17B:26A-1 to 17B:26A-8

LEGISLATIVE HISTORY CHECKLIST

(Medicare supplement insurance contracts-group & individual-minimum standards-require promulgation)

NJSA 17B:26A-1 to 17B:26A-8

LAWS 1982 CHAPTER 94

Bill No. S1428

Sponsor(s) Bornheimer

Date Introduced May 24, 1982

Committee: Assembly ———————

Senate Labor, Industry and Professions

Amended during passage Yes XXX Amendments during passage denoted by asterisks. Substituted for A1464 (not attached since identical to S1428. Assembly Committee statement to A1464 attached)

Date of Passage: Assembly June 24, 1982

Senate June 17, 1982

Date of approval July 28, 1982

Following statements are attached if available:

Sponsor statement	Yes	No	(Below)
Committee Statement: Assembly	Yes	No	
Senate	Yes	No	
Fiscal Note	Yes	No	
Veto Message	Yes	No	
Message on signing	Yes	No	

Following were printed:

Reports	Yes	No
Hearings	Yes	No

Sponsor's statement:

This bill requires the Commissioner of Insurance to promulgate minimum standards for health insurance policies. This will make New Jersey conform with provisions of federal law which require such minimum standards.

6/22/81

[OFFICIAL COPY REPRINT]

SENATE, No. 1428

STATE OF NEW JERSEY

INTRODUCED MAY 24, 1982

By Senator BORNHEIMER

Referred to Committee on Labor, Industry and Professions

AN ACT concerning medicare supplement insurance, and supplementing Title 17B of the New Jersey Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. For the purposes of this act:

a. "Applicant" means:

(1) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group medicare supplement policy, the proposed certificate holder.

b. "Certificate" means any certificate issued under a group medicare supplement policy*,* which **policy** has been delivered or issued for delivery in this State.

c. "Commissioner" means the Commissioner of Insurance.

d. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Pub. L. 89-9;

e. "Medicare supplement policy" means a group or individual **accident and sickness insurance** policy which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare by reason of age. The term does not include:

(1) A policy **[or contract]** of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof,

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter printed in italics *thus* is new matter.

Matter enclosed in asterisks or stars has been adopted as follows:

***—Senate committee amendments adopted June 14, 1982.**

for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or

(2) A policy *[or contract]* of any professional, trade or occupational association for its members or former retired members, or combination thereof, if the association:

(a) Is composed of individuals who are actively engaged in the same profession, trade or occupation;

(b) Has been maintained in good faith for purposes other than obtaining insurance; and

(c) Has been in existence for at least 2 years prior to the date of its initial offering of the policy or plan to its members.

(3) Individual policies *[or contracts]* issued pursuant to a conversion privilege under a policy *[or contract]* of group or individual insurance when the group or individual policy *[or contract]* includes provisions which are inconsistent with the requirements of this act.

2. The commissioner shall issue regulations to establish specific standards for policy provisions of medicare supplement policies, which shall be in addition to and in accordance with applicable laws of this State, and may cover, but shall not be limited to:

a. Terms of renewability;

b. Initial and subsequent conditions of eligibility:

c. Nonduplication of coverage;

d. Probationary periods;

e. Benefit limitations, exceptions and reductions;

f. Elimination periods;

g. Requirements for replacement; *[and]*

h. Recurrent conditions*[.]* *; and*

i. Definition of terms.

3. The commissioner may issue regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, *[or]* *are* unjust, unfair or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy.

4. Notwithstanding any other provision of law of this State to the contrary, a medicare supplement policy may not deny a claim for losses incurred more than 6 months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

5. The commissioner shall issue regulations to establish minimum standards for benefits under medicare supplement policies.

6. Medicare supplement policies shall be expected to return to policyholders benefits which are reasonable in relation to the premium charged. The commissioner shall issue regulations to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. For purposes of regulations issued pursuant to this section, medicare supplement policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

7. a. In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy shall be delivered or issued for delivery in this State, and no certificate shall be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this State unless an outline of coverage is delivered to the applicant at the time application is made*[;]* *.*

b. The commissioner shall prescribe the format and content of the outline of coverage required by subsection a. of this section. For the purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the exceptions, reductions and limitations contained in the policy;

(3) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

(4) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

c. The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for medicare by reason of age, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response *solicitation* insurance policies, the commissioner may require by regulation that the *[information]* *in-

*formational** brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response **solicitation** insurance policies, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare by reason of age, but in no event later than the time of policy delivery.

d. The commissioner may promulgate regulations for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and *[sicknesses]* **sickness** insurance policies sold to persons eligible for medicare by reason of age, other than:

(1) Medicare supplement policies;

(2) Disability income policies;

(3) Basic, catastrophic, or major medical expense policies; or

(4) Single premium, nonrenewable policies.

e. The commissioner may further promulgate regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies **or certificates** by persons eligible for medicare by reason of age.

8. Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 10 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons eligible for medicare by reason of age shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination, the applicant is not satisfied for any reason.

9. This act shall take effect July 1, 1982.

ASSEMBLY BANKING AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1464

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: JUNE 14, 1982

Assembly Bill No. 1464, a companion measure to Assembly Bill No. 1463, requires the Commissioner of Insurance to establish policy provision standards and minimum benefit standards for medicare supplement policies issued pursuant to Title 17B of the New Jersey Statutes. According to the sponsor's statement, the purpose of this bill is to establish minimum standards for medical supplement policies consistent with the requirements of federal law.

Assembly Bill No. 1464 applies to both group and individual medicare supplement policies which are "designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare by reason of age." Subsection 1e. also specifies those policies not subject to the provisions of this bill.

Section 2 requires the commissioner to issue regulations setting contract provision standards for specified and general areas. The commissioner may also prohibit policy provisions that he regards as unjust, unfair or unfairly discriminatory (section 3). Section 4 prohibits medicare supplement policies that deny a pre-existing conditions claim for losses incurred more than 6 months from the effective date of coverage; it also prohibits the definition of a pre-existing condition more restrictively than the condition was defined within 6 months of the effective date of coverage.

Section 5 requires the commissioner to issue regulations establishing minimum benefit standards. Coverage benefits shall be reasonable in relation to the premiums charged, and the commissioner shall establish minimum standards for loss ratios, based on claims experience and earned premiums for the period for which the rates are computed. The provisions of section 5 shall also apply to any medicare supplement policy issued through mail or mass advertising solicitations.

Section 7 establishes fair disclosure requirements for medicare supplement policies, including the replacement of existing coverage with medicare coverage.

Section 8 establishes the right of an applicant to return a policy or certificate within 10 days of delivery and have the premium refunded, except that in the case of policies or certificates issued pursuant to a direct response solicitation, the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded.

This bill is in response to federal law (Pub. L. 96-265; 42 USCA § 1395ss) establishing, effective July 1, 1982, voluntary certification procedures for medicare supplement policies or contracts which satisfy certain policy (contract) requirements and minimum benefit standards. Federal statutory standards can be satisfied in any of three ways:

(1) An insurer may apply for certification by the Secretary of Health and Human Resources;

(2) The policy (or contract) has been approved by the commissioners or superintendents of insurance in states in which more than 30% of such policies are sold; or

(3) The enactment of a State law authorizing a regulatory program that is equal to or more stringent than the National Association of Insurance Commissioners (NAIC) Model Standards and federal law, as certified by the Supplemental Health Insurance Panel created pursuant to Pub. L. 96-265. This bill opts for the third approach.

Current State law (P. L. 1979, c. 78; C. 17B26–45 et seq.) authorizes the State Commissioner of Insurance to establish standards for policy forms and benefits. Chapter 78 limits such standards to individual health insurance policies, including medicare supplement policies, issued by insurers pursuant to chapter 26 of Title 17B of the New Jersey Statutes. This bill and the companion measure, Assembly Bill No. 1463, relate only to medicare supplement policies or contracts, issued on an individual or group basis. The bills apply to both Title 17B insurers and to hospital and medical service corporations.

SENATE LABOR, INDUSTRY AND PROFESSIONS COMMITTEE

STATEMENT TO

SENATE, No. 1428

with Senate committee amendments

STATE OF NEW JERSEY

DATED: JUNE 14, 1982

This bill requires the Commissioner of Insurance to promulgate minimum standards for individual and group medicare supplement policies for accident and health insurance. Medicare supplement policies provide reimbursement for expenses incurred for services and items for which payment may be made under medicare but which are not reimburseable by reason of the applicability of deductibles, coinsurance amounts or other limitations imposed pursuant to medicare.

The Commissioner shall issue regulations to establish:

a. Specific standards for the provisions of medicare supplement policies and these standards may cover terms of renewability, conditions of eligibility, nonduplication of coverage, probationary periods, benefit limitations, elimination periods, requirements for replacement, recurrent conditions and definition of terms (section 2);

b. Minimum standards for benefits under medicare supplement policies (section 5);

c. Minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience and premiums for the entire period for which rates are computed to provide coverage (section 6); and

d. The format and content of an outline of coverage of the medicare supplement policies, which outlines must be given to applicants at the time application is made (section 7).

The Commissioner may issue regulations to:

a. Prohibit policy provisions which are unjust, unfair or unfairly discriminatory to any insured or proposed insured (section 3);

b. Prescribe the form and contents of informational brochures on supplemental and medicare coverage (section 7);

c. Prescribe captions or notice requirements for accident and sickness insurance policies to inform prospective insureds that particular insurance coverages are not medicare supplement coverages (section 7); and

d. Govern the fair and full disclosure of information in connection with the replacement of accident and sickness policies by persons eligible for medicare by reason of age (section 7).

Under the provisions of section 8, an applicant for medicare supplement policies or certificates, if such are not issued pursuant to direct response solicitation, may return the policy or certificate within 10 days of its delivery and have the premium refunded if the applicant is not satisfied for any reason. If the policy or certificate is issued pursuant to a direct response solicitation, an applicant may return the policy or certificate within 30 days of its delivery and have the premium refunded if the applicant is not satisfied for any reason.

This bill does not cover group health policies of one or more employers or labor organizations; nor does it cover most group health policies covering members of professional, trade and occupational associations.

Many technical amendments were made to the bill by the committee.