304.14-615 Required standards and disclosures -- "Pre-existing condition" defined -- Right to return policy.

(1) The commissioner shall promulgate administrative regulations that include standards for full and fair disclosure setting forth the manner, content, and require 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, incidental benefits, lapse of insurance, termination of insurance, continuation of conversion, probationary periods, limitations, exceptions, reductions, elimination periods, premium rating practices and rating increases, requirements for replacement, recurrent conditions, and definitions of terms.

(2) A long-term care insurance policy shall not:

(a) Be canceled, 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;

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

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

(3) (a) A long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group defined in KRS 304.14-600(5)(a), shall not use a definition of "pre-existing condition" which is more restrictive than the following: "Pre-existing condition means a condition for which medical services or treatment was recommended by, or received from, a provider of health care services within six (6) months preceding the effective date of coverage of an insured person."

(b) A long-term care insurance policy or certificate, other than a policy or certificate under a policy issued to a group as defined in KRS 304.14-600(5)(a), shall not exclude coverage for a loss or confinement which is the result of a pre-existing condition unless that loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(c) The commissioner may extend the limitation periods set forth in subsection (3)(a) and (b) of this section as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

(d) 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. Unless otherwise provided in the policy or certificate, a pre-existing condition, regardless of whether it is disclosed on the application, need not be

covered until the waiting period described in paragraph (b) of this subsection expires. A long-term care insurance policy or certificate shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond the waiting period described in paragraph (b) of this subsection.

(4) (a) A long-term care insurance policy shall not be delivered or issued for delivery in this Commonwealth if the policy:

1. Conditions eligibility for any benefits on a prior hospitalization requirement;
2. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
3. Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(b) 1. A long-term care insurance policy 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" the limitations or conditions, including any required number of days of confinement.

2. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

(5) The commissioner may promulgate administrative regulations establishing loss ratio standards for long-term care insurance policies if a specific reference to long-term care insurance policies is contained in the administrative regulations.

(6) Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (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 thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in KRS 304.14-600(5)(a), the applicant is not satisfied for any reason.

(7) (a) 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.

1. The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.
2. In the case of agent solicitations, an agent shall deliver the outline of

coverage prior to the presentation of an application or enrollment form.

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

(b) The 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 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;

4. 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;

5. A description of the terms under which the policy or certificate may be returned and premium refunded; and

6. A brief description of the relationship of the cost of care and benefits.

(8) A certificate issued pursuant to a group long-term care insurance policy which is delivered or issued for delivery in this Commonwealth or a certificate subject to approval by the commissioner 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; and

(c) A statement that the group master policy determine governing contract provisions.

(9) At the time of policy delivery, a policy summary 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 any request, the insurer shall deliver the policy summary no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

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

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

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

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

1. A disclosure of the effects of exercising other rights under the policy;

2. A disclosure of guarantees related to long-term care costs of insurance charges; and

3. Current and projected maximum lifetime benefits.

(10) When a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder by the insurer. The report shall include:

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

(b) 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

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

(11) Any policy or rider advertised or marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of KRS 304.14-600 to 304.14-625.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1165, effective July 15, 2010; and ch. 166, sec. 5, effective July 15, 2010. -- Amended 2002 Ky. Acts ch. 304, sec. 14, effective July 15, 2002. -- Amended 1994 Ky. Acts ch. 93, sec. 8, effective July 15, 1994. â€“ Created 1992 Ky. Acts ch. 423, sec. 4, effective July 14, 1992.

Legislative Research Commission Note (7/15/2010). This section was amended by 2010 Ky. Acts chs. 24 and 166, which do not appear to be in conflict and have been codified together.