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“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 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:27-68, 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 talking 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. “Immediate family” means parents, spouse or domestic partner, children and siblings.

12. “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.”

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

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

15. “Preexisting condition” shall not be more restrictive than a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six months preceding the effective date of coverage of an insured person.

16. “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.

(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.

APPENDIX A
RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF _____
FOR THE REPORTING YEAR _____

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

Signature

Name and Title (please type)

Date

SUBCHAPTER 35. VIATICAL SETTLEMENTS

11:4-35.1 Purpose and scope

(a) The purpose of this subchapter is to implement N.J.S.A. 17B:30A-1 et seq. governing viatical settlements.

(b) This subchapter applies to persons who enter into agreements with New Jersey residents to purchase their life insurance policies for less than the current death benefit.

11:4-35.2 Definitions

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

“Act” means an Act concerning life insurance viatical settlements approved September 17, 1999, N.J.S.A. 17B:30A-1 et seq.

“Commissioner,” unless otherwise stated, means the Commissioner of the Department of Banking and Insurance.

“Department” means the Department of Banking and Insurance.

“Financing entity” means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any person who may be a party to a viatical settlement contract and who has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a licensed viatical settlement provider to act as a participant in a financing transaction.

“Financing transaction” means a transaction in which a licensed viatical settlement provider or a financing entity obtains financing for viatical settlement contracts, viaticated policies or interests therein including, without limitation, any secured or unsecured financing, any securitization transaction or any securities offering either registered or exempt from registration under Federal and State securities law, or any direct purchase of interests in a certificate, if the financing transaction complies with Federal and State securities law.

“Insured” means the person covered under the policy being considered for viatication.

“Mean life expectancy” means the mean number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider, considering medical records and appropriate experiential data.

“Net death benefit” means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens.

“Patient identifying information” means an insured’s address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

“Person” means any individual, corporation, organization, firm, association, partnership or other legal entity.

“Resident (of New Jersey)” means a person who either resides in New Jersey or maintains an office in New Jersey where business is transacted.

“Terminally ill” means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

“Viatical settlement broker” means a person who on behalf of a viator and for a fee, commission or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers. Irrespective of the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator’s instructions and in the best interest of the viator. The term does not include an attorney, accountant or financial planner retained to represent the viator whose compensation is paid directly by or at the direction of the viator.

“Viatical settlement contract” means a written agreement entered into between a viatical settlement provider and a viator. The agreement shall establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator’s assignment, transfer, sale, devise or bequest of the death benefit or ownership of all or a portion of the insurance policy or certificate of insurance. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurer pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

“Viatical settlement provider” means a person, other than a viator, who enters into a viatical settlement contract. Viatical settlement provider also means a person who obtains financing from a financing entity for the purchase, acquisition, transfer or other assignment of one or more viatical settlement contracts, viaticated policies or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates or otherwise disposes of one or more viatical settlement contracts, viaticated policies or interests therein. Viatical settlement provider does not include:

1. A bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

2. The issuer of a life insurance policy providing accelerated benefits pursuant to N.J.A.C. 11:4-30 and pursuant to the policy; or

3. A natural person who enters into no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit.

“Viatical settlement representative” means a person who is an authorized agent of a licensed viatical settlement provider or viatical settlement broker, as applicable, who acts or aids in any manner in the solicitation of a viatical settlement. Viatical settlement representative shall not include: