INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Minimum Standards for Medicare Supplement Coverage

Adopted Amendments: N.J.A.C. 11:4-23

Adopted Repeal: N.J.A.C. 11:4-23 Appendix to Subchapters 16 and 23

Adopted New Rule: N.J.A.C. 11:4-23 Appendix

Proposed: May 2, 2005 at 37 N.J.R 1428(a).

Adopted: August 4, 2005 by Donald Bryan, Acting Commissioner, Department of Banking and Insurance

Filed: August 5, 2005 as R. 2005 d. 291, with substantive changes not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17B:26A-5 and 17:1-8.1

Effective Date: September 6, 2005

Expiration Date: November 30, 2005

Summary of Public Comments and Agency Responses:

Comments were received from UnitedHealth Group.

COMMENT: The commenter suggested removing the current list of expenses included within the definition of "health care expenses" at N.J.A.C. 11:4-23.4(a)4 and relocating the list to N.J.A.C. 11:4-23.11. The commenter believed that the change would "harmonize N.J.A.C. 11:4-23.4(a)4 and 11:4-23.11 with Sections 5D (definition of "health care expenses") and 14A(1)(b) of the NAIC Model." The commenter also suggested that its recommended changes to N.J.A.C. 11:4-

23.4(a)4 and 11:4-23.11 would remove some technical language regarding HMO expenses from Medigap policies and certificates.

RESPONSE: The Department believes that the text contained in the Department's initial proposal provides more information and is less confusing to purchasers of Medicare supplement coverage than the commenter's recommended changes. The changes proposed by the Department conform the text of N.J.A.C. 11:4-23.4 to the language in the NAIC Model. No change has been made.

COMMENT: The commenter noted that the proposal did not include "Outlines of Coverage" and suggested various technical and typographical corrections for the Outlines of Coverage in the NAIC model. The first suggestion corrected the heading for the Medicare Part B table of Plan E Outline of Coverage to "Medical Services - Per Calendar Year" rather than "Medical Services - Per Benefit Period." The next correction referred to errors in the bracketing in the Outlines of Coverage for Plan F/High Deductible Plan F and Plan J/High Deductible Plan J. The next correction removed the references to "the plan's outpatient prescription drug deductible" from the Plan J/High Deductible Plan J Outlines for Part A and Part B. The final correction was to move the reference to hospice care to the end of the Part A - Hospital Services table from the top of the part B- Medical Services table in the Plan J /High Deductible Plan J Outline.

RESPONSE: The Outlines of Coverage were included in the proposal as Appendix Exhibit D. The Department had already included in the proposal the suggested correction to the heading for the Medicare Part B table of Plan E Outline of Coverage and the brackets for Plan F/High Deductible Plan F. The Department thanks the commenter for noting the other errors in the NAIC model. The commenter is correct that the plans discussed do not include outpatient

prescription drug coverage and, therefore, the references to such a deductible in the Plan J/High Deductible J outlines for Part A and Part B were erroneous and are being deleted upon adoption. Also, the commenter is correct that "Hospice Care" was incorrectly included at the top of the Part B - Medical Services table and should have been included at the bottom of the Part A - Hospital Services table. These necessary corrections are also being made to Appendix Exhibit D upon adoption.

COMMENT: The commenter suggested adding an effective date section which would provide for the fact that, despite the fact that some changes to forms are not required until the Medicare Part D program begins in 2006, there is no reason why other changes cannot be implemented in 2005, such as the approval to offer Plans K and L, once the regulation has authorized them. To that end, the commenter suggested the following language:

> "This regulation is effective on {effective date]. Insurers are permitted to continue using current forms, or to make changes to current forms if offering Plan K or L, as appropriate through 2005. Insurers may offer any authorized plan upon approval by the [Commissioner of Insurance or other authority}."

RESPONSE: The Department does not believe any changes are necessary. The rules will be effective upon adoption and those provisions that are not required to be implemented until after December 31, 2005 are clearly indicated in the rules.

Federal Standards Statement

The adopted amendments comply with and do not exceed the standards or requirements imposed by Federal law concerning Medicare Supplement coverage (42 U.S.C. § 1395ss). Therefore, a Federal standards analysis is not required.

Full text of the adopted amendments and new rules follows (additions to proposal indicated in boldface and asterisks

thus; deletions from proposal indicated in brackets and asterisks *[thus]*:

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[This high deductible plan pays the same benefits as Plan J after one has paid a calendar year $[***] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are $[***]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include *[the plan's separate outpatient prescription drug deductible or]* the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[***] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[***] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[***]	$[***] (Part A deductible)	$0
61st thru 90th day	All but $[***] a day	$[***] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[***] a day	$[***] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0****
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[***] a day	Up to $[***] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE** **Available as long as your doctor certifies you are terminally ill and you elect to receive these services	***All but very limited coinsurance for out-patient drugs and inpatient respite care***	***$0***	***Balance***

(continued)

******NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's

“Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.
*** Deductible amounts and out-of-pocket expenses announced annually by CMS.

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[***] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[This high deductible plan pays the same benefits as Plan J after one has paid a calendar year$[***] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are $[***]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include *[the plan's separate outpatient prescription drug deductible or]* the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[***] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[***] DEDUCTIBLE,**] YOU PAY
[HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services]	*[All but very limited coinsurance for out-patient drugs and inpatient respite care]*	*[$0]*	*[Balance]*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[***] of Medicare Approved Amounts*	$0	$[***] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $[***] of Medicare Approved Amounts*	$0	$[***] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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