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ii. Paid claims per month exposed, including the impact, if any, of selection, duration (or year of issue), age and gender;

iii. Paid or written premium per month exposed, including the impact, if any, of selection, duration (or year of issue), age and gender;

iv. Total termination rates by duration (or year of issue), age and gender, including the impact of mode of premium payment, for the year for which the filing is effective;

v. New business to be issued, by age and gender, for the year for which the filing is effective;

vi. Trend factors in paid claims, by duration (or year of issue), age and gender, which trend factors shall only reflect the impact of aging and wear-off of selection after the year for which the filing is effective;

vii. A persistency assumption of 100 percent for years after the year for which the filing is effective, unless the carrier has withdrawn from the market pursuant to N.J.A.C. 11:4-23.13; and

viii. The interest rates to be used in accumulating or discounting paid premiums and claims, which rates shall equal the carrier's recent, current and future expected new investment return rates after investment expenses but before Federal income taxes.

6. The carrier shall submit the originally anticipated loss ratio for the form, the date of the initial rate filing, pursuant to (b) above, in which the originally anticipated loss ratio is given, the date of Department approval of the initial rate filing, and the effective date of the initial rate filing.

7. The carrier shall submit a certification signed by an actuary who is a member of the American Academy of Actuaries, stating that:

i. The assumptions used in the rate filing comply with this rule, are appropriate to the policy form, reasonably represent expected experience to the extent specified by this rule, and substantiate the calculation of the anticipated and aggregate loss ratios; and

ii. The anticipated and aggregate loss ratios, calculated according to the requirements of N.J.A.C. 11:4-23.11(c), exceed the originally anticipated loss ratio.

(d) Carriers shall submit revised rates for filing by the Commissioner. No carrier shall implement any rate revision until such rate revision has been filed. The same supporting documentation required by (c) above shall be submitted with the revised rates. Paid or written premiums and earned premiums as described by (c)2 above, and present value of future paid or written premiums and the sum of future paid or written premiums as described in (c)4 above shall be

submitted both with, and without, the requested rate revision. The supporting documentation shall use reasonable assumptions. The supporting documentation shall demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage and the aggregate loss ratio are at least as great as the originally anticipated loss ratio. The demonstration shall provide the required information and assumptions for each policy form, and shall provide them on a New Jersey basis and, if required by (g) below, shall also provide them on a national basis. Premiums on a national basis shall not be adjusted to reflect the difference, if any, between New Jersey rate levels and national rate levels.

1. For policies issued prior to January 4, 1993, expected claims in relation to premiums shall meet:

i. The originally filed loss ratio when combined with the actual experience since inception;

ii. The appropriate loss ratio requirement from (a)1 and 2 above when combined with actual experience beginning with July 1, 1996 to date; and

iii. The appropriate loss ratio requirement from (a)1 and 2 above over the entire future period for which the rates are computed to provide coverage.

2. In meeting the tests in (d)1i, ii and iii above and for purposes of attaining credibility, an insurer may combine experience under policy forms which provide substantially similar coverage subject to the approval of the Commissioner. Once a combined form is adopted, the insurer may not separate the experience except with the approval of the Commissioner. The Commissioner shall permit pooling in plans having less than 10,000 employee/policyholder months on an annual basis.

3. Prior to the effective date of enhancements in Medicare benefits, carriers shall:

i. Submit for filing appropriate premium adjustments required to produce loss ratios commensurate with the loss ratios anticipated for the current premium for the applicable policies or certificates, with accompanying documentation sufficient to justify the adjustment, in the opinion of the Commissioner; and

ii. Make premium adjustments to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards of (a) above, and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the carrier for the policies and certificates. No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described herein, shall be made at any time other than upon the policy renewal or anniversary date.

4. Every carrier shall submit for filing by the Commissioner a rate reduction whenever the expected aggregate loss ratio reported for a policy or certificate is less than the anticipated loss ratio for that policy or certificate, and the requirements of (c) above may not be met.

5. When a rate adjustment is requested pursuant to a change in the policy or certificate necessary to eliminate benefit duplication with Medicare, the submission for a rate change shall include any riders, endorsements, policy and certificate forms needed to accomplish the Medicare supplement coverage modification necessary to eliminate benefit duplications with Medicare. The forms shall result in a clear description of the Medicare supplement benefits provided by the policy.

6. If a carrier does not make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the appropriate loss ratio.

(e) Carriers shall submit for filing with the Commissioner annually on or before May 31 reports in accordance with the applicable reporting form contained in the Appendix to subchapters 16 and 23 of this chapter, Exhibit F, completed for each type in a standard Medicare supplement benefit plan.

1. If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), a refund or credit calculation shall be required.

i. The refund calculation shall be done on a Statewide basis for each type in a standard Medicare supplement benefit plan.

ii. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

iii. For purposes of this section, for policies or certificates issued prior to January 4, 1993, the carrier shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after May 31, 1996. The first report shall be due by May 31, 1998.

2. A refund or credit shall be made by carriers whenever the benchmark loss ratio exceeds the adjusted experience loss ratio, and the amount to be refunded or credited exceeds a de minimis level.

i. A refund or credit against premiums due shall be made no later than September 30 following the experience year upon which the refund or credit is based.

ii. The refunds and credits shall include interest accruing from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of

the United States Department of Health and Human Services, which in no event shall be less than the average rate of interest for 13-week Treasury notes.

(f) The Commissioner may conduct a public hearing, in his or her discretion, to gather information regarding a request by a carrier for an increase in a rate for a policy or certificate form, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard of (a) above. The determination of compliance shall be made without consideration of any refund or credit for such reporting period. Public notices of the hearing shall be in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

(g) For purposes of complying with (c) and (d) above, premiums, claims, and months exposed shall refer to premiums and claims for insured residents of this State under a specific policy form. However, if the total past and future exposed months for the form is less than 12,000, the anticipated and aggregate loss ratios shall be calculated on both a national experience and State experience basis. A weighted average of loss ratios shall then be calculated for purposes of comparison to the originally anticipated loss ratio. The weighting factor "w" to be applied to the loss ratio based on State experience shall be the square root of the ratio of "a" (the total past and future exposed months) to 12,000, and the weighting factor applied to the national experience shall be 1-w.

Amended by R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.7.

Added "and policies issued as conversions from group policies" in (a)1.

Substituted old text with new text in (b).

Added (b)1, 2; (c); (d); (e).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on required disclosure provisions recodified to 23.14; rule on loss ratio standards recodified from 23.8; standards for refunds and credit added.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.2004 d.246, effective July 6, 2004.

See: 35 N.J.R. 2562(a), 36 N.J.R. 3292(a).

Rewrote the section.

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, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

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

eligible person's Medicare supplement policy with outpatient prescription drug coverage.

(g) At the time of an event described in (c) above because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy or plan, the organization that terminates the contract or agreement, the carrier terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of carriers issuing Medicare supplement policies under (a) and (b) above. Such notice shall be communicated contemporaneously with the notification of termination.

(h) At the time of an event described in (c) above because of which an individual ceases enrollment under a contract or agreement, policy or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the carrier offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of carriers issuing Medicare supplement policies under (a) and (b) above. Such notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

Emergency Rule, R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.12, Filing requirements for policies, certificates and premium rates, recodified to N.J.A.C. 11:4-23.13.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

Amended by R.2001 d.7, effective January 2, 2001.

See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

Amended by R.2003 d.220, effective May 19, 2003.

See: 35 N.J.R. 71(a), 35 N.J.R. 2184(a).

Rewrote the section.

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

In (a), substituted "," for "or" following "termination" and added ", or Medicare Part D enrollment" following "disenrollment"; rewrote (c); in (d), deleted "or" following "date"; in 4, added 5, recodified former 5 as 6; rewrote (f).

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

(a) No carrier shall deliver or issue for delivery in this State any Medicare supplement policy or certificate, any written application therefor, or any printed rider or endorsements to be applied thereto, unless the forms thereof have been submitted to and filed by the Commissioner.

1. At the expiration of 30 days after submission, the form shall be deemed filed unless affirmatively disapproved for filing by the Commissioner prior thereto.

2. If any such form is disapproved for filing by the Commissioner during the said 30-day period, it may not be delivered or issued for delivery unless and until such disapproval for filing is withdrawn. Such disapproval shall be subject to review in accordance with the Administrative

Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

3. The Commissioner may extend the 30-day period no more than another 30 days if written notice is provided to the insurer before the expiration of the initial 30 day period, in which event all but this paragraph shall apply to the extended period.

4. Forms filed by or deemed filed by the Commissioner may subsequently be withdrawn from filing. Insurers shall have the right to a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. An insurer may continue to deliver or issue for delivery such forms until a final decision in accordance with the withdrawal is rendered, following the request for a hearing, or, if no hearing is requested, delivery or issuance for delivery of such forms may continue no later than 30 days following notice of the withdrawal of that form.

(b) Disapproval for filing, or withdrawals of approval of the filing of any form, must be stated in writing with the grounds therefor included in the statement, in accordance with the rules of this State.

(c) No carrier shall use or revise premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been submitted to and filed by the Commissioner in accordance with (a) and (b) above. Pursuant to N.J.S.A. 17:29A-53, and in accordance with N.J.A.C. 11:1-45, notices of requests for prior approval rate increases shall be given to individual policyholders, and to group policyholders so as to enable them to notify certificateholders of the filing of the rate increase request.

(d) The Commissioner shall not file, and carriers shall not submit for filing, more than one Medicare supplement policy or certificate form of each type for each standard Medicare supplement benefit plan, except as the Commissioner may otherwise approve in accordance with (d)2 below.

1. For the purposes of this subchapter, "type" shall mean an individual policy, and a group policy, and at such time as a Medicare Select program shall become effective in this State, an individual Medicare Select policy, and a group Medicare Select policy.

2. The Commissioner may approve carriers, individually, to offer up to four additional policy or certificate forms of the same type for the same standard Medicare supplement benefit plan. Such forms shall be subject to the filing requirements of this section. The four additional policy or certificate forms of the same type shall be limited to one additional form of the same type for:

- i. The inclusion of Innovative Benefits;
- ii. The addition of either a direct response or an agent marketing method;

iii. The addition of either guaranteed issue or underwritten coverage; and

iv. The offering of Medicare supplement coverage to persons eligible for Medicare by reason of disability.

(e) A carrier shall not discontinue offering any policy or certificate form filed by the Commissioner on or after the effective date of this subchapter unless such form has been withdrawn from filing pursuant to (a)4 above, or the carrier provides notice of discontinuance of offer to the Commissioner at least 30 days prior to such discontinuance, in writing.

1. Discontinuance subject to notice to the Commissioner shall include the following:

i. Failure to actively offer for sale a policy or certificate form for more than 12 consecutive months;

ii. Sale or transfer of Medicare supplement policies or certificates to another carrier; and

iii. Revisions in the rating structure or methodology applicable to a Medicare supplement policy or certificate form which has not been otherwise submitted to and filed by the Commissioner in accordance with N.J.S.A. 11:4-23.11.

2. Carriers shall not submit for filing a new form for any Medicare supplement plan of the same type for which the carrier has discontinued issue of a policy or certificate for a period of five years following the notice of discontinuance to the Commissioner. The Commissioner may waive some or all of the five year period, in his or her discretion.

(f) Except for policies or certificates assumed under an assumption reinsurance agreement, the experience of all policy or certificate forms of the same type for a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation set forth at N.J.S.A. 11:4-23.11(d).

(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.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.9, Requirements for replacement recodified to 23.12. Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on application forms and replacement coverage recodified to 3.15; rule on filing requirements recodified from 23.9; (c) through (f) added.

Recodified from N.J.A.C. 11:4-23.12 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.13, Compensation arrangements, recodified to N.J.A.C. 11:4-23.14.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

Amended by R.2004 d.344, effective September 20, 2004.

See: 36 N.J.R. 606(a), 36 N.J.R. 4317(a).

In (c), added the second sentence.

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

Added (g).

11:4-23.14 Compensation arrangements

(a) No carrier or other entity shall provide to any producer a first year commission or first year compensation for the sale of Medicare supplement policies or certificates in an amount which exceeds 200 percent of the commission or compensation to be provided by that insurer or other entity for the selling or servicing of that policy or certificate in the second year or period of that policy or certificate.

(b) The commission or other compensation which may be provided in subsequent renewal years shall be, for no fewer than five renewal years, the same as that commission or compensation provided in the second year or period.

(c) No carrier or other entity shall provide compensation or commission to any producer, nor shall any producer receive commission or other compensation greater than the renewal commission or compensation payable by the replacing carrier on renewal policies or certificates when an existing policy or certificate is replaced.

(d) For purposes of this section, "compensation" means a pecuniary or nonpecuniary remuneration of any kind relating to the sale of a policy or certificate, including, but not limited to:

1. Bonuses;
2. Gifts;
3. Prizes;
4. Awards; and
5. Finders fees.

New Rule, R.1990 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.10, Severability recodified to 23.17.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on filing requirements for advertising recodified to 23.16; rule on compensation arrangements recodified from 23.10; compensation arrangement variables restricted further.

Recodified from N.J.A.C. 11:4-23.13 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.14, Required disclosure provisions, recodified to N.J.A.C. 11:4-23.15.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).