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

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

5. 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 if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

i. [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

ii. [Institutional benefits, by skill level.]

iii. [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should 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 must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

i. Preexisting conditions;

ii. Non-eligible facilities/provider;

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

iv. Exclusions/exceptions;

v. 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 paragraph 6.]

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

8. 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:

i. That the benefit level will *not increase over time;*

ii. Any automatic benefit adjustment provisions;

iii. 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 by a specified amount or percentage;

iv. 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;

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

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[i. Describe the policy renewability provisions;

ii. For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;

iii. Describe waiver of premium provisions or state that there are not such provisions;

iv. State whether or not the company has a right to change premium and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. 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.]

11. PREMIUM.

[i. State the total annual premium for the policy;

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

12. ADDITIONAL FEATURES.

[i. Indicate if medical underwriting is used;

ii. Describe other important features.]

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11:4–34.12 Severability

If any provision or clause of this subchapter or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of the subchapter which can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are declared severable.

11:4–34.13 Actuarial requirements for rate submissions

(a) Pursuant to N.J.A.C. 11:4–18.4(a)1, insurers are required to include with each submission of new or revised rates for individual health insurance not subject to N.J.S.A. 17B:27A–1 et seq. an actuarial memorandum which includes anticipated loss ratio, methodology for calculating gross premium, 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 for individual long-term care policies to comply with N.J.A.C. 11:4–18.4(a)1:

1. The number of years for which the policy is expected to be delivered or issued for delivery in this State, and the number of policies expected to be delivered or issued for delivery in this State for each form in each such year;

2. The anticipated loss ratio calculated over the life of the policy form, with separate disclosures of the present value of future paid benefits and the present value of future paid or written premiums utilized in the calculation of the anticipated loss ratio, when any statutorily required additional actuarial active life reserves are neither reflected in the future benefits nor the future premiums in the calculation;

3. The future benefits on both a paid and incurred basis and the future premiums on both a written and earned basis for each of the years recognized in the calculation of the anticipated loss ratio, when neither the future benefits nor the future premiums include, or are adjusted for, any statutorily required additional actuarial active life reserves;

4. The expected incurred/earned loss ratio for each of the years recognized in the calculation of the anticipated loss ratio, wherein:

i. The expected incurred claims shall equal expected paid claims adjusted for changes in the expected claim liabilities and claim reserves and in any expected statutorily required additional actuarial active life reserves for each such year; and

ii. The expected earned premiums shall equal premiums expected to be received adjusted for any changes in expected advance premiums and in expected unearned premium reserves for each such year, but changes in any expected statutorily required additional actuarial active life reserves shall not be included in the adjustment of premiums expected to be received;

5. The assumptions used in the calculation of the loss ratios for each benefit provision wherein the premiums are determined separately including the following:

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, or total termination rates, by policy duration by issue age and sex, and any skewing of those rates occurring within a policy year resulting from modal premium payments;

iv. The secular trend factors by policy duration by issue age and sex, which secular trend factors, when used in the calculation of the anticipated loss ratio, shall not be applied for a period greater than the number of years for which trending is reflected in the calculation of premiums;

v. The interest rates by policy duration, which rates shall equal an insurer's recent, current and future expected new investment return rates (after investment expenses, but before Federal income taxes). Alternatively, the Department will permit the use of a seven percent interest rate graded linearly to five percent over 10 years and five percent thereafter or a six 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 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 charge; on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable bases;

vii. The distribution of expected policy issues 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 form;

6. The cell and cell weights, when a model office is used in the calculation of the anticipated loss ratio;

7. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the loss ratio of any element of any insurance construct will not differ by more than 10 percent from the anticipated loss ratio for the policy.

ii. For the purpose of this paragraph, "construct" means the risk variables which significantly affect the cost of the coverage. For example, age could be a construct wherein its elements would be age 20, age 21 and so forth. The Department of Insurance is particularly concerned with anticipated loss ratios by issue age or issue age groupings;

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

9. A certification signed by an actuary who is a member of the American Academy of Actuaries or Casualty Actuarial Society 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.

Repeal and New Rule, R.1996 d.180, effective April 1, 1996.
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).
Section was "Compliance".
Public Notice: Alternate interest rates for rate submissions.
See: 31 N.J.R. 1642(b).

11:4–34.14 Loss ratio standards for individual long-term care insurance

(a) Long–term care insurance is subject to the loss ratio requirements set forth at N.J.A.C. 11:4–18.5.

(b) When a long-term care policy is funded by a level premium payable over the life of an insured whose issue age is under 65, the anticipated loss ratio cannot be less than:

$$(A–B–C)/A$$

where: A=the present value at policy issue of one dollar of annualized premium;

B=the present value at policy issue of the product of R and one dollar of annualized premium payable for policy years from policy issue to attained age 65;

C=the present value at policy issue of the product of .35 and one dollar of annualized premium payable for policy years after attained age 64;

and where R=the complement of the applicable loss ratio factor for coverage before attained age 65, with complements of .50 for noncancellable insurance and .45 for guaranteed renewable insurance.

New Rule, R.1996 d.180, effective April 1, 1996.
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

11:4–34.15 Spousal discount

(a) A spousal discount is permitted in individual long-term care insurance when the following conditions are met:

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, insurers 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.

New Rule, R.1996 d.180, effective April 1, 1996.
See: 27 N.J.R. 3725(a), 28 N.J.R. 1882(a).

SUBCHAPTERS 35 THROUGH 36. (RESERVED)

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

11:4–37.1 Purpose and scope

(a) The purpose of this subchapter is to set forth standards and procedures whereby a carrier shall obtain approval from the Commissioner of its offering of health benefits plans utilizing selective contracting arrangements that promote health care cost containment while adequately preserving quality of care.

(b) This subchapter applies to all carriers operating pursuant to Title 17B of the New Jersey statutes, and issuing health benefits plans utilizing selective contracting arrangements in this State or which cover New Jersey residents. This subchapter shall not apply to the following: hospital service corporations operating pursuant to N.J.S.A. 17:48–1 et seq.; medical service corporations operating pursuant to N.J.S.A. 17:48A–1 et seq.; hospital and medical service corporations operating pursuant to N.J.S.A. 17:48B–1 et seq.; dental service corporations operating pursuant to N.J.S.A. 17:48C–1 et seq.; dental plan organizations operating pursuant to N.J.S.A. 17:48D–1 et seq.; or health service corporations operating pursuant to N.J.S.A. 17:48E–1 et seq.

(c) The provisions of these rules shall apply except where in conflict with any policy or contract issued pursuant to the New Jersey Individual Health Coverage Act at N.J.S.A. 17B:27A–1 et seq. or the New Jersey Small Employer

Health Coverage Act at N.J.S.A. 17B:27A–17 et seq. If such a conflict exists, all remaining provisions of these rules determined not to be in conflict shall remain in effect.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
Added (c).

11:4–37.2 Definitions

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

"Allowable expense" means the usual, customary and reasonable item of expense for a covered service when the item of expense is covered at least in part by the health benefits plan.

"Carrier" means any insurance company operating pursuant to Title 17B of the New Jersey statutes and authorized to issue health benefits plans in this State.

"Coinsurance" means the percentage of the allowable expenses payable by the covered person.

"Coinsurance differential" means the difference in the coinsurance percentage applicable to in-network and out-of-network benefits.

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

"Copayment" means a specified dollar amount a covered person must pay for specified covered services.

"Covered person" means a person on whose behalf the carrier is obligated to pay benefits pursuant to the health benefits plan.

"Covered service" means a service provided to a covered person under a health benefits plan for which a carrier is obligated to pay benefits.

"Department" means the New Jersey Department of Banking and Insurance.

"Emergency care" means covered services that are provided by any health care provider for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that absence of immediate attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Evidence of coverage" means any certificate, agreement or contract which includes a statement of the essential benefits, limitations, exclusions and services of the health benefits plan, and which is issued to the covered person by the carrier.

"Formulary" means a list of prescription medications that are preferred for use by a health plan.

"Health benefits plan" means a policy, contract or evidence of coverage delivered or issued for delivery in this State that pays benefits and/or arranges for the provision of covered healthcare services and supplies. For purposes of this regulation, health benefits plan shall not include accident only, Medicare supplement coverage, CHAMPUS supplement coverage, coverage for Medicare services provided pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, and personal injury protection issued pursuant to N.J.S.A. 39:6A–1 et seq.

"Health care provider" means any physician, hospital, facility, or other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.

"Preferred provider" means a health care provider or group of health care providers who have entered into selective contracting arrangements with a carrier or a preferred provider organization.

"Preferred provider organization" or "PPO" means an entity other than a carrier that contracts with preferred providers to establish selective contracting arrangements.

"Selective contracting arrangement" or "SCA" means an arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations.

Amended by R.1998 d.302, effective June 15, 1998.
See: 30 N.J.R. 267(a), 30 N.J.R. 2214(a).
Rewrote "Emergency care", "Evidence of coverage", "Health benefits plan" and "Health care provider"; and inserted "Formulary".

11:4–37.3 Standards for selective contracting arrangements

(a) For purposes of paying for covered services under a health benefits plan, a selective contracting arrangement entered into by a carrier shall meet the following criteria:

1. The selective contracting arrangement shall include a mechanism for the review or control of utilization of covered services;

2. The selective contracting arrangement shall provide for an adequate number of preferred providers by specialty to render covered services in the geographic service area(s) where it functions;