17B:26A-1

LEGISLATIVE HISTORY CHECKLIST
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(Medicare supplement insurance)

NJSA: 17B:26A-1

LAWS OF: 1995 **CHAPTER:** 229

BILL NO: A67

SPONSOR(S): Haytaian

DATE INTRODUCED: June 1, 1995

COMMITTEE: **ASSEMBLY** Insurance

SENATE: Budget

AMENDED DURING PASSAGE: Yes Amendments during passage denoted by superscript numbers
Second reprint enacted

DATE OF PASSAGE: **ASSEMBLY:** June 19, 1995

SENATE: June 26, 1995

DATE OF APPROVAL: August 16, 1995

FOLLOWING STATEMENTS ARE ATTACHED IF AVAILABLE:
SPONSOR STATEMENT: Yes

COMMITTEE STATEMENT: **ASSEMBLY:** Yes

SENATE: Yes

FISCAL NOTE:

VETO MESSAGE:

MESSAGE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

REPORTS: No

HEARINGS: No

See newspaper clipping--attached:
"Law provides Medigap to disabled people over 50," 8-18-95, Asbury Park Press.

KBG:pp

[SECOND REPRINT]

ASSEMBLY, No. 67

STATE OF NEW JERSEY

INTRODUCED JUNE 1, 1995

By Assemblymen HAYTAIAN, LANCE,
Assemblywoman Heck and Assemblyman Roma

AN ACT concerning Medicare supplement insurance coverage and supplementing P.L.1982, c.94 (C.17B:26A-1 et seq.).

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

1. The Legislature finds and declares that:

a. As of April 1, 1995, individuals in the State of New Jersey under age 65 who became eligible for Medicare benefits due to a disability or because they suffer from the end stage of renal disease do not have access to Medicare supplement insurance, otherwise known as "Medigap" insurance.

b. Prior to that date only one health insurance carrier in New Jersey offered Medicare supplement insurance contracts to the under 65 population. Unsustainable losses, caused in part by the fact that this carrier was the only carrier providing such coverage, led to the carrier's withdrawal from the Medicare supplement insurance market for the under 65 population on March 31, 1995.

c. Because Medicare supplement insurance pays for many of the health care expenses not covered by Medicare, the absence of Medicare supplement insurance will eventually leave thousands of blind, AIDS, disabled and dialysis patients in New Jersey without any means of secondary insurance to supplement their Medicare coverage. For many of these people with serious illnesses, the 20 percent co-payments and deductibles charged by Medicare will cause financial hardship and emotional distress. If no action is taken, Medicare recipients under 65 years old will be forced to deplete their personal assets and may eventually be forced to resort to Medicaid to supplement their health care needs.

d. Therefore, the Legislature declares that it is in the public interest:

(1) to ensure that Medicare supplement insurance is available to the individuals under 65 years of age that become eligible for Medicare benefits;

(2) to require all health insurance carriers who currently sell Medicare supplement insurance to the over age 65 population to also offer, at a minimum, Medicare Supplement Plan C coverage to the under age 65 population;

(3) to establish a mechanism that will: allow the premiums on those Medicare supplement insurance policies and contracts to remain affordable; encourage insurance carriers to continue to serve or enter this market; and provide for the equitable sharing of any losses;

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 underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly floor amendments adopted June 19, 1995.
[2] Senate SBA committee amendments adopted June 22, 1995.

(4) to ensure that premiums for the more than 200,000 New Jersey residents who have purchased Medicare supplement insurance remain affordable and do not become subject to excessive rate increases; and

(5) that regulations necessary to effectuate the purposes of this act be promulgated by the Commissioner of Insurance expeditiously due to the urgency of the situation.

2. a. No later than 60 days after the effective date of this act, every carrier issuing or renewing Medicare supplement insurance policies or contracts shall, as a condition of issuing or renewing health benefits plans in this State, offer, at a minimum, Medicare Supplement Plan C policies or contracts to persons in this State 50 years of age or older who are entitled to Medicare benefits due to disability, except as otherwise provided in subsection d. of this section.

b. No carrier shall deny or condition the issuance or renewal of a Medicare supplement insurance policy or contract available for sale in this State pursuant to section a. of this section nor discriminate in the pricing of such policy or contract because of the health status, claims experience, receipt of health care or medical condition of an applicant if an application for the policy or contract is submitted during the six-month period beginning with the first month in which an individual is enrolled for benefits under Medicare Part B or if the application for the policy or contract is submitted within six months after the effective date of this act.

c. Subsections a. and b. of this section shall not be construed as preventing the exclusion of benefits under a policy or contract during the first three months, based on a preexisting condition for which the insured received treatment or was otherwise diagnosed during the six months before the policy or contract became effective, except that the limitation shall not apply to an individual who has, under a prior health benefits policy or contract, with no intervening lapse in coverage, been treated or diagnosed by a physician for a condition under that policy or contract or satisfied a three month preexisting condition limitation.

d. (1) Notwithstanding the provisions of subsection a. of this section to the contrary, a carrier that does not currently issue or renew individual Medicare supplement insurance policies or contracts and does issue and renew Medicare supplement insurance policies or contracts for groups whose membership in the group is not based on health status, claims experience, receipt of health care or medical condition, shall not be required to provide coverage to persons eligible for Medicare supplement insurance coverage pursuant to subsection a. of this section, other than to members of the group.

(2) No group to which the provisions of paragraph (1) of this subsection apply shall institute an age requirement for participation in the group after June 1, 1995.

e. (1) Rates for Medicare supplement insurance policies or contracts issued pursuant to this section shall be no greater than the lowest rate charged by a carrier for the same type of policies or contracts issued to persons 65 years of age and over and shall

be formulated in accordance with the provisions of section 6 of P.L.1982, c.95 (C.17:35C-6) or section 6 of P.L.1982, c.94 (C.17B:26A-6), as appropriate, and any rules or regulations promulgated thereto.

(2) Following the close of each carrier's accounting year, if the commissioner determines that a carrier's loss ratio for policies or contracts issued pursuant to section 2 or 3 of this act was less than 75% for group policies or contracts or less than 65% for individual policies or contracts for that calendar year, the carrier shall be required to refund to the holders of any policy or contract the difference between the amount of net earned premium it received that year and the amount that would have been necessary to achieve the 75% or 65% loss ratio, as appropriate.

3. a. The commissioner shall adopt rules and regulations establishing a plan to provide Medicare Supplement Plan C coverage of the standardized Medicare supplement plans to persons under 50 years of age in this State who are entitled to Medicare benefits due to disability no later than 120 days after the effective date of this act.

b. The plan shall not deny or condition the issuance or renewal of a Medicare supplement insurance policy or contract available for sale in this State pursuant to section a. of this section nor discriminate in the pricing of such policy or contract because of the health status, claims experience, receipt of health care or medical condition of an applicant if an application for the policy or contract is submitted during the six-month period beginning with the first month in which an individual is enrolled for benefits under Medicare Part B or if the application for the policy or contract is submitted within six months after the effective date of this act.

c. Subsections a. and b. of this section shall not be construed as preventing the exclusion of benefits under a policy or contract during the first three months, based on a preexisting condition for which the insured received treatment or was otherwise diagnosed during the six months before the policy or contract became effective.

d. The [1][commissioner] plan[1] shall [1][appoint] provide for the appointment of[1] a contracting carrier [1][to administer the plan established pursuant to] to provide the coverage specified in[1] subsection a. of this section. The carrier shall have experience in providing and servicing standardized Medicare supplement insurance policies or contracts to persons in this State.

e. The rates for the plan established pursuant to subsection a. of this section shall be no greater than the lowest rate charged by the contracting carrier for Medicare Supplement Plan C policies or contracts issued by the contracting carrier to persons pursuant to subsection a. of section 2 of this act.

[1]f. The plan shall provide for the appointment of a governing board which shall be responsible for implementing the provisions of this act consistent with the rules and regulations adopted pursuant to subsection a. of this section. The governing board shall include representatives from, among others, the carriers and health maintenance organizations subject to the provisions of

section 4 of this act.[1]

4. The [1][commissioner] plan[1] shall establish procedures for the equitable sharing of any losses incurred by the contracting carrier [1][administering] providing coverage under[1] the plan pursuant to subsection a. of section 3 of this act as follows:

a. By March 1, 1996 and following the close of each calendar year thereafter, on a date established by the commissioner:

(1) (a) every carrier and health maintenance organization issuing health benefits plans or health maintenance organization subscriber contracts in this State shall file with the commissioner its net earned premium [1][for] in[1] the preceding calendar year ending December 31; and

(b) the contracting carrier issuing Medicare supplement insurance policies or contracts under the plan established pursuant to subsection a. of section 3 of this act shall file with the commissioner its net earned premium on those policies or contracts and the claims paid and the administrative expenses attributable to those policies or contracts [1][for] in[1] the preceding calendar year ending December 31; and

(2) No later than March 1, 1996 and following the close of each calendar year thereafter, on a date established by the commissioner, a contracting carrier issuing Medicare supplement insurance policies or contracts pursuant to subsection a. of section 3 of this act shall file with the commissioner a statement of any net loss on those policies or contracts [1][for] in[1] the calendar year ending December 31, along with any supporting information required by the commissioner. For purposes of this subsection, a loss shall occur if the claims paid and reasonable administrative expenses for Medicare supplement insurance policies or contracts issued to individuals under 50 years of age pursuant to subsection a. of section 3 of this act exceed the net earned premium and any investment income thereon.

b. (1) Every carrier and health maintenance organization authorized to provide health benefits plans or health maintenance organization subscriber contracts in this State shall be liable for an assessment to reimburse the contracting carrier issuing Medicare supplement insurance contracts or policies pursuant to subsection a. of section 3 of this act for any net loss incurred by the contracting carrier [1][for] in[1] the previous year, unless the carrier or health maintenance organization has received an exemption from the commissioner pursuant to paragraph (3) of this subsection.

(2) The assessment of each carrier and health maintenance organization shall be in the proportion that the net earned premium of the carrier or health maintenance organization for all health benefits plans or health maintenance organization subscriber contracts issued or renewed in the calendar year preceding the assessment bears to the net earned premium of all carriers and health maintenance organizations for all health benefits plans or health maintenance organization subscriber contracts issued or renewed in the calendar year preceding the assessment and shall be carried out in a form and manner to be determined by the commissioner.

(3) A carrier or health maintenance organization that is

financially impaired may seek from the commissioner [1]an exemption or[1] a deferment in whole or in part from any assessment issued by the commissioner. The commissioner may [1]exempt a carrier or health maintenance organization from an assessment or[1] defer, in whole or in part, the assessment of a carrier or health maintenance organization if, in the opinion of the commissioner, the payment of the assessment would endanger the ability of the carrier or health maintenance organization to fulfill its contractual obligations. If an assessment against a carrier or health maintenance organization is deferred in whole or in part [1]or if the carrier or health maintenance organization is exempt from the assessment[1], the amount by which the assessment is deferred [1]or the amount that a carrier or health maintenance organization is exempted from paying may be assessed against the other carriers and health maintenance organizations in a manner consistent with the basis for assessment set forth in this section. [1][The carrier or health maintenance organization receiving the deferment shall remain liable for the amount deferred.][1]

c. Payment of an assessment made under this section shall be a condition of issuing health benefits plans and health maintenance organization subscriber contracts in the State for a carrier or health maintenance organization. Failure to pay the assessment shall be grounds for forfeiture of a carrier's or health maintenance organization's authorization to issue health benefits plans and health maintenance organization subscriber contracts in the State, as well as any other penalties permitted by law.

d. Notwithstanding the provisions of this section to the contrary, no carrier or health maintenance organization shall be liable for an assessment to reimburse the contracting carrier pursuant to this section in an amount which exceeds 35% of the net loss of the contracting carrier. To the extent that this limitation results in any unreimbursed loss to the contracting carrier, the unreimbursed loss shall be distributed among all carriers and health maintenance organizations: (1) which owe assessments pursuant to subsection a. of this section; (2) whose assessments do not exceed 35% of the net loss of the contracting carrier; and (3) who have not received an exemption pursuant to paragraph (3) of subsection b. of this section.

[2]5. a. Whenever the contracting carrier reports a net loss to the commissioner pursuant to paragraph (2) of subsection a. of section 4 of this act, the related operations of the contracting carrier and any losses incurred by the contracting carrier regarding Medicare supplement insurance policies or contracts issued pursuant to subsection a. of section 3 of this act shall be subject to an audit conducted by a qualified independent certified public accountant prior to the imposition of any assessment pursuant to subsection b. of section 4 of this act.

b. The auditor shall be selected and approved by the governing board of the plan through a competitive bidding process of certified public accountants qualified in New Jersey to perform such audits. The audit shall include:

(1) a review of the handling and accounting of assets and monies of the contracting carrier;

(2) a determination that administrative expenses have been properly allocated and are reasonable;

(3) a review of the internal financial controls of the contracting carrier;

(4) a review of the annual financial report of the contracting carrier; and

(5) a review of the calculation by the commissioner of any assessments for net losses.

c. A copy of the audit and related management letters shall be delivered to the governing board of the plan, to the commissioner and to each carrier and health maintenance organization to which the provisions of this act apply. The audit report shall be reviewed by the governing board of the plan. Upon recommendation of the governing board, the contracting carrier shall implement any recommendations made by the auditor.[2]

[2][5.] 6.[2] As used in this act:

"Carrier" means an insurance company or service corporation authorized to issue health benefits plans in this State.

"Financially impaired" means a carrier or health maintenance organization which, after the effective date of this act, is not insolvent, but is deemed by the commissioner to be potentially unable to fulfill its contractual obligations, or a carrier or health maintenance organization which is under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Health benefits plan" means a hospital and medical expense insurance policy; hospital service corporation contract, medical service corporation contract or health service corporation contract delivered or issued for delivery in this State.

[2][6.] 7.[2] This act shall take effect immediately.

Concerns Medicare supplement insurance coverage for individuals eligible for Medicare due to disability.

The carrier or health maintenance organization receiving the deferment shall remain liable for the amount deferred.

c. Payment of an assessment made under this section shall be a condition of issuing health benefits plans and health maintenance organization subscriber contracts in the State for a carrier or health maintenance organization. Failure to pay the assessment shall be grounds for forfeiture of a carrier's or health maintenance organization's authorization to issue health benefits plans and health maintenance organization subscriber contracts in the State, as well as any other penalties permitted by law.

d. Notwithstanding the provisions of this section to the contrary, no carrier or health maintenance organization shall be liable for an assessment to reimburse the contracting carrier pursuant to this section in an amount which exceeds 35% of the net loss of the contracting carrier. To the extent that this limitation results in any unreimbursed loss to the contracting carrier, the unreimbursed loss shall be distributed among all carriers and health maintenance organizations: (1) which owe assessments pursuant to subsection a. of this section; (2) whose assessments do not exceed 35% of the net loss of the contracting carrier; and (3) who have not received an exemption pursuant to paragraph (3) of subsection b. of this section.

5. As used in this act:

"Carrier" means an insurance company or service corporation authorized to issue health benefits plans in this State.

"Financially impaired" means a carrier or health maintenance organization which, after the effective date of this act, is not insolvent, but is deemed by the commissioner to be potentially unable to fulfill its contractual obligations, or a carrier or health maintenance organization which is under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Health benefits plan" means a hospital and medical expense insurance policy; hospital service corporation contract, medical service corporation contract or health service corporation contract delivered or issued for delivery in this State.

6. This act shall take effect immediately.

STATEMENT

This bill requires health insurers and service corporations providing Medicare supplement insurance coverage to make available, at a minimum, Medicare Supplement Plan C coverage of the standardized Medicare supplement plans, to applicants 50 years of age and over who are eligible for Medicare benefits due to disability.

The bill authorizes the Commissioner of Insurance to: (1) establish a plan to provide Medicare Supplement Plan C coverage of the standardized Medicare supplement plans to applicants under 50 years of age who are eligible for Medicare benefits due to disability; (2) appoint a contracting carrier, deemed by the commissioner to be experienced in providing and servicing Medicare supplement plans to individuals in this State under 50

ASSEMBLY INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 67

STATE OF NEW JERSEY

DATED: JUNE 1, 1995

The Assembly Insurance Committee reports favorably Assembly, No. 67.

This bill requires health insurers and service corporations providing Medicare supplement insurance coverage to make available, at a minimum, Medicare Supplement Plan C coverage of the standardized Medicare supplement plans, to applicants 50 years of age and over who are eligible for Medicare benefits due to disability.

The bill authorizes the Commissioner of Insurance to: (1) establish a plan to provide Medicare Supplement Plan C coverage of the standardized Medicare supplement plans to applicants under 50 years of age who are eligible for Medicare benefits due to disability; (2) appoint a contracting carrier, deemed by the commissioner to be experienced in providing and servicing Medicare supplement plans to individuals in this State, to administer the plan; and (3) establish procedures for the equitable sharing of any losses realized by the contracting carrier administering the plan by means of an assessment program applicable to all service corporations, health insurers and health maintenance organizations.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[FIRST REPRINT]

ASSEMBLY, No. 67

with Senate committee amendments

STATE OF NEW JERSEY

DATED: JUNE 22, 1995

The Senate Budget and Appropriations Committee reports favorably Assembly Bill No. 67 (1R), with amendments.

Assembly Bill No. 67 (1R), as amended, requires health insurers and service corporations providing Medicare supplement insurance coverage to make available, at a minimum, Medicare Supplement Plan C coverage of the standardized Medicare supplement plans, to applicants 50 years of age and over who are eligible for Medicare benefits due to disability.

As amended and reported, this bill is identical to Senate Bill No. 2167 of 1995 (Sinagra) as amended and reported by this committee on June 22, 1995.

COMMITTEE AMENDMENTS

The committee amendments require an audit, before an assessment can be imposed, of the operations and losses of a carrier related to the Medicare supplement insurance policies issued pursuant to this bill, if a contracting carrier reports a net loss to the Commissioner of Insurance.

FISCAL IMPACT

This bill will not have an impact on State revenues or expenditures.

years of age to administer the plan; and (3) establish procedures for the equitable sharing of any losses realized by the contracting carrier administering the plan by means of an assessment program applicable to all service corporations, health insurers and health maintenance organizations.

Concerns Medicare supplement insurance coverage for individuals eligible for Medicare due to disability.

AL 7

OFFICE OF THE GOVERNOR
NEWS RELEASE

CN-001
Contact: JAYNE REBOVICH
609-777-2600

TRENTON, N.J. 08625
Release: THURSDAY
AUGUST 17, 1995

Gov. Christie Whitman has signed legislation which will enable Medicare-eligible disabled persons under the age of 65 to purchase Medigap coverage, a type of insurance that covers healthcare costs not paid by Medicare.

"The availability of Medigap coverage will ease the financial hardship now experienced by many New Jerseyans suffering from serious medical conditions," said Gov. Whitman.

On April 1, the only carrier in the state that sold Medigap coverage to persons under the age of 65 ceased to do so, leaving these people without financial assistance to cover their medical costs. The bill requires health insurers and service corporations that provide Medigap coverage to Medicare recipients over the age of 65 to also provide a minimum coverage, Medicare Supplement Plan C, to persons 50 years of age and over who are eligible for Medicare due to disability.

The legislation also requires the Commissioner of Insurance to establish a plan to also provide Plan C coverage to Medicare-eligible persons under the age of 50 and to appoint a contracting carrier to administer the plan. The rates for Plan C coverage for this group cannot exceed the lowest rate for the 50 years and older group.

A-67/S-2167 was sponsored by Assembly Speaker Chuck Haytaian (R-Warren) and Assemblyman Leonard Lance (R-Hunterdon) and Senator Jack Sinagra (R-Middlesex).

Gov. Whitman also signed the following:

A-1801/S-1835, sponsored by Assemblyman Richard Bagger (R-Middlesex) and Senator Martin (R-Morris), permits a municipality to exclude certain land designated for open space from consideration for affordable housing development. The bill adds lands already designated on municipal master plans as dedicated to conservation, open space or parklands to the list of properties excluded from consideration as potential sites for low and moderate income housing.

ACS for A-252/842/S626, sponsored by Assemblywoman Marion Crecco (R-Essex) and Assemblymen Christopher Connors (R-Ocean) and Jeffrey Moran (R-Ocean), regulates the location of sexually oriented businesses. The bill prohibits the location of a sexually oriented business within 1,000 feet of an existing sexually oriented business, church, synagogue, temple or other place of worship, schools or bus stops, playgrounds, or any place zoned for residential use. A violation of the bill is a fourth degree crime, punishable by up to 18 months imprisonment and a fine up to $7,500.