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ASSEMBLY, No. 3199

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED FEBRUARY 25, 2020

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SYNOPSIS

Prohibits discrimination against living organ donors in relation to life, health, and long-term care insurance.

CURRENT VERSION OF TEXT

As reported by the Senate Health, Human Services and Senior Citizens Committee on December 7, 2020, with amendments.

(Sponsorship Updated As Of: 11/16/2020)

AN ACT concerning living organ donors and amending P.L.2003, c.207, N.J.S.17B:30-12, and P.L.2008, c.48.

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

1. Section 4 of P.L.2003, c.207 (C.17B:27E-4) is amended to read as follows:

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

"Applicant" means:

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

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

<u>“Living organ donor” means a person who has donated all or part of an organ and is not deceased.</u>

"Long-term care insurance" means any insurance policy, certificate or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. The term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also apply to qualified long-term care insurance contracts.

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Assembly AFI committee amendments adopted October 19, 2020.
[2]Senate SHH committee amendments adopted December 7, 2020.

Long-term care insurance may be issued by insurers; fraternal benefit societies; health, hospital, or medical service corporations; prepaid health plans; or health maintenance organizations. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more qualifying events, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this act.

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

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

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

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

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

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

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

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

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

(cf: P.L.2003, c.207, s.4)

2. Section 6 of P.L.2003, c.207 (C.17B:27E-6) is amended to read as follows:

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

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

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

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

(4) Decline or limit coverage based [1]solely[1] on the [1]status of the[1] insured individual [1]**[**being**]** as[1] a living organ donor; preclude an insured person from donating all or part of an organ [1]**[**; consider the status of a person as a living organ donor in determining the premium rate for coverage of the person**]** as a condition of continuing to receive coverage[1] [2]; consider the status of a person as a living organ donor in determining the premium rate for coverage of the person under a policy of life or health insurance[2] ; or otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price, or other condition of coverage for an individual based solely, and without any additional actuarial risks, on the status of the person as a living organ donor.

b. (1) No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than

the following: preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

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

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

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

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

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

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

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

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

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

d. Long-term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term

care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

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

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

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

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Current and projected maximum lifetime benefits; and

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

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

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

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

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

(cf: P.L.2003, c.207, s.6)

3. N.J.S.17B:30-12 is amended to read as follows:

17B:30-12. a. No person shall discriminate against any person or group of persons because of race, creed, color, national origin or ancestry of such person or group of persons in the issuance, withholding, extension or renewal of any policy of life or health insurance or annuity or in the fixing of the rates, terms or conditions therefor, or in the issuance or acceptance of any application therefor.

b. No person shall use any form of policy of life or health insurance or contract of annuity which expresses, directly or indirectly, any limitation, or discrimination as to race, creed, color, national origin or ancestry or any intent to make any such limitation or discrimination.

c. No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any policy of life insurance or contract of annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such policy of life insurance or contract of annuity.

d. No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such policy or contract, or in any other manner whatever.

e. (1) No person shall discriminate against any individual on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test to the person in the issuance, withholding, extension or renewal of any hospital confinement or other supplemental limited benefit insurance, as defined by regulation of the commissioner, or in the fixing of the rates, terms or conditions therefor, or in the issuance or acceptance of any application therefor.

(2) As used in this subsection and subsection f. of this section:

"Genetic characteristic" means any inherited gene or chromosome, or alteration thereof, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome, or to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome.

"Genetic information" means the information about genes, gene products or inherited characteristics that may derive from an individual or family member.

"Genetic test" means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids such as DNA, RNA and mitochondrial DNA, chromosomes or proteins in order to identify a predisposing genetic characteristic.

f. No person shall make or permit any unfair discrimination against an individual in the application of the results of a genetic test or genetic information in the issuance, withholding, extension or renewal of a policy of life insurance, including credit life insurance, an annuity, disability income insurance contract or credit accident insurance coverage. If the commissioner has reason to believe that such unfair discrimination has occurred, including that application of the results of a genetic test is not reasonably related to anticipated claim experience, and that a proceeding by the commissioner would be

in the interest of the public, the commissioner shall, in accordance with the provisions of N.J.S.17B:30-1 et seq., issue and serve upon the insurer a statement of the charges. Upon a determination that the practice or act of the insurer is in conflict with the provisions of this subsection, the commissioner shall issue an order requiring the insurer to cease and desist from engaging in the practice or act and may order payment of a penalty consistent with the provisions of N.J.S.17B:30-1 et seq.

If, in the issuance, withholding, extension or renewal of any policy of life insurance, including credit life insurance, an annuity, disability income insurance contract or credit accident insurance coverage, an insurer will use the results of a genetic test in compliance with this subsection, the insurer shall notify the individual who is the subject of the genetic test that such a test shall be required and shall obtain the individual's written informed consent for the test prior to the administration of the test, in accordance with the requirements of P.L.1985, c.179 (C.17:23A-1 et seq.). The insurer shall also provide that the physician or other health care professional designated by the individual shall promptly receive a copy of the results of the test and, if required, an interpretation of the test results by a qualified professional, and that the individual shall state in writing whether the individual elects to be informed of the results of the test.

g. No person shall make or permit any unfair discrimination against any individual on the basis of the individual's intent to engage in future lawful foreign travel in the issuance, extension or renewal of any policy of life insurance or in the fixing of the rates, terms or conditions therefor. For purposes of this subsection, "unfair discrimination" means any decision to issue, extend, or renew a policy of life insurance or the fixing of rates, terms, or conditions of a life insurance policy, on the basis of the individual's intent to engage in future lawful foreign travel, which is not based on sound actuarial principles or actual or reasonably anticipated experience.

h. Nothing contained in this section shall be construed to require any agent or company to take or receive the application for insurance or annuity of any person or to issue a policy of insurance or contract of annuity to any person.

i. No person shall decline or limit coverage under a policy of life or health insurance to any individual based [1]solely[1] on the [2]status of the covered[2] individual [2]**[**being**]** as[2] a living organ donor; preclude an individual covered under a policy of life or health insurance from donating all or part of an organ [1]**[**; consider the status of a person as a living organ donor in determining the premium rate for coverage of the person under a policy of life or health insurance**]** as a condition of continuing to receive coverage[1] [2]; consider the status of a person as a living organ donor in determining the premium rate for coverage of the person under a policy of life or health insurance;[2] or otherwise discriminate in the offering, issuance, cancellation, amount of

coverage, price, or other condition of coverage for an individual under a policy of life or health insurance based solely, and without any additional actuarial risks, on the status of the individual as a living organ donor.

As used in this subsection, "living organ donor" means a person who has donated all or part of an organ and is not deceased.

(cf: P.L.2008, c.4, s.1)

4. Section 5 of P.L.2008, c.48 (C.45:9-7.5) is amended to read as follows:

5. The State Board of Medical Examiners, in collaboration with the organ procurement organizations designated pursuant to 42 U.S.C.s.1320b-8 to serve in the State of New Jersey, shall prescribe by regulation the following requirements for physician training:

a. The curriculum in each college of medicine in this State shall include instruction in organ and tissue donation and recovery designed to address clinical aspects of the donation and recovery process and the rights of living organ donors as set forth in paragraph (4) of subsection a. of section 6 of P.L.2003, c.207 (C.17B:27E-6) and subsection i. of N.J.S.17B:30-12.

b. Completion of organ and tissue donation and recovery instruction as provided in subsection a. of this section shall be required as a condition of receiving a diploma from a college of medicine in this State.

c. A college of medicine which includes instruction in organ and tissue donation and recovery as provided in subsection a. of this section in its curricula shall offer such training for continuing education credit.

d. A physician licensed to practice medicine in this State prior to the effective date of this act, who was not required to receive and did not receive instruction in organ and tissue donation and recovery as part of a medical school curriculum, is encouraged to complete such training no later than three years after the effective date of this act. The training may be completed through an on-line, credit-based course developed by or for the organ procurement organizations, in collaboration with professional medical organizations in the State.

(cf: P.L.2008, c.48, s.5)

5. Section 6 of P.L.2008, c.48 (C.45:11-26.1) is amended to read as follows:

6. The New Jersey Board of Nursing, in collaboration with the organ procurement organizations designated pursuant to 42 U.S.C.s.1320b-8 to serve in the State of New Jersey, shall prescribe by regulation the following requirements for professional nurse training:

a. The curriculum in each educational program of professional nursing in this State shall include instruction in organ and tissue

donation and recovery designed to address clinical aspects of the donation and recovery process and the rights of living organ donors as set forth in paragraph (4) of subsection a. of section 6 of P.L.2003, c.207 (C.17B:27E-6) and subsection i. of N.J.S.17B:30-12.

b. Completion of organ and tissue donation and recovery instruction as provided in subsection a. of this section shall be required as a condition of receiving a degree or diploma, as applicable, in professional nursing from a nursing program in this State.

c. A nursing program which includes instruction in organ and tissue donation and recovery as provided in subsection a. of this section in its curricula shall offer such training for continuing education credit.

d. (1) A licensed professional nurse licensed to practice nursing in this State prior to the effective date of this act, who was not required to receive and did not receive instruction in organ and tissue donation and recovery as part of his nursing program curriculum, shall be required, as a condition of relicensure, to document completion of such training to the satisfaction of the board no later than three years after the effective date of this act. The training may be completed through an on-line, one credit hour course developed by or for the organ procurement organizations and approved by the board.

(2) The board may waive the requirement in this subsection if an applicant for relicensure demonstrates to the satisfaction of the board that the applicant has attained the substantial equivalent of this requirement through completion of a similar course in his post-secondary education which meets criteria established by regulation of the board.

(cf: P.L.2008, c.48, s.6)

6. This act shall take effect immediately.