INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF ACTUARIAL SERVICES

Long-Term Care Insurance

Proposed Repeal and New Rules: N.J.A.C. 11:4-34

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17:48-8.1, and 17B:27E-9, and P.L. 2003, c. 207

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2004-461

Submit written comments by February 4, 2005 to:

Douglas A. Wheeler, Assistant Commissioner
Department of Banking and Insurance
Legislative and Regulatory Affairs
20 West State Street
P.O. Box 325
Trenton, NJ 08625-0325
Fax: (609) 292-0896
E-mail: Legsregs@dobi.state.nj.us

The agency proposal follows:

## Summary

The Department of Banking and Insurance (Department) is repealing the current long-term care insurance rules found at N.J.A.C. 11:4-34 and proposing new rules in their place. The Long-Term Care Insurance Act, P.L. 2003, c. 207, was enacted January 8, 2004, and is based on the National Association of Insurance Commissioners' (NAIC) Model Act. The proposed new rules implement the Long-Term Care Insurance Act, and are based in part on the NAIC Model Regulation. The Department's proposed new rules replace its current regulatory requirements for a more uniform regulatory structure.

The Department is proposing new rules at N.J.A.C. 11:4-34 to require every long-term care insurance policy form to be filed with the Commissioner for prior approval. Any form which is filed with the Commissioner and approved may be issued in this State until a subsequent withdrawal of the filing by the Commissioner after a hearing. The proposed new rules also require prior approval of initial rates and future rate changes. Rates must not be excessive, inadequate or unfairly discriminatory.

The purpose of these rules is to promote the public interest, to promote the availability of long-term care 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.

These rules apply to long-term care insurance policies delivered or issued for delivery in this State on or after the effective date of the Long Term Care Insurance Act. These rules are not intended to supersede the obligations of entities to comply with 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.

Additionally, the Life and Health Insurance and Health Maintenance Organization Form Approval Reform Act (the HMO Form Approval Reform Act), P.L. 1995, c.73, was intended to improve and facilitate the internal restructuring of the Department's approval process for life insurance and health insurance policy and contract forms. The HMO Form Approval Reform Act includes a provision requiring all life and health insurance policies or contracts, annuities, or variable contracts delivered or issued for delivery in this State, including any application, rider,

or endorsement that is made a part of that policy or contract, to be filed with the Commissioner for approval. As a result the Department has adopted rules that establish procedures for carriers to obtain the Commissioner's approval prior to use of all life, health and annuity forms, set forth general standards related to all forms for which the Commissioner's approval is sought, and establish specific standards related to specific types of forms (see N.J.A.C. 11:4-40 through 48). Additionally, the Department's proposed rules permit life insurance and long-term care insurance policies to be combined. These rules increase the disclosure requirements on carriers. The Department's proposed new rules also add requirements for disclosure of a carrier's rating practices to consumers. These proposed new rules require the designation of a third party to get notice of a lapse of coverage. The proposed new rules recognize two types of long-term care plans, qualified and non-qualified. The Department's proposed new rules set forth a different rate review process, for long-term care policies.

N.J.A.C. 11:4-34.1 sets forth the purpose and scope of the rules, which combines the current two provisions.

N.J.A.C. 11:4-34.2 provides definitions for the words and terms used in this subchapter. This provision maintains definitions for the terms "carrier," "Department", "exceptional increase," "incidental," "insured," "qualified actuary," "qualified long-term care insurer contract," "similar policy forms." The rule does not include the term "guaranteed renewal". The proposed new rules add definitions for the following terms: "activities of daily living," "acute condition," "adult day care," "bathing," "cognitive impairment," "continence," "dressing," "eating," "hands-on assistance," "home health care services," "personal care," "toileting," "transferring" and "usual, customary and reasonable."

N.J.A.C. 11:4-34.3 establishes the guidelines for the use of certain terms in a long-term care insurance policy delivered or issued for delivery in this State.

N.J.A.C. 11:4-34.4 addresses policy practices and provisions for renewability, limitations and exclusions, extensions of benefits, continuation or conversions, discontinuance and replacement, the purchase of additional coverage, in addition to annuity contracts and life insurance policies.

N.J.A.C. 11:4-34.5 addresses unintentional lapses which is a new requirement. This provision requires notice before lapse, termination and restoration of coverage.

N.J.A.C. 11:4-34.6 requires that long-term care insurance policies contain the following disclosure provisions: renewability, riders and endorsements, payment of benefits, preexisting condition limitations, other limitations or conditions on eligibility for benefits, and benefit triggers.

N.J.A.C. 11:4-34.7 provides the requirements for the disclosure of rating practices to consumers. Additionally this provision requires that carriers provide the applicant with an explanation of potential premium rate revisions, have them sign an acknowledgment, and provide notice of upcoming premium rate schedule increases.

N.J.A.C. 11:4-34.8 addresses the initial filing requirements which apply to any long-term care insurance policy or certificate issued on or after July 1, 2005. This provision also requires that carriers provide the Commissioner with premium rates, rate schedules or rating formula, and an actuarial certification prior to making an long-term care insurance form available for sale.

N.J.A.C. 11:4-34.9 provides the prohibitions against post-claims underwriting. This provision requires applications for long-term care insurance policies or certificates except those

that are guaranteed issue to contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

N.J.A.C. 11:4-34.10 establishes the minimum standards for home health and community care benefits in long-term care insurance policies and certificates.

N.J.A.C. 11:4-34.11 addresses the requirements for offering inflation protection.

N.J.A.C. 11:4-34.12 provides the requirements for application, enrollment forms and replacement coverage. This provision prohibits application forms from including provisions, statements or questions that pertain to race, creed, color, national origin or ancestry of the proposed insured.

N.J.A.C. 11:4-34.13 addresses the reporting requirements of these rules. These rules require carriers to maintain records for each agent's sales. Carriers are required to report this information for the preceding year to the Commissioner by June 30 of each year.

N.J.A.C. 11:4-34.14 provides that a producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by the New Jersey Insurance Producers Licensing Act.

N.J.A.C. 11:4-34.15 states the discretionary powers of the Commissioner which currently appear in N.J.A.C. 11:4-34.10 of the proposed repealed rules.

N.J.A.C. 11:4-34.16 sets forth the reserve standards when long-term care is provided through the acceleration of benefits under group or individual life policies or riders.

N.J.A.C. 11:4-34.17 provides the loss ratio requirements for individual long-term care policies except those covered pursuant to N.J.A.C. 11:4-34.8 and 34.18. This provision also outlines the information that should be included in the actuarial memorandum.

N.J.A.C. 11:4-34.18 addresses premium rate schedule increases and applies to any individual long-term care policy issued in this State on or after 30 days after the effective date of these rules. In accordance with this provision, carriers shall request approval of a revised premium rate schedule at least 60 days prior to the notice to the policyholder. Additionally, this provision sets forth requirements that all premium rate schedule increases must meet.

N.J.A.C. 11:4-34.19 requires a carrier, prior to offering or placing in force group long-term care insurance coverage to or on a resident in this State under a group policy issued in another state, to file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this State.

N.J.A.C. 11:4-34.20 requires every carrier issuing a long-term care insurance or benefit in this State to provide a copy of any long-term care insurance advertisement intended for use in this State.

N.J.A.C. 11:4-34.21 establishes standards that every carrier shall adhere to in marketing long-term care insurance coverage in this State.

N.J.A.C. 11:4-34-22 applies to life insurance policies and annuity contracts providing long-term care benefits except those that only accelerate benefits for long-term care. This provision requires every carrier marketing long-term care insurance to develop suitability standards.

N.J.A.C. 11:4-34.23 addresses prohibitions against preexisting conditions and probationary periods in replacement policies or certificates.

N.J.A.C. 11:4-34.24 sets forth the standards for complying with the nonforfeiture benefit requirements.

N.J.A.C. 11:4-34.25 provides the standards for benefit triggers.

N.J.A.C. 11:4-34.26 states the additional standards for benefit triggers from qualified long-term care insurance contracts.

N.J.A.C. 11:4-34.27 interprets the provisions of N.J.S.A. 17B:21E-6e in prescribing a standard format and the content of an outline of coverage.

N.J.A.C. 11:4-34.28 requires that a long-term care insurance shopper's guide developed by the NAIC be provided to all prospective applicants of long-term care insurance.

N.J.A.C. 11:4-34.29 governs form filings that must be submitted to the Department for review.

N.J.A.C. 11:4-34.30 provides the penalties for violating the provisions of this subchapter.

The Appendix contains reporting forms, a worksheet and a suitability letter and notices to prospective and current policyholders and certificate holders.

A 60-day comment period is provided for this notice of proposal and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

## Social Impact

These rules provide consumer safeguards in terms of policy renewability, relationship of premium to benefits (loss ratio), policy limitations and exclusions, and conversion or continuation of group coverage. These rules also establish definitions for eligible covered services, which will enable interested consumers to effectively compare policies. These rules are necessary to ensure that there is consistency in policy benefits, definitions, limitations and

restrictions, in policies. Inconsistencies in the areas can considerably reduce the likelihood of the insured ever receiving benefits.

These rules promote the public interest by establishing long-term care policies that protect applicants from unfair or deceptive sales or enrollment practices. These rules establish standards for long-term care insurance that facilitates the public's understanding and comparison of long-term care insurance policies. The proposed new rules should provide the consumer with more choices because carriers will not be offering different products. These rules also increase the disclosure requirements on carriers and require the designation of a third party to get notice of a lapse of coverage. Both of these requirements are beneficial to consumers.

The Department's proposed new rules adopt the NAIC Model and benefit carriers by providing uniform rules governing long-term care insurance. These rules should encourage carriers to offer different type of long-term insurance products. Some carriers may not benefit from these rules. Carriers offering products which do not comply with the prescribed standards would not be permitted to continue marketing their products as "long-term care" policies. However, most insurers currently marketing long-term care products should be able to comply with these rules since they are similar to the rules the Department is repealing.

## Economic Impact

These rules will ensure that future long-term care insurance policies will pay benefits for a variety of services not covered by most health insurance policies or Medicare, while restricting certain policy exclusions and limitations that previously reduced the likelihood of receiving benefits. With the availability of viable long-term care insurance products, it is possible to reduce costs to some State Medicaid programs and to reduce long-term care out-of-pocket costs

to individuals and families. Consumers should see more rate flexibility as a result of these rules as well as more products and choices.

The Department's proposed new rules adopt the NAIC long-term care insurance model regulation thereby providing uniform rules for carriers to follow which should be beneficial to carriers. As a result, these rules should make it easier for carriers to utilize approaches that are appropriate and consistent with the types of products they provide in other jurisdictions.

Promulgation of these rules should not result in additional costs to any State agency. Since the Department of Banking and Insurance currently has prior approval authority with respect to long-term care insurance products, regulatory costs to the Department should remain constant.

## Federal Standards Statement

A Federal standards analysis is not required because these rules regulate the business of insurance and are not subject to any Federal requirements or standards.

## Jobs Impact

The Department does not anticipate jobs being generated or lost as a result of the proposed repeal and new rules.

## Agriculture Industry Impact

Pursuant to N.J.S.A. 4:1C-1 et seq., the Right to Farm Act, and N.J.S.A. 52:14B-4(a) of the Administrative Procedure Act, the Department does not expect any agriculture industry impact from the proposed repeal and new rules.

Regulatory Flexibility Analysis

Pursuant to the Regulatory Flexibility Act, at N.J.S.A. 52:14B-17, a "small business" means any business resident in this State which employs fewer than 100 employees; full-time is independently owned and operated; and is not dominant in its field. Some carriers affected by these new rules may meet this definition.

Carriers can expect to incur modest additional administrative expenses, but compliance with the proposed new rules requires only minimal additional reporting and should impose little or no change in the companies' present operations. It is the Department's understanding that the carriers presently maintain, or otherwise provide for, all professional services which may be required in order to comply with the new rules. Consequently, all companies should be able to easily absorb these costs. The Department does not anticipate that professional services will have to be employed in order to comply.

Because the cost of compliance with these proposed new rules is minimal, and imposes no adverse economic impact upon small businesses, no exceptions for compliance by small insurers have been incorporated into the rules.

The Department has determined that these proposed new rules and repeal are reasonable and necessary for the purposes expressed herein and to further implement the changes to the governing law resulting from the enactment of P.L. 2003, c.207, codified at N.J.S.A. 17B: 27E-1 et seq. These rules will apply to all long-term care insurance policies, certificates and riders etc. (see N.J.A.C. 11:4-34.1B) delivered or issued for delivery in this State by insurers, fraternal benefit societies, and health, hospital and medical service corporations. Given the foregoing, no differentiation was made in the controlling statute with respect to long-term care policies issued

by companies of different size. Accordingly, these new rules impose a regulatory requirement that is consistently applied without regard to business size.

Smart Growth Impact

The proposed repeal and new rules have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

**Full text** of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:4-34.1.

**Full text** of the proposed new rules follows:

SUBCHAPTER 34. LONG-TERM CARE INSURANCE

11:4-34.1 Purpose and scope

(a) The purpose of this subchapter is to implement the New Jersey Long-Term Care Insurance Act, P.L. 2003, c. 207, codified at N.J.S.A. 17B:27E-1 et seq., and to promote the public interest and the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined in this subchapter, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to foster flexibility and innovation in the development of long-term care insurance.

(b) Except as otherwise specifically provided, this subchapter applies to all long-term care insurance policies, certificates and riders, including qualified long-term care contracts,

disability income policies with long-term care benefits, and life insurance policies, annuity contracts, certificates and riders that accelerate death benefits for long-term care or provide long-term care as an additional insured benefit or as a form of surrender benefit, that are delivered or issued for delivery in this State by insurers, fraternal benefit societies, and health, hospital and medical service corporations. Certain provisions of this subchapter apply only to qualified long-term care insurance contracts as noted.

11:4-34.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates 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.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or fraternal benefit society authorized to issue long-term care insurance in this State.

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

"Commissioner" means the Commissioner of Banking and Insurance.

"Department" means the Department of Banking and Insurance.

“Exceptional increase” means only those increases filed by a carrier as exceptional and for which the Commissioner determines the need for the premium rate increase is justified due to: changes in laws or regulations applicable to long-term care coverage in this State; or increased and unexpected rate of utilization or cost that affects the majority of carriers or a majority of policyholders of similar policy forms.

1. Except as provided in N.J.A.C. 11:4-34.18, exceptional increases are subject to the same requirements as other premium rate schedule increases.

2. The Commissioner may request a review, at the carrier’s expense, by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

3. The Commissioner, in determining whether a necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

4. The Commissioner may, in determining whether an increase is exceptional and/or necessary, review the findings of other insurance supervisory officials. Such filings will be kept confidential to the extent that they are confidential in the State of the insurance supervisory official who made the findings.

“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.A. 17B:27-2 through 17B:27-8, inclusive, eligible for group life insurance, or at N.J.S.A. 17B:27-27 as eligible for group health insurance, or

2. Any group not referenced 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.

"Incidental" means that the expected value of the long-term care benefits provided is less than ten percent of the total expected value of the benefits provided over the life of the policy. These expected values shall be calculated, as of the date of issue of the policy, for each pricing characteristic (age, gender, policy size, optional benefits). A qualified actuary shall certify that the benefits are incidental.

"Insured" means any applicant provided coverage by a carrier.

"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. Long-term care insurance may be issued by insurance companies; fraternal benefit societies; and health, hospital, and medical service corporations. Long-term care insurance shall not include any insurance policy which is offered primarily to provide Medicare supplemental coverage, hospital expense coverage, medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income, accident only coverage, or dental, vision, prescription drug or other 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 the foregoing, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this subchapter.

"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 insurance company; fraternal benefit society; or health, hospital, or medical service corporation.

"Qualified actuary" means a member in good standing of the American Academy of Actuaries.

"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. § 7702B(b), as follows:

1. The only insurance protection provided under the contract is coverage of qualified long-term care 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. § 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. § 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. § 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 in the event of death of the insured or a complete surrender or cancellation of the contract or certificate shall not exceed the aggregate premiums paid under the contract or certificate; and

6. The contract meets the consumer protection provisions set forth in 26 U.S.C. § 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. § 7702B(b) and (e).

"Similar policy forms" means all of the long-term care insurance policies and certificates issued by a carrier in the same long-term care benefit classification as the policy form being considered. For purposes of determining similar policy forms, long-term care benefit

classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

11:4-34.3 Policy definitions

(a) No long-term care insurance policy delivered or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions are consistent with the following:

1. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

2. "Acute condition" means a condition that renders an individual medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

3. "Adult day care" means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the home.

4. "Bathing" means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

5. "Cognitive impairment" means a deficiency in a person's short or long-term memory; orientation as to person, place and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

6. “Continence” means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

7. “Dressing” means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

8. “Eating” means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

9. “Hands-on assistance” means any physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activities of daily living.

10. “Home health care services” means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

11. “Medicare” means “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title 1, Part 1 of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.”

12. “Mental or nervous disorder” means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

13. “Personal care” means the provision of hands-on services to assist an individual with activities of daily living.

14. “Skilled nursing care”, “intermediate care”, “personal care”, “home care” and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

15. “Toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

16. “Transferring” means moving into or out of a bed, chair or wheelchair.

17. “Usual, customary and reasonable” shall be no more restrictive than:

i. “Usual” means the fee ordinarily charged by the provider for a particular service or supply;

ii. “Customary” means the range of usual fees charged by providers for the same service or supply under like circumstances within the geographic or socio-economic area where the service or supply is performed or furnished. The range of usual fees charged by physicians shall consider training and experience; and

iii. “Reasonable” means a fee above usual and customary which is justified by unusual complexity of the treatment required.

18. All providers of services, including, but not limited to, “skilled nursing facility,” “extended care facility,” “intermediate care facility,” “convalescent nursing home,” “personal care facility,” and “home care agency” shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

11:4-34.4 Policy practices and provisions.

(a) Renewability: The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of N.J.A.C. 11:4-34.6 and 34.7.

1. A policy issued to an individual shall not contain renewal provisions other than “guaranteed renewable” or “noncancellable”.

2. The term “guaranteed renewable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the carrier has no unilateral right to make any change in any provision of the policy while the insurance is in force, and cannot decline to renew, except that rates may be revised by the carrier on a class basis.

3. The term “noncancellable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the carrier has no right to unilaterally make any change in any provision of the policy or in the premium rate.

4. The term “level premium” may only be used when the carrier does not have the right to change the premium.

5. In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(b) Limitations and Exclusions: A policy may not be delivered or issued for delivery in this State as long-term care insurance if the policy limits or excludes coverage for long-term care services by type of illness, treatment, medical condition or accident, except as follows:

1. Preexisting conditions or diseases: A preexisting condition exclusion shall not exclude coverage for more than six months after the effective date of coverage under the policy for a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within six months before the effective date of coverage.

2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

3. Alcoholism and drug addiction;

4. Illness, treatment or medical condition arising out of:

i. War or act of war (whether declared or undeclared) as permitted by N.J.A.C. 11:22-6;

ii. Participation in a riot or insurrection, or the commission of or attempt to commit a felony;

iii. Service in the armed forces or units auxiliary thereto as referenced in N.J.A.C. 11:22-6;

iv. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

v. Aviation (this exclusion applies only to non-fare-paying passengers);

5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of

the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

6. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount; and

7. This subsection is not intended to prohibit exclusions and limitations for services provided outside of the United States.

(c) Extension of Benefits: Termination of long-term care insurance shall be without prejudice to any benefits payable for continuous loss which began while the long-term care insurance was in force and continues without interruption after termination of the long-term care insurance. Such extension of benefits beyond the period the long-term care insurance was in force may be predicated upon the insured's continuous inability to perform activities of daily living or cognitive impairment, and may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits, and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(d) Continuation or Conversion: Group long-term care insurance issued in this State on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

1. For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing in force group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premiums and/or contributions when due.

2. For the purposes of this section, “a basis for conversion of coverage” means a policy provision that states that an individual whose coverage under the in force group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six months immediately prior to termination, shall be entitled to the issuance of a conversion policy by the carrier under whose group policy he or she is or was covered, without evidence of insurability.

3. For the purposes of this section, “conversion policy” means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made.

4. Written application for the conversion policy shall be made and the first premium due, if any, shall be paid as directed by the carrier not later than 31 days after termination of coverage under the group policy. The conversion policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

5. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the conversion policy shall be calculated on the basis of the insured’s age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the conversion policy shall be calculated on the basis of the insured’s age at inception of coverage under the prior group policy.

6. Continuation of coverage or issuance of a conversion policy shall be mandatory, except where:

i. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

ii. The terminating coverage is replaced, not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

(1) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(2) The premium for which is calculated in a manner consistent with the requirements of (d)5 above.

7. The conversion policy may provide that the benefits payable under the conversion policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and in effect.

8. Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(e) Discontinuance and Replacement: If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding carrier shall offer coverage to all persons covered under the previous group policy on its date of

termination. Coverage provided or offered to individuals by the carrier and premiums charged to persons under the new group policy shall not:

1. Result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced: and

2. Vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(f) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under N.J.A.C. 11:4-34.24, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under N.J.A.C. 11:4-34.24, the initial annual premium shall be based on the reduced benefits. The premium charged to an insured shall not increase due to either:

1. The increasing age of the insured at ages beyond 65; or

2. The duration the insured has been covered under the policy.

(h) A policy that provides coverage in addition to long-term care coverage shall separately identify the premium, rate or charge for the long-term care coverage. Where flexible premiums or charges can be applied to purchase long-term care or other coverage, the form must disclose how premiums will be applied, including any options the policyholder has for the application of these premiums and provisions for protection against unintentional lapse of one or the other coverage.

(i) Individual long-term care insurance policies shall contain the required provisions described at N.J.S.A. 17B:26-3. N.J.S.A. 17B:26-16 will also apply to provisions respecting the

matters set forth therein that are contained in individual long-term care policies. Group long-term care insurance policies shall contain the standard provisions required by N.J.S.A. 17B:27-33. Group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance shall apply the above cited provisions only to the long-term care benefit.

(j) No long-term care 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;

2. Require, for purposes of a restoration of benefits provision, that the period between confinements be more than six months; or

3. Contain a mandatory case management provision.

(k) Annuity contracts and life insurance policies that provide directly or which supplement long-term care insurance shall comply with the statutes and regulations governing individual life insurance, group life insurance, variable contracts and annuities, as applicable.

11:4-34.5 Unintentional lapse

(a) Each carrier offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

1. Notice before lapse or termination.

i. No individual long-term care policy or group certificate shall be issued until the carrier has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for non-payment of premium or required contribution, or a written waiver dated and

signed by the applicant electing not to designate an additional person to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability by the third party for services provided to the insured. The form used for the written designation must provide space clearly earmarked for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance for non-payment of premium or required contribution. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive this notice." The carrier shall notify the insured in writing in a clear and conspicuous manner of the right to change this written designation, no less often than once every two years for insureds who have not attained sixty-two and a half years and no less than annually for insureds who have attained age sixty-two and a half years of age.

ii. When the policyholder or certificate holder pays premium for long-term care insurance coverage through a payroll or pension deduction plan, the requirements contained in (a)1i above need not be met until 60 days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

2. Lapse or termination for non-payment of premium. No individual long-term care policy or group certificate shall lapse or be terminated for nonpayment of premium or required contribution unless the carrier, at least 30 days before the effective date of the lapse or

termination, has given written notice to the insured and to those persons designated pursuant to (a)1 above, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium or contribution is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(b) Restoration of Coverage: In addition to the requirement in (a), above a long-term care insurance policy or group certificate shall include a provision that provides for restoration of coverage in the event of lapse, if the carrier is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before a premium or contribution was required to be paid. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium or contributions, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy and certificate.

11:4-34.6 Required disclosure provisions

(a) Renewability: Individual long-term care insurance policies shall contain a renewability provision.

1. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to individual life insurance policies and annuity contracts that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the insured or owner.

2. A long-term care insurance policy, other than one where the carrier does not have the right to change the premium, shall include a statement that premium rates may change.

(b) Riders and Endorsements: Except for riders or endorsements by which the carrier effectuates a request made in writing by the insured under an individual long-term care insurance policy or which are required by law, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy, or that increase benefits or coverage with a concomitant increase in premium, may be rejected by the individual insured and can be added only with signed acceptance by the individual insured. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

(c) Payment of Benefits: A long-term care insurance policy or certificate that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import shall include a definition of these terms and an explanation of the terms in the accompanying outline of coverage.

(d) Preexisting Condition Limitations: If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations.”

(e) Other Limitations or Conditions on Eligibility for Benefits: A long-term care insurance policy or certificate may contain limitations or conditions for eligibility, other than those prohibited by N.J.S.A. 17B: 27E-6c(2), provided the policy or certificate describes such

limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate. The policy or certificate shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

1. Disclosure of Tax Consequences: With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy, certificate or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or certificate and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

(f) Benefit Triggers: Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph that shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, an explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(g) A qualified long-term care insurance contract shall include a disclosure statement in the policy, or certificate and in the outline of coverage as contained in item 3 in the form for outline of coverage at N.J.A.C. 11:4-34.27(a)5, that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(h) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy, or certificate and in the outline of coverage as contained in item 3 in the form for outline of coverages at N.J.A.C. 11:4-34.27(a)5, that the policy is not intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

11:4-34.7 Required disclosure of rating practices to consumers

(a) This section applies to any long-term care policy or certificate issued on or after the effective date of this rule.

(b) Other than policies for which no applicable premium rate or rate schedule increases can be made, carriers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, a carrier shall provide all of the information listed below to the applicant no later than at the time of delivery of the policy or certificate.

1. A statement that the policy or certificate may be subject to rate increases in the future, including the circumstances that might lead to a rate increase. The description of circumstances shall include those factors that pose significant risk of rate increases to policyholders or certificate holders;

2. An explanation of potential premium rate revisions, and the policyholder's or certificate holder's option(s) in the event of a premium rate revision, including a description of any contingent benefits or other benefits upon lapse;

3. The premium rate or rate schedule applicable to the applicant that will be in effect until a request is made for an increase;

4. A general explanation for applying premium rate or rate schedule adjustments that shall include:

i. A description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date, next billing date, etc.); and

ii. A statement that a copy of the revised premium rate or rate schedule as provided in (b)3 above, will be provided if the premium rate or rate schedule is changed; and

5. Information regarding each premium rate increase on this policy or certificate form or similar policy or certificate forms over the past 10 years for this State and any other state.

i. Such information will identify:

(1) The form numbers and marketing names of the policy and certificate forms for which premium rates have been increased;

(2) The calendar years when the form was available for purchase; and

(3) The amount and percentage of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

ii. The carrier may, in a fair manner, provide additional explanatory information related to the rate increases.

iii. A carrier shall have the right to exclude from the disclosure information to be provided premium rate increases that only apply to blocks of business acquired

from other nonaffiliated carriers or the long-term care policies acquired from other nonaffiliated carriers when those increases occurred prior to the acquisition.

iv. If an acquiring carrier files for a rate increase on a long-term care policy form acquired from nonaffiliated carriers or a block of policy forms acquired from nonaffiliated carriers on or before the later of the effective date of this section or the end of a 24-month period following the acquisition of the block or policies, the acquiring carrier may exclude that rate increase from the disclosure information. However, the nonaffiliated selling carrier shall include that rate increase in its disclosure information in accordance with (b)5i above.

v. If the acquiring carrier in (b)5iv above files for a subsequent rate increase, even within the 24-month period, on the same policy form or block of policy forms acquired from nonaffiliated carriers referenced in (b)5iv above, the acquiring carrier shall make all disclosures required by this paragraph including disclosure of the earlier rate increase referenced in (b)5iv. above.

(c) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the carrier made the disclosure required under (b)1 and 5 above. If, due to the method of application, the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign such an acknowledgement no later than at the time of delivery of the policy or certificate.

(d) A carrier shall use the forms in subchapter Appendices B and F incorporated herein by reference to comply with the requirements of (b) and (c)above.

(e) A carrier shall provide notice of an upcoming premium rate schedule increase to all policyholders and certificateholders, if applicable, at least 45 days prior to the implementation

of the premium rate schedule increase by the carrier. The notice shall include the information required by (b) above when the rate increase is implemented.

(f) In the case of a policy providing long-term care benefits in combination with other benefits, a description of how premiums paid for the policy are allocated between long-term care and other benefits shall be disclosed in the policy and certificate.

11:4-34.8 Initial filing requirements

(a) This section applies to any long-term care insurance policy or certificate issued in this State on or after July 1, 2005.

(b) A carrier shall provide the information listed below to the Commissioner at least 60 days prior to making a long-term care insurance form available for sale.

1. The premium rates, rate schedules or rating formula. Where long-term care coverage is provided in combination with other coverage, a description of how these filed premium rates interact with the rates or premiums for the other coverage;

2. A copy of the disclosure documents required by N.J.A.C. 11:4-34.7;

3. An actuarial certification consisting of the following:

i. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

ii. A statement that the policy design and coverage provided have been reviewed and taken into consideration in setting the assumptions and rates;

iii. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration in setting the assumptions and rates; and

iv. A complete description of the basis for contract reserves that are anticipated to be held under the form, which shall include:

(1) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(2) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(3) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(4) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. For the purposes of this statement:

(A) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and

(B) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Commissioner may request a demonstration under (c) below based on a standard age distribution; and

4. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the carrier except for reasonable differences attributable to benefits; or a comparison of the premium schedules for

similar policy forms that are currently available from the carrier with an explanation of the differences.

(c) The Commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for premium or benefit differences, relevant and credible data from other studies, or both. The Commissioner may also request an actuarial memorandum as specified at N.J.A.C. 11:4-34.17(c) except for the restrictions on interest rates in N.J.A.C. 11:4-34.17(c)5v.

1. In the event the Commissioner asks for the additional information described above, the 60-day time period referenced in (b) above shall include the period during which the carrier is preparing the requested information.

(d) A spousal discount is permitted in individual long-term care insurance provided:

1. The objective basis of the rate differential is included in the actuarial memorandum as required by N.J.A.C. 11:4-18.4(a)1iv;

2. All conditions required to be satisfied in order to receive and retain the discount shall be disclosed and shall be related to the objective basis of the rate differential. When improved morbidity is the objective basis for a spousal discount, carriers shall extend the discount to all married individuals regardless of whether the insured’s spouse is covered under a long-term care policy; and

3. When a husband and wife both apply for and are issued a long-term care policy offering a spousal discount, both individuals shall receive the discount.

11:4-34.9 Prohibition against post-claims underwriting.

(a) Carriers must complete underwriting prior to issuing a policy or certificate and are prohibited from reunderwriting at the time of claim.

(b) All applications for long-term care insurance policies or certificates except those that are guaranteed issue, that is, that are issued without medical or other underwriting, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

1. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

2. If the medications listed in the application were known by the carrier, or should have been known at the time of application, to be directly related to a medical condition for which coverage would have been but was not denied, then the policy or certificate shall not be rescinded for that condition.

(c) Except for policies or certificates which are guaranteed issue, that is, that are issued without medical or other underwriting:

1. The following language shall be set out in boldface and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [carrier] has the right to deny benefits or rescind your [policy] [certificate].

2. The following language, or language substantially similar to the following, shall be set out in boldface on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied] [and has been attached to your] [policy][certificate]. If your answers are incorrect or untrue, the carrier has the right to deny benefits or rescind your [policy][certificate]. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the carrier at this address: [insert address]

3. Prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the carrier shall obtain one of the following:

i. A report of a physical examination;

ii. An assessment of functional capacity;

iii. An attending physician's statement; or

iv. Copies of medical records.

(d) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application. Pursuant to N.J.S.A. 17B:24-3, no application for any long term care coverage issued on an individual basis shall be admissible in evidence in any action relative to such coverage, unless a copy of the application was attached to or endorsed upon the policy or certificate when issued.

(e) Every carrier selling or issuing long-term care insurance coverage shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated, and shall annually furnish this information to the Commissioner in the format prescribed by the National Association of Insurance Commissioners in subchapter Appendix A, incorporated herein by reference.

11:4-34.10 Minimum standards for home health and community care benefits in long-term care insurance policies and certificates.

(a) A long-term care insurance policy or certificate if it provides benefits for home health care or community care services, shall not limit or exclude benefits:

1. By requiring that the insured would need care in a skilled nursing facility if home health care services were not provided;

2. By requiring that the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

3. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. By requiring that a nurse or therapist provide covered services that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of this or her licensure or certification;

5. By excluding coverage for the personal care services provided by a home health aide;

6. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

7. By requiring that the insured have an acute condition before home health care services are covered;

8. By limiting benefits to services provided by Medicare-certified agencies or providers; or

9. By excluding coverage for adult day care services.

(b) A long-term care insurance policy or certificate that provides for home health or community care services shall provide total home health or community care coverage in a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(c) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

11:4-34.11 Requirement to offer inflation protection

(a) No carrier may offer a long-term care insurance policy unless the carrier also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Carriers must offer to each policyholder, or certificate holder where required, at the time of purchase, the option to purchase coverage with an inflation protection feature no less favorable than one of the following:

1. Benefit levels increase annually in a manner so that the increases are compounded annually at a rate not less than five percent;

2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than

the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

3. Covers a specified percentage of actual or usual, customary and reasonable charges and does not include a maximum specified indemnity amount or limit.

(b) Where the policy is issued to a group, the required offer in subsection (a) above shall be made to the group policyholder; except, if the policy is issued to a group set forth in paragraph 2 of the definition of "group long-term care insurance," other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(c) The offer in (a) above shall not be required of life insurance policies, certificates and riders nor of annuity contracts and riders containing only accelerated long-term care benefits.

(d) Carriers shall include the following information in or with the outline of coverage:

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period; and

2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. A carrier may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(e) Inflation protection benefit increases under a policy or certificate that contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(f) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the carrier expects to remain constant. The offer shall

disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(g) Inflation protection as provided in (a)1 above shall be included in a long-term care insurance policy unless a carrier obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state:

> I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this [policy][certificate] with and without inflation protection. Specifically, I have reviewed Plans ______, and I reject inflation protection.

11:4-34.12 Requirements for application, enrollment forms and replacement coverage

(a) Application forms shall not include provisions, statements or questions that:

1. Pertain to race, creed, color, national origin or ancestry of the proposed insured;

2. Change the terms of the policy to which it is attached;

3. State that the applicant has not withheld any information or concealed any facts; or

4. Require the applicant to agree that an untrue or false answer material to the risk shall render the policy or certificate void.

(b) If the carrier makes any changes or amendments to the application, signed acceptance by the applicant is required.

(c) Factual-type questions shall be used whenever possible to ascertain the past and present health of a proposed insured. The application shall provide that the answers and statements are to the best of the applicant's knowledge and belief.

(d) Questions concerning alcohol and drug abuse shall be based on specific criteria such as treatment, driving records, work attendance records, etc. Questions such as "Do you use alcohol or drugs to excess" shall not be used.

(e) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to an employer, labor union or trustee group as defined by N.J.S.A. 17B:27-2, 4, 5 and 27, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement:

1. Do you have another long-term care insurance policy or certificate in force?

2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

i. If so, with which carrier?

ii. If that policy or certificate lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

(f) Agents shall list any other health insurance policies they have sold to the applicant, including:

1. Policies sold that are still in force; and

2. Policies sold in the past five years that are no longer in force.

(g) Solicitations other than direct response. Upon determining that a sale will involve replacement, a carrier, other than a carrier using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the carrier. The required notice shall be provided in accordance with subchapter Appendix H, incorporated herein by reference.

(h) Carriers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy or certificate. The required notice shall be provided in accordance with subchapter Appendix I, incorporated herein by reference.

(i) Where replacement is intended, the replacing carrier shall notify, in writing, the existing carrier of the proposed replacement. The existing policy or certificate shall be identified by the carrier, and name of the insured and policy number or address including ZIP code. Notice shall be made within five working days from the date the application is received by the carrier or the date the policy or certificate is issued, whichever is sooner.

(j) Individual life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is an individual life insurance policy, the carrier shall comply with the replacement requirements of N.J.A.C. 11:4-2. If an individual life insurance policy that accelerates benefits for long-term care is replaced by another such individual policy, the replacing carrier shall comply with both the long-term care and the life insurance replacement requirements.

11:4-34.13 Reporting requirements

(a) Every carrier shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of long-term care insurance policies sold by the agent that lapsed as a percent of the agent's total annual sales.

(b) Every carrier shall report annually by June 30 to the Commissioner the 10 percent of its agents with the greatest percentages of lapses and replacements as measured by (a) above. The report shall be in accordance with subchapter Appendix G, incorporated herein by reference.

(c) Every carrier shall report annually by June 30 to the Commissioner the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. The report shall be in accordance with Appendix G.

(d) Every carrier shall report annually by June 30 to the Commissioner the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. The report shall be in accordance with Appendix G.

(e) Every carrier shall report annually by June 30 to the Commissioner, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. The report shall be in accordance with subchapter Appendix E, incorporated herein by reference.

(f) For purposes of this section:

1. "Policy" means only long-term care insurance;

2. Subject to (e) above "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

3. "Denied" means the carrier refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4. "Report" means on a Statewide basis.

11:4-34.14 Licensing

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by the New Jersey Insurance Producer Licensing Act of 2001, N.J.S.A. 17:22A-26 et seq.

11:4-34.15 Discretionary powers of Commissioner

(a) The Commissioner may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this subchapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds;

2. The purpose to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

3. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

11:4-34.16 Reserve standards

(a) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with N.J.S.A. 17B: 19-8a.vii. Claim reserves shall also be established in accordance with N.J.A.C. 11:4-6 when the policy or rider is in claim status.

1. Reserves for policies and riders subject to this subsection should be based on the multiple decrement model using all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the combined reserves for the long-term care

benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

2. In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

i. Definition of insured events;

ii. Covered long-term care facilities;

iii. Existence of home convalescence care coverage;

iv. Definition of facilities;

v. Existence or absence of barriers to eligibility;

vi. Premium waiver provision;

vii. Renewability;

viii. Ability to raise premiums;

ix. Marketing method;

x. Underwriting procedures;

xi. Claims adjustment procedures;

xii. Waiting period;

xiii. Maximum benefit;

xiv. Availability of eligible facilities;

xv. Margins in claim costs;

xvi. Optional nature of benefit;

xvii. Delay in eligibility for benefit;

xviii. Inflation protection provisions; and

xix. Guaranteed insurability option.

(b) Any applicable valuation morbidity table used in complying with (a) above shall be certified as appropriate by a member of the American Academy of Actuaries as a statutory valuation table.

(c) When long-term care benefits are provided other than as in (a) above, reserves shall be determined in accordance with N.J.A.C. 11:4-6.

11:4-34.17 Loss ratio

(a) This section applies to all rates for individual long-term care policies except those covered pursuant to N.J.A.C. 11:4-34.8 and 34.18.

(b) Premiums and benefits under long-term care insurance policies whose rates are subject to this section shall meet the loss ratio requirements of N.J.A.C. 11:4-18.5.

(c) Carriers shall include with each submission of new or revised rates for individual long-term care insurance an actuarial memorandum which includes anticipated loss ratio, methodology for calculating gross premiums, an explanation and documentation supporting the premium assumptions and the objective basis for any rate differentials. The following information shall be included in the actuarial memorandum.

1. The number of years for which the policy is expected to be issued in this State (with these rates), and the number of policies for each form expected to be issued in each year. If the policies are no longer being issued, the actuarial memorandum shall so state;

2. The anticipated and aggregate loss ratios calculated over the life of the policy form, showing separately the present value of past and future paid benefits and the present

value of past and future paid or written premiums. Any required additional active life reserves are not reflected in either the past and future benefits nor the past and future premiums;

3. The benefits, on both a paid and incurred basis, and the premiums, on both a paid/written and earned basis, for each of the years recognized in the calculation of the anticipated and aggregate loss ratios. For incurred benefits, changes in active life reserves shall be shown separately;

4. Paid and incurred/earned loss ratios for each of the years recognized in (c)3 above, where the incurred/earned loss ratio should be calculated both without and with the change in active life reserves;

5. The assumptions used in the calculation of the loss ratio, including:

i. The annual claim costs (ultimate) by attained age and sex;

ii. The select and/or anti-select morbidity factors by policy duration (year) by issue age and sex;

iii. The lapse and mortality rates, by policy duration by issue age and sex;

iv. The secular trend factors by policy duration by issue age and sex;

v. The interest rates by policy duration, which rates shall equal a carrier's recent, current and future expected new investment return rates (after investment expenses, but before federal income taxes). Alternatively, the Department will permit use of a six percent interest rate graded linearly to four percent over 10 years and four percent thereafter or a five percent level interest rate. The Commissioner shall review annually the alternate interest rate and adjust those rates based on corporate bond yields for Aaa and Baa bonds as reported in U.S. Financial Data which is published by the Research and Public Information

Division of the Federal Reserve Bank of St. Louis. The Commissioner shall provide public notice of new alternate interest rates by publication in the New Jersey Register;

vi. Expenses by policy duration, including commission, override and bonus rates; other marketing expense rates; other maintenance expense rates; any new-market expense rates; other acquisition expense rates; and the explicit profit margin or risk charged on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable basis;

vii. The distribution of expected policies by policy and rider benefits by issue age and sex; and

viii. A summary statement of the underwriting standards (such as short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market (that is, the segment(s) of the general public, for example., middle income based on predetermined ZIP code selections) for the policy forms;

6. The specific formulas and methodology used in calculating gross premiums; and

7. A certification signed by an actuary who is a member of the American Academy of Actuaries stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio.

11:4-34.18 Premium rate schedule increases

(a) This section applies to any individual long-term care policy issued in this State on or after (30 days after the effective date of these rules) and for which initial rates were filed pursuant to N.J.A.C. 11:4-34.8.

(b) A carrier shall request approval of a revised premium rate schedule, including an exceptional increase, from the Commissioner at least 60 days prior to sending the notice to be provided to the policyholders, and the carriers request shall include:

1. Information required by N.J.A.C. 11:4-34.7 concerning disclosure of rating practices;

2. Certification by a qualified actuary that:

i. If the requested premium rate schedule increase is implemented and the underlying assumptions for the revised rate filing which reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated; and

ii. The premium rate filing is in compliance with the provisions of N.J.A.C. 11:4-34.18;

3. An actuarial memorandum justifying the rate schedule change request that includes:

i. Lifetime projections of earned premiums and incurred claims (on a year-to-year basis), based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale; and

ii. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger a contingent benefit upon lapse;

iii. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, a comparison of the pricing assumptions and current assumptions and what other actions taken by the carrier have been relied on by the actuary; and

iv. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and

5. Sufficient information for review and approval of the premium rate schedule increase by the Commissioner.

(c) All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits whose cost exceeds the assumed cost in the initial premium;

2. Premium rate schedule increases that are not exceptional shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

i. The accumulated value of the initial earned premium times 58 percent;

ii. Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

iii. The present value of future projected initial earned premiums times 58 percent; and

iv. Eighty-five percent of the present value of future projected premiums not in (c)2iii above on an earned basis;

3. In the event that a policy form has both exceptional and other increases, the values in (c)2ii and iv above will also include seventy percent for exceptional rate increase amounts; and

4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in N.J.A.C. 11:4-6.16.

(d) For each rate increase that is implemented, the carrier shall file for approval by the Commissioner updated projections, as defined in (b)3i above annually for the next three years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that insure 250 or more persons where the policyholder has 5,000 or more eligible employees of a single employer or where the policyholder pays 20 percent or more of the total premium for the group in the calendar year prior to the year a rate increase is filed, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Commissioner.

(e) If any premium rate in the revised premium rate schedule is greater than 150 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in

(b)3i above, shall be filed for approval by the Commissioner every five years following the end of the required period in (d) above.

(f) If the Commissioner has determined that the actual experience following a rate increase does not adequately match the projected experiences and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in (c) above, the Commissioner may require the carrier to implement either of the following:

1. Premium rate schedule adjustments; or

2. Other measures to reduce the difference between the projected and actual experience.

(g) If 25 percent or more of the policies to which the increase is applicable are eligible for the contingent benefit upon lapse, the carrier shall file:

1. A plan, subject to Commissioner approval, for improved administration and/or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in (h) below; and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to (c) above had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in (c)2i and iii above.

(h) If twenty five percent or more of the policies to which a rate increase is applicable are eligible for contingent benefit upon lapse, the Commissioner shall review, for all policies

included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated.

(i) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evident in the actual results as presented in the updated projections provided by the carrier following the requested rate increase, the Commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Commissioner may require the carrier to offer, without underwriting, to all in force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the carrier or its affiliates. If the carrier or its affiliates are no longer offering one or more reasonably comparable products, the Commissioner may take other steps, including requiring pooling of all of the carrier's long term care policies for rating purposes, or disapproving or reducing rate increase requests.

1. The offer shall:

i. Be subject to the approval of the Commissioner;

ii. Be based on actuarially sound principles, but not on attained age; and

iii. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

2. The carrier shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

i. The maximum rate increase determined based on the combined experience; and

ii. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

(j) If the Commissioner determines that the carrier has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of (i) above, prohibit the carrier from either of the following:

1. Filing and marketing comparable coverage for a period of up to five years; or

2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(k) Subsections (a) through (j) above shall not apply to policies for which the long-term care benefits are incidental, provided the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements, as applicable, in N.J.S.A. 17B:25-19, N.J.S.A. 17B:25-20 or N.J.A.C. 11:4-44.3(b);

3. The policy meets the disclosure requirements of N.J.S.A. 17B:27E-6;

4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements, as applicable, in N.J.A.C. 11:4-52 and N.J.S.A. 17B:28-1 et seq.; and

5. An actuarial memorandum is filed that includes:

i. A description of the rates for long-term care coverage and a description of the basis on which the long-term care rates were determined;

ii. A description of the basis for the separate reserves for long-term care;

iii. A summary of the type of policy, benefits, renewability, general marketing method, and limits on age of issuance;

iv. A description and table of each actuarial assumption, including expense factors used in determining long-term care rates;

v. A description and method of calculation of the anticipated long-term care policy reserves and additional long-term care reserves to be held in each future year for active lives, including a copy of or citation to any published or available mortality or morbidity tables;

vi. The estimated distribution of annual premium per policy and the estimated distribution of issue ages;

vii. A statement as to whether underwriting for long-term care is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting; and

viii. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status, including:

(1) A demonstration that the benefits other than long-term care benefits satisfy the minimum nonforfeiture requirements cited in (k)2 above, and

(2) A demonstration that the benefits are incidental as defined in N.J.A.C. 11:4-34.2.

11:4-34.19 Filing requirement

(a) Prior to a carrier offering or placing in force group long-term care insurance coverage to or on a resident of this State under a group policy issued in another state pursuant to N.J.S.A. 17B:27E-5b, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this State.

(b) The carrier shall also file with the Commissioner evidence that a state having statutory or regulatory long-term care insurance requirements similar to those adopted in this State has made a determination that the group may be insured for group long-term care insurance in accordance with sound underwriting principles.

11:4-34.20 Filing requirements for advertising

(a) Every carrier issuing long-term care insurance or benefits in this State shall provide a copy of any long-term care insurance advertisement intended for use in this State whether through written, radio or television medium, to the Commissioner for review. The

Commissioner may disapprove an advertisement at any time if the advertisement is not in compliance with this rule or is in violation of the Trade Practices Act, N.J.S.A. 17B:30-1 et seq., or N.J.A.C. 11:2-11. An advertisement which has been disapproved by the Commissioner shall continue to be disapproved until the disapproval is withdrawn by the Commissioner. In addition, copies of all advertisements shall be retained by the carrier for at least three years from the date the advertisement was first used.

(b) The Commissioner may exempt from these requirements any advertising form or material when, in the Commissioner's opinion, this requirement may not be reasonably applied.

11:4-34.21 Standards for marketing

(a) Every carrier marketing long-term care insurance coverage in this State, directly or through its producers, shall:

1. Establish marketing procedures and agent training requirements to assure that:

i. Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

ii. Excessive insurance is not sold or issued.

2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage, policy and certificate the following:

"Notice to buyer: This [policy] [certificate] may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all [policy] [certificate] limitations."

3. Provide copies of the disclosure forms required in N.J.A.C. 11:4-34.7(c) (subchapter Appendices B and F) to the applicant;

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

5. Establish auditable procedures for verifying compliance with this subsection.

6. At solicitation, provide written notice to the prospective policyholder and certificateholder that the New Jersey State Health Insurance Program is available to provide counseling to seniors interested in purchasing long-term care insurance and shall provide the address and telephone number of the program.

7. For long-term care health insurance policies and certificates, use the terms “noncancellable” or “level premium” only when the policy or certificate conforms to N.J.A.C. 11:4-34.4(a)3 and 4; and

8. Provide an explanation of the contingent benefit upon lapse provided for in N.J.A.C. 11:4-34.24(c)2.

(b) In addition to the practices prohibited in N.J.S.A. 17B:30-1 et seq., the following acts and practices are prohibited.

1. High pressure tactics, which means employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat,

whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

2. Cold lead advertising, which means making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the marketing is solicitation of the purchase of insurance and that contact will be made by an agent or carrier.

(c) The following shall apply with respect to associations that endorse or make available long-term care insurance to members:

1. The association shall educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or made available by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or made available.

2. The carrier shall file with the Department the following material:

i. The policy and certificate;

ii. A corresponding outline of coverage; and

iii. All advertisements requested by the Department.

3. The association shall disclose in any long-term care insurance solicitation:

i. The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or availability of the policy or certificate to its members; and

ii. A brief description of the process under which the policies and the carrier issuing the policies were selected.

4. If the association and the carrier have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

5. The boards of directors of associations endorsing or making available long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the carrier.

6. The association shall also, except for qualified long-term care insurance contracts:

i. At the time of the association's decision to endorse the coverage, engage the services of a person with expertise in long-term care insurance not affiliated with the carrier to conduct an examination of the policies, including their benefits, features, and rates and update the examination thereafter in the event of material change;

ii. Actively monitor the marketing efforts of the carrier and its agents; and

iii. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

7. No group long-term care insurance policy may be issued to an association unless the carrier files with the Department the information required in this subsection.

8. The carrier shall not issue a long-term care policy or certificate to an association or member of an association or continue to market such a policy or certificate unless the carrier certifies annually that the association has complied with the requirements set forth in this subsection.

9. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of N.J.S.A. 17B:30-1 et seq.

11:4-34.22 Suitability

(a) This section shall not apply to life insurance policies and annuities that only accelerate benefits for long-term care, but shall apply to any other life insurance policy and annuity contract providing long-term care benefits.

(b) Every carrier marketing long-term care insurance shall:

1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

2. Train its agents in the use of its suitability standards; and

3. Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

(c) To determine whether the applicant meets the standards developed by the carrier, the agent and carrier shall develop procedures that take the following into consideration:

1. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

2. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

3. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(d) The carrier and, where an agent is involved, the agent shall make reasonable efforts to obtain the information specified in (c) above. The efforts shall include presentation to

the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the carrier shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The carrier may request the applicant to provide additional information to comply with its suitability standards. A copy of the carrier's personal worksheet shall be filed with the Commissioner.

1. A completed personal worksheet shall be returned to the carrier prior to the carrier's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their family members or dependents.

2. The sale or dissemination outside the company or agency by the carrier or agent of information obtained through the personal worksheet in Appendix B is prohibited.

(e) The carrier shall use the suitability standards it has developed pursuant to this section in determining whether the issuance of long-term care insurance coverage to an applicant is appropriate.

(f) Agents shall use the suitability standards developed by the carrier in marketing long-term care insurance.

(g) At the same time that the personal worksheet is provided to the applicant, the disclosure form entitled: "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in subchapter Appendix C, incorporated herein by reference, in not less than 12-point type.

(h) If the carrier determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the carrier may reject the application. In the alternative, the carrier shall send the applicant a letter similar to subchapter

Appendix D, incorporated herein by reference. However, if the applicant has declined to provide financial information, the carrier may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(i) The carrier shall report annually to the Commissioner the total number of applications received from residents of this State, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

11:4-34.23 Prohibition against preexisting conditions and probationary periods in replacement polices or certificates

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing carrier shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy or certificate for similar benefits to the extent that similar exclusions have been satisfied under the original policy or certificate. This waiver must be in the form of an endorsement to the replacement policy or certificate.

11:4-34.24 Nonforfeiture benefit requirement

(a) This section does not apply to life insurance policies, annuity contracts, or riders providing long-term care benefits only through acceleration of life or annuity benefits. Such life insurance policies, annuity contracts, or riders must have nonforfeiture benefits that comply with N.J.S.A. 17B:25-19 or 17B:25-20, as applicable.

(b) To comply with the requirement to offer a nonforfeiture benefit pursuant to N.J.S.A. 17B:27E-8:

1. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The additional charge for the nonforfeiture benefit shall be reasonable in relation to the cost of providing the benefit. The nonforfeiture benefit included in the offer shall meet the requirements in (d) below; and

2. The offer shall be in writing if the nonforfeiture benefits are not otherwise described in the Outline of Coverage or other materials given to the prospective policyholders.

(c) If the offer required to be made under N.J.S.A. 17B:27E-8 is rejected, individual and group policies may be issued without nonforfeiture benefits but must contain a contingent benefit upon lapse.

1. If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate of coverage under a group policy shall provide either the nonforfeiture benefit if such benefit is elected by the certificate holder, or the contingent benefit upon lapse if the nonforfeiture benefit is not elected by the certificate holder.

2. The contingent benefit on lapse for an individual policy or group certificate shall be triggered every time a carrier increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, a policyholder or certificate holder shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

| Issue Age | Percentage Increase Over Initial Premium |
|---|---|
| 29 and under | 200% |
| 30-34 | 190% |
| 35-39 | 170% |
| 40-44 | 150% |
| 45-49 | 130% |
| 50-54 | 110% |
| 55-59 | 90% |
| 60 | 70% |
| 61 | 66% |
| 62 | 62% |
| 63 | 58% |
| 64 | 54% |
| 65 | 50% |
| 66 | 48% |
| 67 | 46% |
| 68 | 44% |
| 69 | 42% |
| 70 | 40% |
| 71 | 38% |
| 72 | 36% |
| 73 | 34% |
| 74 | 32% |
| 75 | 30% |
| 76 | 28% |
| 77 | 26% |
| 78 | 24% |
| 79 | 22% |
| 80 | 20% |
| 81 | 19% |
| 82 | 18% |
| 83 | 17% |
| 84 | 16% |
| 85 | 15% |
| 86 | 14% |
| 87 | 13% |
| 88 | 12% |
| 89 | 11% |
| 90 and over | 10% |

3. On or before the effective date of a substantial premium increase as defined in (c)2 above, the carrier shall do all of the following:

i. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased. This reduction shall bear a reasonable relationship to the premium increase otherwise required and shall not impair any other contractual option to reduce benefits;

ii. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of (d) below. This option may be elected at any time during the 120-day period referenced in (c)2 above; and

iii. Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in (c)2 above shall be deemed to be the election of the offer to convert in (c)3ii above.

(d) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

1. For purposes of this subsection, attained age rating is defined as a schedule of premium starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

2. For the purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in (d)3 below.

3. The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits, less any claims paid. The carrier may offer additional shortened benefit period options, as long as the

benefits for each duration equal or exceed the standard nonforfeiture credit for the duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of (e) below.

4. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter. However, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

i. The end of the 10th year following the policy or certificate issue date; or

ii. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(e) All benefits paid by the carrier while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium paying status.

(f) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(g) The provisions of this section apply to any long-term care policy issued in this State on or after(30 days after the effective date of these rules). However, this section does not

apply to certificates issued under a group long-term care insurance policy that was in force at the time this provision became effective.

(h) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of N.J.A.C. 11:4-34.17 and 34.18 treating the policy as a whole.

(i) To determine whether contingent nonforfeiture upon lapse provisions are triggered under (c)2 above, a replacing carrier that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another carrier shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original carrier.

(j) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

1. The nonforfeiture provision shall be appropriately captioned;

2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Commissioner for the same contract form; and

3. The nonforfeiture provision shall provide at least one of the following:

i. Reduced paid-up insurance;

ii. Extended term insurance;

iii. Shortened benefit period; and

iv. Other similar offerings approved by the Commissioner.

(k) Every policy with a premium payment period less than the term of eligibility for benefits under the policy shall provide a reduced paid up benefit upon lapse. The benefit shall be provided after five years or, in the case of a premium payment period of less than 10 years, after half of the premium payment period.

1. The amount of the reduced paid up benefit will be the policy benefit times the ratio of the number of premiums paid under the policy and the number of required premium payments.

2. The coverage period, benefit period, and all other requirements will be the same for the reduced paid-up benefit.

11:4-34.25 Standards for benefit triggers

(a) A long-term care insurance policy or certificate shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(b) Activities of daily living shall include at least bathing, continence, dressing, eating, toileting and transferring as defined in N.J.A.C. 11:4-34.3.

1. Carriers may use activities of daily living in addition to those listed above to trigger covered benefits as long as they are defined in the policy and certificate.

(c) A carrier may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in (a) and (b) above.

(d) For purposes of this section, the determination of a deficiency shall not be more restrictive than:

1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

2. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

(e) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(f) Long-term care insurance policies and certificates shall include a clear description of the process for appealing and resolving benefit determinations.

(g) The provisions of this section shall not apply to certificates issued under group long-term care insurance policies that were in force on the effective date of this rule.

11:4-34.26 Additional standards for benefit triggers for qualified long-term care insurance contracts.

(a) For purposes of this section, the following definitions apply:

1. "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2. "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a

chronically ill individual means any individual who has been certified by a licensed health care practitioner as being unable to perform (without substantial assistance from another individual) as least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; and

i. The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

3. "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the United States Secretary of the Treasury.

4. "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(b) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(c) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

(d) Certifications regarding activities of daily living and cognitive impairment required pursuant to (c) above shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the United States Secretary of the Treasury.

(e) Certifications required pursuant to (c) above may be performed by a licensed health care practitioner at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

(f) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determination.

11:4-34.27 Standard format outline of coverage

(a) This section implements, interprets and makes specific the provisions of N.J.S.A. 17B:27E-6e in prescribing a standard format and the content of an outline of coverage.

1. The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

2. The outline of coverage shall contain no material of an advertising nature.

3. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

4. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

5. Format for outline of coverage.

[CARRIER NAME]
[ADDRESS – CITY & STATE]
[TOLL FREE TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied] [has been attached to your] [policy] [certificate]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [Indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY [OR CERTIFICATE] CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificate describe one of the following permissible policy renewability provisions:

(1) Policies and certificate that are guaranteed renewable shall contain the following statement.] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your [policy] [certificate] to continue this [policy] [certificate] as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your [policy] [certificate] on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your [policy] [certificate] to continue this [policy] [certificate] as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your [policy] [certificate] on its own and cannot change the premium you currently pay. However, if your [policy] [certificate] contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type large than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return – “free look” provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage 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, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph is the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not be a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(d) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

11:4-34.28 Requirement to deliver shopper's guide

(a) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the

Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

1. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(b) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under N.J.S.A. 17B:27E-6g.

11:4-34.29 Form filings

Long-term care insurance policies that are to be delivered or issued for delivery in this State, and certificates and riders for use with such policies, shall be submitted to the Department for review and approval prior to use pursuant to the procedures in N.J.A.C. 11:4-40.

11:4-34.30 Penalties

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