INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Minimum Standards for Medicare Supplement Coverage

Proposed Repeal and New Rule: N.J.A.C. 11:4-23 Appendix Exhibit D

Proposed Amendments: N.J.A.C. 11:4-23.3, 23.6, 23.7, 23.8 and 23.15

Proposed New Rules: N.J.A.C. 11:4-23.a and 23.24

Authorized By: Steven M. Goldman, 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 2009-74

Submit comments by May 1, 2009 to:

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The agency proposal follows:

Summary

The conference report of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173 included language encouraging the National Association of Insurance Commissioners (NAIC) to modernize the Medigap market. This language prompted a review of Medigap plans and benefits, and in 2005 the NAIC formed a Subgroup to develop a modernization proposal. In March 2007, the NAIC Plenary approved this modernization proposal, in the form of

revisions to the NAIC Medigap model. However, at the time states were unable to adopt the revisions until further congressional authority was enacted.

On July 15, 2008, this authority was granted by the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110-175 (MIPPA). In addition, on May 21, 2008 Congress enacted the Genetic Information Nondiscrimination Act of 2008, Pub. L. 110-233 (GINA). This law also calls for changes to the NAIC Medigap model. Pursuant to Section 104(c), the effective date of GINA is May 21, 2009. However, Section 104(d) provides that states, such as New Jersey, which require regulatory changes to conform their rules to the new GINA requirements, will not be considered out of compliance if the GINA changes are implemented by July 1, 2009. A new NAIC Medigap model encompassing these changes was adopted by the NAIC Plenary on September 24, 2008 and on October 2, 2008, a new Model was published.

The changes to the Medigap model that comply with MIPPA must be adopted by September 24, 2009. However, the changes to effectuate compliance with GINA must be implemented by July 1, 2009. Therefore, in order to be in full compliance with the Federal requirements, the new rules and amendments proposed herein must be adopted by July 1, 2009.

The revisions to the NAIC model required by the MIPPA included: (1) the elimination of plans E, H, I and J from the standard Medigap plans A through L; (2) the addition of two new plans (called M and N in the revision); (3) the creation of a new hospice benefit which is added to every plan as a part of Basic (core) benefits; (4) the elimination of the "at-home recovery" benefit and the "preventative care" benefit; and (5) the replacement of the 80 percent Part B Excess Charges Benefit with 100% Benefit.

MIPPA provides that policyholders may keep their old policies. Therefore, the NAIC model contains definitions which clarify the distinctions among Medicare supplement benefit plans. The

proposed amendments to N.J.A.C 11:4-23.3 include the proposed definitions differentiating the various Medicare supplement plans. The new series of benefit plans, which cannot be effective until on or after June 1, 2010, is identified as "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan," or "2010 plan" and defined as a group or individual policy of Medicare supplemental insurance issued on or after June 1, 2010. The existing Medigap plans are identified as either: "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan," or "1990 plan," defined as a group or individual policy of Medicare supplement insurance issued on or after January 4, 1993 and prior to June 1, 2010 and which includes Medicare supplement insurance policies and certificates renewed on or after June 1, 2010 which are not replaced by the carrier at the request of the insured; or as the "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan," defined as a group or individual policy of Medicare supplement insurance issued prior to January 4, 1993.

The changes to the NAIC Medigap model to comply with GINA are being proposed as N.J.A.C. 11:4-23.24. This new rule, effective for all policies with policy years beginning on or after May 21, 2009, prohibits an issuer of a Medicare supplement policy or certificate from denying or conditioning the issuance or effectiveness of the policy or certificate on the basis of the genetic information with respect to such individual. GINA also limits the ability of Medicare supplement carriers from requesting or requiring genetic testing, and prohibits the collection of genetic information for underwriting purposes or other purposes prior to enrollment. The term "underwriting" can be used to refer to the process of accepting or rejecting applications for the initial issuance and renewal of coverage or to the process of rating a particular policy, or both. In these rules the term is used to refer to both processes.

N.J.A.C. 11:4-23.6(b)3 is amended to provide that benefits designed to cover the coinsurance amounts not covered under Medicare will, like the treatment of the applicable Medicare deductible and copayment under the current rule, be changed automatically to coincide with any changes in the applicable Medicare coinsurance amounts. N.J.A.C. 11:4-23.6(c)1ii is amended to reference the minimum standards to be offered prior to, and on and after, June 1, 2010.

The headings of N.J.A.C. 11:4-23.7 and 23.8 and the text of N.J.A.C. 11:4-23.8(a) are amended to include terminology consistent with the proposed and amended rules and differentiate these provisions from those applicable to the 2010 plan. N.J.A.C. 11:4-23.8(c)4 is added to provide for the standards for making a written offer to exchange a 1990 Standardized plan for a 2010 Standardized plan.

Proposed new rule N.J.A.C. 11:4-23.8A sets forth the minimum benefit standards for 2010 Standardized Medicare supplement benefit plan policies or certificates for delivery on or after June 1, 2010 for Plans A, B,C,D,F,G,K,L,M and N to conform to the NAIC Model.

N.J.A.C. 11:4-23.24 sets forth the prohibitions against the use of genetic information and requests for genetic testing as required by GINA. This new rule, to be effective for all policies with policy years beginning on or after May 21, 2009, prohibits an issuer of a Medicare supplement policy or certificate from denying or conditioning the issuance or effectiveness of the policy or certificate on the basis of the genetic information with respect to any individual. GINA also limits the ability of Medicare supplement carriers to request genetic testing, and prohibits the collection of genetic information for underwriting purposes or other purposes prior to enrollment.

N.J.A.C. 11:4-23 Appendix Exhibit D, which contains the current standardized marketing material for group or individual policies of Medicare supplement insurance issued on or after January 4, 1993 and prior to June 1, 2010, is proposed to be repealed and replaced with a new

Exhibit D which contains the standardized marketing material for 2010 plans and conforms to the NAIC model. It is intended that the repeal of current Exhibit D and adoption of proposed new Exhibit D will not become operative until June 1, 2010.

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 continues to be important to the health and financial security of these Medicare beneficiaries who lack other resources (such as employer or former employer health plans) to pay for medical expenses not covered by Medicare. Further, the health security of Medicare beneficiaries will be enhanced by the GINA prohibitions upon denying, conditioning or discriminating in the pricing of Medicare supplement insurance on the basis of genetic information.

The Department believes that the proposed amendments, repeal and new rules will have a beneficial effect on carriers, as conforming New Jersey's rules to the NAIC model and the Federal regulations mandated by MIPPA and GINA will enable the Department to retain Federal certification of its Medicare supplement regulatory program, thereby relieving carriers of the need to file for approval of their Medicare supplement forms and rates by the Federal government. The Department also anticipates that these new rules, repeal and amendments will result in greater predictability and availability of Medicare supplement products.

Economic Impact

The proposed amendments, repeal and new rules are expected to have a positive impact on consumers and carriers. Uniformity of product throughout the country saves carriers the expense of modifying their products from state to state. Consumers are positively impacted by the increased availability of coverage and the reduced costs of nationally standardized plans, as opposed to the higher cost of state-specific plans. Consumers may also benefit from GINA's prohibition against discrimination in pricing a Medicare supplement plan on the basis of genetic information.

The implementation of the new plans may have a negative impact on carriers, as they will incur the costs of developing and presenting the new products, and of training their employees about the new products. There may also be a minimal negative economic impact on the Department for utilizing the resources necessary to review the forms and rates on the new plans.

Federal Standards Statement

The proposed amendments, repeal and new rules 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.

Jobs Impact

The Department does not believe that the proposed amendments, repeal and new rules 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 rules.

Agriculture Industry Impact

The Department does not expect any agriculture impact from the proposed amendments, repeal and new rules (See 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 rules 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 rules have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact

The proposed amendments, repeal and new rule will have an insignificant impact on affordable housing in New Jersey and there is an extreme unlikelihood that the amendments, repeal and new rules would evoke a change in the average costs associated with housing because the

proposed amendments, repeal and new rules concern minimum standards for Medicare supplement insurance.

Smart Growth Development Impact

The Department believes that there is an extreme unlikelihood that the proposed amendments, repeal and new rules would evoke a change in housing production in Planning areas 1 or 2 or within designated centers under the State Development and Redevelopment Plan in New Jersey because the proposed amendments, repeal and new rules concern minimum standards for Medicare supplement insurance.

Full text of the rule proposal for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:4-23 Appendix Exhibit D.

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

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.

. . .

"1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan," or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after January 4, 1993 and prior to June 1, 2010 and includes Medicare

supplement insurance policies and certificates renewed on or after that date which are not replaced by the carrier at the request of the insured.

. . .

"Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to January 4, 1993.

. . .

"2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

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. - 2. (No change.)

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible**,** [amounts and] copayment [percentage factors, if any, in response to which premiums]**, or coinsurance amounts. Premiums** may be correspondingly modified subject to the requirements of N.J.A.C. 11:4-23.11.

4. – 7. (No change.)

(c) A carrier shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation. With respect to terminations of group policies, or membership in a group, the following standards shall apply:

1. If a group policyholder terminates the group Medicare supplement policy without replacing that policy as provided in (c)3 below, the carrier shall offer individuals covered under group policies at least the following two coverage choices:

i. (No change.)

ii. An individual Medicare supplement policy which provides only benefits that otherwise are required to meet N.J.A.C. 11:4-23.8 **if offered prior to June 1, 2010 and N.J.A.C. 11:4-23.8A(d) if offered on or after June 1, 2010**.

2. – 3. (No change.)

11:4-23.7 Minimum benefits for **Pre-Standardized Medicare supplement benefit plan** policies and certificates delivered or issued for delivery prior to January 4, 1993

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

11:4-23. 8. Minimum benefit standards for **1990 Standardized Medicare supplement benefit plan** policies and certificates delivered or issued for delivery on or after January 4, 1993 **and prior to June 1, 2010**

(a) No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy on or after January 4, 1993 **and prior to June 1, 2010**

unless it complies with the standards of N.J.A.C. 11:4-23.6 and the benefit standards set forth below.

(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. §1396v through 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. – 3. (No change.)

4. If an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan to a 2010 Standardized plan, the offer and subsequent exchange shall comply with the following requirements:

i. A carrier need not provide justification to the Commissioner if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of

the insured. The method proposed to be used by a carrier must be filed with the Commissioner.

ii. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

iii. A carrier may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

iv. The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or Federal law.

(d) – (g) (No change.)

11:4-23.8A Minimum benefit standards for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010

(a) No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy or certificate on or after June 1, 2010 unless it complies with the standards of N.J.A.C. 11:4-23.6 and the benefit standards set forth in this section. No carrier may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010.

(b) Medicare supplement policies shall be guaranteed renewable.

(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. §1396v through 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 resumption of coverage 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. 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) All carriers delivering or issuing for delivery in this State Medicare supplement policies or certificates of group Medicare supplement policies shall offer to all applicants a policy or certificate providing only the basic (core) benefits defined at (g) below. A policy or certificate providing only basic (core) benefits shall be designated as standardized Medicare supplement benefit plan A.

1. If a carrier makes available any additional benefits as described in (g)3 through 7 below or offers standardized benefit Plans K or L (as described in (e)7 and 8 below), then the carrier shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits (as described in (g)1 below), a policy form or certificate form containing the standardized benefit Plan C (as described in (e)2 below) or standardized benefit Plan F (as described in (e)4 below).

(e) Carriers may offer to all applicants policies or certificates providing the basic (core) benefits and additional benefits defined at (g) below. Only those additional benefits defined at (g) below may be included in 2010 Standardized Medicare plan 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. Standardized Medicare supplement benefit plan B shall provide:

i. The Basic (Core) Benefit; and

ii. One hundred percent of the Medicare Part A Deductible benefit:

2. Standardized Medicare supplement benefit plan C shall provide:

i. The Basic (Core) Benefit;

ii. One hundred percent of the Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Coverage of one hundred percent of the Medicare Part B Deductible; and

v. The Medically Necessary Emergency Care in a Foreign Country benefit.

3. Standardized Medicare supplement benefit plan D shall provide:

i. The Basic (Core) Benefit;

ii. One hundred percent of the Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit; and

iv. The Medically Necessary Emergency Care in a Foreign Country benefit.

4. Standardized Medicare supplement benefit Plan F shall provide:

i. The Basic (Core) Benefit;

ii. One hundred percent of the Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. One hundred percent of the Medicare Part B Deductible benefit;

v. One hundred percent of the Medicare Part B Excess Charges Benefit; and

vi. The Medically Necessary Emergency Care in a Foreign Country benefit.

5. Standardized Medicare supplement benefit high deductible plan F shall include 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible, and shall provide: the Basic (Core) Benefit; 100 percent of the Medicare Part A Deductible benefit; the Skilled Nursing Facility Care benefit; 100 percent of the Medicare Part B Deductible benefit; the 100 percent of Medicare Part B Excess Charges benefit; and the Medically Necessary Emergency Care in a Foreign Country benefit. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the

Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500, and shall be adjusted annually from 1999 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 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.00.

6. Standardized Medicare supplement benefit plan G shall provide:

i. The Basic (Core) Benefit;

ii. One hundred percent of the Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. One hundred percent of the Medicare Part B Excess Charges benefit; and

v. The Medically Necessary Emergency Care in a Foreign Country benefit.

7. 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)7x. 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)7x. 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)7x. 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 (e)7x below;

viii. Except for coverage provided in (e)7ix 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)7x below;

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

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.

8. 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)8x below;

v. Coverage for 75 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)8x 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)8x below;

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)8x below;

viii. Except for coverage provided in (e)8ix 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)8x below;

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

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.

9. Standardized Medicare supplement benefit plan M shall provide:

i. The Basic (Core) Benefit;

ii. Coverage of 50 percent of the Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit; and

iv. The Medically Necessary Emergency Care in a Foreign Country benefit.

10. Standardized Medicare supplement benefit plan N shall provide:

i. The Basic (Core) Benefit;

ii. One hundred percent of the Medicare Part A Deductible benefit subject to the copayment in (e)10v below;

iii. The Skilled Nursing Facility Care benefit subject to the copayment in (e)10v below; and

iv. The Medically Necessary Emergency Care in a Foreign Country subject to the copayment in (e)10v below; and

v. A copayment in the following amounts will apply to Part B benefits as described in (g)1v below:

(1) The lesser of $20.00 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(2) The lesser of $50.00 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency room visit is subsequently covered as a Medicare Part A expense.

(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, K, L, M and N 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. "Basic (Core) Benefit" means coverage of:

i. Medicare Part A eligible expenses for hospitalization from the 61st day through the 90th day in any Medicare benefit period, to the extent not covered by Medicare;

ii. Medicare Part A eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used, to the extent not covered by Medicare;

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 applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment. The provider shall accept the carrier's payment as payment in full and may not bill the insured for any balance;

iv. The reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by Federal regulations) under Medicare Parts A and B, unless replaced in accordance with Federal regulation;

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; and

vi. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

2. "Innovative Benefits" means benefits that a carrier may, with the prior approval of the Commissioner pursuant to N.J.S.A. 17B:26A-6, offer in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, are cost-effective, and do not adversely impact the goal of Medicare supplement simplification. Innovative benefits shall not include an

outpatient prescription drug benefit. Innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

3. "Medically Necessary Emergency Care in a Foreign Country" means coverage to the extent not covered by Medicare of 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if received in the United States, and which care began during the first 60 consecutive days of each trip outside the United States, to the extent billed charges are not covered by Medicare, and subject to a calendar year deductible of $250.00 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

4. "Medicare Part A Deductible" means coverage of 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

5. "Medicare Part B Deductible" means coverage of 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

6. "One hundred percent of the Medicare Part B Excess Charges" means coverage for all of the difference between the Medicare Part B approved charge and the actual Medicare Part B billed charge, up to but not exceeding any charge limitation established by the Medicare program or this State's law, if any.

7. "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 post-hospital skilled nursing facility care eligible under Medicare Part A.

11:4-23.15 Required disclosure provisions

(a) (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 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) – (e) (No change.)

11:4-23.24 Prohibition against use of genetic information and requests for genetic testing

(a) For all policies with policy years beginning on or after May 21, 2009, the following prohibitions against the use of genetic information and requests for genetic testing shall apply:

1. An issuer of a Medicare supplement policy or certificate shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual.

2. An issuer of a Medicare supplement policy shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

3. Nothing in (a)1 and/or 2 above shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, to:

i. Deny or condition the issuance or effectiveness of the policy or certificate or increase the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

ii. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

4. An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

5. An issuer of a Medicare supplement policy or certificate may obtain and use the results of a genetic test in making a determination regarding payment (as defined

at 45 CFR 164.501 for the purposes of applying the regulations promulgated under part C of Title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with (a)1 and 2 above.

6. For purposes of carrying out (a)5 above, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

7. Notwithstanding (a)4 above, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

i. The request is made pursuant to research that complies with part 46 of Title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

ii. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Non-compliance will have no effect on enrollment status or premium or contribution amounts.

iii. No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain

enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

iv. The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted; and

v. The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

8. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

9. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

10. If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of (a)9 above if such request, requirement, or purchase is not in violation of (a)8 above.

11. For the purposes of this section only:

i. "Issuer of a Medicare supplement policy or certificate" includes a third-party administrator, or other person acting for or on behalf of such issuer.

ii. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

iii. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

iv. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

v. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested

disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

vi. "Underwriting purposes" means,

(1) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(2) The computation of premium or contribution amounts under the policy;

(3) The application of any pre-existing condition exclusion under the policy; and

(4) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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