GENERAL ASSEMBLY OF NORTH CAROLINA
1987 SESSION

CHAPTER 331
SENATE BILL 462

AN ACT TO PROVIDE STANDARDS FOR LONG-TERM CARE INSURANCE**.**

The General Assembly of North Carolina enacts:

Section 1. General Statute Chapter 58 is amended by adding a new Article to read:

"ARTICLE 42.
"Long-Term Care Insurance.

"**§ 58-540. Short title.–**This Article may be cited as the 'Long-Term Care Insurance Act'.

"**§ 58-541. Purposes.–**The purposes of this Article are to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

"**§ 58-542. Scope.–**This Article applies to new and renewed long-term care insurance policies delivered or issued for delivery in this State on or after September 1, 1987. This Article is not intended to supersede the obligations of any person subject to its provisions to comply with other applicable laws and rules if such laws and rules do not conflict with this Article. The laws and rules established to govern the medicare supplement insurance policies shall not apply to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance is not subject to this Article.

"**§ 58-543. Definitions.–**As used in this Article:

(1) 'Applicant' means:

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

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

(2) 'Certificate' means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.

(3) 'Group long-term care insurance' means a long-term care insurance policy that is delivered or issued for delivery in this State and issued to:

a. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or both, for employees or former employees or both, or

for members or former members or both, of the employers or labor organizations; or

b. Any professional, trade, or occupational association for its members or former or retired members, or all, if such association:
   (i) Comprises individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and
   (ii) Has been maintained in good faith for purposes other than obtaining insurance; or

c. An association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering such policy within this State, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. Thirty days after such filing the association or associations will be deemed to have satisfied such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

d. A group other than as described in subdivisions (3)a., (3)b., and (3)c. of this section, subject to a finding by the Commissioner that:
   (i) The issuance of the group policy is not contrary to the best interest of the public;
   (ii) The issuance of the group policy would result in economies of acquisition or administration; and
   (iii) The benefits are reasonable in relation to the premiums charged.

(4) 'Long-term care insurance' means any policy or certificate 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. 'Long-term care insurance' includes group and individual policies whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization. 'Long-term care insurance'

does not include any policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(5) 'Policy' means any policy, contract, certificate, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital or medical service corporation, prepaid health plan, health maintenance organization, or any similar organization.

"**§ 58-544. Limits of group long-term care insurance.–**No group long-term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in G.S. 58-543(3)(d), unless the Commissioner or the insurance regulator of the other state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this State has made a determination that such requirements have been met.

"**§ 58-545. Disclosure and performance standards for long-term care insurance.–**(a) The Commissioner may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

(b) No long-term care insurance policy may:

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

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(c) Pre-existing condition:

(1) No long-term care insurance policy or certificate shall use a definition of 'pre-existing condition' that is more restrictive than the following: pre-existing condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within the following limitation periods:

a. Six months preceding the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

b. Twenty-four months preceding the effective date of coverage of an insured person who is under age 65 on the effective date of coverage.

(2) No long-term care insurance policy may exclude coverage for a loss or confinement that is the result of a pre-existing condition unless such loss or confinement begins with the following periods:

a. Six months following the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

b. Twenty-four months following the effective date of coverage of an insured person who is under 65 on the effective date of coverage.

(3) The Commissioner may extend the limitation periods set forth in subdivisions (c)(1) and (2) of this section as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of 'pre-existing condition' does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

(d) No long-term care insurance policy that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(e) The Commissioner may adopt rules establishing loss ratio standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the rules.

(f) An individual long-term care insurance policyholder has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that unless the policyholder has received benefits under the policy, the policyholder has the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(g) A person insured under a long-term care insurance policy issued pursuant to a direct response has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that unless the insured person has received benefits under the policy, the insured person shall have the right to return the policy within 30 days of its

delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(h) An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request; but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

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

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

(3) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and

(4) A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

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

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

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

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

(j) No policy or certificate may be advertised, marketed, or offered as long-term care or nursing home insurance unless it complies with the provisions of this Article.

"**§ 58-546. Facilities, services, and conditions defined.–**(a) Whenever long-term care insurance provides coverage for the facilities, services, or physical or mental conditions listed below, unless otherwise defined in the policy and certificate, and approved by the Commissioner, such facilities, services, or conditions are defined as follows:

(1) 'Adult day care program' shall be defined in accordance with the provisions of G.S. 131D-6(b).

(2) 'Chore' services include the performance of tasks incidental to activities of daily living that do not require the services of a trained homemaker or other specialist. Such services are provided to enable individuals to remain in their own homes and may include such services as: assistance in meeting basic care needs such as meal preparation; shopping for food and other necessities; running necessary errands; providing transportation to essential service facilities; care and cleaning of the house, grounds, clothing, and linens.

(3) 'Combination home' shall be defined in accordance with the terms of G.S. 131E-101(1).

(4) 'Domiciliary home' shall be defined in accordance with the terms of G.S. 131D-2(a)(3).

(5) 'Family care home' shall be defined in accordance with the terms of G.S. 131D-2(a)(5).

(6) 'Group home for developmentally disabled adults' shall be defined in accordance with the terms of G.S. 131D-2(a)(6).

(7) 'Home for the aged and disabled' shall be defined in accordance with the terms of G.S. 131D2-(a)(7).

(8) 'Home health services' shall be defined in accordance with the terms of G.S. 131E-136(3).

(9) 'Homemaker services' means supportive services provided by qualified para-professionals who are trained, equipped, assigned, and supervised by professionals within the agency to help maintain, strengthen, and safeguard the care of the elderly in their own homes. These standards must, at a minimum, meet standards established by the North Carolina Division of Social Services and may include: Providing assistance in management of household budgets; planning nutritious meals; purchasing and preparing foods; housekeeping duties; consumer education; and basic personal and health care.

(10) 'Hospice' shall be defined in accordance with the terms of G.S. 131E-176(13a).

(11) 'Intermediate care facility' shall be defined in accordance with the terms of G.S. 131E-176(14).

(12) 'Nursing home' shall be defined in accordance with the terms of G.S. 131E-101(6).

(13) 'Respite care, institutional' means provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual by taking over the tasks of that person for a limited period of time. The insured receives care for the respite period in an institutional setting, such as a nursing home, family care home, rest home, or other appropriate setting.

(14) 'Respite care, non-institutional' means provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual by taking over the tasks of that person for a limited period of time in the home of the insured or other appropriate community location.

(15) 'Skilled Nursing Facility' shall be defined in accordance with the terms of G.S. 131E-176(23).

(b) Whenever long-term care insurance provides coverage for organic brain disorder syndrome, progressive dementing illness, or primary degenerative dementia, such phrases shall be interpreted to include Alzheimer's Disease. Clinical diagnosis of 'organic brain disorder syndrome', 'progressive dementing illness', and 'primary degenerative dementia' must be accepted as evidence that such conditions exist in an insured when a pathological diagnosis cannot be made; provided that such medical evidence substantially documents the diagnosis of the condition and the insured received treatment for such condition."

Sec. 2. This act shall become effective September 1, 1987.

In the General Assembly read three times and ratified this the 10th day of June, 1987.