CHAPTER 207

AN ACT concerning the regulation of long-term care insurance.

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

C.17B:27E-1 Purpose of act on long-term care insurance.

1. The purpose of this act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

C.17B:27E-2 Application of act.

2. The requirements of this act shall apply to policies delivered or issued for delivery in this State on or after the effective date of this act intended for use as long-term care insurance. This act is not intended to supersede the obligations of entities subject to this act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

C.17B:27E-3 Short title.

3. This act shall be known and may be cited as the "New Jersey Long-Term Care Insurance Act."

C.17B:27E-4 Definitions relative to regulation of long-term care insurance.

4. As used in this act, unless the context requires otherwise:

"Applicant" means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(2) In the case of a group long-term care insurance policy, the proposed certificate holder.

"Certificate" means any certificate or evidence of coverage issued under a group long-term care insurance policy, which has been delivered or issued for delivery in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this State and issued to:

(1) a group conforming to one of the descriptions set forth at N.J.S. 17B:27-2 through 17B:27-8 inclusive, or N.J.S. 17B:27-27; or

(2) any group not set forth in paragraph (1) of this definition, which in the opinion of the commissioner may be insured for group long-term care insurance in accordance with sound underwriting principles.

"Long-term care insurance" means any insurance policy, certificate or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. The term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also apply to qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; health, hospital, or medical service corporations; prepaid health plans; or health maintenance organizations. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more qualifying events, and which provide the

option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this act.

"Policy" means any policy, contract, subscriber agreement, rider or endorsement providing long-term care insurance coverage delivered or issued for delivery in this State by an insurer; fraternal benefit society; health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of 26 U.S.C. s. 7702B(b), as follows:

(1) The only insurance protection provided under the contract is coverage of qualified long-term services. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act (42 U.S.C. s. 1395 et seq.) or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act (42 U.S.C. s. 1395 et seq.) only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(3) The contract is guaranteed renewable, within the meaning of 26 U.S.C. s. 7702B(b)(1)(C);

(4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in paragraph (5) of this definition;

(5) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract shall not exceed the aggregate premiums paid under the contract; and

(6) The contract meets the consumer protection provisions set forth in 26 U.S.C. s. 7702B(g).

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by a rider or as part of the contract and that satisfies the requirements of 26 U.S.C. s. 7702B(b) and (e).

C.17B:27E-5 Compliance required.

5. a. Any policy, certificate or rider advertised, marketed or offered as long-term care insurance shall comply with the provisions of this act.

b. No group long-term care insurance coverage shall be offered to a resident of this State under a group policy issued in another state to a group described in paragraph (2) of the definition of "group long-term care insurance" in section 4 of this act, unless this State, or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this State, has made a determination that those requirements have been met.

C.17B:27E-6 Prohibitions relative to long-term care insurance.

6. a. No long-term care insurance policy or certificate shall:

(1) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

(2) Contain a provision establishing a new waiting period in the event existing

coverage is converted to or replaced by a new or other form within the same company or affiliated company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled nursing care in a facility than coverage for lower levels of care.

b. (1) No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the following: preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate shall exclude coverage for a loss or confinement which is the result of a preexisting condition unless that loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The definition of "preexisting condition" shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (2) of this subsection b. expires. No long-term care insurance policy or certificate shall exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (2) of this subsection b.

(4) A preexisting condition limitation shall only apply to the long-term care insurance coverage and shall not apply to any death benefit or other life insurance benefit provided by a long-term care insurance policy or certificate.

c. (1) No long-term care insurance policy or certificate shall be delivered or issued for delivery in this State if that policy or certificate:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits, other than waiver of premium, post-confinement, post-acute care or recuperative benefits, on a prior institutionalization requirement.

(2) (a) A long-term care insurance policy or certificate containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" those limitations or conditions, including any required number of days of confinement.

(b) A long-term care insurance policy or certificate which conditions eligibility for non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days.

d. Long-term care insurance applicants 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 of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates 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 of the policy or certificate, the applicant is not satisfied for any reason.

e. (1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(a) The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(b) In the case of insurance producer solicitations, an insurance producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in

conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

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

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and the premium refunded;

(f) A brief description of the relationship of cost of care and benefits; and

(g) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 26 U.S.C. s. 7702B(b).

f. A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this State, shall include:

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

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

(3) A statement that the group master policy determines governing contractual provisions.

g. At the time of policy delivery, a policy summary as prescribed by the commissioner pursuant to subsection e. of this section shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make that delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) Any exclusions, reductions and limitations on benefits of long-term care;

(4) A statement as to whether any long-term care inflation protection option is available under this policy;

(5) If applicable to the policy type, the summary shall also include:

(a) A disclosure of the effects of exercising other rights under the policy;

(b) A disclosure of guarantees related to long-term care costs of insurance charges;

(c) Current and projected maximum lifetime benefits; and

(6) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with regulations promulgated by the commissioner or into the life insurance policy summary which is required to be delivered in accordance with regulations promulgated by the commissioner.

h. Whenever a long-term care benefit, funded through a life insurance policy by the acceleration of the death benefit, is in benefit payment status, a monthly report as specified by the commissioner shall be provided to the policyholder or certificate holder. The report shall include:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy, such as death benefits or cash values, due to long-term care benefits being paid out; and

(3) The amount of long-term care benefits existing or remaining.

C.17B:27E-7 Grounds for rescinding policy, denying a claim.

7. a. For a policy or certificate that has been in force for less than six months, an insurer

may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

b. For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

c. After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone; such a policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

d. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments shall not be recovered by the insurer if the policy or certificate is rescinded.

e. In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by N.J.S.17B:25-4 or 17B:27-12, as appropriate. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

C.17B:27E-8 Conditions for delivery, issuance of policy.

8. a. Except as provided in subsection b. of this section, a long-term care insurance policy shall not be delivered or issued for delivery in this State unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

b. When a group long-term care insurance policy is issued, the offer required in subsection a. of this section shall be made to the group policyholder.

C.17B:27E-9 Regulations.

9. The commissioner shall promulgate regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to effectuate the purposes of this act including, but not limited to, regulations dealing with disclosure requirements, eligibility, renewability, non-duplication of coverage, dependent coverage, preexisting conditions, termination of coverage, continuation or conversion, loss ratio, and other information that the commissioner feels necessary.

C.17B:27E-10 Prior approval of commissioner required.

10. a. Every long-term care insurance policy or contract, including any application, certificate, rider or endorsement to be issued or delivered in this State shall be filed with the commissioner for prior approval as provided in this section.

b. A policy, contract or related form filed with the commissioner for approval pursuant to this section shall be deemed approved upon the expiration of 60 days after the submission of the form unless disapproved in writing by the commissioner within that time. Any such disapproval shall be based only on the specific provisions of applicable statutes or regulations. A disapproved policy, contract or related form may be resubmitted.

c. A long-term care insurance policy, contract or related form submitted for approval pursuant to this section and disapproved by the commissioner before the expiration of 60 days after its submission shall be deemed withdrawn at the expiration of 60 days after the transmittal of the commissioner's specific objections unless the filer submits a complete written response to all of the commissioner's objections regarding the submission within the 60-day period.

d. A long-term care insurance policy, contract or related form resubmitted in response to the commissioner's objections pursuant to subsection b. of this section shall be deemed approved

upon the expiration of 30 days after its resubmission unless disapproved in writing by the commissioner within that time. No disapproval by the commissioner of a resubmission shall be based on any objection not specified by the commissioner in his initial disapproval of the filing, except that the commissioner may disapprove that form based on any new provisions introduced in the resubmission or, if in addressing the specific objections cited in the commissioner's disapproval, the insurer changes or modifies any substantive provisions of the form. Any policy, contract or related form resubmitted for approval pursuant to this section and disapproved by the commissioner before the expiration of 30 days after its submission shall be deemed withdrawn at the expiration of 30 days after the transmittal of the commissioner's specific objections, unless the filer submits a complete written response to all of the commissioner's objections regarding the submission within the 30-day period.

e. Any form which is filed with the commissioner and approved or deemed approved may be so delivered or issued for delivery until such time as any subsequent withdrawal of the filing by the commissioner, following an opportunity for a hearing held in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) and any rules adopted thereunder, becomes final in accordance therewith.

f. For the purposes of this section, "days" means calendar days, except that when the last day of any specified time period is a Saturday, Sunday, or State holiday, then the time period shall end on the next following business day. With respect to any specified time period pertaining to correspondence between an insurer and the commissioner, the time period shall commence on the date that correspondence is postmarked or submitted to a private delivery service.

C.17B:27E-11 Insurer to file rates, rating schedule, supporting documentation.

11. An insurer providing long-term care insurance issued on an individual basis in this State shall file, for the commissioner's approval, its rates, rating schedule and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this State. All filings of rates and rating schedules shall demonstrate that the benefits are reasonable in relation to the premium charged and that the rates are not excessive, inadequate or unfairly discriminatory.

C.17B:27E-12 Additional penalties.

12. In addition to any other penalties provided by the laws of this State, any insurer and any insurance producer found to have violated any requirement of this State relating to the regulation of long-term care insurance or the marketing of that insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy or certificate involved in the violation, or $10,000, whichever is greater.

13. This act shall take effect on the 180th day following enactment.

Approved January 8, 2004.