

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

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

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

i. 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) of the Social Security Act (Medicare 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) of the Social Security Act (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) of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act (42 U.S.C. § 1395eee), or a Medicare Select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) (42 U.S.C. § 1395w-2) of the Federal Social Security Act); or

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

(d) The guaranteed issue time periods shall be:

1. In the case of an individual described in (c)1 above, the guaranteed issue period begins on the date the indi-

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

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

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

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

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

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

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

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

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

(f) The Medicare supplement policy to which eligible persons are entitled under (c)1, 2, 3, 4 and 5 above is a Medicare supplement policy which has a benefit package classified as Plan A, B, C or F 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.

(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.

#### **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;