MEETING MINUTES OF THE
NEW JERSEY UNDER 50 MED SUPP PROGRAM BOARD

SEPTEMBER 7, 1999

Board Members Present:

Bob Hoffman	-	Public Member
Victor Shulman	-	Public Member
David Kreiss	-	Oxford Health Plans
Keitha Lackey	-	Horizon Blue Cross Blue Shield of NJ
Christina Palme-Krizak	-	United HealthCare
Rebecca L. Smart	-	Mutual of Omaha

Others Present:

Debbie Breslin	-	CHIME
Bob Vehec	-	Department of Banking and Insurance
Bob King	-	Department of Banking and Insurance
Mike Malloy	-	Department of Banking and Insurance
Joan Fusco	-	Horizon Blue Cross Blue Shield of NJ
Sandi Kelly	-	Horizon Blue Cross Blue Shield of NJ

The New Jersey Medigap Under 50 Plan Board met via conference call at 1:00 p.m. (EDT) on Tuesday September 7, 1999.

1) **Minutes**

The minutes of the March 25, 1999 and May 14, 1999 Board meetings were reviewed and approved.

2) **Market Share Report Review**

Rebecca reported that the calculation of Market Share Report and recommendation for Program Assessment had been submitted to the Department of Banking and Insurance for Commissioner review and approval on July 21, 1999. Bob Vehec reported that he had been in contact with the Commissioner's office and felt that we could be expecting a response within the next couple of weeks.

3) **Status of Program Audit**

Keitha Lackey reported that Arthur Andersen would be commencing their audit of the Program around mid-September.

4) **Coverage Issues**

Coverage questions had been raised regarding the handling of individuals who were eligible for COBRA coverage, as well as applicability of pre-existing condition limitation waivers. In the past, an individual who was eligible for Medicare was not eligible for COBRA coverage. That has changed so there are circumstances where an individual who is covered by Medicare would be entitled to COBRA coverage. The questions presented to the Board for consideration were:

a) Is an individual who is losing group coverage and eligible for COBRA eligible for open enrollment in this Program?

b) If an individual chooses to take COBRA, do they have to fully exhaust that coverage before being eligible for open enrollment in this Program?

After much debate and discussion, the Board concluded that it would be appropriate to allow individuals the choice to enroll in the Program at the time they lose their group coverage without requiring that they exhaust their COBRA rights before becoming eligible. Therefore, the answer to a) is yes; the answer to b) is that an individual would not have to fully exhaust the COBRA coverage before becoming eligible.

The primary factor in the decision for the Board was a recognition of the fact that COBRA coverage is most often very expensive. If an individual is required to fully exhaust COBRA before being eligible for this Program and they are unable to take advantage of COBRA because of cost, they would be forever estopped from being eligible for this Program.

Under the current rules of the Program, an individual is given credit toward their pre-existing condition limitation if they have had three months of continuous Creditable Coverage. The question arose as to whether or not, if prior coverage was less than three months, there should be partial credit for the length of the prior coverage. It was the decision of the Board that partial credit should be allowed.

Secondly, it was noted that under Federal law (BBA/HIPAA), if an individual loses Creditable Coverage under certain circumstances, no pre-ex limitation can apply no matter how long coverage was in effect. The question was whether or not that should apply to this Program also. It was agreed by the Board that the same guidelines should apply to the Program.

It was agreed that Rebecca would work with Horizon Blue Cross Blue Shield to prepare an Addendum #2 for the Plan of Operation of the Program which would contain the Administrative Guidelines previously set forth in Addendum #1, along with the changes reflecting the COBRA and the pre-existing condition limitation waiver decisions. This addendum would then be submitted to the Commissioner for approval as part of the Plan of Operation of the Program.

5) Status of Regulatory Changes

The Administrative Guidelines which the Board had adopted and which have been approved by the Department of Banking and Insurance as Addendum #1 to the Plan of Operation, as well as the additional changes addressed during the meeting as outlined above, were primarily based on changes made under the Federal law governing Medicare Supplement coverage. Through discussion with the Department of Banking and Insurance representatives, a project to make recommendations for statutory and regulatory changes in those sections of the insurance code governing this Program has been initiated. Bob King reported that a rough draft of changes had been crafted and that the document was being circulated within the Department of Banking and Insurance for internal sign-off.

6) Other

Bob Vehec reminded the Board that in accordance with NJAC 11.4-23A.3(e) that the Program is required to submit a financial and operational report no later than 120 days after December 31 of each calendar year.

There being no further issues, the meeting was adjourned.

Amended and Approved at 03/08/00 Board Meeting

ADDENDUM #2

This Addendum is attached to and made a part of the Plan of Operation of the Governing Board of the Medicare Supplement "Under 50" Program approved by the Department of Banking and Insurance on November 26, 1996.

ADMINISTRATIVE GUIDELINES EFFECTIVE _____
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:

1) during the six-month period beginning with the first month in which an individual is enrolled for benefits under Medicare Part B; or

2) in the case of a retroactive determination of Medicare eligibility, during the six-month period beginning with the month in which the determination is made; or

3) within 63 days of the applicant losing Creditable Coverage under the following circumstances:

   a) the individual is no longer eligible for coverage under the plan,
   b) the plan terminates or ceases to provide benefits,
   c) coverage under a risk/cost HMO, demonstration or HCPP policy terminates due to termination of the entity's certification, the individual moves outside of the service area, or the individual elects termination for cause; or

4) for an individual who is losing group major medical coverage and who is eligible for COBRA coverage:

   a) within 63 days of losing group coverage if the individual does elect COBRA coverage; or
   b) if the individual elects COBRA coverage:
      i) at any time during the COBRA coverage period if the individual chooses to terminate the COBRA coverage; or
      ii) within 63 days of COBRA coverage terminating.

5) under other circumstances as the Board deems appropriate to meet the objectives of the Program in a fair and equitable manner.

Under all circumstances, the effective date of coverage is the first of the month following the date the applicant enrolls in the Program and makes premium payment.

B. Nothing in A. above shall be construed to prohibit the exclusion of benefits during the first three months, based on a pre-existing condition for which the insured received treatment or was otherwise diagnosed during the six months before the policy or contract became effective subject to the following:

1) ~~However,~~ if an individual submits an application during the time period referenced in A. 1), 2), or 3a) above and has had a continuous period of Creditable Coverage, ~~of at least three (3) months, coverage shall not exclude benefits based on a pre-existing condition.~~ the period of any pre-existing condition exclusion will be reduced by the amount of time the applicant was covered under the Creditable Coverage plan(s); or

2) if an individual submits an application during the time period referenced in A.3) b) or c) above, there will be no exclusion of benefits based on pre-existing conditions.

C. As used herein "Creditable Coverage" means:

1) Group major medical coverage, including COBRA;
2) Individual major medical coverage;
3) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
4) Chapter 55 of Title 10 United States Code (CHAMPUS);
5) A medical care program of the Indian health Service or of a tribal organization;
6) A State health benefits risk pool;
7) A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
8) A public health plan as defined in federal regulation;
9) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e).

"Creditable Coverage" shall not include:

(a) Coverage only for accident or disability income insurance, or any combination thereof;
(b) Coverage issued as a supplement to liability insurance;
(c) Liability insurance, including general liability insurance and automobile liability insurance;
(d) Workers' compensation or similar insurance;
(e) Automobile medical payment insurance;
(f) Credit-only insurance;
(g) Coverage for on-site medical clinics;
(h) Other similar insurance coverage, specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits;
(i) Limited scope dental or vision benefits;
(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
(k) Coverage only for a specified disease or illness;
(l) Hospital indemnity or other fixed indemnity insurance;

(m) Such other similar, limited benefits;

(n) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under chapter 55 or title 10, United States Code (CHAMPUS); and

(p) Similar supplemental coverage provided to coverage under a group health plan.