

806 KAR 17:081. Minimum standards for long-term care insurance policies.

RELATES TO: KRS 304.1-040, 304.2-310, 304.6-070, 304.6-130-304.6-180, 304.9-080, 304.12-020, 304.12-030, 304.12-130, 304.14-120(2), 304.14-600-304.14-644, 304.15-310, 304.15-315, 304.18-120, 304.18-127, 304.29-600, 304.32-290, 304.38-220, 26 U.S.C. 7702B, 42 U.S.C. 1395x(r), 45 C.F.R. 160.103

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.14-615, 304.14-620, 304.32-250, 304.38-150

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the Commissioner of Insurance to promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code. KRS 304.14-615(1) requires the Commissioner of Insurance to promulgate administrative regulations establishing minimum standards for the manner, content, and sale of long-term care insurance policies. KRS 304.14-620 requires the Commissioner of Insurance to promulgate administrative regulations to establish minimum standards for marketing practices, agent compensation, agent testing, penalties, and reporting practices for long-term care insurance. KRS 304.32-250 authorizes the Commissioner of Insurance to promulgate reasonable administrative regulations necessary for the proper administration of KRS Chapter 304.32. KRS 304.38-150 authorizes the Commissioner of Insurance to promulgate reasonable administrative regulations necessary for the proper administration of KRS Chapter 304.38. EO 2008-507, effective June 16, 2008, established the Department of Insurance and the Commissioner of Insurance as the head of the Department. This administrative regulation establishes minimum standards for long-term care insurance.

Section 1. Definitions.

- (1) "Applicant" is defined in KRS 304.14-600(3).
- (2) "Attained age rating" means a schedule of premiums starting from the issue date which increases age at least one (1) percent per year prior to age fifty (50), and at least three (3) percent per year beyond age fifty (50).
- (3) "Certificate" is defined in KRS 304.14-600(4).
- (4) "Chronically-ill individual", pursuant to 26 U.S.C. 7702B(c)(2):
 - (a) Means any individual who has been certified by a licensed health care practitioner as:
 1. Being unable to perform without substantial assistance from another individual at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or
 2. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; and
 - (b) Shall not include an individual otherwise meeting these requirements unless within the preceding twelve month period a licensed health care practitioner has certified that the individual meets these requirements.
- (5) "Claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.
- (6) "Cold lead advertising" means the use of any method of marketing which fails to disclose in a clear, easy to notice manner that a purpose of the method of marketing is solicitation of insurance and contact will be made by an insurance agent or insurance company.
- (7) "Commissioner" means the Commissioner of Insurance.
- (8) "Denied claim" means the insurer refuses to pay a claim for any reason except for failure to meet the waiting period or due to an applicable preexisting condition.
- (9) "Department" means the Department of Insurance.

(10) "Exceptional increase" means a premium rate increase filed by an insurer as exceptional, which the commissioner determines is necessary and justified due to:

(a) Changes in Kentucky laws or administrative regulations applicable to long-term care coverage; or

(b) Increased and unexpected utilization that affects the majority of insurers of similar products.

(11) "Group long-term care insurance" is defined in KRS 304.14-600(5).

(12) "High pressure tactics" means employing any method of marketing that may affect or induce the purchase of insurance through force, fright, explicit or implied threat, or create undue pressure to purchase or recommend the purchase of insurance.

(13) "Incidental" is defined in KRS 304.14-600(1).

(14) "Individually-identifiable information" means personal information gathered in connection with an insurance transaction from which judgment may be made regarding an individual's character, habits, avocations, finances, occupation, general reputation, credit, health or other personal characteristics including an individual's name, address, and medical record information.

(15) "Insurer" is defined in KRS 304.1-040.

(16) "Interlocking directorates" means two (2) separate boards of directors that have at least one (1) director in common.

(17) "Kentucky insurance code" means the statutes referenced in KRS 304.1-010 and the administrative regulations established in KAR Title 806.

(18) "Licensed health care practitioner" means a physician as defined in 42 U.S.C. 1395x(r), registered nurse, licensed social worker, or other individual who meets the requirements of 26 U.S.C. 7702B(c)(4).

(19) "Limited distribution channel" means a discrete entity, including a financial institution or brokerage, through which a specialized product is made available to a purchaser other than the general public.

(20) "Long-term care benefits classifications" means:

(a) Institutional long-term care benefits only;

(b) Noninstitutional long-term care benefits only; or

(c) Comprehensive long-term care benefits.

(21) "Long-term care insurance" is defined in KRS 304.14-600(2).

(22) "Maintenance or personal care services" means care for which the primary purpose is the provision of needed assistance with a disability as a result of which the individual is a chronically-ill individual, including protection from threats to health and safety due to severe cognitive impairment.

(23) "Managed-care plan" means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

(24) "Misrepresentation" means misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(25) "Policy" is defined in KRS 304.14-600(6).

(26) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

(27) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means:

(a) An individual or group insurance contract that meets the requirements of 26 U.S.C. 7702B(b) as follows:

1. The insurance protection provided under the contract shall be limited to coverage of qualified long-term care services and the contract shall not fail to satisfy the requirements of this subparagraph 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.

a. The contract shall 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, as amended, 42 U.S.C. 1395 et seq., or would be reimbursable except for the application of a deductible or coinsurance amount;

b. The requirements of this subparagraph shall not apply to expenses that are reimbursable under 42 U.S.C. 1395 et seq. as a secondary payor; and

c. The contract shall not fail to satisfy the requirements of this subparagraph 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 shall be guaranteed renewable, as established in 26 U.S.C. 7702B(b)(1)(C);

4. The contract shall not provide for a cash surrender value or other money that may be paid, assigned, pledged as collateral for a loan, or borrowed except as required in subparagraph 5 of this paragraph;

5. Refunds of premiums and policyholder dividends or similar amounts under the contract shall be applied as a reduction in future premiums or to increase future benefits, except that a refund upon death of the insured, a complete surrender, or cancellation of the contract shall not exceed the aggregate premiums paid under the contract; and

6. The contract shall meet the consumer protection provisions as established in 26 U.S.C. 7702B(g); or

(b) The portion of a life insurance contract that:

1. Provides long-term care insurance coverage by rider or as part of the contract; and

2. Meets the requirements of 26 U.S.C. 7702B(b) and (e).

(28) "Qualified long-term care services" means services required in 26 U.S.C. 7702B(c)(1), including necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically-ill individual, and provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(29) "Similar policy forms" means:

(a) Long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered; or

(b) Certificates of groups, as identified in KRS 304.14-600(5)(a) similar to other comparable certificates of groups that meet the definition in KRS 304.14-600(5)(a) with the same long-term care benefit classifications.

(30) "Twisting" means knowingly making a misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or tending to induce, a person to:

(a) Lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy; or

(b) Secure an insurance policy from another insurer.

Section 2. Policy Definitions. A long-term care insurance policy delivered or issued for delivery in Kentucky shall not include the following terms unless the terms are defined in the policy and the definitions satisfy the following requirements:

(1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

(2) "Acute condition" means that the individual is medically unstable and requires frequent monitoring by medical professionals, including physicians and registered nurses,

in order to maintain health status.

(3) "Adult day care" means a program for four (4) or more individuals, of social- or health-related, or both, services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who may benefit from care in a group setting outside the home.

(4) "Bathing" means washing oneself by sponge bath, or in 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, if unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

(7) "Dressing" means putting on and taking 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, including a plate, cup, or table, or by a feeding tube or intravenously.

(9) "Hands-on assistance" means minimal, moderate, or maximal physical assistance without which the individual would not be able to perform the activity of daily living.

(10) "Home health-care services" means medical and nonmedical services, including homemaker services, assistance with activities of daily living, and respite care services, provided to ill, disabled, or infirmed persons in their residences.

(11) "Medicare" means:

(a) "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended;"

(b) "Title I, Part I 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;" or

(c) Words similar to paragraph (a) and (b) of this subsection.

(12) "Mental or nervous disorder" means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(13) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(14) "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 shall be delivered.

(15) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(16) "Transferring" means moving into or out of bed, chair, or wheelchair.

(17)

(a) "Skilled nursing facility", "extended care facility", "intermediate care facility", "convalescent nursing home", "personal care facility", "assisted living facility", "home care agency", "specialized care providers", and other providers of services shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services; and

(b) If the definition requires that the provider be appropriately licensed, certified, or registered, the definition shall also include the requirements that a provider shall meet in lieu of licensure, certification or registration if the state in which the service is provided:

1. Does not require a provider of these services to be licensed, certified or registered;
or

2. Licenses, certifies or registers the provider of services under another name.

Section 3. Policy Practices and Provisions.

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in an individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 6 of this administrative regulation.

(a) A long-term care insurance policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(b) The term "guaranteed renewable" shall not be used unless:

1. The insured has the right to continue the long-term care insurance in force by the timely payment of premiums; and
2. Except for a revision of rates on a class basis, the insurer has no unilateral right to make a change in a provision of the policy or rider while the insurance is in force, and shall not decline to renew.

(c) The term "noncancellable" shall be not be used unless the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during the period in which the insurer has no right to unilaterally make a change in a provision of the insurance or in the premium rate.

(d) The term "level premium" shall not be used unless the insurer does not have the right to change the premium.

(e) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, pursuant to 26 U.S.C. 7702B(b)(1)(C).

(2)

(a) Limitations and exclusions. A policy shall not be delivered or issued for delivery in Kentucky as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

1. Preexisting conditions or diseases in accordance with KRS 304.14-615(3)(d);
2. Mental or nervous disorders except for Alzheimer's disease;
3. Alcoholism and drug addiction;
4. Illness, treatment, or medical condition as a result of:
 - a. War or act of war, whether declared or undeclared;
 - b. Participation in a felony, riot, or insurrection;
 - c. Service in the armed forces or auxiliary units;
 - d. Suicide, if sane or insane, attempted suicide, or intentionally self-inflicted injury; or
 - e. Except for fare-paying passengers, aviation;
5.
 - a. Treatment provided in a government facility, unless otherwise required by law;
 - b. Services for which benefits are available under:
 - (i) Medicare or other governmental program, except Medicaid;
 - (ii) A state or federal workers' compensation;
 - (iii) Employer's liability or occupational disease law; or
 - (iv) A motor vehicle no-fault law;
 - c. Services provided by a member of the covered person's immediate family; and
 - d. Services for which no charge is normally made in the absence of insurance;
6. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; and
7. If a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses:
 - a. Are reimbursable under 42 U.S.C. 1395 et seq.; or

- b. Would be reimbursable except for the application of a deductible or coinsurance amount;
- (b)
 - 1. This subsection is not intended to prohibit the delivery or issue for delivery of a long-term care policy with exclusions and limitations by type of provider; and
 - 2. A long-term care insurer shall not deny a claim because services are provided in a state other than the state of policy issue under the following conditions, if the state other than the state of policy issue:
 - a. Does not have the provider licensing, certification, or registration required in the policy and the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
 - b. Licenses, certifies or registers the provider under another name; and
- (c) This subsection is not intended to prohibit the delivery or issue for delivery of a long-term care policy with territorial limitations.
- (3) Extension of benefits.
 - (a) Termination of long-term care insurance shall be without prejudice to any; benefits payable for institutionalization if the institutionalization:
 - 1. Began while the long-term care insurance was in force; and
 - 2. Continues without interruption after termination.
 - (b) The extension of benefits beyond the period the long-term care insurance was in force may be:
 - 1. Limited to the:
 - a. Duration of the benefit period, if any; or
 - b. Payment of the maximum benefits; and
 - 2. Subject to:
 - a. Any policy waiting period; and
 - b. All other applicable provisions of the policy.
- (4) Continuation or conversion. Group long-term care insurance issued in Kentucky on or after July 15, 2002 shall provide a covered individual with a basis for continuation or conversion of coverage.
 - (a) A basis for continuation shall be identified as a policy provision, which provides for continued coverage under the existing group policy if the coverage would otherwise terminate and be subject to the continued timely payment of premium when due.
 - 1. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy; and
 - 2. The commissioner shall:
 - a. Make a determination as to the substantial equivalency of benefits as identified in subparagraph 1 of this paragraph; and
 - b. In making the determination identified in clause a. of this subparagraph, take into consideration the differences between managed-care and nonmanaged-care plans, including:
 - (i) Provider system arrangements;
 - (ii) Service availability;
 - (iii) Benefit levels; and
 - (iv) Administrative complexity.
 - (b) A basis for conversion shall be identified as a policy provision, which provides that an individual shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability, if the:
 - 1. Individual's coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its

entirety or with respect to an insured class; and

2. Individual has been continuously insured under the group policy and any group policy which it replaced, for at least six months immediately prior to termination.

(c)

1. A converted policy shall be an individual policy of long-term care insurance that provides benefits identical to or benefits determined by the commissioner to be substantially similar to or in excess of those provided under the group policy from which conversion is made.

2. If the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial similarity of benefits, shall take into consideration the differences between managed-care and non managed-care plans, including:

- a. Provider system arrangements;
- b. Service availability;
- c. Benefit levels; and
- d. Administrative complexity.

(d)

1. No later than thirty-one (31) days after termination of coverage under the group policy, an individual who desires a converted policy shall:

- a. Make written application for the converted policy; and
- b. Pay the first premium that is due, if any.

2. A converted policy shall be:

- a. Issued effective on the day following date of termination of coverage under the group policy; and
- b. Renewable annually.

(e) The premium for a converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy:

1. From which conversion is made unless the group policy from which conversion is made replaced previous group coverage; or
2. Replaced, if the group policy from which conversion is made replaced previous group coverage.

(f) Continuation of coverage or issuance of a converted policy shall be mandatory, except if:

1. Termination of group coverage resulted from an individual's failure to make a required payment of premium or contribution when due; or
2. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the date of termination of coverage:
 - a. Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and
 - b. The premium for which is calculated in a manner consistent with the requirements of paragraph (e) of this subsection.

(g) Notwithstanding any other provision of this section, a converted policy issued to an individual who at conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if:

1. The benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses; and

2. The converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(h) A converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(i) Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(5) Discontinuance and replacement.

(a) If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to persons covered under the previous group policy on its date of termination; and

(b) Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy shall not:

1. Result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
2. Vary or depend on the individual's:
 - a. Health or disability status;
 - b. Claim experience; or
 - c. Use of long-term care services.

(6)

(a) The premium charged to an insured for long-term care insurance shall not increase due to the:

1. Increasing age of the insured at ages beyond sixty-five (65); or
2. Duration that the insured has been covered under the policy.

(b)

1. The purchase of additional coverage shall not be considered a premium rate increase; and
2. For the calculation required under Section 25(6) of this administrative regulation, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(c)

1. A reduction in benefits shall not be considered a premium change; and
2. for the calculation required under Section 25(6) of this administrative regulation, the initial annual premium shall be based on the reduced benefits.

(7) Electronic enrollment for group policies.

(a) A requirement that a signature of a group long-term care insured be obtained by an agent or insurer shall be deemed satisfied if:

1. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer;
2. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the:
 - a. Accuracy, retention, and prompt retrieval of records; and
 - b. Maintenance of the confidentiality of personally-identifiable information pursuant to 806 KAR 3:210, 3:220 and 3:230.

(b) A verification of enrollment information shall be provided to an enrollee.

(c) Upon request of the commissioner, an insurer shall make available records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

Section 4. Unintentional Lapse. An insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(1)

(a) Notice before lapse or termination. An individual long-term care policy or certificate shall not be issued until the insurer has received from the applicant a written:

1. Designation of at least one (1) person, in addition to the applicant, who shall receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or
2. Waiver:
 - a. Dated and signed by the applicant; and
 - b. Electing not to designate additional persons to receive notice.
 - c. Designation shall not constitute acceptance of any liability of the third party for services provided to the insured.
 - d. The form used for the written designation shall provide space clearly designated for listing at least one (1) person.
 - e. The designation shall include each person's full name and home address.
 - f. If an applicant elects not to designate an additional person, the waiver shall contain the language as established in HIPMC-LTC-10.
 - g. The insurer shall notify the insured of the right to change a written designation, at least once every two (2) years.

(b)

1. If a policy holder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the policy or certificate shall not be required to meet the requirements of paragraph (a) of this subsection until sixty (60) days after the policyholder or certificate holder is no longer on the payment plan.
2. The application or enrollment form for the policy or certificate shall clearly indicate the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium.

1. An individual long-term care policy or certificate shall not lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and any person designated pursuant to paragraph (a) of this subsection, at the address provided by the insured for purposes of receiving notice of lapse or termination.
2. Notice of lapse or termination shall:
 - a. Be given by first class U.S. mail, postage prepaid;
 - b. Not be given until thirty (30) days after a premium is due and unpaid; and
 - c. Be deemed to have been given as of five (5) days after the date of mailing.

(2) Reinstatement.

(a) In addition to meeting the requirements of subsection (1) of this section, a long-term care insurance policy or certificate shall include a provision for reinstatement of coverage:

1. When lapse occurs; and
2. If the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.

(b) The reinstatement of coverage option as identified in paragraph (a) of this subsection shall:

1. Be available to the insured if requested within five (5) months after termination; and
2. Allow for the collection of past due premium, if appropriate.

- (c) The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for cognitive impairment or loss of functional capacity as established in the policy and certificate.

Section 5. Required Disclosure Provisions.

(1) Renewability.

- (a) An individual long-term care insurance policy shall contain a renewability provision, which shall:

1. Be appropriately captioned;
2. Appear on the first page of the policy; and
3. State clearly that the coverage is guaranteed renewable or noncancellable.

- (b) Paragraph (a) of this subsection shall not apply to a life insurance policy with a long-term care insurance rider:

1. Which does not contain a renewability provision; and
2. Under which the right to nonrenew is reserved solely to the policyholder.

- (c) Except for a long-term care insurance policy for which an insurer does not have the right to change the premium, a long-term care insurance policy or certificate shall include a statement that premium rates may change.

(2) Riders and endorsements.

- (a) Except for a rider or endorsement by which an insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, a rider or endorsement added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduces or eliminates benefits or coverage in the policy shall require signed acceptance by the individual insured.

- (b) Except for increases in benefits or coverage that are required by the Kentucky insurance code, a rider or endorsement shall be agreed to in writing and signed by the insured, if the rider or endorsement:

1. Is issued after the date of policy issue; and
2. Increases benefits or coverage with a concomitant increase in premium during the policy term.

- (c) If a separate additional premium is charged for benefits provided in connection with a rider or endorsement, the premium charged shall be disclosed in the policy, rider, or endorsement.

- ##### (3) Payment of benefits. A long-term care insurance policy which provides payment of benefits based on standards described as usual and customary, reasonable and customary, or words of similar import shall include:

- (a) A definition of these terms or words; and
- (b) An explanation of these terms or words in its accompanying outline of coverage.

- ##### (4) Limitations. If a long-term care insurance policy or certificate contains any limitations, which apply to preexisting conditions, the limitations shall:

- (a) Appear as a separate paragraph of the policy or certificate; and
- (b) Labeled as Preexisting Condition Limitations.

- ##### (5) Other limitations or conditions on eligibility for benefits. Except for limitations or conditions prohibited in KRS 304.14-615(4)(b), a long-term care insurance policy or certificate containing a limitation or condition for eligibility shall:

- (a) Provide a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate; and
- (b) Label the paragraph as established in paragraph (a) of this subsection as "Limitations or Conditions on Eligibility for Benefits."

- ##### (6) Disclosure of tax consequences. A disclosure statement, as identified in paragraph (a) of this subsection, shall be required for a life insurance policy which provides an accelerated benefit for long-term care.

- (a) The disclosure statement shall:
 - 1. Be required:
 - a. Upon application for the policy or rider; and
 - b. When the accelerated benefit payment request is submitted;
 - 2. Disclose that:
 - a. Receipt of the benefits may be taxable; and
 - b. Assistance from a personal tax advisor is recommended; and
 - 3. Be prominently displayed on the first page of the:
 - a. Policy or rider; and
 - b. Documents related to the policy or rider.
- (b) This subsection shall not apply to a qualified long-term care insurance contract.
- (7) Benefit triggers.
 - (a) Activities of daily living and cognitive impairment shall be:
 - 1. Used to measure an insured's need for long-term care;
 - 2. Described in the policy or certificate in a separate paragraph; and
 - 3. Labeled "Eligibility for the Payment of Benefits".
 - (b) Any benefit triggers not identified in paragraph (a) of this subsection shall also be explained in the benefit triggers section of the policy or certificate.
 - (c) If benefit triggers differ for different benefits, an explanation of the trigger shall accompany each benefit description.
 - (d) If certification of a certain level of functional dependency by an attending physician or other specified person is required for determination of eligibility for benefits, the required certification shall be disclosed.
- (8) A qualified long-term care insurance contract shall include a disclosure statement:
 - (a) In the policy and as established in Outline of Coverage, HIPMC-LTC-7; and
 - (b) Which states that the policy is intended to be a qualified long-term care insurance contract under 29 U.S.C. 7702B(b).
- (9) A nonqualified long-term care insurance contract shall include a disclosure statement:
 - (a) In the policy and as established in Outline of Coverage, HIPMC-LTC-7; and
 - (b) Which states that the policy is not intended to be a qualified long-term care insurance contract.

Section 6. Required Disclosure of Rating Practices to Consumers.

- (1) Except as provided in subsection (2) of this section, this section shall apply to any long-term care policy or certificate issued in Kentucky beginning January 15, 2003.
- (2) For a certificate issued on or after July 15, 2002, under a group long-term care insurance policy as identified in KRS 304.14-600(5)(a), which was in force July 15, 2002, the provisions of this section shall apply on the policy anniversary following July 15, 2003.
- (3) Except for a policy for which no applicable premium rate or rate schedule increases may be made, an insurer shall provide the information listed in this subsection to the applicant when application or enrollment occurs, unless the method of application does not allow for delivery at that time:
 - (a) A statement that the policy may be subject to rate increases in the future;
 - (b) An explanation of potential future premium rate revisions and the policyholder's or certificate holder's option if a premium rate is revised;
 - (c) The premium rate or rate schedules applicable to the applicant that shall be in effect until a request for an increase is made;
 - (d) A general explanation for applying premium rate or rate schedule adjustments that shall include:
 - 1. A description of when premium rate or rate schedule adjustments shall be effective, including the next anniversary date or billing date; and

2. If the premium rate or rate schedule is changed, the right to a revised premium rate or rate schedule as provided in paragraph (c) of this subsection; and

(e)

1. Information regarding each premium rate increase on the policy form or similar policy forms during the past ten (10) years for Kentucky or any other state that, at a minimum, shall identify:

- a. The policy forms for which premium rates have been increased;
- b. The calendar years when the form was available for purchase; and
- c. The amount or percent of each increase. The percentage may be expressed as:
 - (i) A percentage of the premium rate prior to the increase; or
 - (ii) If the rate increase is variable by rating characteristics, the minimum and maximum percentages.

2. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

3. An insurer may exclude, from the disclosure premium rate increases that occurred prior to the acquisition of and only apply to:

- a. Blocks of business acquired from other nonaffiliated insurers; or
- b. Long-term care policies acquired from other nonaffiliated insurers.

4. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from a nonaffiliated insurer or block of policy forms acquired from a nonaffiliated insurer and if those increases occurred prior to the acquisition on or before the later of July 15, 2002 or the end of a twenty-four (24) month period following the acquisition of the block of business or policies, the acquiring insurer may exclude that rate increase from the disclosure.

- a. The rate increase that may be excluded pursuant to this subparagraph shall be disclosed by the nonaffiliated selling company in accordance with subparagraph 1 of this paragraph; and
- b. If the acquiring insurer files for a subsequent rate increase, within the twenty-four (24) month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from a nonaffiliated insurer, the acquiring insurer shall make the disclosures required by this paragraph, including disclosure of the earlier rate increase.

(4) If the method of application does not allow for delivery when application or enrollment occurs, the information listed in subsection (3)(a) and (e) of this section shall be delivered to the applicant no later than the date the policy or certificate is delivered.

(5) An applicant shall sign an acknowledgement that the insurer made the disclosure required under subsection (3)(a) and (e) of this section:

- (a) When application occurs; or
- (b) If the method of application does not allow signature when application occurs, no later than the delivery date of the policy or certificate.

(6) An insurer shall use forms HIPMC-LTC-1 and HIPMC-LTC-2, to comply with the requirements of subsections (3) and (5) of this section.

(7) An insurer shall provide notice of an upcoming premium rate schedule increase to a policyholder or certificate holder, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer.

(8) The notice required, pursuant to subsection (7) of this section, shall include the information required by subsection (3) of this section when the rate increase is implemented.

Section 7. Initial Filing Requirements.

(1) This section shall apply to a long-term care policy issued in Kentucky beginning January 15, 2003.

(2) An insurer shall provide the information listed in this subsection to the commissioner in accordance with the time period established in KRS 304.14-120(2), including:

(a) A copy of the disclosure documents required in Section 6 of this administrative regulation; and

(b) An actuarial certification consisting of at least the following:

1. A statement that the:

a. Initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience; and

b. Premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

2. A statement that the policy design and coverage have been reviewed and considered;

3. A statement that the underwriting and claims adjudication processes have been reviewed and considered;

4. A complete description of the basis for contract reserves that are anticipated to be held under the form, including:

a. Sufficient detail or sample calculations to depict completely the reserve amounts to be held;

b. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

c. A statement that except for the attained-age rating, if permitted, the net valuation premium for renewal years does not increase; and

d. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses, or if the statement cannot be made, a complete description of the situations in which this does not occur;

(i) An aggregate distribution of anticipated issues may be used if the underlying gross premiums maintain a reasonably consistent relationship; and

(ii) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration as identified under subsection (3) of this section based on a standard age distribution; and

5.

a. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms currently also available from the insurer except for reasonable differences attributable to benefits; or

b. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(3) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums which shall include:

(a) Premium and claim experience on similar policy forms, adjusted for any premium and benefit differences;

(b) Relevant and creditable data from other studies; or

(c) Premium and claims experience, and relevant and creditable data as identified in paragraphs (a) and (b) of this subsection.

Section 8. Prohibition Against Postclaims Underwriting.

(1) Except for an application which is guaranteed issue, an application for a long-term care insurance policy or certificate shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2)

(a) If an application for long-term care insurance contains a question which asks if the applicant has had medication prescribed by a physician, it shall also ask the applicant

to list the medication that has been prescribed.

(b) If at application, the medications listed in the application were known by the insurer, or should have been known, to be directly related to a medical condition for which coverage would be denied, the policy or certificate shall not be rescinded for that condition.

(3) Except for a policy or certificate which is guaranteed issue:

(a) The language shall be conspicuous and located in close proximity to the applicant's signature block on an application for a long-term care insurance policy or certificate: "Caution: If your answers on this application, to the best of your knowledge and belief, are incorrect or untrue, (insurer name) has the right to deny benefits or rescind your policy."

(b) The language identified in HIPMC-LTC-10, or substantially similar language, shall be clear and easy to read on the long-term care insurance policy or certificate when it is delivered.

(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one (1) of the following:

1. A report of a physical examination;
2. An assessment of functional capacity;
3. An attending physician's statement; or
4. A copy of the medical records.

(4) A copy of the completed application or enrollment form, as applicable, shall be delivered to the insured no later than the delivery date of the policy or certificate unless it was retained by the applicant at application.

(5) An insurer issuing long-term care insurance benefits shall:

(a) Except for a policy or certificate rescission voluntarily effectuated by the insured, maintain a record of all policy or certificate rescissions, both Kentucky and countrywide; and

(b) Annually submit the information identified in paragraph (a) of this subsection to the commissioner using HIPMC-LTC-3.

Section 9. Minimum Standards for Home Health and Community Care Benefits in Long-term Care Insurance Policies.

(1) A long-term care insurance policy or certificate which provides benefits for home health care or community care services shall not limit or exclude benefits by:

(a) Requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(b) Requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

(c) Limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) Requiring that a nurse or therapist provide services covered by the policy that may be provided by a:

1. Home health aide; or
2. Other licensed or certified home care worker acting within the worker's scope of licensure or certification;

(e) Excluding coverage for personal care services provided by a home health aide;

(f) Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(g) Requiring that the insured or claimant have an acute condition before home health care services are covered;

- (h) Limiting benefits to services provided by Medicare-certified agencies or providers;
or
 - (i) Excluding coverage for adult day care services.
- (2)
- (a) A long-term care insurance policy or certificate which includes home health or community care services shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy or certificate, when covered home health or community care services are received.
 - (b) The requirement identified in paragraph (a) of this subsection shall not apply to a policy or certificate issued to a resident of a continuing care retirement community.
- (3) In determining maximum coverage under the terms of a policy or certificate, home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate.

Section 10. Requirement to Offer Inflation Protection.

- (1) In addition to any other inflation protection, an insurer offering a long-term care insurance policy shall offer to the policyholder, an option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy and when the policy is purchased, the option to purchase a policy with an inflation protection feature that is no less favorable than one (1) of the following:
- (a) Increases benefit levels annually in a manner that increases are compounded annually at a rate no less than five (5) percent;
 - (b) If the option for the previous period has not been declined, guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status. The amount of the additional benefit shall not be less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five (5) percent for the period:
 - 1. Beginning with the purchase of the existing benefit; and
 - 2. Extending until the year in which the offer is made; or
 - (c)
 - 1. Covers a specified percentage of actual or reasonable charges; and
 - 2. Does not include a maximum specified indemnity amount or limit.
- (2) If a long-term care policy is issued to a:
- (a) Group, the required offer in subsection (1) of this section shall be made to the group policyholder; or
 - (b) Group as defined in KRS 304.14-600(5)(d) other than to a continuing care retirement community, the required offer in Subsection (1) of this section shall be made to each proposed certificate holder.
- (3) The offer in subsection (1) of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.
- (4) An insurer:
- (a) Shall disclose, in or with the outline of coverage:
 - 1. A graphic comparison of the benefit levels of a policy, which:
 - a. Increases benefits over the policy period; and
 - b. Does not increase benefits over the policy period; and
 - 2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases;
 - (b) Shall show the benefit levels as identified in paragraph (a)1 of this subsection for a period of twenty (20) years or more; and

- (c) May use a reasonable hypothetical, or a graphic demonstration for the disclosure identified in paragraphs (a) and (b) of this subsection.
- (5) Inflation protection benefit increases under a policy which contains these benefits shall continue regardless of an insured's:
 - (a) Age;
 - (b) Claim status;
 - (c) Claim history; or
 - (d) Length of time the person has been insured under the policy.
- (6) An offer of inflation protection which provides automatic benefit increases shall:
 - (a) Include an offer of a premium which the insurer expects to remain constant; and
 - (b) Disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.
- (7)
 - (a) Inflation protection as identified in subsection (1)(a) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.
 - (b) As established in HIPMC-LTC-10, the rejection of inflation protection, which may be either in the application or in a separate form, shall be considered a part of the application.

Section 11. Requirements for Application Forms and Replacement Coverage.

- (1)
 - (a) Application forms shall include questions designed to obtain information to determine if:
 - 1. The applicant has another long-term care insurance policy or certificate in force on the date of application; or
 - 2. A long-term care insurance policy or certificate is intended to replace:
 - a. An accident and sickness policy or certificate currently in force; or
 - b. A long-term care policy or certificate currently in force.
 - (b) A supplementary application or other form, containing the questions required by this section, may be used if signed by the:
 - 1. Applicant; and
 - 2. Agent, if coverage is sold by an agent.
 - (c) If a replacement policy is issued to a group, as defined by KRS 304.14-600(5)(a), the following questions shall be included and may be modified only to the extent necessary to obtain information about a health or long-term care insurance policy other than the group policy being replaced if the certificate holder has been notified of the replacement.
 - 1. Do you have another long-term care insurance policy or certificate in force, including a health-care service contract or health maintenance organization contract?
 - 2. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?
 - a. If yes, with which company?
 - b. If that policy lapsed, when did it lapse?
 - 3. Are you covered by Medicaid?
 - 4. Do you intend to replace any of your medical or health insurance coverage with this policy or certificate?
- (2) An agent shall list other health insurance policies sold by the agent to the applicant which:
 - (a) Are currently in force; and
 - (b) Were sold in the past five (5) years and are no longer in force.
- (3) Solicitations other than direct response.

- (a) Upon determining that a sale will involve replacement, an insurer, which does not use direct response solicitation methods or an agent of the insurer, shall provide the applicant with a notice regarding replacement of accident and sickness or long-term care coverage as established in the HIPMC-LTC-8.
- (b)
 - 1. One (1) copy of the notice identified in this subsection shall be retained by the applicant; and
 - 2. A copy of the notice shall be signed by the applicant and retained by the insurer.
- (c) The notice, as identified in this subsection shall be provided prior to issuance or delivery of the individual long-term care insurance policy.
- (4) Direct response solicitations. An insurer which uses direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant:
 - (a) If it is determined that a sale will involve a replacement; and
 - (b) As established in the HIPMC-LTC-9.
- (5)
 - (a) If replacement is intended, the replacing insurer shall provide written notification to the existing insurer of the proposed replacement.
 - (b) The existing policy shall be identified by the:
 - 1. Insurer;
 - 2. Name of the insured; and
 - 3.
 - a. Insured's policy number; or
 - b. Insured's address, including ZIP code.
 - (c) The notice shall be delivered within five (5) business days of the date the application is received by the insurer or the date the policy is issued, whichever is sooner.
- (6)
 - (a) A life insurance policy which accelerates benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy.
 - (b) If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of KRS 304.12-030 and 806 KAR 12:080.
 - (c) If a life insurance policy which accelerates benefits for long-term care is replaced by another life insurance policy which accelerates benefits for long-term care, the replacing insurer shall comply with the:
 - 1. Long-term care replacement requirements as identified in paragraph (a) of this subsection; and
 - 2. Life insurance replacement requirements as identified in paragraph (b) of this subsection.

Section 12. Reporting Requirements.

- (1) For each agent, an insurer shall maintain records, including an agent's amount of:
 - (a) Replacement sales as a percent of the agent's total annual sales; and
 - (b) Lapses of long-term care insurance policies sold as a percent of the agent's total annual sales.
- (2) An insurer shall use the HIPMC-LTC-11 to report to the department annually by June 30 the ten (10) percent of the insurer's agents with the greatest percentages of lapses and replacements based upon information identified in subsection (1) of this section.
- (3) Reported replacement and lapse rates shall not alone constitute a violation of the Kentucky insurance code or necessarily imply wrongdoing. The reports, as referenced in subsections (1) and (2) of this section, shall be used by the department to conduct a comprehensive review of agent activities regarding the sale of long-term care insurance.

(4) An insurer shall report to the department annually by June 30 using HIPMC-LTC-11, the number of:

- (a) Lapsed long-term care insurance policies as a percent of the insurer's total:
 - 1. Annual sales; and
 - 2. Number of long-term care insurance policies in force at the end of the preceding calendar year; and
- (b) Replacement long-term care insurance policies sold as a percent of the insurer's total:
 - 1. Annual sales; and
 - 2. Number of long-term care insurance policies in force as of the preceding calendar year.

(5) For qualified long-term care insurance contracts an insurer shall file a report with the department annually by June 30, containing the number of claims denied for each class of business, expressed as a percentage of claims denied, using the HIPMC-LTC-4.

(6) Reports required in this section shall include information on a statewide basis.

Section 13. Licensing. An agent shall not be authorized to market, sell, solicit, or negotiate with respect to long-term care insurance except as authorized by KRS 304.9-080(1).

Section 14. Discretionary Powers of Commissioner. Upon written request and after an administrative hearing pursuant to KRS 304.2-310, the commissioner may issue an order to modify or suspend an identified provision of this administrative regulation regarding a long-term care insurance policy or certificate upon a written finding that:

- (1) The modification or suspension is in the best interest of the insureds;
- (2) The purposes to be achieved may not be effectively or efficiently achieved without the modification or suspension; and
- (3)
 - (a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;
 - (b)
 - 1. The policy or certificate is issued to residents of:
 - a. A life care or continuing care retirement community; or
 - b. A residential community for the elderly other than a life care or continuing care retirement community; and
 - 2. The modification or suspension is reasonably related to the special needs or nature of the community as identified in subparagraph 1 of this paragraph; or
 - (c) The modification or suspension is necessary to permit long-term care insurance to be sold as part of or in conjunction with, another insurance product.

Section 15. Reserve Standards.

- (1)
 - (a) If long-term care benefits are provided through the acceleration of benefits under a group or individual life insurance policy or rider to a group or individual life insurance policy, policy reserves for these benefits shall be determined in accordance with KRS 304.6-130 to 304.6-180.
 - (b) If the policy or rider is in claim status, claim reserves shall be established.
 - (c) Except for voluntary termination rates or as established in paragraph (d) of this subsection, reserves for a policy or rider subject to the requirements of this subsection shall be based on:
 - 1. The multiple decrement model utilizing relevant decrements; or
 - 2. Single decrement approximations, if the:
 - a. Calculation produces essentially similar reserves;
 - b. Reserve is clearly more conservative; or

- c. Reserve is immaterial.
- (d) Calculations may consider the reduction in life insurance benefits due to the payment of long-term care benefits, except the reserves for the long-term care benefit and the life insurance benefit shall not be less than the reserves for the life insurance benefit assuming no long-term care benefit.
- (e) In the development and calculation of reserves for a policy and rider subject to the requirements of this subsection, consideration shall be given to the applicable policy provisions, marketing methods, administrative procedures, and other considerations which have an impact on projected claim costs, including:
 - 1. Definition of insured events;
 - 2. Covered long-term care facilities;
 - 3. Existence of home convalescence care coverage;
 - 4. Definition of facilities;
 - 5. Existence or absence of barriers to eligibility;
 - 6. Premium waiver provision;
 - 7. Renewability;
 - 8. Ability to raise premiums;
 - 9. Marketing method;
 - 10. Underwriting procedures;
 - 11. Claims adjustment procedures;
 - 12. Waiting period;
 - 13. Maximum benefit;
 - 14. Availability of eligible facilities;
 - 15. Margins in claim costs;
 - 16. Optional nature of benefit;
 - 17. Delay in eligibility for benefit;
 - 18. Inflation protection provisions; and
 - 19. Guaranteed insurability option.
- (f) An applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.
- (2) If long-term care benefits are not provided through the acceleration of benefits under a group or individual life policy or rider to this policy, reserves shall be determined in accordance with KRS 304.6-070.

Section 16. Loss Ratio.

- (1) Except for a policy or certificate that is subject to Sections 7 and 17 of this administrative regulation, a long-term care insurance policy or certificate shall comply with this section.
- (2)
 - (a) Benefits under a long-term care insurance policy shall be deemed reasonable in relation to premiums if the expected loss ratio is:
 - 1. At least sixty (60) percent; and
 - 2. Calculated in a manner for adequate reserving of the long-term care insurance risk.
 - (b) In evaluating the expected loss ratio, consideration shall be given to relevant factors, including:
 - 1. Statistical credibility of incurred claims experience and earned premiums;
 - 2. The period for which rates are computed to provide coverage;
 - 3. Experienced and projected trends;
 - 4. Concentration of experience within early policy duration;
 - 5. Expected claim fluctuation;
 - 6. Experience refunds, adjustments, or dividends;

7. Renewability features;
8. Expense factors, as appropriate;
9. Interest;
10. Experimental nature of the coverage;
11. Policy reserves;
12. Mix of business by risk classification; and
13. Product features including:
 - a. Long elimination periods;
 - b. High deductibles; and
 - c. High maximum limits.

(3) Subsection (2) of this section shall not apply to a life insurance policy which accelerates benefits for long-term care.

(4) A life insurance policy which funds long-term care benefits entirely by accelerating the death benefit shall be considered to provide reasonable benefits in relation to premiums paid, if the policy complies with the following:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed to be no less than the minimum guaranteed interest rate for cash value accumulations without long-term care as identified in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of KRS 304.15-310;

(c) The policy meets the following disclosure requirements:

1. If an application for a long-term care insurance contract or certificate is approved, the insurer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval;

2. When the policy is delivered, a policy summary shall be delivered in accordance with KRS 304.14-615(9);

3. If the long-term care inflation protection option required by Section 10(1) of this administrative regulation is not available, the policy summary shall state that long-term care inflation protection option required by Section 10(1) of this administrative regulation is not available under the policy;

4. The policy summary required by subparagraph 2 of this paragraph may be incorporated into a basic illustration that meets the requirements of 806 KAR 12:140, Sections 8 and 9; and

5. If a long-term care benefit, funded through a life insurance product by the acceleration of the death benefit, is in the benefit payment status, a monthly report shall be provided in accordance with KRS 304.14-615(10);

(d) Any policy illustration meets the applicable requirements of 806 KAR 12:140, Section 3; and

(e) An actuarial memorandum is filed with the department, which includes:

1. A description of the basis on which the long-term care rates were determined;

2. A description of the basis for the reserves;

3. A summary of the:

a. Type of policy;

b. Benefits;

c. Renewability;

d. General marketing method; and

e. Limits on ages of issuance;

4.

a. A description and a table of each actuarial assumption used; and

b. For expenses, shall include the percent of premium dollars per policy and dollars per unit of benefits, if any;

5. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
6. The estimated average annual premium per policy and the average issue age;
7.
 - a. A statement that:
 - (i) Indicates if underwriting is performed upon application; and
 - (ii) If underwriting is used, includes a description of the type of underwriting used, including medical underwriting or functional assessment underwriting; and
 - b. If related to a group policy, the statement as established in clause a of this paragraph shall indicate:
 - (i) If the enrollee or a dependent shall be underwritten; and
 - (ii) When underwriting shall occur; and
8. For active lives and insureds in long-term care status, a description of the long-term care policy provision on:
 - a. Required premiums;
 - b. Nonforfeiture values; and
 - c. Reserves on the underlying life insurance policy.

Section 17. Premium Rate Schedule Increases.

- (1)
 - (a) Except as required in paragraph (b) of this subsection, this section shall apply to a long-term care policy or certificate issued in Kentucky beginning January 15, 2003.
 - (b) For a certificate issued on or after the effective date of this administrative regulation under a group long-term care insurance policy in force on July 15, 2002, the provisions of this section shall apply on the policy anniversary following July 15, 2003.
- (2) An insurer shall provide a notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least thirty (30) days prior to the notice issued to policyholders, which shall include:
 - (a) Information required by Section 6 of this administrative regulation;
 - (b) Certification by a qualified actuary that:
 1. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and
 2. The premium rate filing is in compliance with the provisions of this section;
 - (c) An actuarial memorandum justifying the rate schedule change request which includes:
 1. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
 - a. Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
 - b. Unless the rate increase is an exceptional increase, the projections shall include the development of the lifetime loss ratio;
 - c. The projections shall demonstrate compliance with subsection (3) of this section; and
 - d. For exceptional increases:
 - (i) The projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

- (ii) If the commissioner makes a determination as required in subsection (12) (b) of this section that offsets may exist, the insurer shall use appropriate net projected experience;
- 2. If the rate increase triggers the contingent benefit upon lapse, disclosure of how reserves have been incorporated in this rate increase;
- 3. Disclosure of the analysis performed to determine:
 - a. Why a rate adjustment is necessary;
 - b. Which pricing assumptions were not realized and why; and
 - c. What actions taken by the company have been relied on by the actuary;
- 4. A statement that consideration was given to:
 - a. Policy design;
 - b. Underwriting; and
 - c. Claims adjudication practices; and
- 5. If necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates;
- (d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and
- (e) Sufficient information for review and approval of the premium rate schedule increase by the commissioner.
- (3) Premium rate schedule increases shall be determined in accordance with the following requirements:
 - (a) Exceptional increases shall provide that seventy (70) percent of the present value of projected additional premiums from the exceptional increase shall be returned to policyholders in benefits;
 - (b) Premium rate schedule increases shall be calculated in a manner that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, shall not be less than the sum of the following:
 - 1. The accumulated value of the initial earned premium multiplied by fifty-eight (58) percent;
 - 2. Eighty-five (85) percent of the accumulated value of prior premium rate schedule increases on an earned basis;
 - 3. The present value of future projected initial earned premiums multiplied by fifty-eight (58) percent; and
 - 4. Eighty-five (85) percent of the present value of future projected premiums not included in subparagraph 3 of this paragraph on an earned basis;
 - (c) If a policy form has exceptional and other increases, the values in paragraph (b)2 and 4 of this subsection shall also include seventy (70) percent for exceptional rate increase amounts; and
 - (d)
 - 1. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as required by 806 KAR 6:080, Section 1(3)(a); and
 - 2. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- (4) For each rate increase implemented, an insurer shall file for review by the commissioner updated projections, as identified in subsection (2)(c)1 of this section, annually for the next three (3) years, which shall include a comparison of actual results to projected values.

- (a) If actual results are not consistent with projected values from prior projections, the commissioner may extend the period to greater than three (3) years.
 - (b) For group insurance policies that meet the conditions in subsection (11) of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- (5)
- (a) If a premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as established in subsection (2)(c)1 of this section, shall be filed for review by the commissioner every five (5) years following the end of the required period identified in subsection (4) of this section.
 - (b) For group insurance policies that meet the conditions in subsection (11) of this section, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
- (6)
- (a) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (3) of this section, the commissioner may require the insurer to implement any of the following:
 - 1. Premium rate schedule adjustments; or
 - 2. Measures other than premium rate schedule adjustments to reduce the difference between the projected and actual experience.
 - (b) In determining if the actual experience adequately matches the projected experience, consideration shall be given to subsection (2)(c)5 of this section, if applicable.
- (7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse:
- (a) The insurer shall file:
 - 1. The original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to subsection (3) of this section had the greater of the original anticipated lifetime loss ratio or fifty-eight (58) percent been used in the calculations described in subsection (3)(b)1 and 3 of this section; and
 - 2.
 - a. A plan, subject to commissioner's approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both; or
 - b. Documentation, which demonstrates that appropriate administration and claims processing have been implemented or are in effect; or
 - (b) If an insurer does not comply with paragraph (a)2 of this subsection, the commissioner may impose the condition identified in subsection (8) of this section.
- (8)
- (a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapse rates have occurred or are anticipated:
 - 1. The rate increase is not the first rate increase requested for the specific policy form or forms;
 - 2. The rate increase is not an exceptional increase; and
 - 3. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapse rates have occurred, are anticipated in the filing, or are evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists.

(c) Following a determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to insureds subject to the rate increase the option to replace existing coverage with one (1) or more comparable products offered by the insurer or an affiliate of the insurer.

1. The offer shall:

- a. Be subject to the approval of the commissioner;
- b. Be based on actuarially sound principles;
- c. Not be based on attained age; and
- d. Provide maximum benefits under a new policy, which shall be:
 - (i) Accepted by an insured; and
 - (ii) Reduced by comparable benefits already paid under the existing policy.

2.

- a. The insurer shall maintain the experience of all replacement insureds separate from the experience of insured's originally issued the policy forms.
- b. If a rate increase on the policy form is requested, the rate increase shall be limited to the lesser of:
 - (i) The maximum rate increase which was determined on the basis of the combined experience; and
 - (ii) The maximum rate increase which was determined on the basis of the experience of the insured's originally issued the form plus ten (10) percent.

(9) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may impose the provisions of subsection (8) of this section and prohibit the insurer from:

- (a) Filing and marketing comparable coverage for a period of up to five (5) years; or
- (b) Offering all other similar coverage's and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(10) Subsections (1) through (9) of this section shall not apply to a policy for which the long-term care benefits provided by the policy are incidental, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed to be no less than the minimum guaranteed interest rate for cash value accumulations without long-term care as identified in the policy;

(b) The portion of the policy which provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements, as applicable, in any of the following:

1. KRS 304.15-310;
2. KRS 304.15-315;
3. 806 KAR 15:010; or
4. 806 KAR 15:030;

(c) The policy meets the disclosure requirements of Section 16(4)(c) of this administrative regulation;

(d) The portion of the policy, which provides insurance benefits other than long-term care coverage meets the requirements, as applicable, in the following:

1. Policy illustrations as required in 806 KAR 12:140; and
2. Disclosure requirements as required in 806 KAR 15:010 and 15:030; and

(e) An actuarial memorandum is filed with the department, which includes:

1. A description of the basis for determination of the long-term care rates;

2. A description of the basis for the reserves;
 3. A summary of the:
 - a. Type of policy;
 - b. Benefits;
 - c. Renewability;
 - d. Marketing method; and
 - e. Limits on ages of issuance;
 4. A description and table of each actuarial assumption used, including expenses, for which an insurer shall include:
 - a. Percent of premium dollars per policy; and
 - b. Dollars per unit of benefits, if any;
 5. A description and table of the:
 - a. Anticipated policy reserves for active lives; and
 - b. Additional reserves to be held in each future year for active lives;
 6.
 - a. The estimated average annual premium per policy; and
 - b. The average issue age;
 7. A statement regarding the performance or nonperformance of underwriting at application.
 - a. The statement shall:
 - (i) Indicate whether underwriting is used; and
 - (ii) If underwriting is used, include a description of the type of underwriting used, including medical underwriting or functional assessment underwriting; and
 - b. If the statement relates to a group policy, the statement shall indicate:
 - (i) If the enrollee or dependent will be underwritten; and
 - (ii) When underwriting will occur; and
 8. A description of the effect of the long-term care policy provision on the:
 - a. Required premiums;
 - b. Nonforfeiture values; and
 - c. For active lives and for insured's in long-term care claim status, reserves on the underlying insurance policy.
- (11) Subsections (6) and (8) of this section shall not apply to insurance policies issued to a group identified in KRS 304.14-600(5)(a) if the:
- (a)
 1. Policies insure 250 or more persons; and
 2. Policyholder has 5,000 or more eligible employees of a single employer; or
 - (b) The policyholder, and not the certificate holder, pays a material portion of the premium, which shall not be less than twenty (20) percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.
- (12) For an exceptional increase, the commissioner:
- (a) May request a review of the basis for a request that an increase be considered an exceptional increase by:
 1. An independent actuary; or
 2. A professional actuarial body; and
 - (b) In determining that the necessary basis for an exceptional increase exists, shall determine any potential offsets to higher claim costs.
- (13) Except as required in this section, an exceptional increase shall be subject to the same requirements as any premium rate schedule increase.

Section 18. Filing Requirement for a Group Policy Issued in Another State. Prior to offering group long-term care insurance issued in another state to a resident of Kentucky pursuant to

KRS 304.14-610, an insurer shall file with the commissioner evidence that the group policy or certificate issued under the group policy has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to requirements in Kentucky.

Section 19. Filing Requirements for Advertising.

- (1) An insurer providing long-term care insurance or benefits in Kentucky shall provide a copy of a long-term care insurance advertisement intended for use in Kentucky whether through written, radio, or television medium to the commissioner for review in accordance with this administrative regulation and KRS 304.12-020, 304.14-120, 304.14-620, and 806 KAR 12:010, 806 KAR 14:005, 806 KAR 14:007, Section 5(2);
- (2) An advertisement shall be retained by the insurer for at least five (5) years from the date the advertisement was first used.
- (3) The commissioner may exempt advertising from the requirements of this section pursuant to KRS 304.14-120(4).

Section 20. Standards for Marketing.

- (1) An insurer marketing long-term care insurance coverage in Kentucky, directly or through its agents, shall:
 - (a) Establish marketing procedures and agent training requirements to assure that:
 1. Marketing activities, including a comparison of policies, by its agent, shall be fair and accurate; and
 2. Excessive insurance shall not be sold or issued.
 - (b) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy, the notice as established in HIPMC-LTC-10.
 - (c) Provide to the applicant a copy of each disclosure form required in Section 6(5) and (6) of this administrative regulation.
 - (d) Inquire and make every reasonable effort to identify:
 1. If a prospective applicant or enrollee for long-term care insurance has accident and sickness or long-term care insurance; and
 2. The type and amount of insurance identified in subparagraph 1 of this paragraph.
 - (e) For a qualified long-term care insurance contract, not be required to make an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance, in accordance with paragraph (d) of this section.
 - (f) Establish auditable procedures for verifying compliance with the requirements of this subsection.
 - (g) At solicitation, provide:
 1. Written notice to the prospective policyholder and certificate holder that the Kentucky State Health Insurance Assistance Program is available; and
 2. The address and telephone number of the program as identified in subparagraph 1 of this paragraph.
 - (h) For a long-term care insurance policy and certificate, use the terms, noncancellable or level premium, if the policy or certificate conforms to Section 3(1)(c) and (d) of this administrative regulation.
 - (i) Provide an explanation of:
 1. Contingent benefit upon lapse as described in Section 25(6)(c) of this administrative regulation; and
 2. If applicable, the additional contingent benefit upon lapse provided to all policies with fixed or limited premium paying periods as described in Section 25(6)(d).
- (2) An insurer shall:
 - (a) Comply with the requirements of KRS Chapter 304.12; and
 - (b) Not perform the following acts and practices:
 1. Twisting;

2. High pressure tactics;
3. Cold lead advertising; and
4. Misrepresentation.

(3)

(a) To comply with the requirements of this subsection, an association, as defined in KRS 304.14-600(5)(b) shall have the primary responsibility of educating its members concerning long-term care issues in general:

1. If endorsing or selling long-term care insurance; and
2. To ensure that its members make informed decisions.

(b) An association shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by the association to ensure that its members receive a balanced and complete explanation of the features of the policy or certificate that is endorsed or sold.

(c) An insurer shall file with the department the following:

1. An insurance policy and, if applicable, a certificate;
2. An outline of coverage, which corresponds to the filed policy or certificate; and
3. Advertisements as requested by the department pursuant to Section 19(1) of this administrative regulation.

(d) An association shall disclose in a long-term care insurance solicitation:

1. The specific nature and amount of the compensation arrangements, including fees, commissions, administrative fees, and other forms of financial support, which the association receives from endorsement or sale of the policy or certificate to its members; and
2. A brief description of the process used to select the policy and the insurer, which issued the policy.

(e) If an association and insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to the association members.

(f) The board of directors of an association selling or endorsing a long-term care insurance policy or certificate shall review and approve the:

1. Insurance policy; and
2. Compensation arrangements made with the insurer.

(g) Except for a qualified long-term care insurance contract, an association shall:

1. Upon a decision to endorse a long-term care insurance contract, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to:
 - a. Conduct an examination of the policy, including its benefits, features, and rates; and
 - b. Update the examination, if a material change is made to the contract;
2. Actively monitor the marketing efforts of the insurer and its agents; and
3. Review and approve:
 - a. Marketing materials; or
 - b. Insurance communications other than marketing materials, including communications:
 - (i) Used to promote sales; or
 - (ii) Sent to members regarding the policy or certificate.

(h) A group long-term care insurance policy or certificate shall not be issued to an association unless the insurer files with the commissioner the information required in this subsection.

(i) Unless an insurer certifies annually that an association has complied with the requirements established in this subsection, an insurer shall not:

1. Issue a long-term care policy or certificate to the association; or
2. Continue to market the policy or certificate.

(j) Failure to comply with the filing and certification requirements of this section shall constitute an unfair trade practice in violation of KRS 304.12-010.

Section 21. Suitability.

- (1) This section shall not apply to life insurance policies that accelerate benefits for long-term care.
- (2) An insurer marketing long-term care insurance shall:
 - (a) Develop and use suitability standards to determine if the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
 - (b) Train an agent to use the suitability standards identified in paragraph (a) of this subsection; and
 - (c) Maintain a copy of the suitability standards, which shall be available for inspection upon request by the commissioner.
- (3)
 - (a) To determine if an applicant meets the suitability standards developed by the insurer, the agent and insurer shall develop a procedure, which considers the:
 1. Applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 2. Applicant's goals or needs with respect to:
 - a. Long-term care; and
 - b. Advantages and disadvantages of insurance to meet the applicant's goals or needs; and
 3. Values, benefits, and costs of the applicant's existing insurance, if any, as compared to the values, benefits, and costs of the recommended purchase or replacement.
 - (b) The insurer and, if an agent is involved, the agent, shall make a reasonable effort to obtain the information identified in paragraph (a) of this subsection using the HIPMC-LTC-1 Long-term Care Insurance Personal Work Sheet, which shall:
 1. Be presented to the applicant at or prior to application;
 2. Include not less than the information identified in the format of the HIPMC-LTC-1;
 3. Be provided in no less than twelve (12) point type; and
 4. Be filed with the commissioner.
 - (c) The insurer may request additional information from the applicant to comply with its suitability standards.
 - (d) Except for a Long-term Care Personal Work Sheet completed for the sale of employer group long-term care insurance to employees and spouses of employees, a Long-term Care Personal Work Sheet shall be completed and returned to the insurer prior to the insurer's consideration of the applicant for coverage.
 - (e) An insurer or agent shall not sell or disseminate information obtained from a Long-term Care Personal Work Sheet outside the company or agency.
- (4) An insurer shall use the suitability standards as identified in subsection(2) of this section to determine if the issuance of long-term care insurance coverage is appropriate for an applicant.
- (5) An agent shall use the suitability standards of an insurer in marketing long-term care insurance.
- (6) When the Long-term Care Personal Work Sheet is provided to the applicant pursuant to subsection (3)(b) of this section, the disclosure form entitled Things You Should Know Before You Buy Long-term Care Insurance, HIPMC-LTC-5 shall be provided in at least twelve (12) point type.
- (7)

- (a) If an insurer determines that the applicant does not meet the financial suitability standards, or if the applicant has declined to provide the information as identified in the Long-term Care Personal Work Sheet, the insurer may reject the application or send to the applicant, a:
 - 1. Long-term Care Suitability Letter, HIPMC-LTC-6; or
 - 2. Letter, which is:
 - a. Similar to the Long-term Care Suitability Letter identified in Subparagraph 1 of this paragraph; and
 - b. Approved by the commissioner.
- (b) If the applicant declined to provide financial information, the insurer may verify the applicant's intent using an alternative method.
- (c) The applicant's returned HIPMC-LTC-6 or a record of the alternative method of verification shall be maintained as part of the applicant's file.
- (8) For the previous calendar year, an insurer shall report annually by June 30 to the commissioner:
 - (a) The total number of applications for long-term care insurance received from Kentucky residents;
 - (b) Of the number reporting in paragraph (a) of this subsection, the number of applicants who:
 - 1. Declined to provide information on the personal worksheet;
 - 2. Did not meet the suitability standards; and
 - 3. Chose to confirm after receiving a suitability letter.

Section 22. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Section 23. Availability of New Services or Providers.

- (1)
 - (a) An insurer shall notify a policyholder of the availability of a new long-term policy product, which provides coverage for new long-term care services or providers material in nature and not previously available to the general public through the insurer.
 - (b) The notice shall be provided within twelve (12) months of the date the new policy product is made available for sale in Kentucky.
- (2) An insurer:
 - (a) Shall not be required to provide the notification identified in subsection (1) of this section:
 - 1. For a policy issued prior to January 1, 2009; or
 - 2. To a policyholder or certificate holder who:
 - a. Is currently eligible for benefits:
 - (i) Within an elimination period; or
 - (ii) On a claim;
 - b. Previously had been in claim status; or
 - c. May not be eligible to apply for coverage due to issue age limitations under the new policy; and
 - (b) To add new services or providers, may require a policyholder to meet eligibility requirements, including:
 - 1. Underwriting; and
 - 2. Payment of the required premium.

- (3) The insurer shall make the new coverage available by:
- (a)
 - 1. Adding a rider to the existing policy; and
 - 2. Charging a separate premium for the new rider based on the insured's attained age;
 - (b)
 - 1. Exchanging the existing policy or certificate for a different policy or certificate with an issue age based on the present age of the insured; and
 - 2. Recognizing past insured status by granting premium credits, which shall be based on premiums paid or reserves held for the prior policy or certificate, toward the premiums for the new policy or certificate;
 - (c) Exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged; or
 - (d) If filed and approved by the commissioner, an alternative program developed by the insurer, which meets the intent of this section.
- (4) The cost of a new policy or certificate, as identified in subsection (3)(c) of this section, may recognize the difference in reserves between the:
- (a) New policy or certificate; and
 - (b) Original policy or certificate.
- (5) An insurer shall:
- (a) Not be required to notify a policyholder of a new proprietary policy product, created and filed for use in a limited distribution channel; and
 - (b) Notify a policyholder of a new proprietary policy product if a new long-term care product, which provides coverage for new long-term care services or providers material in nature, is made available to that limited distribution channel.
- (6)
- (a) A policy issued pursuant to this section shall:
 - 1. Be considered an exchange; and
 - 2. Not be considered a replacement.
 - (b) An exchange as identified in paragraph (a) of this subsection shall not be subject to:
 - 1. Requirements of Sections 11 and 21 of this administrative regulation; and
 - 2. Reporting requirements of Section 12(1) through (4) of this administrative regulation.
- (7) If the policy is:
- (a) Offered through an employer, labor organization, professional, trade or occupational association, the notification required in subsection (1) of this section shall be issued to the offering entity; or
 - (b) Issued to a group identified in KRS 304.14-600(5)(d), the notification required in Subsection (1) of this Section shall be issued to each certificate holder.
- (8)
- (a) Pursuant to this section, an insurer may offer a policy, rider, certificate or coverage change to a policyholder or certificate holder.
 - (b) Upon request, a policyholder may apply for currently available coverage, which includes a new service or provider.
 - (c) To add a new service or provider, an insurer may require a policyholder to meet eligibility requirements, including:
 - 1. Underwriting; and
 - 2. Payment of the required premium.
- (9) A life insurance policy or rider, which includes accelerated long-term care benefits, shall not be subject to the requirements of this section.

Section 24. Right to Reduce Coverage and Lower Premiums.

- (1)
 - (a) A long-term care insurance policy and certificate shall include a provision, which allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one (1) of the following ways:
 1. Reducing the maximum benefit; or
 2. Reducing the daily, weekly or monthly benefit amount.
 - (b) An insurer may offer a reduction option not identified in paragraph (a) of this subsection, which is consistent with the:
 1. Policy or certificate design; or
 2. The insurer's administrative processes.
- (2) The provision, identified in subsection (1) of this section, shall include:
 - (a) A description of the ways in which coverage may be reduced; and
 - (b) The process for requesting and implementing a reduction in coverage.
- (3) The age used to determine a premium for the reduced coverage shall be based on the age used to determine a premium for the current coverage.
- (4) An insurer may limit a reduction in coverage to a plan or option:
 - (a) Available for that policy form; and
 - (b) For which benefits shall be available after consideration of claims paid or payable.
- (5) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificate holder of the right to reduce coverage and premiums in the notice required by section 4(1)(c) of this administrative regulation.
- (6) A life insurance policy or rider, which includes accelerated long-term care benefits shall not be subject to the requirements of this Section.
- (7) The requirements of this section shall apply to a long-term care policy issued in Kentucky on or after January 1, 2010.

Section 25. Nonforfeiture Benefit Requirement.

- (1) A life insurance policy or rider, which includes accelerated long-term care benefits shall not be subject to the requirements of this section.
- (2) Except as required in subsection (3) of this section, a long-term care insurance policy shall not be delivered or issued for delivery unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit.
 - (a) The offer of a nonforfeiture benefit may be in the form of a rider, which is attached to the policy.
 - (b) If a policyholder or certificate holder declines the nonforfeiture benefit identified in paragraph (a) of this subsection, the insurer shall provide a contingent benefit upon lapse, which shall be available for 120 days, following a substantial increase in premium rate, as established in subsection (6) of this section.
- (3) If a group long-term care insurance policy is issued:
 - (a) The offer required in subsection (2) of this section shall be made to the group policyholder; or
 - (b) As group long-term care insurance as defined in KRS 304.14-600(5)(d), other than to a continuing care retirement community or other similar entity, the offer shall be made to each proposed certificate holder.
- (4) A nonforfeiture benefit offer as identified in subsection (2) of this section shall:
 - (a) Include coverage elements, eligibility, benefit triggers, and benefit length, which are identical to coverage issued without nonforfeiture benefits;
 - (b) Be the benefit described in subsection (7) of this section; and
 - (c) Be in writing if the nonforfeiture benefit is not described in:
 1. The Outline of Coverage required under KRS 304.14-615(7); or

2. Materials other than the Outline of Coverage, which are given to the prospective policyholder.
- (5) If the offer required under subsection (2) of this section is:
- (a) Rejected, the insurer shall provide the contingent benefit upon lapse described in this section; or
 - (b) Accepted for a policy with a fixed or limited premium paying period, the contingent benefit upon lapse in subsection (6)(d) of this section shall apply.
- (6)
- (a) After rejection of the offer required under subsection (2) of this section, the insurer shall provide a contingent benefit upon lapse for a policy issued after July 15, 2002, including:
 - 1. An individual policy without a nonforfeiture benefit; and
 - 2. A group policy without a nonforfeiture benefit.
 - (b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
 - (c)
 - 1. A contingent benefit upon lapse shall be triggered as identified in the following table if:
 - a. An insurer increases the premium rates to a level, which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as established in this paragraph based on the insured's issue age; and
 - b. The policy or certificate lapses within 120 days of the due date of the increased premium:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%

70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

2. Unless required by Section 6(7) of this administrative regulation, a policyholder shall be notified at least thirty (30) days prior to the due date of a premium reflecting the rate increase, as identified in this paragraph.

(d)

1. A contingent benefit upon lapse shall be triggered for a policy, which includes a fixed or limited premium paying period, as identified in the following table, if:

- a. An insurer increases the premium rates to a level, which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as established in this paragraph based on the insured's issue age;
- b. The policy or certificate lapses within 120 days of the due date of the premium, which increased; and
- c. The ratio in paragraph (f)2 of this subsection is forty (40) percent or more:

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. Unless an insurer provides notice as established in Section 6(7) of this administrative regulation, a policyholder shall be notified at least thirty (30) days

prior to the due date of the premium reflecting a rate increase by the insurer.

3.

a. An insurer shall be subject to this paragraph and the contingent benefit upon lapse provision of paragraph (c) of this subsection; and

b. If a trigger as identified in paragraph (c) of this subsection and a trigger as identified in this paragraph are identified, the benefit provided shall be at the option of the insured.

(e) On or before the effective date of a substantial premium increase as established in paragraph (c) of this subsection, an insurer shall:

1. Offer to reduce policy benefits provided by the current coverage without requiring additional underwriting to prevent an increase in required premium payments;

2.

a. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (7) of this section; and

b. Allow this option to be elected by the policyholder or certificate holder within the 120-day period identified in paragraph (c) of this subsection; and

3. Notify the policyholder or certificate holder that a default or lapse, which occurs within the 120-day period identified in paragraph (c) of this subsection shall be deemed to be an election of the offer to convert as identified in subparagraph 2 of this paragraph unless the automatic option in paragraph (f)3 applies.

(f) On or before the effective date of a substantial premium increase as identified in paragraph (d) of this subsection, the insurer shall:

1. Offer to reduce policy benefits provided by the current coverage without requiring additional underwriting in order that required premium payments are not increased;

2.

a. Offer to convert the coverage to a paid-up status if the amount payable for each benefit is ninety (90) percent of the payable amount, which was in effect immediately prior to lapse, multiplied by the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period; and

b. Allow this option to be elected within the 120-day period identified in paragraph (d) of this subsection; and

3. Notify the policyholder or certificate holder that a default or lapse, which occurs within the 120-day period identified in paragraph (d) of this subsection shall be deemed to be an election of the offer to convert in subparagraph 2 of this paragraph if the ratio is forty (40) percent or more.

(7) A benefit continued as a nonforfeiture benefit, including a contingent benefit upon lapse in accordance with subsection (6)(c) of this section, shall be provided as follows:

(a)

1. Pursuant to this subsection, a nonforfeiture benefit shall include a shortened benefit period, which provides paid-up long-term care insurance coverage after lapse.

2. The same benefit, including amount and frequency, in effect at lapse and not be increased in the future, shall be payable for a qualifying claim, except the lifetime maximum dollars or days of benefits shall be determined as established in paragraph (b) of this subsection.

(b)

1. A standard nonforfeiture credit shall be equal to 100 percent of the sum of premiums paid, including the premiums paid prior to a change in benefits.

2. An insurer may offer an additional shortened benefit period option, if the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration.

3. The minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit upon lapse.

4. The calculation of a nonforfeiture credit shall be subject to the limitation of subsection (8) of this section.

(c)

1.

a. Except for a policy or certificate with attained age rating, a nonforfeiture benefit shall begin no later than the final day of the third year following the policy or certificate issue date.

b. A contingent benefit upon lapse shall be effective on the date of policy or certificate issue.

2. For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of the end of the:

a. Tenth year following the policy or certificate issue date; or

b. Second year following the date the policy or certificate is no longer subject to attained age rating.

(d) A nonforfeiture credit may be used up to the limit identified in the policy or certificate for care and services qualifying for benefits under the terms of the policy or certificate.

(8) Benefits paid by an insurer when the policy or certificate is in premium paying status and paid up status shall not exceed the maximum benefits, which would be payable if the policy or certificate had remained in premium paying status.

(9) For a group and individual policy, an insurer shall provide the minimum nonforfeiture benefit as required under this section.

(10)

(a) Except as provided in subsection (6) and paragraph (b) and (c) of this subsection, the requirements of this section shall apply to a long-term care policy issued in Kentucky on or after July 15, 2003.

(b) The requirements of this section shall not apply to a certificate issued on or after July 15, 2003 under a group long-term care insurance policy, as identified in KRS 304.14-600(5)(a), which was in force before July 15, 2003.

(c) Except for a new certificate under a group policy, as identified in KRS 304.14-600(5)(a), issued on July 16, 2003, the requirements of subsections (5)(b) and (6)(d) and (f) of this section shall apply to a long-term care insurance policy or certificate issued on and after January 16, 2003.

(11) A premium charged for a policy or certificate, which contains a nonforfeiture benefit or a contingent benefit upon lapse shall be subject to the loss ratio requirements established in Section 16 or 17 of this administrative regulation, as applicable, treating the policy as a whole.

(12) To determine if a contingent benefit upon lapse provision as identified in subsection (6)(c) or (d) of this section is triggered, a replacing insurer, which purchased or assumed a block of long-term care insurance policies from an insurer, shall calculate the percent increase based on the initial annual premium paid by the insured on the date the policy was purchased from the original insurer.

(13) For a qualified long-term care insurance contract, which is a level premium contract, the nonforfeiture benefit offered by an insurer shall:

(a) Be appropriately captioned;

(b) Indicate that the nonforfeiture benefit is available if a default in the premium payment occurs;

(c) State that the amount of the benefit may be adjusted subsequent to being initially granted, as necessary, to reflect a change in claims, persistency, and interest as

reflected in a change in a rate for a premium paying contract approved by the commissioner for the identical contract form; and

(d) Provide at least one (1) of the following:

1. Reduced paid up insurance;
2. Extended term insurance;
3. Shortened benefit period; or
4. An offering, which is:
 - a. Similar to an offering as identified in subparagraphs 1, 2, or 3 of this paragraph; and
 - b. Approved by the commissioner.

Section 26. Standards for Benefit Triggers.

(1) A long-term care insurance policy shall condition the payment of benefits based upon a determination of the insured's:

- (a) Ability to perform activities of daily living; and
- (b) Cognitive impairment.

(2) Eligibility for the payment of benefits shall not be more restrictive than requiring:

- (a) A deficiency in the ability to perform no more than three (3) activities of daily living; or
- (b) The presence of cognitive impairment.

(3)

(a) Activities of daily living shall include no less than the activities defined in Section 2(1) of this administrative regulation and the policy; and

(b) To trigger covered benefits, an insurer may use activities of daily living, which are:

1. Described in paragraph (a) of this subsection; and
2. In addition to activities identified in paragraph (a) if defined in the policy.

(4)

(a) An insurer may use a provision other than activities of daily living as identified in subsection (3) of this section to determine the date benefits are payable under a policy or certificate; and

(b) If a provision as established in paragraph (a) of this subsection is used by the insurer, the provision shall not:

1. Restrict the requirements identified in subsections (1), (2), and (3) of this section; and
2. Be used in lieu of the requirements of subsections (1), (2), and (3) of this section.

(5) A determination of a deficiency, as identified in this section, shall not be more restrictive than:

(a) Requiring the hands on assistance of another person to perform the prescribed activities of daily living as identified in subsection (3) of this section; or

(b) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

(6) An assessment of an insured's activities of daily living and cognitive impairment shall be performed by a licensed or certified professional, including a:

- (a) Physician;
- (b) Nurse; or
- (c) Social worker.

(7) A long-term care insurance policy shall include a clear description of the process for an appeal and resolution of a benefit determination.

(8) The requirements identified in this section:

(a) Except as provided in paragraph (b) of this subsection, shall apply to a long-term care policy issued in Kentucky on or after July 15, 2002; and

(b) Shall not apply to a certificate under a group long-term care insurance policy, as identified in KRS 304.14-600(5)(a), which was in force before July 15, 2003.

Section 27. Additional Standards for Benefit Triggers for Qualified Long-term Care Insurance Contracts.

- (1) A qualified long-term care insurance contract shall pay for a qualified long-term care service received by a chronically-ill individual if the service is provided in accordance with a plan of care prescribed by a licensed health care practitioner.
- (2) A qualified long-term care insurance contract shall condition the payment of benefits on a certified determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to:
 - (a) A loss of functional capacity; or
 - (b) Severe cognitive impairment.
- (3) A certification as required pursuant to subsection (2) of this section:
 - (a) Shall be performed by a licensed or certified professional, including a licensed health care practitioner; and
 - (b) May be performed at the direction of an insurer, if the certification is reasonably necessary to determine payment for a specific claim.
- (4) If a licensed health care practitioner certified that an insured is unable to perform activities of daily living for an expected period of time of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status:
 - (a) The certification performed pursuant to subsection (3)(b) of this section shall not be rescinded; and
 - (b) An additional certification shall not be performed until the ninety (90) day period has expired.
- (5) A qualified long-term care insurance contract shall include a clear description of the process for the appeal and resolution of a dispute regarding a benefit determination.

Section 28. Standard Format and Content of an Outline of Coverage. Pursuant to the requirements of KRS 304.14-615(7):

- (1) An outline of coverage shall:
 - (a) Be a freestanding document, which is printed in no less than ten (10) point type; and
 - (b) Not contain material of an advertising nature.
- (2) Text, which is capitalized or underscored in the standard format outline of coverage, may be emphasized by using a method, which provides prominence equivalent to the:
 - (a) Capitalization; or
 - (b) Underscoring.
- (3) Except as indicated, use of the text and sequence of text shall be:
 - (a) Mandatory; and
 - (b) Consistent with the Outline of Coverage, HIPMC-LTC-7.
- (4) The format to be used for the outline of coverage shall be Consistent with the Outline of Coverage, HIPMC-LTC-7.

Section 29. Requirement to Deliver Shopper's Guide.

- (1) A long-term care insurance shopper's guide developed by the National Association of Insurance Commissioners, which is available at www.naic.org, or a guide developed or approved by the commissioner, shall be provided to a prospective applicant of a long-term care insurance policy or certificate.
 - (a) For agent solicitation, an agent shall deliver the shopper's guide prior to the presentation of an application or enrollment form.
 - (b) For direct response solicitation, an insurer shall deliver the shopper's guide in conjunction with an application or enrollment form.

(2) An insurer offering a life insurance policy or rider, which includes accelerated long-term care benefits shall:

- (a) Not be required to provide a shopper's guide as identified in subsection (1) of this section; and
- (b) Provide a policy summary, including a:
 - 1. Statement, which establishes that a long-term care inflation protection option as identified in Section 10 of this administrative regulation is not available under the policy; and
 - 2. Items as identified and required under KRS 304.14-615(9).

Section 30. Penalties. An insurer or agent, who is identified as violating a requirement of Kentucky Insurance Code relating to the regulation or marketing of long-term care insurance shall be subject to the greater of:

- (1) A fine of up to three (3) times the amount of a commission paid for each policy involved in the violation or up to \$10,000; or
- (2) A penalty as identified in KRS Chapter 304, subtitles 3, 9, 12, 14, 17, and 99, and this administrative regulation.

Section 31. Permitted Compensation Arrangements.

- (1) Upon replacement the replacing insurer shall not provide compensation to its agents or other producers greater than 200 percent of the renewal compensation payable by the replacing insurer on renewal policies.
- (2) A commission or other compensation provided in subsequent renewal years by the replacing insurer shall be:
 - (a) The same as that provided in the second year or period; and
 - (b) Provided for a reasonable number of renewal years.
- (3) If long-term care insurance is provided under annuities or life insurance policies or riders, the requirements of this section shall apply only to the commissions or other compensation attributable to the long-term care insurance provided by these policies or riders.

Section 32. Incorporated by Reference.

- (1) The following material is incorporated by reference:
 - (a) "Long-term Care Insurance Personal Worksheet, HIPMC-LTC-1", 09/2008;
 - (b) "Long-term Care Insurance Potential Rate Increase Disclosure Form, HIPMC-LTC-2", 09/2008;
 - (c) "Rescission Reporting Form for Long-term Care Policies, HIPMC-LTC-3", 09/2008;
 - (d) "Claims Denial Reporting Form for Long-term Care Insurance, HIPMC-LTC-4", 09/01;
 - (e) "Things You Should Know Before You Buy Long-term Care Insurance, HIPMC-LTC-5", 09/2008;
 - (f) "Long-term Care Insurance Suitability Letter, HIPMC-LTC-6", 09/2008;
 - (g) "Outline of Coverage, HIPMC-LTC-7", 09/2008;
 - (h) "Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-term Care Insurance, HIPMC-LTC-8", 09/2008;
 - (i) "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-term Care Insurance, HIPMC-LTC-9", 09/2008;
 - (j) "Disclosures and Language for Long-term Care Policies and Certificates, HIPMC-LTC-10", 09/2008; and
 - (k) "Long-term Care insurance replacement and lapse reporting form, HIPMC-LTC-11", 09/2008.

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(19 Ky.R. 1029; Am. 1756; eff. 2-8-93; 28 Ky.R. 1922; 2359; 29 Ky.R. 114; eff. 7-15-2002; TAm eff. 8-9-2007; 35 Ky.R. 1029; 1742; eff. 2-6-09; Crt eff. 2-26-2020; TAm eff. 3-10-2020.)