department of **Banking and** Insurance

Division of [Financial Solvency] **Solvency Regulation**

20 West State Street

[CN] **P.O. Box** 325

Trenton, New Jersey 08625

(f) - (j) (No change.)

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