INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Minimum Standards for Medicare Supplement Coverage

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

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

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

Authorized By: Donald Bryan, Acting Commissioner, Department of Banking and Insurance

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

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

Proposal Number: PRN 2005-164

Submit comments by July 1, 2005 to:

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The agency proposal follows:

Summary

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173 (MMA) was signed by the President on December 8, 2003. Among

other things, it added Part D to Medicare, providing prescription drug benefits. It also required the National Association of Insurance Commissioners (NAIC) to make several changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act to conform to the Federal law. The bill provided a nine-month time frame for the NAIC to amend its model regulation to conform to MMA. The NAIC met this deadline by conducting an electronic vote on September 8, 2004. The specific revisions to the model regulation required by MMA included: (1) Add two new plans (called K and L in the amendments) to the standard Medigap plans A through J; (2) Revise the standard H, I and J plans to eliminate prescription drug coverage for those who enroll in Medicare Part D; (3) Prohibit the sale of prescription drug coverage in Medigap after December 30, 2005 (that is. when Part D comes into effect); and (4) Make any other changes to the model regulation that might be required as a result of the legislation. The NAIC task force only considered changes that were directly related to the unambiguous changes the NAIC needed to make as a result of the bill, with some minor exceptions for clarification purposes. Therefore, in order to conform to Federal law, foster uniformity and cooperation among the states and to maintain Federal certification of New Jersey's Medicare Supplement regulatory program, the following rules and amendments based on the model regulations are proposed.

Specifically, the term "Medicare+Choice" is removed and replaced with the term "Medicare Advantage" throughout the subchapter. In N.J.A.C. 11:4-23.3, the definition of "Medicare supplement policy" is amended to clarify that it does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that

provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

N.J.A.C. 11:4-23.4(a)4 is amended to clarify that the definition of "health care expenses" is for purposes of N.J.A.C. 11:4-23.11.

N.J.A.C. 11:4-23.4(a)7 is amended to clarify that "Medicare eligible expenses" shall mean those expenses covered by Medicare Parts A and B. Pursuant to N.J.A.C. 11:4-23.4(a), no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

New subsections are added at N.J.A.C. 11:4-23.5(d), (e) and (f) concerning the issuance or renewal after December 31, 2005, of Medicare supplement plans with benefits for outpatient prescription drugs. Specifically, N.J.A.C. 11:4-23.5(d) states the conditions under which a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D, at the option of the policyholder. N.J.A.C. 11:4-23.5(e) prohibits a Medicare supplement policy with benefits for outpatient prescription drugs from being issued after December 31, 2005 and N.J.A.C. 11:4-23.5(f) sets forth the conditions for renewing such a Medicare supplement policy after a policyholder enrolls in Medicare Part D. Those conditions are that the policy must be modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan and premiums must be adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment.

N.J.A.C. 11:4-23.6(b)5 is amended to clarify that receipt of Medicare Part D benefits will not be considered in determining continuous loss upon termination of a Medicare supplement policy or certificate.

N.J.A.C. 11:4-23.6(b)7 is added to state that if a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of the subchapter.

The minimum benefit standards for policies and certificates codified at N.J.A.C. 11:4-23.8(c)3 regarding reinstitution of suspended coverage are being amended to provide that if the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension.

N.J.A.C. 11:4-23.8(e)8, 9 10 and 11 are amended to state that the Basic Outpatient Prescription Drug Benefit and the Extended Outpatient Prescription Drug Benefit shall not be included in a Medicare supplement plan sold after December 31, 2005

The Coverage rules for Standardized Medicare supplement benefit plans K through L are added at N.J.A.C. 11:4-23.8(e)12 and 13, respectively. The rules delineate the percentage and duration of coverage for each Medicare plan. The rules address percentage of coverage for hospital coinsurance, skilled nursing facilities, hospice, and respite care, costs for blood, and out of pocket limitations for applicable Medicare supplement plans.

N.J.A.C. 11:4-23.8(f) is amended to reference the new Medicare supplement plans K and L.

In N.J.A.C. 11:4-23.8(g)1iv, "transferring" is added to activities of daily living for at-home recovery services. N.J.A.C. 11:4-23.8(g)2 is amended to state that the outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

N.J.A.C. 11:4-23.8(g)3iii is amended to reflect the changes to the definition of "Core Benefit" describing the payment methodology for Medicare Part A eligible expenses for hospitalization upon exhaustion of Medicare hospital inpatient coverage, including lifetime reserve days, up to a maximum lifetime benefit of 365 days. The benefits shall be paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment. Further, the provider shall accept the carrier's payment as payment in full and may not bill the insured for any balance.

N.J.A.C. 11:4-23.8(g)5 is amended to state that the outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

At N.J.A.C. 11:4-23.8(g)11, the "Preventive Medical Care Benefit" is amended to clarify that the attending physician determines the selection and frequency of preventive screening and/or preventive services associated with the annual clinical preventive medical history and physical examination.

N.J.A.C. 11:4-23.9(d) is amended to add a reference to the limitation at N.J.A.C. 11:4-23.12 and update a reference to N.J.A.C. 11:4-23.15(d) to N.J.A.C. 11:4-23.16(d).

N.J.A.C. 11:4-23.12(a) and (c) are amended to add another definition of eligible person for guaranteed issue, that being an individual that enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminated enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in N.J.A.C. 11:4-23.12(f).

N.J.A.C. 11:4-23.12(d)5 is recodified as (d)6 and new N.J.A.C. 11:4-23.12(d)5 is added to define the guaranteed issue time periods in the case of those eligible persons described at new N.J.A.C. 11:4-23.12(c)8 as beginning on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement carrier during the 60 day period immediately preceding the initial Part D enrollment period and ending on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

N.J.A.C. 11:4-23.12(f) is amended to add Medicare supplement policy F with a high deductible, K or L offered by any carrier. New language is added stating that, after December 31, 2005, if the Medicare supplement policy under which an eligible person entitled under N.J.A.C. 11:4-23-12(c)6 was most recently enrolled is a Medicare supplement policy with an outpatient prescription drug benefit, the eligible person will be entitled to the same policy from the same carrier but modified to remove outpatient prescription drug coverage, or the eligible person may elect a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F(including F with a high deductible), K or L offered by any carrier. The Medicare supplement policy to which

eligible persons are entitled under N.J.A.C. 11:4-23.12(c)8 is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F(including F with a high deductible), K or L that is offered and is available for issuance to new enrollees by the same carrier that issued the eligible person's Medicare supplement policy with outpatient prescription drug coverage.

N.J.A.C. 11:4-23.13(g) is added to provide that when outpatient prescription drug benefits are removed from a Medicare supplement policy or certificate delivered or issued for delivery in this State as required by the MMA, the form used to endorse or amend the policy or certificate must be submitted to and filed by the Commissioner.

N.J.A.C. 11:4-23.15(a) is amended to change the reference to the Health Care Financing Administration to the Centers for Medicare and Medicaid Services and N.J.A.C. 11:4-23.15(b)3 is amended to update the reference to "all plans" from A to J to the A to L.

A new rule is added at N.J.A.C. 11:4-23.15(e) which requires carriers to comply with any notice requirements of the MMA.

N.J.A.C. 11:4-23.16 is amended to require application forms to address questions necessary to ascertain whether, as of the date of the application, the applicant currently has a Medicare supplement policy or Medicare Advantage, Medicaid coverage or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policies or certificates in force. The requirement regarding direct carriers is deleted to conform the language to the NAIC Model.

N.J.A.C. 11:4-23.19(c) is added to state that a carrier shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination of the individual's Part C coverage.

N.J.A.C. 11:4-23.21 is amended to update the address for submissions to reflect changes made within the Department.

The existing subchapter's Appendix is repealed and is replaced by a new Appendix containing all the forms attached to the model regulation. The new forms reflect the changes made to the rules above, such as the substitution of the title "Medicare+Choice" with "Medicare Advantage" and the inclusion Medicare Supplement Plans K and L.

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

In New Jersey, Medicare Supplement Insurance covers approximately 300,000 Medicare beneficiaries, and is provided by approximately 10 carriers. The availability of affordable Medicare Supplement Insurance is important to the health and financial security of these Medicare beneficiaries who lack other resources (such as health plans of an employer or former employer, Medicare Advantage and similar programs, or social programs such as Medicaid) to pay for medical expenses not covered by Medicare.

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The Department anticipates that the proposed amendments, repeal and new rule will have a beneficial social impact on carriers who offer supplemental insurance. Conforming New Jersey's rules to the model regulation and the Federal regulations mandated by the MMA such as the addition of two new plans and the elimination of prescription drug coverage allows New Jersey carriers to retain Federal certification of their Medicare Supplement regulatory program. This should enhance the availability and as well as the affordability of Medicare Supplement Insurance. Further, by conforming to the changes mandated by the MMA, the proposed amendments, repeal and new rules give carriers the means to comply with the new Federal mandates without adding an additional layer of regulatory authority.

The Department anticipates that these amendments, repeal and new rule will result in greater predictability of, and in the increased availability of Medicare Supplement insurance products.

Economic Impact

The proposed amendments, repeal and new rule are expected to have a positive economic impact on carriers and consumers. Uniformity of product throughout the country saves carriers the expense of modifying their products from state to state. Further, the elimination of an additional layer of regulatory authority as referred to in Social Impact above, positively impacts carriers by avoiding redundant expenses and other costs of compliance. Consumers are positively economically impacted by the increased availability of coverage and the reduced cost of that coverage, as opposed to the cost of state-specific products.

It is also possible that the uniformity of the rules will have a positive economic impact on the Department, as any expense incurred in researching and generating state specific regulations may be saved. The proposed amendments are expected to have a positive economic impact on carriers and consumers. Uniformity of product throughout the country saves carriers the expense of modifying their products from state to state. Consumers are positively economically impacted by the increased availability of coverage and the reduced cost of that coverage, as opposed to the cost of state-specific products.

It is also possible that the uniformity of the rules will have a positive economic impact on the Department, as any expense incurred in researching and generating state specific regulations may be saved.

Federal Standards Statement

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

Jobs Impact

The Department does not believe that the proposed amendments, repeal and new rule will cause any jobs to be generated or lost. The Department invites interested parties to submit any data or studies concerning the jobs impact of the proposed amendments, repeal and new rule.

Agriculture Industry Impact

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

Regulatory Flexibility Statement

The Department does not believe that any of the carriers providing Medicare supplemental insurance affected by the proposed amendments, repeal and new rule employ fewer than 100 full-time employees and are small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, no regulatory flexibility analysis is required. The Department notes that if a small business were affected in the future, the application of the proposed standards to that small business would be appropriate because they are necessary for the Department to efficiently perform its regulatory function in this area and to maintain consistency with the NAIC model and Federal law. The standards are applicable irrespective of the size of the regulated entity.

Smart Growth Impact

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

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:4-23 Appendix to Subchapter 16 and 23.

Full text of the proposed Amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 23. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT COVERAGE

11:4-23.3 Definitions

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

. . .

"Bankruptcy" means when a [Medicare+Choice] **Medicare Advantage** organization that is not a carrier has filed, or has had filed against it, a petition for declaration of bankruptcy pursuant to the United States Bankruptcy Code, 11 U.S.C. §§ 101 et seq. and has ceased doing business in the State.

. . .

"[Medicare+Choice] **Medicare Advantage** plan" means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 of Title IV, Subtitle A, Chapter 1 of P.L. 105-33 (42 U.S.C. § 1395w-28), and includes:

1. (No change)

2. Medical savings account plans coupled with a contribution into a [Medicare+Choice] **Medicare Advantage** medical savings account; and

3. [Medicare+Choice] **Medicare Advantage** private fee-for-service plans.

"Medicare supplement policy" means a group or individual policy which is advertised, marketed or designed primarily as, or is otherwise held out to be a supplement to reimbursements under Medicare, other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 et seq.), or a contract or policy issued under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1). This term does not include a policy or certificate of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or combination thereof, of the labor organization. "**Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.**

11:4-23.4 Policy definitions and terms

(a) No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

1. - 3. (No change)

4. "Health care expenses" means**, for purposes of N.J.A.C. 11:4-23.11,** expenses of health maintenance organizations which expenses are associated with

the delivery of health care services and are analogous to incurred losses of insurers. Expenses shall not include the following costs:

i.-vii. (No change.)

5. - 6. (No change.)

7. "Medicare eligible expense" shall mean expenses of the kinds covered by Medicare **Parts A and B**, to the extent recognized as reasonable and medically necessary by Medicare.

8. - 11. (No change.)

11:4-23.5 Policy provisions

(a) - (c) (No change.)

(d) Subject to N.J.A.C. 11:4-23.6(b)4 and 7, 23.6(c), 23.7(c) and 23.8(b), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

(e) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(f) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

1. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

2. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

11:4-23.6 General minimum benefit standards

(a) (No change.)

(b) The following general standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this subchapter.

1. - 4. (No change.)

5. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the covered person limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. **Receipt of Medicare Part D benefits will not be considered in determining continuous loss.**

6. (No change.)

7. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subchapter.

(c) (No change.)

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 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. § 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. - 2. (No change.)

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

i. (No change.)

ii. Provide for **resumption of** coverage [which] **that** is substantially equivalent to the coverage that was in effect before the date of the suspension**. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension**; and

iii. (No change.)

(d) (No change.)

(e) Carriers may offer to all applicants policies or certificates providing the core benefits and additional benefits defined at (g) below. Only those additional benefits defined at (g) below may be included in Medicare supplement policies or certificates delivered or issued for delivery in this State. Policies or certificates providing additional benefits shall be structured and designated as follows:

1. - 7. (No change.)

8. Standardized Medicare supplement benefit plan H shall provide:

i. - iii. (No change.)

iv. The Basic Outpatient Prescription Drug Benefit. **The Basic Outpatient Prescription Drug Benefit shall not be included in a Medicare supplement plan sold after December 31, 2005**; and

v. (No change.)

9. Standardized Medicare supplement benefit plan I shall provide:

i. - iv. (No change.)

v. The Basic Outpatient Prescription Drug Benefit. **The Basic Outpatient Prescription Drug Benefit shall not be included in a Medicare supplement plan sold after December 31, 2005**; [and]

vi. - vii. (No change.)

10. Standardized Medicare supplement benefit plan J shall provide:

i. - v. (No change.)

vi. The Extended Outpatient Prescription Drug Benefit. **The Extended Outpatient Prescription Drug Benefit shall not be included in a Medicare supplement plan sold after December 31, 2005**;

vii. - ix. (No change.)

11. Standardized Medicare supplement benefit high deductible plan J shall provide 100 percent of covered expenses following the payment of the annual high deductible plan J deductible, and shall provide: the Core Benefit; the Medicare Part A Deductible benefit; the Skilled Nursing Facility Care benefit; the Medicare Part B Deductible benefit; the One Hundred Percent (100 percent) of the Medicare Part B Excess Charges Benefit; the Extended Outpatient Prescription Drug Benefit; the Medically Necessary Emergency Care in a Foreign Country benefit; the Preventive Medical Care Benefit; and the At-Home Recovery Benefit. **The Extended Outpatient Prescription Drug Benefit shall not be included in a Medicare supplement plan sold after December 31, 2005.** The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.00.

12. Standardized Medicare supplement benefit plan K shall provide:

i. Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

ii. Coverage of 100 percent of the Part A hospital coinsurance for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

iii. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the carrier's payment as payment in full and may not bill the insured for the balance;

iv. Coverage of 50 percent of the Medicare Part A Deductible until the out-of-pocket limitation is met as described in (e)12x below;

v. Coverage for 50 percent of the coinsurance amount for each day from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in e(12)x below;

vi. Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses for hospice and respite care until the out-of-pocket limitation is met as described in (e)12x below;

vii. Coverage for 50 percent under Medicare A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations until the out-of-pocket limitation is met as described in subparagraph e(12)x below.

viii. Except for coverage provided in (e)12ix below, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (e)12x below;

ix. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible;

x. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

13. Standardized Medicare supplement benefit plan L shall provide:

i. Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

ii. Coverage of 100 percent of the Part A hospital coinsurance for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

iii. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the carrier's payment as payment in full and may not bill the insured for the balance;

iv. Coverage of 75 percent of the Medicare Part A Deductible until the out-of-pocket limitation is met as described in (e)13x

v. Coverage for 75 percent of the coinsurance amount for each day from the 21st day through the hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (e)13x below;

vi. Coverage for 75 percent of cost sharing for all Part A Medicare eligible expenses for hospice and respite care until the out-of-pocket limitation is met as described in (e)13x;

vii. Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations until the out-of-pocket limitation is met as described in (e)13x below.

viii. Except for coverage provided in (e)13ix below, coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (e)13x below;

ix. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible;

x. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(f) No groupings, packages or combinations of Medicare supplement benefits shall be offered which differ from the standardized Medicare supplement benefit plans

specified in (d) and (e) above, except as an Innovative Benefit which may be approved by the Commissioner. Benefit plans shall be uniform in structure, language, designation and format to the standardized Medicare supplement benefit plans A, B, C, D, E, F, G, H, I [and]**,** J **, K and L** as set forth in (d) and (e) above. For purposes of this section, "structure," "language," and "format" means style, arrangement and overall content of a benefit.

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

1. "At-Home Recovery Benefit" means coverage for services to provide short term, at-home assistance with activities of daily living for persons recovering from an illness, injury or surgery. At-home recovery services shall be services which are designed primarily to assist with activities of daily living.

i. -iii (No change.)

iv. Activities of daily living shall include, but not be limited to, bathing, dressing, personal hygiene, **transferring,** eating, ambulating, assistance with drugs that are normally self-administered, and changing of bandages or other dressings.

v. - vii. (No change.)

2. "Basic Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a $250.00 calendar year deductible and a maximum per calendar year benefit per insured of $1,250. **The basic outpatient prescription**

drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

3. "Core Benefit" means coverage of:

i-ii. (No change.)

iii. **One hundred percent of** Medicare Part A eligible expenses for hospitalization upon exhaustion of Medicare hospital inpatient coverage, including lifetime reserve days, up to a maximum lifetime benefit of 365 days, to be paid at the [Diagnostic Related Group (DRG) outlier per diem] **applicable prospective payment system (PPS) rate**, or other appropriate **Medicare** standard of payment [as set forth by the Health Care Financing Administration of the United States Department of Health and Human Services for Medicare payments when DRG day outlier payment is not appropriate] **The provider shall accept the carrier's payment as payment in full and may not bill the insured for any balance**;

iv. - v. (No change.)

4. (No change.)

5. "Extended Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a $250.00 deductible per calendar year, and a maximum per calendar year per insured benefit of $3,000. **The extended outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

6. - 10. (No change.)

11. "Preventive Medical Care Benefit" means coverage of the following services not otherwise covered by Medicare in the calendar year for the actual charges up to 100 percent of the Medicare-approved amount for each service (as if Medicare were to cover the service as identified in the American Medical Association Current Procedural Terminology Codes), subject to a maximum benefit of $120.00 per calendar year:

i. An annual clinical preventive medical history and physical examination that shall include patient education to address preventive health care measures and [any one or a combination of the following] preventive screening tests [or] **and/or** preventive services, the **selection and** frequency of which is [considered] **determined to be** medically appropriate **by the attending physician**[:]**.**

[(1) Fecal occult blood test and/or digital rectal examination;

(2) Mammogram;

(3) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(4) Pure tone (air only) hearing screening test administered or ordered by a physician;

(5) Serum cholesterol screening (every five years);

(6) Thyroid function test; and

(7) Diabetes screening;

ii. Influenza vaccine administered at any appropriate time during a calendar year;

iii. Tetanus and diphtheria booster (every 10 years); and

iv. Other tests or preventive measures determined appropriate by the attending physician.]

12. "Skilled Nursing Facility Care" means coverage for the actual billed charges up to the Medicare coinsurance amount from the 21st day through the 100th day in a Medicare benefit period, for [posthospital] **post-hospital** skilled nursing facility care eligible under Medicare Part A.

11:4-23.9 Open enrollment

(a) - (c) (No change.)

(d) Except as provided in N.J.A.C. 11:4-[23.15(d)] **23.12, 23.16(d)** and in (b) and (c) above, nothing in (a) above shall be construed to prohibit or limit a carrier's use of permissible preexisting condition exclusion provisions in any Medicare supplement policy or certificate as set forth in this subchapter.

11:4-23.12 Guaranteed issue for eligible persons

(a) Eligible persons are those individuals described in (c) below who seek to enroll under the policy during the period specified in (d) below, and who submit evidence of the date of termination [or]**,** disenrollment**, or Medicare Part D enrollment** with the application for a Medicare supplement policy.

(b) (No change.)

(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] **Medicare Advantage** organization under a [Medicare+Choice] **Medicare Advantage** Plan under Part C of Medicare, and any of the 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] **Medicare Advantage** plan:

i. - iv. (No change.)

4. - 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] **Medicare Advantage** organization under [Medicare+Choice] **Medicare Advantage** 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 cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act (42 U.S.C. § 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 eligible for benefits under Medicare Part A at age 65 or older, enrolls in a [Medicare+Choice] **Medicare Advantage** 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[.]**; or**

8. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminated enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in (f) below.

(d) The guaranteed issue time periods shall be:

1. - 3. (No change.)

4. In the case of an individual described in (c)3, 5ii or iii, 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 63 days after the effective date; [or]

5. In the case of an individual described in (c)8 above, the guaranteed issue period begins on the date the individual receives notice pursuant to

Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement carrier during the sixty-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

[5] **6**. (No change in text.)

(e) (No change.)

(f) The Medicare supplement policy to which eligible persons are entitled under (c)1, 2, 3, 4 and 5 above is a Medicare supplement policy which has a benefit package classified as Plan A, B, C [or]**,** F **(including F with a high deductible), K or L** offered by any carrier. The Medicare supplement policy to which eligible persons are entitled under (c)6 above is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same carrier, or, if not so available, a policy described in the preceding sentence. **However, after December 31, 2005, if the Medicare supplement policy, under which an eligible person entitled under (c)6 above was most recently enrolled, is a Medicare supplement policy with an outpatient prescription drug benefit, the eligible person described in (c)6 above will be entitled to the same policy from the same carrier but modified to remove outpatient prescription drug coverage, or the eligible person may elect a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F(including F with a high deductible), K or L offered by any carrier.** The Medicare supplement policy to which eligible persons are entitled under (c)7 above shall include any Medicare supplement policy offered by any carrier. **The Medicare supplement policy to which eligible persons are entitled under (c)8 above is a Medicare**

supplement policy which has a benefit package classified as Plan A, B, C, F(including F with a high deductible), K or L that is offered and is available for issuance to new enrollees by the same carrier that issued the eligible person's Medicare supplement policy with outpatient prescription drug coverage.

(g) -(h) (No change.)

11:4-23.13 Filing requirements for policies, certificates and premium rates

(a) - (f) (No change.)

(g) When outpatient prescription drug benefits are removed from a Medicare supplement policy or certificate delivered or issued for delivery in this State as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the form used to endorse or amend the policy or certificate must be submitted to and filed by the Commissioner in accordance with (a) above.

11:4-23.15 Required disclosure provisions

(a) General rules concerning required disclosure provisions include the following:

1. -5. (No change.)

6. Carriers issuing policies or certificates which provide hospital or medical expense coverage on an expense incurred, indemnity, or service benefit basis to persons eligible for Medicare shall provide to all applicants an informational brochure entitled "Guide to Health Insurance for People with Medicare", hereinafter referred to as "the Guide", in the form developed jointly by the National Association of Insurance Commissioners and the [Health Care

Financing Administration] **Centers for Medicare and Medicaid Services**. The Guide is intended to improve the buyer's understanding of Medicare and ability to select the most appropriate coverage. Delivery of the Guide shall be made whether or not policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as set forth by this subchapter.

7. - 9. (No change.)

(b) Outline of Coverage requirements for Medicare supplement policies and certificates shall include:

1-2. (No change)

3. The outline of coverage provided to applicants pursuant to (b)1 above shall be in the language and format prescribed in Exhibit D of the Appendix [to subchapters 16 and 23] of this chapter, incorporated herein by reference, in no less than 12 point type. The outline of coverage shall consist of a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the carrier. All plans A through [J] **L** shall be shown on the cover page, and the plan(s) offered by the carrier shall be prominently identified. Premium information for the plan(s) offered by the carrier shall be provided on the cover page, or immediately following the coverage page, clearly and prominently, specifying both the premium and the mode. All possible premiums for the applicant on all plans offered to the applicant by the carrier shall be illustrated.

(c)- (d) (No change.)

(e) Carriers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

11:4-23.16 Requirements for application forms and replacement coverage

(a) Application forms shall include the following questions designed to elicit information as to whether**, as of the date of the application, the applicant currently has** a Medicare supplement **or Medicare Advantage, Medicaid coverage or another health insurance** policy or certificate **in force or whether a Medicare supplement policy or certificate** is intended to [be additional to] **replace** any **other accident and sickness**[such] policies or certificates **in force**. A supplementary application or other form to be signed by the applicant and agent may be used. [In the case of a direct response carrier, a copy of the application or supplemental application, signed by the applicant and acknowledged by the carrier, shall be returned to the applicant by the carrier upon delivery of the policy or certificate.] The application form or supplementary application form shall contain the questions and statements set forth below.

1. Statements shall be as follows:

i. (No change.)

ii. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage**s**.

iii. (No change.)

iv. [The] **If after purchasing this policy, you become eligible for Medicaid, the** benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement

to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your **suspended Medicare supplement** policy **(or, if that is no longer available, a substantially equivalent policy)** will be reinstituted if requested within 90 days of losing Medicaid eligibility. **If the Medicare supplement policy provided coverage for outpatient prescription drugs and you were enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.**

v. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based health plan. If the Medicare supplement policy provided for outpatient prescription

drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will be substantially equivalent to your coverage before the date of suspension.

[v.]**vi.** (No change in text.)

2. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[2.] **3.** Questions, **which shall be** numbered 1, 2, 3 [and]**,** 4 **and 5**, shall be as follows and shall be prefaced by the statement "To the best of your knowledge" **and, unless noted differently, should be answered yes or no**:

[i. Do you have another Medicare supplement policy or certificate in force? If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?

ii. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(1) If so, with which company?

(2) What kind of coverage?

iii. Are you covered for medical assistance through the State Medicaid program:

(1) As a Specified Low-Income Medicare Beneficiary (SLMB)?

(2) As a Qualified Medicare Beneficiary (QMB)?

(3) For other Medicaid medical benefits?]

i. (1) Did you turn 65 in the last 6 months?

(A) Yes ____ No ____

(2) Did you enroll in Medicare Part B in the last 6 months?

(A) Yes ____ No ____

(3) If yes, what is the effective date?

(A) _____

ii. Are you covered for medical assistance through the State Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend_Down Program" and have not met your "Share of Cost", please answer NO to this question.)

(1) Yes ____ No ____ If yes

(A) Will Medicaid pay your premiums for this Medicare supplement policy?

(B) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

iii. (1) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example. a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

(A) START __/ / END / / ____

(2) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

(A) Yes ____ No ____

(3) Was this your first time in this type of Medicare plan?

(A) Yes ____ No ____

(4) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

(A) Yes ____ No ____

iv. (1) Do you have another Medicare supplement policy in force?

(A) Yes ____ No ____

(2) If so, with what company, and what plan do you have (optional for Direct Mailers)?

(A) _____

_____

(3) If so, do you intend to replace your current Medicare supplement policy with this policy?

(A) Yes ____ No ____

v. (1) Have you had coverage under any other health insurance plan within the last 63 days?

(A) Yes ____ No ____

(2) If so, with what company and what kind of policy?

(A) _____

_ _____ _____

_ _____

_____ _____

(3) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

(A) START __/ / END / / ____

(b) - (e) (No change.)

11:4-23.19 Appropriateness of recommended purchase and excessive coverage

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

(c) A carrier shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination of the individual's Part C coverage.

11:4-23.21 Addresses for submissions for filing

(a) All forms, rates, loss ratio reporting and advertisements submitted for filing with or by the Commissioner shall be submitted to the [Division] **Office** of Life and Health Actuarial Services, New Jersey Department of Insurance, PO Box 470, Trenton, New Jersey 08625-0470 [directed to specific bureaus as follows:

1. Managed Care Bureau, for submissions from health maintenance organizations, dental plan organizations, and dental service corporations; and

2. Health Bureau, for submissions from insurers and health, hospital and medical service corporations].

(b) (No change.)

Full text of the proposed new rule follows:

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