

1. Effective January 1, 1990, no Medicare supplement policy in force in this State shall contain benefits provided by Medicare.

2. Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

3. For Medicare supplement policies subject to the minimum standards adopted by this State pursuant to the Medicare Catastrophic Coverage Act of 1988, and all policies and certificates delivered or issued for delivery on or after April 16, 1990 but prior to January 4, 1993, the minimum benefit standards for Medicare supplement policies are:

i. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

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

iii. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

iv. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

v. Coverage under Medicare Part A for 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 or already paid for under Part B;

vi. Coverage of Part B Medicare eligible expenses to the extent not covered by Medicare regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible;

vii. Coverage under Medicare Part B for the reasonable cost of the first three pints (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(c) Medicare supplement policies shall be guaranteed renewable.

New Rule, R.1993 d.26, effective January 4, 1993.

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

Rule on Standards for claims payment recodified to 23.10.

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

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

(b) Medicare supplement policies shall be guaranteed renewable.

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

1. Benefits and premiums shall not be suspended unless the policyholder or certificateholder provides the carrier notice of entitlement to medical assistance under Title XIX of the Social Security Act within 90 days following the date the policyholder or certificateholder was determined to be so entitled.

2. Upon loss of entitlement to medical assistance within the period of suspension, or upon the date following the final day of the period of suspension, the policy or certificate shall be automatically reinstated, effective as of the date of termination of entitlement, or effective as of the day following the final day of the period of suspension, if within 90 days following the date of entitlement termination or the final day of the suspension period, the policyholder or certificateholder provides notice to the carrier for reinstatement of the policy or certificate, and pays the premium required by the carrier, which premium shall be for a period of coverage not exceeding six months, inclusive of the 90 day notice period, but exclusive of any period during which the policyholder or certificateholder was entitled to medical assistance pursuant to Medicaid.

3. The coverage under the policy or certificate reinstated:

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

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

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

(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 core benefits defined at (g) below. A policy or certificate providing only core benefits shall be designated as standardized Medicare supplement benefit plan A.

(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. Standardized Medicare supplement benefit plan B shall provide:

- i. The Core Benefit; and
- ii. The Medicare Part A Deductible benefit.

2. Standardized Medicare supplement benefit plan C shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit; and
- v. The Medically Necessary Emergency Care in a Foreign Country benefit.

3. Standardized Medicare supplement benefit plan D shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- v. The At-Home Recovery Benefit.

4. Standardized Medicare supplement benefit Plan E shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- v. The Preventive Medical Care benefit.

5. Standardized Medicare supplement benefit Plan F shall provide:

- i. The Core Benefit;

- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit;
- v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit; and
- vi. The Medically Necessary Emergency Care in a Foreign Country benefit.

6. 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 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%) of the 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 annual high deductible Plan F deductible shall be \$1,500 for 1998 and 1999, and shall be based on the 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 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.00.

7. Standardized Medicare supplement benefit plan G shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Eighty Percent (80%) of the Medicare Part B Excess Charges benefit;
- v. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- vi. The At-Home Recovery Benefit.

8. Standardized Medicare supplement benefit plan H shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Basic Outpatient Prescription Drug Benefit; and
- v. The Medically Necessary Emergency Care in a Foreign Country benefit.

9. Standardized Medicare supplement benefit plan I shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;
- v. The Basic Outpatient Prescription Drug Benefit; and
- vi. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- vii. The At-Home Recovery Benefit.

10. Standardized Medicare supplement benefit plan J shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit;
- v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;
- vi. The Extended Outpatient Prescription Drug Benefit;
- vii. The Medically Necessary Emergency Care in a Foreign Country benefit;
- viii. The Preventive Medical Care benefit; and
- ix. The At-Home Recovery Benefit.

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 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.

(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 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. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services prescribed are necessary due to a condition for which a home care plan of treatment was approved by Medicare.

ii. Coverage shall be limited to:

(1) The number and type of at-home recovery visits certified as necessary by the insured's attending physician, received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit, the total number of which shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(2) Care furnished on a visiting basis in the insured's home by a care provider as defined at (g)1v below for up to seven visits in any one week; and

(3) Actual charges up to \$40.00 per visit to a maximum per calendar year benefit of \$1,600.

iii. Coverage shall be excluded for home care visits reimbursed by Medicare or other government programs and for care provided by family members, unpaid volunteers, or providers who do not otherwise meet the definition of a care provider, to the extent Medicare would exclude coverage for care provided by such individuals.

iv. Activities of daily living shall include, but not be limited to, bathing, dressing, personal hygiene, eating, ambulating, assistance with drugs that are normally self-

administered, and changing of bandages or other dressings.

v. A care provider shall be a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or a licensed nurses registry.

vi. Any place used by the insured as a place of residence shall be the insured's home, provided that such place would qualify as a residence for home health care services under Medicare. A hospital or skilled nursing facility shall not be considered the insureds' place of residence.

vii. An at-home recovery visit shall be that period of a visit required to provide at-home recovery care. The duration of any such visit shall not be limited, but each consecutive four hours in a 24 hour period of services provided by a care provider shall constitute one visit for purposes of this section.

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.

3. "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. 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, or other appropriate 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;

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; and

v. The coinsurance amount (or in the case of hospital outpatient department services under a prospective payment system, the copayment amount) of Medicare Part B eligible expenses (generally 20 percent of the approved amount; 50 percent of the approved charges for outpatient psychiatric services), regardless of hospital confinement, subject to the Medicare Part B deductible.

4. "Eighty Percent (80%) of the Medicare Part B Excess Charges" means coverage for 80 percent of the difference between the Medicare-approved Part B charge and the actual Medicare Part B charge billed, up to but not exceeding any charge limitation established by the Medicare program or this State's law, if any.

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.

6. "Innovative Benefits" means benefits that are in addition to the benefits specified for standardized Medicare supplement benefit plans A, B, C, D, E, F, G, H, I and J, that are appropriate to Medicare supplement insurance and do not duplicate any benefit provided by Medicare, and that are otherwise unavailable, cost effective, and offered in a manner consistent with simplification of Medicare supplement policies. No carrier shall include an Innovative Benefit in a policy or certificate offered for delivery in this State without the prior approval of the Commissioner.

7. "Medically Necessary Emergency Care in a Foreign Country" means coverage 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.

8. "Medicare Part A Deductible" means coverage of all of the Medicare Part A inpatient hospital deductible amount per benefit period.

9. "Medicare Part B Deductible" means coverage of all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

10. "One Hundred Percent (100%) 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.

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 preventive services, the frequency of which is considered medically appropriate:

- (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 skilled nursing facility care eligible under Medicare Part A.

New Rule, R.1993 d.26, effective January 4, 1993.

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

Rule on loss ratio standards recodified to 23.11; new rule added on minimum benefit standards for policies and certificates delivered or issued for delivery on or after the effective date of this subchapter. 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.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

In (e), inserted a new 6, recodified former 6 through 9 as 7 through 10, and added 11; and in (g)3v, inserted "(or in the case of hospital outpatient department services under a prospective payment system, the copayment amount)".

#### 11:4-23.9 Open enrollment

(a) Carriers shall not deny or condition the effectiveness or issuance, nor discriminate in the pricing, of Medicare supplement policies or certificates based on the health status, claims experience, receipt of health care by, or medical condition of an applicant if the application is submitted for Medicare supplement coverage prior to or during the six month period beginning with the first day of the first month in which the applicant is 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate shall be made available to all applicants who qualify under this section without regard to age.

(b) If an applicant qualifies under (a) above and submits an application during the time period referenced in (a) above and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the carrier shall not exclude benefits based on a preexisting condition.

(c) If the applicant qualifies under (a) above and submits an application during the time period referenced in (a) above and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the carrier shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in N.J.A.C. 11:4-23.15(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.

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 recodified to 23.12; new rule added on open enrollment.

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.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

Inserted new (b) and (c); and recodified former (b) as (d), and inserted "and in (b) and (c) above" following "N.J.A.C. 11:4-23.15(d)".

#### 11:4-23.10 Standards for claims payment

(a) Every carrier providing Medicare supplement policies and certificates shall comply with Section 1882(c)(3) of the Social Security Act as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) by:

1. Acceptance of notice from a Medicare-Carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits under the Medicare supplement policy or certificate as sufficient claim notice without requiring other or additional claims forms to be submitted, and making a payment determination based on the information contained in the notice from the Medicare-Carrier;
2. Notification of the participating physician or supplier, and the beneficiary, of the payment determination, and making payment directly to the participating physician or supplier;
3. Providing each enrollee, at the time of enrollment, a card listing the policy name, policy number, and a mailing address to which notices from a Medicare-Carrier may be sent;
4. Payment of user fees for claim notices that are transmitted electronically or otherwise; and

5. Providing to the Secretary of Health and Human Services at least annually, a central mailing address to which all claims may be sent by the Medicare-Carrier.

(b) Compliance with the requirements set forth in (a) above shall be certified on the Medicare supplement experience reporting form.

(c) Payment of benefits for Medicare eligible expenses shall be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims.

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 23.7 Loss Ratio Standards recodified to 23.8.

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

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

Standards for claims payment recodified from 23.7; requirements for compliance specified at (a)1 through 5.

#### **11:4-23.11 Loss ratio standards, annual filing of premium rates and refund or credit calculation**

(a) Medicare supplement policy forms or certificate forms shall be expected to return to policyholders and certificateholders in the form of aggregate benefits under the policy or certificate (exclusive of any anticipated refund or credit), for the entire period for which rates are computed to provide coverage, calculated on the basis of paid claims experience (or paid health care expenses for coverage provided by a health maintenance organization on a service rather than reimbursement basis) and written premiums for such period and with adjustment for interest to reflect the timing of payments:

1. At least 75 percent of the aggregate amount of premiums or subscription charges collected in the case of group policies and policies issued as conversions from group policies.

2. At least 65 percent of the aggregate amount of premiums or subscription charges collected in the case of individual policies.

(b) Each carrier shall include with the initial submission of rates for a new Medicare supplement policy an actuarial memorandum which includes the following:

1. The number of years for which the policy is expected to be delivered or issued for delivery in this State, and the number of policies expected to be delivered or issued for delivery for each form in each such year;

2. The anticipated loss ratio calculated over the life of the policy form, with separate disclosures of the present value of future paid benefits and the present value of future paid or written premiums utilized in the calculation of the anticipated loss ratio, where any statutorily required additional actuarial active life reserve is neither reflected in the future benefits nor the future premiums in the calculation;

3. The future benefits on both a paid and incurred basis and the future premiums on both a written and earned basis for each of the years recognized in the calculation of the anticipated loss ratio, where neither the future benefits nor the future premiums include, or are adjusted for, any statutorily required additional actuarial active life reserve;

4. The expected incurred/earned loss ratio for each of the years recognized in the calculation of the anticipated loss ratio, wherein:

i. The expected incurred claims shall equal expected paid claims adjusted for changes in the expected claim liabilities and claim reserves and in any expected statutorily required additional actuarial active life reserve for each such year; and

ii. The expected earned premiums shall equal premiums expected to be received adjusted for any changes in expected advance premiums and in expected unearned premium reserves for each such year, but changes in any expected statutorily required additional actuarial active life reserves shall not be included in the adjustment of premiums expected to be received;

5. The realistic assumptions used in the calculation of the loss ratios for each benefit provision wherein the premiums are determined separately including the following:

i. The annual claim costs (ultimate) by attained age and sex;

ii. The select and/or antiselect morbidity factors by policy duration (year) by issue age and sex;

iii. The lapse and mortality rates, or total termination rates, by policy duration by issue age and sex, and any skewing of those rates occurring within a policy year resulting from modal premium payments;

iv. The secular trend factors by policy duration by issue age and sex, which secular trend factors, when used in the calculation of the anticipated loss ratio, shall not be applied for a period greater than the number of years for which trending is reflected in the calculation of premiums;

v. The interest rates by policy duration, which rates shall equal an insurer's recent, current and future expected new investment return rates (after investment expenses, but before Federal income taxes);

vi. Expenses by policy duration, including commission, override and bonus rates, other marketing expense rates, other maintenance expenses rates, any new-market expense rates, other acquisition expense rates, and the explicit profit margin or risk charge, provided on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable bases;

vii. The distribution of expected policy issues by policy and rider benefits by issue age and sex;

viii. The percentage of policies expected to be issued with extra premiums for any physical, mental or medical conditions which result in substandard morbidity; and

ix. A summary statement of the underwriting standards (for example: short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market for the policy form (that is, the segment(s) of the general public to which the form will be marketed: middle income based on predetermined ZIP code selections for example);

6. The cell and cell weights, when a model office is used in the calculation of the anticipated loss ratio;

7. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the recognition or nonrecognition or the homogenization of the elements of any insurance construct will not result in an anticipated loss ratio which would differ by more than 10 percent from the anticipated loss ratio of any element of the construct if the elements of the construct were not recognized or separately recognized, as the case may be.

ii. For the purpose of this paragraph, construct shall mean the risk variables which significantly affect the cost of the coverage. For example, age could be a construct wherein its elements would be age 65, age 66, age 67 and so forth. (Of particular concern are anticipated loss ratios by issue age or issue age groupings.); and

8. A certification signed by an actuary who must be a member of the Society of Actuaries or Casualty Actuarial Society, stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio.

(c) Every carrier shall submit annually for filing by the Commissioner its rates. Supporting documentation, including ratios of incurred losses to earned premiums by policy duration shall be submitted annually with the rates. Any revision of rates is subject to the requirements of (d) below. The supporting documentation shall demonstrate, using reasonable assumptions, that the anticipated and aggregate loss ratio are at least as great as the originally anticipated loss ratio. Such demonstration shall exclude active life reserves.

(d) Carriers shall submit for filing by the Commissioner in accordance with N.J.A.C. 11:4-23.12 all rate revisions. No carrier shall implement any rate revision until such rate revision has been filed. Submission of rate revisions for

filing shall demonstrate that both 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.

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 State-wide 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 and claims shall refer to premiums and claims for insured residents of this State under a specific policy form. However, if the experience is based on fewer than 1,000 life years of exposure for residents of this State, then the premiums and claims shall be a weighted average of the premiums and claims for this State and national experience, where the weighting factor applied to the State experience is the square root of the ratio of "a" to 1,000 ("a" being the number of the life years of exposure).

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).

#### 11:4-23.12 Guaranteed issue for eligible persons

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

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

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

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

2. The individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, the plan ceases to provide all health benefits to the individual or the individual leaves the plan;

3. The individual is enrolled with a Medicare + Choice organization under a Medicare + Choice plan under Part C of Medicare, and any of the following circumstances apply:

- i. The organization's or plan's certification under Part C of Medicare has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
  - ii. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the Federal Social Security Act (42 U.S.C. § 1395w-21) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856 (42 U.S.C. § 1395w-26)), or the plan is terminated for all individuals within a residence area;
  - iii. The individual demonstrates, in accordance with guidelines established by the Secretary, that:
    - (1) The organization offering the plan substantially violated a material provision of the organization's contract under Part C of Medicare in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
    - (2) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
  - iv. The individual meets such other exceptional conditions as the Secretary may provide;
4. The individual is enrolled with any of the following, and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under (c)3 above:
- i. An eligible organization under a contract under Section 1876 (42 U.S.C. § 1395mm) (Medicare risk or cost);
  - ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
  - iii. An organization under an agreement under Section 1833(a)(1)(A) (42 U.S.C. § 1395) (health care prepayment plan); or
  - iv. An organization under a Medicare Select policy;
5. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because of the following:
- i. Either the insolvency of the carrier or bankruptcy of the noncarrier organization, or other involuntary termination of coverage or enrollment under the policy;
  - ii. The carrier substantially violated a material provision of the policy; or
  - iii. The carrier, or an agent or other entity acting on the carrier's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;
6. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, any eligible organization under a contract under Section 1876 (42 U.S.C. § 1395mm) (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under Section 1833(a)(1)(A) (42 U.S.C. § 1395) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) (42 U.S.C. § 1395w-2) of the Federal Social Security Act); or
7. The individual, upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.
- (d) 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 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. The Medicare supplement policy to which eligible persons are entitled under (c)7 above shall include any Medicare supplement policy offered by any carrier.
- (e) 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.
- (f) 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 cessa-

tion 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).

### 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.

(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).

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).

#### 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;