DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Medicare Supplement Coverage
Minimum Benefit Standards for Policies and Certificates Delivered or Issued on or after January 4, 1993; Standards for the Guaranteed Issuance of Coverage to Eligible Person

Proposed Amendments: N.J.A.C. 11:4-23.8 and 23.12

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

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

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

Proposal Number: PRN 2002-431

Submit comments by March 7, 2003 to:

Douglas 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

The Department of Banking and Insurance proposes to amend N.J.A.C. 11:4-23.8, which sets forth minimum benefit standards for policies and certificates delivered or issued for delivery on or after January 4, 1993, and N.J.A.C. 11:4-23.12, which sets forth the standards for the guaranteed issuance of coverage to eligible persons.

The purpose of the amendments is to conform the rule to recent changes in Federal law affected by the Balanced Budget Reconciliation Act of 1999 (BBRA) and the Medicare, Medicaid, and State Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) P.L. 106-554.

In considering the best way to amend current rules, the Department concluded that it should closely follow the model language generated by the National Association of Insurance Commissioners (NAIC) because that would help achieve uniformity with other jurisdictions while continuing to protect New Jersey consumers. TO make the language in the current rules consistent with the NAIC model, the department proposed to delete current subsection N.J.A.C. 11:4-23.8(c) and replace it with language from the NAIC model. This change produced no substitute changes from our current rule.

The new subsection would continue to require that Medicare supplement policies or certificates permit suspension of coverage at the request of the policyholder or certificateholder, for a period not to exceed 24 months, when the policyholder or certificateholder is entitled to medical assistance under Title XIX of the Social Security Act. Similar suspension requirements apply for policyholders or certificateholders who are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan.

Policyholders and certificateholders in either of the above situations who lose coverage would be able to reinstate up to 90 days after losing coverage by paying the premium for the period since the loss of coverage. Reinstatements shall not contain a waiting period with respect to preexisting conditions, and shall provide for substantially equivalent coverage and no change in classification of premiums.

The Department's current rules set forth the time period for the guaranteed issue of Medicare Supplement coverage. N.J.A.C. 11:4-23.12(a). The proposed amendments to N.J.A.C. 11:4-23.12 would (1) modify the guaranteed issue period for beneficiaries losing coverage under a terminating Medicare + Choice plan, (2) define the trigger for guaranteed issue coverage for eligible beneficiaries enrolled in an employee welfare benefit plan or Medicare supplement plan, (3) modify the 12 month trial period for eligible beneficiaries enrolled in a Medicare + Choice plan, and (4) with respect to the remaining classes of eligible beneficiaries, would change the timing of the guaranteed issue period. The proposal would not expand the class of beneficiaries eligible for guaranteed issue of a Medicare supplement policy, nor would it alter the plans for which eligible beneficiaries are entitled

A 60-day comment period is provided for in this 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 Department anticipates that there will be a beneficial social impact from the amendments. The proposed amendments would benefit consumers by modifying and clarifying the guarantee issue requirements applicable to Medicare Supplement policies as required by BIPA and BBRA. It would require that Medicare supplement policies be made available in more circumstances than under the current rules. Thus, New Jersey citizens who qualify for Medicare coverage will have more opportunities for guaranteed issue of Medicare Supplement coverage than under current rules. Insurance companies offering Medicare Supplement coverage would be required to provide Medicare Supplement coverage on a guarantee issue basis in more situations than under current rules.

Economic Impact

The Department thinks that the proposed amendments will have a beneficial economic impact on consumers by setting forth the guarantee issue requirements applicable to Medicare Supplement policies as required by BIPA and BBRA, and by requiring that coverage be made available in more circumstances than under the current rules. Thus New Jersey citizens who qualify for Medicare coverage will have more opportunities for guaranteed issue of Medicare Supplement coverage than under current rules and will defer the costs of covered medical

expenses. Insurance companies offering Medicare Supplement coverage would be required to provide Medicare Supplement coverage on a guarantee issue basis on more frequently than under current rules. Companies may apply for appropriate rate adjustments with respect to any increased costs associated with the provision of this additional coverage. Finally, by making the current rule conform more closely with federal law and the model regulations of the NAIC, the amendments should facilitate the transaction of Medicare Supplement insurance business across state lines. Overall, the Department believes that the regulations will have a beneficial economic impact.

Federal Standards Statement

The purpose of the amendments is to conform the Department's rules to recent changes in Federal law effected by BBRA (42 U.S.C. § 1395) and BIPA (P.L. 106-554). The proposed amendments do not contain standards or requirements that exceed standards or requirements imposed by Federal law.

Jobs Impact

The Department does not believe that the proposed amendments will 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

Pursuant to N.J.S.A. 4:1C-1 et seq., the Right to Farm Act, and N.J.S.A. 52:14B-4(a)(2), the Administrative Procedure Act, the Department does not expect any agriculture industry impact from the proposed amendments.

Regulatory Flexibility Statement

The BIPA proposed amendments would apply only to insurance companies and none of the entities which would be affected by the proposed amendments are small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52B14B-16 et seq. because none of them have fewer than 100 employees. Therefore, no regulatory flexibility analysis is 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 **thus**; deletions indicated in brackets [thus]):

11:4-23.8 Minimum benefit standards for policies and certificates delivered or issued for delivery on or after January 4, 1993

(a) - (b) (No change.)

[(c) A Medicare supplement policy or certificate shall provide that benefits and premium shall be suspended for a period of up to 24 months upon the request of a policyholder or certificateholder who has applied for and been determined entitled to medical assistance under Title XIX of the Social Security Act (that is Medicaid), during or at the end of which period of suspension, the policy or certificate shall be reinstituted automatically upon notice to the carrier by the policyholder or certificateholder.

1. Benefits and premiums shall not be suspended unless the policyholder or certificateholder provides the carrier notice of entitlement to medical assistance under Title XIX of the Social Security Act (42 U.S.C.A. § 1396 – v -end) within 90 days following the date the policyholder or certificateholder was determined to be so entitled.

2. Upon loss of entitlement to medical assistance within the period of suspension or upon the date following the final day of the period of suspension, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, or effective as of the day following the final day of the period of suspension, if within 90 days following the date of entitlement termination or the final day of the suspension period, the policyholder or certificateholder provides notice to

the carrier for reinstitution of the policy or certificate, and pays the premium required by the carrier which premium shall be for a period of coverage not exceeding six months, inclusive of the 90 day notice period, but exclusive of any period during which the policyholder or certficateholder was entitled to medical assistance pursuant to Medicaid.

3. The coverage under the policy or certificate reinstated:

i. Shall not be subject to any waiting period with respect to treatment or preexisting conditions;

ii. Shall be substantially equivalent to coverage which was in effect prior to the date of suspension of the policy or certificate; and

iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.]

(c) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, (42 U.S.C.A. § 1396 – v-end) but only if the policyholder or certificateholder notifies the issuer of the policy or certificate

within 90 days after the date that the individual becomes entitled to that assistance.

1. If suspension occurs and if the policyholder or certificateholder loses entitlement to Title XIX medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of the termination of the entitlement) if the policyholder or certificateholder provides notice of their loss of the entitlement to the Title XIX assistance within 90 days after the date of that loss and the policyholder or certificateholder pays the premium attributable to the period subsequent to the date of the termination of the entitlement.

2. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by Federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act, 42 U.S.C. § 426(b), and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act 42 U.S.C. § 1395y(b)(1)(A)(v). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium

attributable to the period from the date of the termination of their enrollment in the group health plan.

3. Reinstitution of coverage as described in (c)1 and 2 above shall:

i. Not impose any waiting period with respect to treatment of preexisting conditions;

ii. Provide for coverage which is substantially equivalent to the coverage that was in effect before the date of the suspension; and

iii. Provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(d) - (f) (No change.)

(g) The following terms and phrases, as used in this section, shall have the following meanings:

1 - 2. (No change.)

3. "Core Benefit" means coverage of:

i. - iv. (No change.)

v. The coinsurance amount [(] or**,** in the case of hospital outpatient department services **paid** under a prospective payment system, the copayment amount [)] of Medicare Part B eligible

expenses (generally 20 percent of the approved amount; 50 percent of the approved charges for outpatient psychiatric services), regardless of hospital confinement, subject to the Medicare Part B deductible.

4. - 12. (No change.)

11:4-23.12 Guaranteed issue for eligible persons

(a) Eligible persons are those individuals described in (c) below who [apply] **seek** to enroll under the policy [not later than 63 days after the date of the termination of enrollment described in (c)] **during the period specified in (d)** below, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(b) With respect to eligible persons, a carrier shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in [(d)] **(f)** below that is offered and is available for issuance to new enrollees by the carrier, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(c) An eligible person is an individual described in any of the following paragraphs:

1. - 2. (No change.)

3. The individual is enrolled with a Medicare + Choice organization under a Medicare + Choice Plan under Part C of Medicare, and any of the [following] circumstances **described in (c)3i through iv below** apply[:]**, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare + Choice plan**:

i. - iv. (No change.)

4. The individual is enrolled with any of the following, and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under (c)3 above:

i. An eligible organization under a contract under Section 1876 (42 U.S.C. §.1395mm) **of the Social Security Act** (Medicare [risk or] cost);

ii. (No change.)

iii. An organization under an agreement under Section 1833(a)(1)(A) (42 U.S.C. §.1395) **of the Social Security Act** (health care prepayment plan); or

iv. (No change.)

5. (No change.)

6. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare + Choice organization under a Medicare + Choice plan under Part C of Medicare, any eligible organization under a contract under Section 1876 (42 U.S.C. § 1395mm) **of the Social Security Act** (Medicare [risk or] cost), any similar organization operating under demonstration project authority, [an organization under an agreement under Section 1833(a)(1)(A) (42 U.S.C. §. 1395) (health care prepayment plan,] **any PACE provider under Section 1894 of the Social Security Act (42 U.S.C.A. § 1395eee),** or a Medicare Select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) (42 U.S.C. § 1395w-2) of the Federal Social Security Act); or

7. The individual, upon first becoming [enrolled in] **eligible for benefits under** Medicare Part [B] **A** [for benefits] at age 65 or older, enrolls in a Medicare + Choice plan under Part C of Medicare, **or with a PACE provider under Section 1894 of the Social Security Act (42 U.S.C. § 1395eee),** and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

(d) The guaranteed issue time periods shall be:

1. In the case of an individual described in (c)1 above,

the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, in the absence of the receipt of such notice, the individual receives notice that a claim has been denied because of such a termination or cessation and ends 63 days after the date of the applicable notice;

2. In the case of an individual described in (c)3, 4, 6 or 7 above whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of such termination and ends 63 days after the date the applicable coverage is terminated;

3. In the case of an individual described in (c)5i above, the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated. The guaranteed issue period ends on the date that is 63 days after the date the coverage is terminated;

4. In the case of an individual described in (c)3, 5ii or 5iii, or (c)6 or 7 above who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; or

5. In the case of an individual described in (c) above but not described in the preceding paragraphs of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(e) The following shall apply to extended Medicare Supplement access for interrupted trial periods:

1. In the case of an individual described in subsection (c)6 above (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in (c)6 above is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in (c)6 above;

2. In the case of an individual described in (c)7 above (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in (c)7 above is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in (c)7 above; and

<u>3. For purposes of (c)6 and 7 above, no enrollment of an individual with an organization or provider described in (c)6 above, or with a plan or in a program described in (c)7 above, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.</u>

Recodify existing (d) - (f) as (f) as (h) (No change in text.)

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