NEW JERSEY MEDICARE SUPPLEMENT "UNDER 50" PROGRAM

Temporary Plan of Operation

Article I. Purpose and Scope

Pursuant to P.L. 1995, c. 229, the New Jersey Medicare Supplement "Under 50" Program ("Program") has been established to provide Plan C coverage of the standardized Medicare supplement plans to persons under 50 years of age residing in New Jersey who are enrolled in Medicare due to disability, or due to end stage renal disease.

The Program shall be administered by a Governing Board ("Governing Board") through a Plan of Operation approved by the Commissioner. All meetings of the Governing Board shall take place in New Jersey.

The purposes of the New Jersey Medicare Supplement "Under 50" Program are:

1. To provide standardized Medicare supplement Plan C ("Plan C") coverage through a contracting carrier appointed by the Governing Board to persons under 50 years of age who are eligible for Medicare;

2. To select a contracting carrier to provide the Plan C coverage;

3. To provide a mechanism for sharing the losses incurred by the contracting carrier in providing this coverage; and

4. To provide greater affordability of this coverage by requiring that Program Plan C premium rate charged by the contracting carrier not exceed the lowest premium rate charged by the contracting carrier for Plan C coverage issued to persons 65 years of age or older.

This program shall take effect on January 1, 1997.

Article II. Definitions

The following words and terms, when used in the Plan of Operation, shall have the following meanings, unless otherwise stated:

"Applicant" means an individual who, at the time of application for the Program, has not attained the age of 50 years. In the event that an applicant for Program coverage is disqualified solely because of age, the date of application to the Program shall be deemed to apply to any application for coverage pursuant to N.J.A.C. 11:4-23B.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"Contracting carrier" means an insurer selected and appointed to service the Program in accordance with this Plan of Operation.

"Financially impaired" means an insurer or HMO which, after August 16, 1995, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or an insurer or HMO which is under an order of liquidation, 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 New Jersey or a health maintenance organization subscriber contract delivered or issued for delivery in New Jersey.

"HealthStart Plus" means the program providing coverage to pregnant women and infants up to one year of age who are in families with incomes between 185 percent and 300 percent of the poverty level, established pursuant to the Health Care Cost Reduction Act, P.L. 1991, c. 187, section 25 (N.J.S.A. 26:2H-18.47).

"HMO" means a health maintenance organization authorized in accordance with N.J.S.A. 26:2J-1 et seq.

"Insurer" means an insurance company or hospital, medical or health service corporation authorized to issue health benefits plans in New Jersey.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c. 413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

"Net earned premium" means the premium earned in New Jersey on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plans. "Net earned premium" shall include the aggregate premiums earned in the insurer's insured group and individual business and HMO business, including premiums from contracts covering Medicaid and HealthStart Plus recipients and premiums from Medicare cost and risk contracts. "Net earned premium" shall not include premiums from any stop loss or excess coverage to the extent that such coverage:

1. Is issued to self-funded arrangements to reimburse only the self-funded arrangements for expenses exceeding per person or aggregate limits, and for which employees or other individuals are not third party beneficiaries under the policy; and

2. The per person limit is no less than $20,000 per year, and additionally, or in the alternative, the aggregate limit is no less than 125 percent of expected claims.

"Net loss of the contracting carrier" means net earned premiums and any investment income thereon less the amount in claims paid and reasonable administrative expenses of the contracting carrier paid in the preceding calendar year.

"Net loss of the Program" means the net loss of the contracting carrier plus any reasonable administrative expenses of the Governing Board and any other associated administrative expenses.

"Program" means the Medicare Supplement – Under 50 Plan established pursuant to N.J.A.C. 11:4-23A.1 et seq. and administered in accordance with this Plan of Operation.

"Reasonable administrative expenses of the contracting carrier" means actual expenses or the expense allowance, but in no event shall the administrative expenses exceed 25 percent of premium.

"Resident" means a person whose primary residence for the majority of a year is in the State of New Jersey.

Article III. Program Coverage

A. The Program shall provide Plan C of the standardized Medicare supplement plans through a contracting carrier to New Jersey residents, under 50 years of age, who are enrolled in Medicare due to disability or due to end stage renal disease. Due to delays in its becoming operational, the Program shall not deny coverage to an individual who satisfies all the eligibility requirements of the Program except that the individual attained age 50 between December 13, 1995 and the date the Commissioner certified this Temporary Plan of Operation.

B. The Program shall not deny or condition the issuance or renewal, nor discriminate in the pricing of coverage because of the health status, claims experience, receipt of health care or medical condition of an applicant if the application for coverage 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 is submitted within six months of the effective date of the Program, whichever is later.

C. Nothing in the foregoing paragraph B shall be construed to prohibit the exclusion of benefit during the first three months, based upon a preexisting condition for which the insured received treatment or was otherwise diagnosed during the six months before Program coverage became effective.

D. Program coverage will cease upon the occurrence of any of the following: (1) non-payment of premium; (2) a determination of fraud or material misrepresentation with regard to an application for coverage or submission of a claim under the Program; (3) the individual is no longer enrolled in Medicare Part B; or (4) the individual fails to respond to requests for information or documentation necessary to confirm eligibility for Program coverage.

E. Qualified Applicant

The Program shall provide coverage to an applicant commencing no later than the first day of the calendar month after the applicant furnishes the contracting carrier with the following:

1. A completed application form;

2. Proof of age (under 50 at time of initial application);

3. Proof of enrollment in Medicare Part B;

4. Proof at time of initial application that the applicant is a current resident of New Jersey;

5. Payment of the appropriate advance premium, which may not be required to exceed one quarter's annual premium; and

6. Such other information or documentation as the Governing Board determines is necessary.

F. Termination

1. The Program may terminate coverage only as authorized in paragraph D. Termination based on D(1), (2), or (4) shall be effective upon 30 days written notice to the insured. Where termination is based on D(3), Program coverage will terminate as of the date Part B Medicare coverage terminated, and the insured will be refunded all premium paid for Program coverage subsequent to that date, on a pro rata basis. Replacement of the contracting carrier does not constitute termination of Program coverage.

2. An insured may request voluntary termination of Program coverage upon written notice. Refund of any premium will be calculated on a pro rata basis by subtracting the amount of premium needed to provide coverage to the requested termination date from the amount of advance premium paid.

G. Notice of other coverage availability to insureds attaining age 65

The Program shall establish procedures for advising an insured attaining the age of 65 pf the open enrollment opportunities with the contracting carrier as well as with other Medicare supplement insurers and shall also advise such insureds of the availability of additional Medicare supplement plans other than Plan C.

Article IV. Governing Board

A. Composition

1. The Program shall be administered by a Governing Board ("Governing Board") consisting of eight (8) directors. Six (6) directors shall be appointed by the Commissioner as follows:

a. Two (2) directors shall be representative of insurers writing Medicare Supplement insurance coverage in New Jersey;

b. One (1) director shall be a representative of an HMO nominated by the New Jersey Association of Health Maintenance Organizations;

c. One (1) director shall be a representative of an insurer nominated by the Health Insurance Association of America; and

d. Two (2) directors shall be members of the public who are knowledgeable about Medicare supplement coverage, but who are not employed by or otherwise affiliated with insurers, health maintenance organizations, insurance producers, or other entities of the insurance industry.

Upon its selection and appointment by the Governing Board, the contracting carrier shall have a representative serve as a director on the Governing Board, eligible to vote on all matters except those relating to the contracting carrier, or the selection of an auditor or except as provided in paragraph B1 below, during its term of appointment as contracting carrier.

The Commissioner or the Commissioner's designee shall serve as an ex-officio non-voting director on the Governing Board.

2. No insurer or HMO, its affiliates or subsidiaries shall serve in more than one (1) director position on the Governing Board at the same time.

3. For the initial Governing Board, the Commissioner shall appoint three (e) directors for a term of one year and three (3) directors for a term of two years, or until their successors are appointed. Thereafter, all directors appointed by the Commissioner shall serve for a term of two years or until a successor is appointed. Directors shall be eligible for reappointment for an unlimited number of terms.

4. The directors shall annually elect from among their members a Chairman and Secretary and such other officers as they deem appropriate. The Chairman shall notify the Commissioner of the results of such elections within 30 calendar days of their occurrence.

5. A director may be removed by the Commissioner for cause, including absence from at least three consecutive meetings.

6. Directors shall serve without compensation but directors who are appointed pursuant to paragraph 1d above to represent the public may be reimbursed for reasonable expenses, including reasonable travel expenses, incurred in connection with attendance of meetings of the Governing Board.

B. Meetings

1. The Governing Board shall meet as often as may be necessary to perform the general duties of administration of the Program. Meetings may be conducted by telephone conference. A majority of the directors shall constitute a quorum for the transaction of business. The majority vote of the quorum of voting directors shall be required for passage of any measure. A director shall disclose any potential conflict of interest prior to voting on a particular measure and the remaining directors, by majority vote, shall decide whether a director with the potential conflict may vote.

2. Subsequent to the initial meeting, an annual meeting of the Governing Board shall be held in New Jersey on the second Monday in June to review the Plan of Operation and submit proposed amendments, if any, to the Commissioner for approval.

3. A written record of the proceedings of each meeting, including closed or executive sessions, shall be made and submitted to the Commissioner and to all directors within 30 days of each meeting. The original of the record shall be retained by the Secretary of the Governing Board.

C. Duties

The Governing Board shall have the power and duty to:

1. Develop and submit to the Commissioner for approval a plan of operation and amendments thereto;

2. Establish minimum requirements and performance standards for the contracting carrier, which shall include evidence of prior experience in providing and servicing Medicare supplement insurance policies or contracts in New Jersey;

3. Establish procedures to select an auditor to review the operations of the contracting carrier relating to the Program;

4. Review the auditor's report and implement any recommendation determined to be appropriate;

5. Retain appropriate actuarial, accountant, or other employees, professionals and contractors as necessary to provide assistance in the operation of the Program;

6. Enter into contracts as are necessary or proper to implement and operate the Program;

7. Sue or be sued on behalf of the Program, including, but not limited to, taking any legal actions necessary or proper for the recovery of any assessments against any member of the Program;

8. Take legal actions necessary to avoid or recover the payment of improper claims against the Program;

9. Establish practices and procedures for assessments under the Program;

10. Assess insurers and HMOs in accordance with P.L. 1995, c. 229 and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments following the close of the calendar year; and

11. Perform such other functions as may be necessary and appropriate.

Artivle V – Contracting Carrier

A. Selection and Appointment

1. Within 5 days of the approval of the Temporary Plan of Operation by the Governing Board, the Governing Board shall provide written notice to every carrier that has experience in providing and servicing standardized Medicare supplement policies or contracts in New Jersey advising them of the Program. This Program notice shall invite any carrier interested in being considered for appointment as the contract carrier for the Program to advise the Governing Board in writing within 7 working days.

2. The contracting carrier shall be selected and approved through a competitive review process of all interested carriers.

3. In the event that no carrier expresses interest in being considered for appointment as the contracting carrier, the Governing Board shall consider for appointment any carrier that was sent a notice pursuant to paragraph 1.

4. In evaluating a possible contracting carrier, the Governing Board shall consider such factors as the extent of experience a carrier has with standardized Medicare supplement policies, the number of such policies or contracts a carrier has issued and services in New Jersey, the ability of a carrier to furnish such policies or contracts on a Statewide basis, the ability of a carrier to adequately perform all the functions expected of a contracting carrier, and such other factors as the Governing Board deems relevant for the successful operation of the Program.

5. The Governing Board shall select and appoint a contracting carrier no later than 30 days following the approval of this Temporary Plan of Operation. The contracting carrier appointment shall be for a term of 2 years, unless terminated for cause as provided in Section C of this Article. The terms and conditions of such an appointment shall be incorporated into a written agreement between the Governing Board and the contracting carrier and a copy of such agreement shall be filed with the Commissioner.

6. At least 3 months prior to the expiration of the term of a contracting carrier appointment, the Governing Board shall provide written notice to every carrier that has experience in providing and servicing Medicare supplement contracts in New Jersey, inviting carriers interest in being considered for appointment as the contracting carrier to advise the Governing Board in writing within 7 working days. Appointment of a contracting carrier for a new term shall be made prior to expiration of the existing appointment and shall be in accordance with paragraph 2 or 3, as appropriate, and subject to paragraphs 4 and 5. A contracting carrier may be reappointed for an unlimited number of terms.

B. Performance Standards

1. Performance standards for the contracting carrier shall be established by contract and shall include provisions that set specific time frames during which the contracting carrier must accomplish certain functions, including the following: issuance of original policy; renewals; refunds; and claims handling.

2. Financial Records and Accounting

a. Within 15 working days of its appointment, the contracting carrier shall submit to the Governing Board for its approval, procedures describing its proposed methods and means for collecting, investing and disbursing funds obtained on behalf of the Program.

b. The books of account, records, reports and other documents of the contracting carrier relating to its operation of the Program shall be maintained in New Jersey and shall be open to inspection by the Commissioner, the Governing Board, and the auditor selected in accordance with Article VIII.

3. Rates

The rate charged for Program coverage by the contracting carrier shall be no greater than the lowest rate that the contracting carrier charges for Medicare supplement Plan C policies or contracts that it issues to persons 65 years or older.

C. Replacement/Termination

1. At the expiration of a term of appointment, a contracting carrier may be replaced by the Governing Board.

2. If the contracting carrier fails to satisfy the performance standards, or fails to remedy any deficiency noted by the Governing Board, the Governing Board may terminate and replace the contracting carrier upon 120 days notice.

3. The contracting carrier being replaced or terminated shall cooperate in any replacement action to ensure an orderly transition and minimize disruption to the operation of the Program.

4. Where the contracting carrier is being replaced pursuant to paragraph 1, the replacing contracting carrier shall notify existing insureds of the change as their policies come up for renewal. The replaced contracting carrier shall continue to serve the existing insureds during the runoff period and shall be reimbursed for losses incurred during the runoff.

D. Compensation

The contracting carrier shall be entitled to reasonable administrative expenses. In determining reasonable administrative expenses, the Governing Board shall allow actual expenses or the expense allowance, whichever is less but in no event shall the administrative expenses exceed 25 percent of premium. The Governing Board may consider the contracting carrier's failure to satisfy any performance standard and the financial impact of such failure on Program costs in evaluating the appropriateness of reimbursement for any administrative expense and may deny reimbursement for any expense resulting from performance related errors.

Article VI – Appeals to Governing Board

The Governing Board shall have the power and duty to investigate appeals and may appoint an Appeals Committee to investigate such appeals on its behalf. The Governing Board, or Appeals Committee appointed by the Governing Board, may hear any appeal from an applicant, insured, insurer or other interested party on a matter pertaining to the proper administration of the Program. Each notice of cancellation or denial of coverage under the provisions of the Program shall contain or be accompanies by a statement that the insured or applicant has a right of appeal to the Governing Board. If an Appeals Committee is appointed, it shall make a recommendation to the Governing Board for their final action. The Governing Board shall sustain, reverse, or modify the decision of the Appeals Committee. The Governing Board shall permit an appellant to present evidence or request additional information to assist in their determination of the appeal. The action of the Governing Board may be appealed to the Commissioner.

The Governing Board shall promptly notify the applicant, insured, insurer, or other interested party of the disposition of the appeal. Notification in the case of refusal to sustain a cancellation shall include notice that, upon the payment of premium to the contracting carrier, a policy will be issued.

Article VIX – Assessments

A. Every insurer and HMO providing health benefits plans or health maintenance organization subscriber contracts in New Jersey shall be liable for an assessment to pay its equitable share of any net loss paid by the Program in the previous calendar year, unless the insurer or HMO has received an exemption or deferment from the Commissioner. Any advance interim assessment made for organizational and interim operating expenses that has been paid by an insurer or HMO shall be credited as an offset against any regular assessment.

B. The assessment of each insurer and HMO described in A above shall be in the propostion that its net earned premium bears to the net earned premium of all insurers and HMOs, except that no insurer or HMO shall be liable for an assessment amount greater than 35 percent of the total net loss incurred by the Program in any calendar year.

C. Assessment amounts for insurers and HMOs granted a deferment or exemption, or that portion of assessment that exceeds the 35 percent limited noted in B above, shall be reapportioned to other insurers and HMOs based on their respective net earned premium. Payment of deferred assessment amounts shall be credited against the regular assessment of all insurers and HMOs in the year in which the deferred assessment amount is paid.

D. Upon receipt and review of the reports required pursuant to N.J.A.C. 11:4-23A.8, the Commissioner shall notify the Governing Board of the amount of assessment. Assessment notices shall be mailed by the Governing Board to each insurer and HMO and shall be due and payable upon receipt by the insurer or HMO of the invoice for the assessment. Any assessments, or portion of an assessment, not paid within 30 days of the date of the invoice shall be subject to interest of 1.5 percent of the assessment amount not timely paid per month, accruing from the date of the invoice of the assessment.

E. Assessments for net losses of the Program may be determined or apportioned, and may include calculations based upon the information provided pursuant to N.J.A.C. 11:4-23A.8, but the contracting carrier shall not be reimbursed for its total reported net losses until the conclusion of an audit of the losses reported by the contracting carrier and its related operations, conducted in accordance with this Plan of Operation. The contracting carrier may be paid for a portion of its reported net losses prior to the completion of the audit, provided that such partial payment is authorized by the Governing Board and further provided that such payment does not exceed 80% of the undisputed reported net losses.

F. The Governing board may initiate legal action to recover any assessment or portion of assessment, including late interest, imposed to cover the equitable share of any net loss of the Program that an insurer or HMO has not paid within 45 days of the date of invoice.

G. In addition to the action noted in F, the Governing Board shall also send a list of any insurer or HMO that has not paid its invoice assessment to the Commissioner for such action as the Commissioner deems appropriate.

Article VIII – Audit

A. Whenever a contracting carrier reports a net loss and prior to the reimbursement of the contracting carrier for its total reported net losses, an audit of the contract carrier's operation of the Program shall be conducted by a qualified independent certified public accountant. The cost of such audit shall be paid as an administrative expense of the Program.

B. The auditor shall be selected and approved by the Governing Board through a competitive bidding process. The audit shall include:

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

2. a review of the allocation and reasonableness of the administrative expenses of the contracting carrier;

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, to the Commissioner and to each carrier and HMO subject to P.L. 1995, c. 229. The Governing Board shall review the audit report and may, upon its recommendation, require the contracting carrier to implement any recommendations of the auditor.

D. Upon completion of the audit by the auditor and its acceptance by the Governing Board, the Governing Board shall recalculate, if necessary, the Program assessment and shall reimburse the contracting carrier for the outstanding portion of its total reported net losses, as determined in accordance with the audit report.

E. As often as it deems necessary, the Governing Board shall also have performance audits conducted of the contracting carrier to evaluate its compliance with the performance standards established in Article V, Section B.

Article IX – Financial Administration

A. Books and Records

The Governing Board shall cause to be established and maintained in New Jersey all the records, books of account and other related materials for the proper administration of the Program, which shall be open to inspection and audit by the Commissioner.

B. Bank Accounts

All bank accounts/checking accounts relating to the collection and disbursement of funds by the Program shall be established and maintained in the name of the Program in a financial institution in New Jersey, and shall be approved by the Governing Board. Only the Chair and Secretary of the Governing Board shall be authorized check signers, except as otherwise authorized by the Governing Board.

C. Investments

The Program may invest in those securities, bonds, notes or other evidences of debt as are authorized as admitted assets for a domestic New Jersey health insurer.

Article X – Committees

The Governing Board may appoint or organize itself into such committees as it determines are necessary and appropriate to carry out the purposes of the Program.

Article XI – Indemnification

The Program shall indemnify each member or director of the Governing Board for any and all claims, suits, costs of investigations, costs of defense, settlements of judgments against them and all other reasonable and necessary costs and expenses, including attorney fees, on account of an act or omission arising out of and in connection with a member's duties under the Program, reasonably believed by said member to be within the scope of their duties. The Program shall refuse to indemnify if it determines that the act or failure to act was due to actual fraud, willful misconduct or actual malice.

Any individual or member seeking indemnification under this Article shall promptly notify the Program in writing of any action, suit or proceeding, or threat thereof. Any settlement of any claim must be made with the prior approval of the Governing Board in order for indemnification under this Article to be available.

The costs of fulfilling the Program's obligations under this Article shall be an administrative cost of the Governing Board.