KENTUCKY

LONG-TERM CARE II

PARTNERSHIP

The content of this course is CLEARCERT Certified

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The Kentucky Long-Term Care Partnership Insurance Program Notice

Introduction:

In 2008, legislation was passed which allowed Kentucky to establish the Kentucky Long-term Care Partnership Insurance Program through a partnership among the Department for Medicaid Services (DMS), the Department of Insurance (DOI), and private long-term care (LTC) insurance companies. Under this program, special LTC insurance policies may be issued to encourage an individual to insure against the cost of providing for LTC needs without depleting all assets and assist in reducing the financial burden on the Kentucky Medicaid Program. These policies will be available beginning [effective date of 806 KAR 17:083] and must meet certain state and federal requirements.

What is Long-Term Care and Why Do I Need Long-Term Care Insurance?

LTC insurance is a form of health insurance that provides coverage for nursing home care for at least a year. A LTC insurance policy will pay for various services to maintain an individual's quality of life. Long-term care services refer to a wide range of medical and/or personal services for people who need hands-on or standby assistance with activities of daily living, including getting in and out of bed, toileting, bathing, dressing, and eating – or medical care due to functional limitations, chronic health conditions or cognitive (thinking) impairment like Alzheimer's disease. Someone with a cognitive impairment normally needs supervision, protection or verbal reminders to do everyday activities. LTC services might include skilled, intermediate or personal nursing care, home health care, adult day care, respite care, rehabilitation and assistance with activities of daily living.

The majority of people will need some type of LTC in the future and Medicare and health insurance policies usually do not cover LTC services. Therefore, you may wish to purchase LTC insurance to cover these services. This decision should be based on your personal health and finances. As with any insurance policy, only you can decide if a LTC insurance policy is right for you.

What is Medicaid?

Medicaid is a Medical Assistance program for families and individuals who meet both technical and financial eligibility requirements. The guidelines and income standards are not the same in every state. The Department for Medicaid Services, which is part of the Cabinet for Health and Family Services, Administers the Kentucky Medicaid Program (http://www.chfs.ky.gov/dms/).

General Medicaid Eligibility Requirements and Information:

- √ The purchase of a LTC partnership insurance policy **does not** guarantee eligibility for Medicaid.
- √ Medicaid eligibility is complex and must be determined on a case by case basis by an eligibility specialist at your local Department for Community Based Services Office.
- √ Applicants must provide:
  - Proof of Income;
  - Evidence of Social Security Number;
  - Proof of Identity (Driver's License);
  - Proof of Citizenship (Birth Certificate);
  - Proof of Health Insurance, if applicable, including any LTC insurance information;
  - Documentation of all resources or assets currently owned and anything disposed of in the three to five years prior to application.
- √ Medicaid eligibility has special rules that relate to married couples, property where the Medicaid applicant resides, homes over a certain value, vehicles, and burial arrangements.
- √ Medicaid recipients of LTC assistance are subject to Medicaid estate recovery, which means that Medicaid has the right to recover any money spent on your behalf from your estate after your death.

How Does the Kentucky Long-term Care Partnership Insurance Program Work?

The DOI and DMS developed the requirements for LTC partnership insurance policies, which are consistent with federal law. These requirements are published as Kentucky administrative regulations. The insurance companies develop policies that follow these requirements and train their agents in order for the company to sell long-term care partnership insurance.

Inflation protection – also called inflation benefits – helps a LTC policy keep up with the rising costs of LTC services by automatically increasing benefits each year. A LTC partnership insurance policy is required to include:

- √ For an individual who had not attained age 61 as of the original date of purchase, an annual inflation benefit of not less than three percent (3%) calculated on a compound basis; and
- √ For an individual who had attained age 61 to 75 as of the original date of purchase, an annual inflation benefit of not less than three percent (3%) calculated on a simple basis.

Inflation protection is not required for individuals over age 76, but it is available for an additional cost.

All LTC partnership insurance policies are "federally tax qualified." This means that the benefits or claims you receive from the policy may not be considered "taxable income." If you itemize your deductions, you may be able to deduct LTC insurance premiums as medical expenses up to the Internal Revenue Service limit. Many states, including Kentucky, may offer state tax incentives for individuals obtaining a LTC insurance policy. Please consult with your tax specialist for specific information regarding the tax treatment of LTC partnership insurance policies.

Medicaid eligibility is very complex and must be determined on a case by case basis by an eligibility specialist at your local Department for Community Based Services Office. If you apply for Medicaid benefits, a LTC partnership insurance policy allows you to keep assets equal to the amount of LTC partnership insurance benefits you received. For every dollar that a LTC partnership insurance policy pays in benefits, a dollar of personal assets may be protected (disregarded or not counted) by Medicaid during the eligibility review and, if approved, those protected assets would not be subject to estate recovery. Generally, an unmarried person utilizing LTC services may qualify for Medicaid when he or she has assets of $2,000 or less. For example, if you have $100,000 in assets (stocks, bank accounts, investments, etc), Medicaid could require you to "spend down" $98,000 in assets before you could be eligible for Medicaid benefits. However, if you have a LTC partnership insurance policy that has paid out $50,000 dollars in benefits, Medicaid could disregard $50,000 and you would be required to "spend down" $48,000 in assets before you could be eligible for Medicaid benefits.

Kentucky has entered into a reciprocal agreement with the majority of states that offer LTC partnership programs. This means that if you buy a LTC partnership insurance policy in Kentucky and later move to another state with a LTC partnership insurance program, you may receive the same dollar for dollar asset protection benefit from the other state's Medicaid program. Not all states participate in a reciprocal agreement; therefore, it is important to check before you move.

Partnership Insurance Policy Facts:

- √ Asset Protection (asset disregard or assets not counted for Medicaid eligibility) is based on the amount that the insurance company pays in benefits. Asset Protection is NOT based on the value of the policy or the amount of premiums paid.
- √ Existing LTC insurance policies will not automatically qualify as LTC partnership insurance policies. Contact your insurance company for information on exchanging an existing policy.
- √ Purchasing a partnership insurance policy does not guarantee eligibility for the Kentucky Medicaid Program; you must meet Medicaid eligibility requirements. Contact the Department for Medicaid Services if you have Medicaid eligibility questions.

Additional Information.

If you have questions regarding LTC partnership insurance policies please contact [carrier name and telephone number & any other contact information and/or] the Kentucky Department of Insurance at 1-800-595-6053 or visit www.insurance.ky.gov. If you have questions regarding Medicaid eligibility, you can visit the Department for Medicaid Services Web site at http://chfs.ky.gov/dms/Eligibility.htm or contact the Medicaid Eligibility Policy Branch at 502-564-6204.

Long-Term Care Insurance Partnership Program
Frequently Asked Questions

What is the long-term care partnership program?

The Kentucky Long-Term Care Insurance Partnership Program is an agreement between state government and private insurance companies to assist consumers in planning for their long-term care (LTC) needs. The program was designed to increase awareness of issues related to long-term care, to create ways to reduce Medicaid costs for nursing home care, and to provide an incentive to consumers to purchase certain insurance policies in order to protect assets from Medicaid spend down requirements.

How does the program work?

The Department of Insurance, working with the Kentucky Department for Medicaid Services, developed the requirements for partnership insurance policies. State agencies also have been in close contact with federal officials in the development of this initiative. The asset protection (explained in more detail below) aspect of these policies is an important element as it relates to Medicaid eligibility and spend down requirements. Partnership policies may be sold after July 1. However, companies will need to finalize plans and get approval from the Department of Insurance prior to selling so consumers should not expect policies to be available immediately. Information on the availability of partnership policies will be included in future editions of the long-term care consumer guide published by the Department of Insurance. Contact your insurer for more detailed information on when the policies are available for purchase.

What are the requirements of a partnership policy?

The partnership policies must include inflation protection for certain age groups to assist with the increasing costs of long-term care. The benefits of the policy will automatically increase each year. Inflation protection is not required for individuals who are 76 years old or older but the benefit is available at an additional cost. All LTC partnership policies must be "federally tax qualified," which means the benefits you receive from the policy will not be considered taxable income. Contact your tax advisor for information on deductions or tax incentives.

If I've already purchased a long-term care policy, will my policy switch to a partnership policy?

Existing long-term care policies will not automatically qualify as a partnership policy. Contact your insurance company or agent for information on exchanging an existing policy. If your policy qualifies, you will receive a notice from your insurer offering you the opportunity to exchange your policy for a long-term care partnership policy. Please pay close attention to the time period you are given to respond. You will have at least 90 days. Your current health status and age will not be considered for the new policy with the same benefits. The company's notice will include any premium change and a statement that you will not lose any rights, benefits or value. In addition, you will receive credit for satisfying pre-existing condition exclusion, elimination and incontestability periods.

Are partnership policies more expensive than non-partnership policies?

The premium for a partnership policy will be calculated the same way as any long-term care policy so the cost should be comparable to a non-partnership policy with similar benefits and inflation protection options.

Which insurers offer a partnership policy?

Every insurance company authorized to sell health insurance in Kentucky is authorized to offer partnership policies but the insurer must receive permission from the Department of Insurance prior to selling a policy.

Will insurance agents receive training on these new partnership policies?

Yes, companies are responsible for training agents before they will be allowed to sell partnership policies. The special training will include details on how the policies work with the Medicaid program.

Does having a partnership policy guarantee acceptance into Kentucky's Medicaid program?

No. Eligibility for Medicaid can be very complicated and is reviewed on a case-by-case basis. However, if you purchase a LTC partnership policy and later apply and are declared eligible for Medicaid benefits, you can keep assets equal to the amount of benefits you have received through the insurance coverage. In addition, these assets would not be subject to estate recovery after your death, allowing you to leave a portion of your assets to your heirs.

Generally, an unmarried person would not qualify for Medicaid until he/she has assets of $2,000 or less. For example, if you have $100,000 in assets (stocks, bank accounts, etc.), Medicaid would require you to spend down $98,000 in assets before you would be eligible for benefits. However, if you have a long-term care partnership policy that has paid out $50,000 in benefits, Medicaid would disregard $50,000 and you would be required to spend down $48,000 in assets before you would be eligible. Keep in mind that asset protection (also known as asset disregard) is based on the amount the insurance company pays in benefits, not the value of the policy or the amount of premiums you have paid.

What if I move?

Kentucky has entered into a reciprocal agreement with most states offering partnership programs. If you buy a partnership policy in Kentucky and later move to a state with a partnership program and an agreement with the commonwealth, you may receive the same dollar-for-dollar asset protection benefit from that state's Medicaid program. However, not all states participate in a reciprocal agreement so it is important to check before you move.

A. A FINANCIAL ABYSS

The percentage of elderly among the American population in less than 40 years will be the same as the percentage of elderly in Florida today.

According to the 1990 census, approximately 450,000 Kentuckians, or 12% of the Commonwealth's population is 65 years or older; 25,000 to 30,000 Kentuckians reside in a nursing home.

The average nursing home stay is about 30 months, or 2-1/2 years. More than half of all nursing home patients stay less than 3 months, and about 1 in 4 stay for more than a year. The latter figure is often referred to as "custodial care."

The average cost of nursing home care for one year: $45,000 to $50,000.

Although this figure tends to be higher in New England, few people anywhere can afford $3,600/month for nursing home care without soon draining their bank accounts and selling their homes.

Moreover, it is not just the ailing who stay in nursing homes. Approximately 61% of all residents entering a nursing home do so without a prior hospital stay.

The big picture is even more expensive. In 1980, almost 30 years ago, Americans spent $20 billion on nursing home care. By 1989, just 20 years ago, the figure more than doubled to $47.9 billion -- a 140% increase .

As explained later in this text, Medicare (for the elderly) and Medicaid (for the indigent) do not come close to paying this bill. Neither program is intended to cover continuous custodial care.

So, who foots the bill? As the following table indicates, most of the expenses are paid out-of-pocket by the patients or their families:

SOURCE OF PAYMENT	*PERCENTAGE PAID*
Out-of-Pocket	50%
Medicaid	40%
Medicare	5%
Other	5%
Source: American Health Care Association	

Medicaid picks up over 40% of the tab, although this figure is somewhat misleading, if not downright bizarre. Since Medicaid is designed for welfare families, the elderly whose bills are paid by Medicaid are, obviously, living in poverty.

No doubt, you have read that Americans over age 65 are the financially best off segment of our population by age. What explains the large number of Medicaid recipients?

Medicaid requires elderly patients to "spend down" their assets before the program kicks in to pay nursing home expenses. Some elderly do so by signing them over to their children or others (the federal government has tightened up on this as discussed later in this text). Some elderly people, however, literally sell everything, pour the money into nursing home care and let Medicaid handle the bills after they are financially non-existent within a few months.
A "few months" is not an exaggeration, either. More than half of all unmarried persons who enter a nursing home fall below the national poverty line within 13 weeks. The national poverty line is defined as a monthly income of $581 for a single person, $786 for a married couple.

About 65% -- 2 in 3 -- of all Americans who would enter a nursing home and attempt to pay for their own care would become eligible for Medicaid within 1 year, according to a Harvard University study.

Most people view Medicaid as a medical welfare program for the truly indigent of the U.S. living in such areas New York City's South Bronx or Chicago's West Side or Roseland. This is not how most people view their grandparents.

The insurance industry has attempted to respond to this crisis through the creation of Long-Term Care (LTC) policies and "Living Benefits" riders to life insurance contracts, which are the subject of this continuing education course. First, however, a review of Medicare and supplemental "Medigap" insurance is in order.

QUIZ A

In brief, why would an individual need long-term insurance coverage?

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B. MEDICARE CAN'T DO EVERYTHING

One of the most common misconceptions among prospects is that Medicare will handle the majority of long-term nursing home costs. As we have seen, the program covers only about 5% of the national nursing home tab. Private health insurance, including Medigap policies, cover and additional 5%. Let's review the Medicare system and see why percentages are so low.

A Great Society program of socialized medicine, Medicare is available to:

Persons age 65 or older,
Persons receiving Social Security Disability Benefits for more than 24 months, regardless of age,
Persons with end-stage renal disease (kidney failure) regardless of age,
Survivors and dependents of such persons may also qualify.

Medicare is divided into 2 parts:

Part A
Hospital Insurance

Part B
Medical Insurance

Among the facilities and services covered by Medicare:

Hospitals	Home Health Agencies
Hospices	Ambulance Service
Outpatient Rehabilitation	Physical Therapy
Chiropractors	Rural Health Clinics and others

Nursing home care is covered under Parts A and B, but only to a limit. Nursing home covered by Medicare must be certified by the program as a skilled nursing facility (SNF). This entails meeting state and local licensing requirements and additional stringent federal mandates. Local social Security offices maintain lists of Medicare-certified providers.

An SNF is neither intermediate nor custodial nursing home care. SNF refers to a special facility that may be part of (or separate from) a hospital that offers skilled nursing and rehabilitative services. For Medicare to pay, the patient must enter an SNF within 30 days of discharge from the hospital for continuing treatment of the condition that caused the hospitalization. Also, the hospital stay must have been for at least 3 days.

Custodial Care is what most people view as typical nursing home care offered on a long-term chronic basis. Medicare pays only for acute care -- also called restorative care -- which is short-term medical care and treatment.

Custodial Care is defined as assistance with activities in daily living, or ADLs, which are discussed later in this text. Such activities include dressing, eating, toiletry, bathing and walking. Medicare covers none of this. Medicare only covers skilled care provided on a 24-hour basis. Medicare does not cover the bills of patients needing care only once or twice weekly. Finally, Medicare must approve the patient's stay.

These facts will unnerve your prospects:

Only 3 in 10 nursing homes qualify as an SNF,
About 1/3 of those qualify as Medicare approved,
Only 15% of all U.S. nursing homes meet both qualifications,
Some facilities have a 6 to 9 months waiting list (for Medicare to pay,
the patient must enter within 30 days of hospital discharge),
Only 61% of nursing home patients were hospitalized immediately before
entering a nursing home,

Even if the patient enters a certified SNF, Medicare does not pick up the tab for very long.

Medicare divides benefit periods into spells of illness that last from the day the patient is admitted until date of discharge. If a nursing home is certified as an SNF, Medicare will pay the full cost of the first 20 days in each benefit period. From the 21st to the 100th day of SNF care in a particular spell of illness, the patient must pay a certain amount per day as coinsurance. Medicare coverage completely expires after the 100th day of SNF care per benefit period. (Remember that the average nursing home stay is 465 days!)

Among SNF services covered by Medicare Part A:

Semi-Private Room (Private room if medically necessary)
Meals (including special diets)
Skilled nursing care (given or supervised by a registered nurse)
Pharmaceuticals, supplies & equipment
Blood transfusions (except the first 3 pints)
Medical Social Services
Physical, Occupational and Speech Therapy.

Among SNF services excluded by Medicare Part A:

Doctor's services while patient is in and SNF (covered by Part B, along with surgeons' and Osteopaths'; services provided in an SNF),
Extra charge for private room (unless medically necessary),
Luxury room items such as TV or telephone,
SNF stays longer than 100 days,
Custodial Care (explained earlier).

QUIZ B

Explain, as you would to a prospect, why Medicare does not cover long-term nursing home costs?

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C. ARE MEDIGAP AND MEDICAID ALTERNATIVES?

As we have demonstrated, Medicare does not even come close to paying many nursing home patients' bills. It is not designed to do so.

After you review the facts with your prospects, many of them will reply that their "Medigap" will fill the long-term nursing home hole left by Medicare. Wrong again. Although many Medigap policies do a good job of filling various coverage holes, almost none will fill those related to long-term nursing home care.

MEDICAID

A Great Society socialized medicine program for the indigent, Medicaid pays for nursing home custodial care, but only after financially draining the patient.

Eligibility requirements for Medicaid vary among the states, the normal Medicaid recipient must qualify for public assistance (AKA, welfare, Aid to Families with Dependent Children [AFDC] or Supplemental Security Income (SSI) for indigent people who are 65 years or older, disabled or blind.

To qualify for Medicaid, an applicant must fall below the State's limits on income and financial resources. A Kentucky applicant may be allowed to keep his home. "Resources" include cash, bank accounts, stocks and bonds, and life insurance cash values. Applicants receiving income (e.g. Social Security, pensions, other income) are allowed to keep only $40 per month for personal needs; the rest is paid directly to the nursing home. Pretty horrible, isn't it? For most people, Medicaid is not an attractive option to pay nursing home bills.

According to the much-repealed Medicare Catastrophic Act of 1988 (although this part of the act remained), a non-institutionalized person (whose spouse is in a nursing home) is allowed to keep a basic income of 150% of the U.S. poverty level. Again, the national poverty level for a single person is a monthly income of $581, for a married couple it is a monthly income of $786.

The non-institutionalized spouse (community spouse) may keep an even larger amount, if the income is solely in his/her name or he/she has inordinate utility and housing costs. The maximum monthly income received is $1,769 (annually adjusted for inflation). Some institutionalized spouses can keep "shelter allowances" to cover housing costs as well, although a discussion of that is beyond the scope of this text.

It should be noted that a community spouse and the institutionalized spouse can retain combined total resources of $72,740. Upon receiving Medicaid, the institutionalized spouse has 6 months to transfer resources to the community spouse. These arrangements are inspected annually by the Kentucky Department of Social Insurance.

To quickly latch on to Medicaid, some relatively comfortable people were rumored to "spend down" (i.e., give to relatives) their assets to become indigent and eligible. To end this charade, the Medicare Catastrophic Coverage Act of 1988 denied Medicaid eligibility to people making a prohibited transfer of resources.

Such a transaction includes disposing of Medicaid-type resources for less than their market value 30 months before the date the individual applied for Medicaid or the date the individual began receiving care, if earlier.
When a person makes a prohibited transfer, Medicaid eligibility is denied for the lesser of 30 months, or the number of months' care that the transfers would have purchased. This is subject to change based on new legislation in the past few years.

Without effecting Medicaid eligibility, the applicant may transfer his/her home to a spouse, child (if the child is blind, disabled or under 21 years of age), a brother or sister with equity interest in the house (was living there at least one year before care began), an adult child who lived in the house and provided care that delayed entry into a nursing home for 2 or more years. Resources other than a home may be transferred to a non-institutionalized spouse or a child who is blind or mentally retarded.

Medicaid, of course, will pay such Medicare costs as co-payments and Part B premiums:

QUIZ C

Your fairly well-to-do prospect is planning to let Medicaid pick up the tab if he goes into a nursing home. Why wouldn't you recommend that he do so?

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D. LONG-TERM CARE INSURANCE

Although every carrier's LTC policies are different, there are some commonalties that apply to a majority. With this in mind, let us discuss the basic nature of LTC insurance.

LTC policies will often be issued on an age basis, such as coverage for policyholders aged 55-79. Few policies cover persons under 40, since the program is designed for nursing home care for the elderly rather than AIDS sufferers. LTC policies covering persons more that 79 years of age often come with great restrictions and waiting periods.

With few exceptions, LTC policies are offered on a "guaranteed renewable" basis to a stated age, often 79. Some are renewable for life. Guaranteed renewable refers to the right of the policyholder, not the carriers, to cancel the policy. The carrier cannot change coverage, either, although it retains the right to adjust premiums (for all insured of the same class).

Rarely are LTC policies offered on a "non-cancelable" basis, wherein the policy cannot be canceled and the premium can never be raised. Some policies are offered on a conditionally renewable basis, wherein the carrier can refuse renewed coverage after a certain age for reasons stated in the policy. The carrier can adjust premiums and benefits on a class basis.

By Kentucky Law, LTC policies can only be issued on a guaranteed renewable or non-cancelable basis. [806 KAR 17:081 (3) (1)]

The majority of LTC policies are underwritten on an application basis; some require certification from the attending physician. Conventional life underwriting methods are employed when LTC coverage is by rider to a life policy.

Most LTC premiums are level throughout the duration of the contract. Of course, carriers reserve the right to adjust premiums in almost all cases. A few carriers provide a form of "term LTC" where premiums rise at certain ages, not unlike term life insurance. Some companies raise premiums every 5 years, the "stair-step approach."

By Kentucky Law, an insurer cannot increase premiums on the basis of age for insureds over age 65. [806 KAR 17:081 (3) (6)].

Most LTC policies do not require the payment of any fees, except the premium. Most also provide for waiver of premium, anywhere from 60 to 180 days after confinement. Some LTC policies provide a discount for married couples applying at the same time -- 10% is typical.

BENEFITS

As in any other form of insurance, higher benefits mean higher premiums. Ditto, the coverage varies widely among carriers. Usually it is expressed in maximum daily benefit amounts for nursing home or home healthcare.

An LTC policy sold alone might offer a base daily benefit of $20/day, increasing in $10 increments (at the policyholder's option) to a total of $150/day. As a rider to a life policy, a monthly, not daily, benefit is usually determined as a percentage of the death benefit, say, 2%. If covered at all, the benefit for home healthcare or adult daycare will be as a percentage of the maximum daily benefit, usually 50% and 25%, respectively.

Benefit lengths can also vary, although one basic rule never varies, "The longer the benefit period, the higher the premium." Length will range from 1 to 12 years. Lifetime benefits are also available.

Elimination periods -- waiting periods -- are also varied. Similar to a deductible in other forms of insurance, the elimination period is the specified number of days of care that elapse before coverage kicks in. The period will range from 20 to 150 days, although there are exceptions in both directions.

Some LTC policies provide a "restoration of benefits" wherein full benefits are restored after the policyholder has been out of the nursing home for a given number of days, often 180 days. The majority of LTC policies do not offer this provision.

All Kentucky LTC policies must offer inflation protection, which is important, since the cost of nursing home care is growing faster than the general rate of inflation. This is discussed later in this text under Kentucky Law 806 KAR 17:081 (7).

REGULATIONS

The National Association of Insurance Commissioners (NAIC) looked at the spectrum of LTC policies and prepared a Long-Term Care Insurance and Model Act and Regulation for adoption by the states. The Model Act became effective in Kentucky on July 15, 1992; it does not require that policies sold before then be amended to include its provisions.

While some Kentucky requirements have been discussed throughout this text, all agents should know that the Department of Insurance will provide free to anyone upon request, *The Consumer's Guide to Long-Term Care Insurance in Kentucky.*

The guide contains the following information:

- > Definition of long-term services, cost of services, sources of payment and eligibility for assistance programs;
- > Factors that affect premium rates, such as age, deductibles, duration of benefits and daily benefits;
- > Explanation of benefit limits;
- > Checklist that covers items that should be considered when buying a policy;
- > Comparison of all policies available in Kentucky with respect to:
  - Premiums at ages 55, 65 and 75,
  - Services covered,
  - Length of coverage,
  - Limitations on coverage,
  - Prior institutionalization requirements,
  - Elimination period, *(KRS 304.14-560)*

E KENTUCKY STATUTES AND REGULATIONS

The Department of Insurance regulates the sale of Long-Term care policies through regulations and statutes. The following are some of the highlights of Kentucky Insurance Law as it applied to LTC insurance.

304.14-615 Required standards and disclosures; right to return policy; "pre-existing condition" defined

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

(a) Be canceled, non-renewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is covered to or with respect to an increase in benefits voluntarily selected by the insured individual or group policy holder;

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

(3) A LTC policy shall not:

(a) Use a definition of "pre-existing condition" that is more restrictive than: Was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person."

(b) A LTC policy shall not exclude coverage for loss or confinement that results from a pre-existing condition unless that loss or confinement <u>begins within 6 months following the effective date of coverage.</u>

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

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

Unless otherwise provided in the policy, a pre-existing condition, regardless of whether it is the waiting period described in period (b) of this subsection expires.

A LTC policy shall not exclude or use waivers or riders to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond the waiting period described in Paragraph (b) of this subsection.

(4) (a) A LTC policy shall not be delivered or issued in the Commonwealth if it:
1. Conditions eligibility for any benefits on a prior hospitalization requirement;
2. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
3. Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(b) 1. A LTC policy containing pose-confinement, post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy entitled "limitations on conditions for eligibility for benefits" the limitations or conditions, including any required number of days of confinement.
2. A LTC policy that conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days.

(6) LTC applicants have the right to return the policy within 30 days after its delivery and to have the premium refunded if, after examination of the policy, the applicant is not satisfied for any reason. LTC policies shall have a notice prominently printed on the first page or attached thereto stating this.

(7) (a) An outline of coverage shall be delivered to a prospective applicant for LTC insurance at the prominently direct the applicant's attention to the document and its purpose.
1. The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.
2. In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.
(The outline of coverage follows in Section 19 of 806 KAR 17:081, "Standard Format Outline of Coverage").

(8) A certificate issued pursuant to a group LTC policy that is delivered or issued in Kentucky shall include:
(a) A description of the principal benefits and coverage provided in the policy;
(b) A statement of the principal exclusions, reductions and limitations contained in the policy;
(c) A statement that the group master policy determines governing contract provisions.

(9) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides LTC benefits within the policy or by rider. In addition to complying with all applicable requirements, the summary shall also include:
(a) An explanation of how the LTC benefit interacts with other components of the policy, including deductions from health benefits;
(b) An illustration of the amount of benefits, the length of benefit and the guaranteed lifetime benefits, if any, for each covered person;
(c) Any exclusions, reductions, and limitations on benefits of LTC insurance; and
(d) If applicable to the policy type, the summary shall also include:
1. A disclosure of the effects of exercising other rights under the policy;

2. A disclosure of guarantees related to LTC of insurance charges; and
3. Current and projected maximum lifetime benefits.

To assist in the enforcement of these statutes passed by the Kentucky General Assembly, the Commissioner of Insurance promulgated 806 KAE 17:081, Minimum Standards for Long-Term Care Insurance Policies, a rule effective as of February 8, 1993.

SECTION 3. POLICY PRACTICES AND PROVISIONS.

(1) Renewability. The terms "guaranteed renewable" and "non-cancelable" shall not be used in any individual LTC insurance policy without further explanatory language in accordance with the disclosure requirements of Section 5 of this regulation.

(a) LTC policies issued to individuals shall not contain renewal provisions other than "guaranteed renewable" or "non-cancelable."

(b) The term "guaranteed renewable" may be used only when the insured has the right to continue the LTC and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(c) The term "non-cancelable" may be used only when the insured has the right to continue the LTC insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

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

(a) Pre-existing conditions or diseases;

(b) Mental or nervous disorders, but this shall nor permit exclusion or limitation of benefits on the basis of Alzheimer's disease;

(2) (c) Alcoholism and drug addiction

(d) Illness, treatment, or medical condition arising out of:

1. War or act of war (whether declared or undeclared);
2. Participation in a felony, riot, or insurrection;
3. Service in the armed forces or auxiliary units;
4. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
5. Aviation (this exclusion applies only to nonfare-paying passengers).

(e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other government program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.

(f) The requirements of this subsection are not intended to prohibit exclusions and limitations by type of provider or 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 began while the long-term care insurance was in force and continues without interruption after termination.

(b) The extension of benefits beyond the period of long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits, and may be subject to any policy waiting period, and all other applicable provisions of the

policy.

(4) Continuation of conversion. Group long-term care insurance policies shall provide for continuation and conversion as required by KRS 304.18-110 and 304.18-120.

(5) Discontinuance and replacement. 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 all persons covered under the previous group policy on its date of termination in accordance with KRS 304.18-127.

(6) The premiums charged to an insured for long-term care insurance shall not increase due to either:
- (a) The increasing age of the insured at ages beyond 65; or
- (b) The duration the insured has been covered under the policy.

SECTION 4. REQUIRED DISCLOSURE PROVISIONS.

(1) Renewability.
- (a) Individual long-term care insurance policies shall contain a Renewability provision.
- (b) The provision shall:
  1. Be appropriately captioned;
  2. Appear on the first page of the policy;
  3. State the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(1) (c) This subsection shall not apply to policies that do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder.

(2) Riders and endorsements
- (a) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured,
- (b) After the date of policy issue, a rider or endorsement that increases benefits or coverage with an increase in premium during the policy term shall be agreed to in writing signed by the insured, except if increased benefits or coverage are required by law.
- (c) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

(3) Payment of benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of these terms and an explanation of these terms in its accompanying outline of coverage.

(4) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-existing Condition Limitations."

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in

KRS 304.14-615(4) (b) shall set forth 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 shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."

(6) Disclosure of tax consequences.

(a) A disclosure statement shall be required as specified in Paragraphs (b), (c) and (d) of this subsection, for life insurance policies that provide an accelerated benefit for long-term care.

(b) 1. Of application for the policy or rider; and
2. The accelerated benefit payment request is submitted.

(c) The statement shall disclose that:
1. Receipt of the accelerated benefits may be taxable; and
2. Assistance should be sought from a personal tax advisor.

(d) The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

SECTION 5. PROHIBITION AGAINST POSTCLAIMS UNDERWRITING

(1) Applications for long-term care insurance policies or certificates except those that are guaranteed issue, 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 that asks whether 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 the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(3) Except for policies or certificates that are guaranteed issue:

(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

"Caution: If your answers on this application are incorrect or untrue, (insurer's name) has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at time of delivery:

"Caution: The issuance of this long-term care insurance (policy or certificate) is based upon your responses to the questions on your application. A copy of your (applicant or enrollment form) (is enclosed or was retained by you when you applied.) If your answers are incorrect or untrue, the insurer has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the insurer at this address: (insert address)."

(c) Prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:
1. A report of a physical examination;
2. An assessment of functional capacity;
3. An attending physician's statement; or

4. Copies of medical records.

(4) A copy of the complete application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(5) Every insurer issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both Kentucky and country-wide, except those that the insured voluntarily effectuated, and shall annually furnish this information to the Commissioner in the format prescribed by the National Association of Insurance Commissioners.

SECTION 6. MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS.

(1) If a LTC policy provides benefits for home health care or community care services, it 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 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 can be provided by a home health aide or other licensed or certified home care worker acting with the scope of his licensure or certification;
- (e) Excluding coverage or personal care services provided by a home health aid;
- (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) If a LTC policy provides for home health or community care services, it shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of the year's coverage available for nursing home benefits under the policy, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(3) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy.

SECTION 7. REQUIREMENT TO OFFER INFLATION PROTECTION

(1) An insurer shall not offer a LTC policy unless it also offers, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or a policy that provides for an increase in the period of coverage that shall meet anticipated increases in the costs of LTC services covered by the increases in the costs of LTC services covered by the policy. Insurers shall offer to each policyholder, at the time of

purchase, the option to purchase a policy with an inflation protection feature no less favorable than any one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5%;

(1) (b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined.

The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the policy is issued to a group, the required offer in subsection (1) of this section shall be made to the group policyholder.

(3) The offer in subsection (1) of this section shall not be required of life insurance policies or riders containing accumulated LTC benefits.

(4) Insurers shall include the following information in or with the outline of coverage. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period; and

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status, or claim history, or the length of time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium is guaranteed to remain constant.

(7) (a) Inflation protection as provided in Subsection (1) (a) of this section shall be included in a LTC insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.

(b) The rejection shall be considered a part of the application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection."

SECTION 8. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE

(1) Application forms shall include the following questions designed to elicit information as to whether:

(a) The application has another LTC insurance policy or certificate in force as of the date of application; or

(b) A LTC policy or certificate is intended to replace:

1. Any other accident and sickness policy or certificate presently in force or
2. Any other LTC policy or certificate presently in force.

(c) Except where coverage is sold without an agent, 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.

(d) If a replacement policy is issued to a group, the following questions may be modified only to the extent necessary to elicit information about health or LTC policies other than the group policy being replaced if the certificate holder ahs been notified of the replacement.

1. Do you have another LTC policy in force (including health care service contract or HMO contract)?
2. Did you have another LTC policy in force during the past 12 months?
   a. If so, 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?

(2) Agents shall list other health insurance policies they have sold to the applicant which:

(a) Are still in force; and

(b) Were sold in the past 5 years, but are no longer in force.

(3) Solicitations <u>other than</u> direct response.

(a) Upon determining that a sale will involve replacement, an insurer or its agent shall furnish the applicant, prior to inssuance or delivery of the individual LTC policy, a notice regarding replacement of accident and sickness or LTC coverage.

(b) One of the notices shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.

(c) The notice shall be provided as follows:

NOTICE TO APPLLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

(INSURER'S NAME AND ADDRESS)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (Your application or information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (insurer's name). Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or

long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

(a) Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing condition or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Signature of Agent _____
Type Name of Agent _____
Type Address of Agent _____

The above "Notice of Applicant" was delivered to me:

Date: _____
Applicant's Signature: _____

(4) This subsection deals with direct response solicitors. For reference, consult the Kentucky insurance code.

SECTION 9. REPORTING REQUIREMENTS

(1) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of LTC policies sold by the agent as a percent of the agent's total annual sales.

(2) Each insurer shall report annually by June 30 the 10% of its agents with the greatest percentages of lapses and replacements as measured by Subsection (1) of this section.

(3) Reported replacement and lapse rates shall not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of LTC insurance.

(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding year.

(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding year.

(6) For purposes of this section, "policy" shall mean only LTC insurance and "report" means on a state-wide basis.

SECTION 11. DISCRETIONARY POWERS OF THE COMMISSIONER.

The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision(s) of this administrative regulation with respect to a specific LTC policy upon written finding that:

(1) The modification or suspension would be in the best interest of the insureds;

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3) (a) The modification or suspension is necessary to development of an innovative and reasonable approach for insuring LTC; or
(b) The policy is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of the community; or
(c) The modification or suspension is necessary to permit LTC insurance to be sold as part of, or in conjunction with, another insurance product.

SECTION 13. LOSS RATIONS *(Ed note: this is abbreviated to one sentence.)*

Benefits under LTC policies shall be deemed reasonable in relation to premiums if the expected loss ration is at least 60%.

SECTION 15. FILING REQUIREMENTS FOR ADVERTISING

(1) (a) Every insurer providing LTC insurance or benefits in Kentucky shall provide a copy of any LTC insurance or benefits in Kentucky shall provide a coy of any LTC insurance advertisement intended for use in Kentucky whether through written, radio, or television medium to the commissioner for review to the extent it may be required under state law.
(b) In addition, all advertisements shall be retained by the insurer for at least 3 years from the date the advertisement was first used.

(2) The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

SECTION 16. STANDARDS FOR MARKETING.

(1) Every insurer marketing LTC insurance in Kentucky directly or through its agents shall:

(a) Established marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for LTC insurance already has accident and sickness or LTC insurance and the types and amounts of this insurance.

(e) Every insurer marketing LTC insurance shall establish auditable procedures for verifying compliance with the requirements of this subsection.

(f) If the state in which the policy is to be delivered or issued has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospect that such a program is available and the name, address and telephone number of the program.

(2) In addition to the practices prohibited in KRS Chapter 304.12, the following acts and practices are prohibited:

(a) "Twisting" Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take our a policy of insurance with another insurer.

(b) "High pressure tactics" Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(c) "Cold lead advertising" Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

SECTION 17. APPROPRIATENESS OF RECOMMENDED PURCHASE.

In recommending the purchase or replacement of any LTC policy, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase of replacement.

SECTION 18. PROHIBITION AGAINST PRE-EXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

If a LTC policy replaces another LTC policy, the replacing insurer shall waive any time periods applicable to pre-existing conditions and probationary periods in the new LTC policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

SECTION 19. STANDARD FORMAT OUTLINE OF COVERAGE.

This section is per KRS 304.14-615(7)

(1) The outline of coverage shall be a freestanding document using no smaller than 10-point type.

(2) The outline of coverage shall contain no material of an advertising nature.

(3) Text that is emphasized in the standard format outline of coverage may be emphasized by any means that provide prominence to the text.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) Format for outline of coverage:

(INSURER NAME)
(ADDRESS -- CITY & STATE)
(TELEPHONE NUMBER)
(LONG-TERMCARE INSURANCE OUTLINE OF COVERAGE)
(Policy number or group master policy number)

(Except for policies that are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your (application or enrollment form (is enclosed or was retained by you when you applied). If your answers are incorrect or untrue, the insurer has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the insurer at this address: (insert address:

(a) This policy is (individual or group) that was issued in the (jurisdiction in which policy was issued.)

(b) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY CAREFULLY!

(c) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

1. (Provide a brief description of the right to return -- "free look" provision of the policy.)
2. (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon death of insured or surrender of the policy. If the policy contains either provision, include a description.)

(d) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurer.

1. (For agents) Neither (insert insurer name) nor its agents represent Medicare, the federal government, or any state government.
2. (Deals with direct response writers.)

(e) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide

coverage for one or more necessary or medically necessary diagnostic preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations) (waiting periods) and (co-insurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.

(f) BENEFITS PROVIDED BY THIS POLICY.

1. (Covered services, related deductible[s], waiting periods, elimination periods, and benefit maximums.)
2. (Institutional benefit, by skill level.)
3. (Non-institutional benefits, by skill level.)
   (Any benefit screens shall be explained in this section. If these screens differ for different benefits, explanation of the screen shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this shall be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens shall be explained.)

(g) LIMITATIONS AND EXCLUSIONS. Describe:

1. Pre-existing conditions;
2. Non-eligible facilities or providers;
3. Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by family member, etc.);
4. Exclusions and exceptions; and
5. Limitations.
   This section shall provide a brief description of any policy provisions that limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Paragraph (f) of this subsection.
   THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

(h) RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the costs of long-term services will likely increase over time, you should consider whether and how the benefits of this plan will be adjusted. (As applicable, indicate the following:

1. That the benefit level will not increase over time;
2. Any automatic benefit adjustment provisions;
3. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount of percentage;
4. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and
5. Describe whether there will be any additional premium charge imposed, and how that is to be calculated.

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

1. Describe the policy renewability provisions
2. For group coverage, specifically describe continuation and conversion provisions applicable to the certificate and group policy;
3. Describe waiver of premium provisions or state that there are no waiver of premium

provisions; and

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

(j) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.
(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for these insureds.)

(k) PREMIUM

1. State the total annual premium of the policy; and
2. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium that corresponds to each benefit option.

(l) ADDITIONAL FEATURES

1. Indicate if medical underwriting is used.
2. Describe other important features.

SECTION 20. REQUIREMENT TO DELIVER SHOPPER'S GUIDE.

(1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioner, or a guide developed or approved by the commissioner (commonly, "Kentucky Consumer's Guide to Long-Term Care Insurance"), shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(a) In the case of agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an applicant or enrollment form.

(b) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the shopper's guide, but shall furnish the policy summary required under KRS 304.14-615.

SECTION 21. PREMITTED COMPENSATION ARRANGEMENTS.

(1) Upon replacement, the replacing insurer shall not provide compensation to its agents or other producers greater than 200% of the renewal compensation payable by the replacing insurer or renewal policies. The commission or other compensation provided in subsequent (renewal) years by the replacing insurer shall be the same as the provided in the second year or period and shall be provided for a reasonable number of renewal years.

(2) 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.

QUIZ ANSWERS
LONG-TERM DISABILITY INSURANCE

QUIZ A

For most people no other form of insurance adequately fills the need, including Medicare, Medicaid, Medigap, health and life. Also, long-term nursing home care is prohibitively expensive for most people.

QUIZ B

Because Medicare only offers unlimited benefits in very restrictive circumstances for just the first 20 days of a nursing home stay, within less than the next 3 months, the Medicare policyholder will incur $6,280 in bills. After 100 days of stay, Medicare pays none of a nursing home tab.

QUIZ C

Because he/she must meet the federal definition of poverty for more than 30 months before applying for Medicaid, or benefits will be cut dramatically.

LONG-TERM CARE
GLOSSARY

ACUTE CARE	Immediate, short-term care; usually medical in nature.
CHRONIC CARE	Long-term care; may or may not be medical in nature.
CONSUMER'S GUIDE TO LONG-TERM CARE INSURANCE POLICIES	Published by the Kentucky Department of Insurance and offered free of charge, the guide compares all LTC policies available in Kentucky.
CUSTODIAL CARE	Non-medical in nature and does not require trained nurses; term normally used when a patient requires assistance in activities of daily living.
ELIMINATION PERIOD	Similar to a deductible in other forms of insurance, the period of time that must elapse before benefits of LTC policy take effect (AKA, waiting period).
GUARANTEED RENEWABLE BASIS	Basis of offering LTC insurance (to a stated policyholder age) wherein only policyholder can cancel; carrier can adjust premium for all members of a class.
HOME CARE	Provided by visiting nurse or visiting homemaker when such services as cleaning, cooking and laundry are required.
HOSPICE CARE	Care provided for terminally ill patients.
INTERMEDIATE CARE	Care ordered by a physician and provided by an RN, LPN or professional in the areas of speech, physical, occupational and respiratory therapy. Not necessarily on a 24-hour basis.
KAR	(Kentucky Administrative Regulations) – Laws effecting all aspects of insurance in the State promulgated by the Kentucky Department of Insurance.
KRS	(Kentucky Revised Statutes) -- Laws effecting all aspects of insurance in the State passed by the Kentucky General Assembly and signed by the Governor.
LONG-TERM CARE	(LTC) -- Insurance designed to cover cost of long-term nursing home care; also provides benefits for hospice care, home health care and adult day care.
LOOK-BACK PERIOD	Period wherein carrier can determine received (or should have received) medical advice or treatment for a pre-existing condition.
MEDICAID	Federal government program of medical care for the indigent.
MEDICARE	Federal government program of medical care for persons over age 65, disabled persons, and their dependents.
MEDIGAP INSURANCE	Private health insurance designed to fill in the holes left by Medicare coverage (AKA, "Medicare Supplement Insurance).
ORGANIC CAUSE	In mental illness or nervous disorders, caused by a deficiency in the normal functioning of the human body.

PROHIBITED TRANSFER OF ASSETS	In Medicare, a transfer of assets (within 30 months of application for coverage) to make the applicant indigent and thus eligible for coverage.
SKILLED NURSING CARE	24-hour care ordered by a physician and provided by an RN, LPN or professional in the areas of speech, physical, occupational and respiratory therapy. Often hospitalization is the only alternative.
SKILLED NURSING FACILITY	(SNF) -- Facility that meets state and local licensing requirements and additional strigent federal mandates; only 30% of all U.S. nursing homes qualify as SNFs.
SPELL OF ILLNESS	In Medicare, benefits period that last from the day the patient is admitted until discharge.
WAITING PERIOD	See elimination period.

Resources:

Long-term Care Insurance 2009-2010 is available from the Kentucky Department of Insurance. This consumer guide contains information about long-term care options, longterm care insurance buying tips, worksheets, a glossary and sample rates. For a copy, you can go online http://insurance.ky.gov/kentucky/Documents/Health/2008LTCguideComplete010709online.pdf
or http://insurance.ky.gov/ to Free Publications; guide is located under Health) or
call 800-595-6053.

Title 42, Chapter 7, Subchapter XIX, § 1396p

Leans Adjustment and Recoveries, and Transfer of Assests

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan
(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—
(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or
(B) in the case of the real property of an individual—
(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and
(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,
except as provided in paragraph (2).
(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—
(A) the spouse of such individual,
(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or
(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),
is lawfully residing in such home.
(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.
(b) Adjustment or recovery of medical assistance correctly paid under a State plan
(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:
(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.
(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—
(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or
(ii) at the option of the State, any items or services under the State plan.
(C)
(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.
(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—
(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.
(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:
(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.
(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.
(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).
(IV) If the policy is sold to an individual who—
(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;
(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and
(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.
(V) The State Medicaid agency under section 1396a (a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.
In the case of a long-term care insurance policy which is exchanged for another such policy, sub clause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.
(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.
(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.
(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.
(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—
(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and
(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when—
(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and
(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the

satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),
is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.
(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.
(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—
(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and
(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.
(5)
(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:
(i) In the case of the model regulation, the following requirements:
(I) Section 6A (relating to guaranteed renewal or non-cancel-ability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.
(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.
(III) Section 6C (relating to extension of benefits).
(IV) Section 6D (relating to continuation or conversion of coverage).
(V) Section 6E (relating to discontinuance and replacement of policies).
(VI) Section 7 (relating to unintentional lapse).
(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.
(VIII) Section 9 (relating to required disclosure of rating practices to consumer).
(IX) Section 11 (relating to prohibitions against post-claims underwriting).
(X) Section 12 (relating to minimum standards).
(XI) Section 14 (relating to application forms and replacement coverage).
(XII) Section 15 (relating to reporting requirements).
(XIII) Section 22 (relating to filing requirements for marketing).
(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
(XV) Section 24 (relating to suitability).
(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).
(XVII) The provisions of section 26 relating to contingent non-forfeiture benefits, if the policyholder declines the offer of a non-forfeiture provision described in paragraph (4).
(XVIII) Section 29 (relating to standard format outline of coverage).
(XIX) Section 30 (relating to requirement to deliver shopper's guide).
(ii) In the case of the model Act, the following:
(I) Section 6C (relating to preexisting conditions).
(II) Section 6D (relating to prior hospitalization).
(III) The provisions of section 8 relating to contingent non-forfeiture benefits.
(IV) Section 6F (relating to right to return).
(V) Section 6G (relating to outline of coverage).
(VI) Section 6H (relating to requirements for certificates under group plans).
(VII) Section 6J (relating to policy summary).
(VIII) Section 6K (relating to monthly reports on accelerated death benefits).
(IX) Section 7 (relating to incontestability period).
(B) For purposes of this paragraph and paragraph (1)(C)—
(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);
(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)

(A) In order to meet the requirements of this subsection for purposes of section 1396a (a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)

(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)

(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d (a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)

(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)

(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a non-institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—
(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by
(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.
(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—
(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and
(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.
(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.
(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—
(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or
(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.
(G) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless—
(i) the annuity is—
(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or
(II) purchased with proceeds from—
(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;
(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or
(cc) a Roth IRA described in section 408A of such Code; or
(ii) the annuity—
(I) is irrevocable and non-assignable;
(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and
(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.
(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—
(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and
(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.
(I) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—
(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);
(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
(iii) prohibits the cancellation of the balance upon the death of the lender.
In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).
(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.
(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—
(i) the spouse of such individual;
(ii) a child of such individual who
(I) is under age 21, or
(II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;
(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or
(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;
(B) the assets—
(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,
(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,
(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or
(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c (a)(3) of this title);
(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that
(i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration,
(ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or
(iii) all assets transferred for less than fair market value have been returned to the individual; or
(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.
The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.
(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.
(4) A State (including a State which has elected treatment under section 1396a (f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.
(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.
(d) Treatment of trust amounts
(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.
(2)
(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:
(i) The individual.
(ii) The individual's spouse.
(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.
(C) Subject to paragraph (4), this subsection shall apply without regard to—
(i) the purposes for which a trust is established,
(ii) whether the trustees have or exercise any discretion under the trust,
(iii) any restrictions on when or whether distributions may be made from the trust, or
(iv) any restrictions on the use of distributions from the trust.
(3)
(A) In the case of a revocable trust—
(i) the corpus of the trust shall be considered resources available to the individual,
(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and
(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.
(B) In the case of an irrevocable trust—
(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—
(I) to or for the benefit of the individual, shall be considered income of the individual, and
(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and
(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.
(4) This subsection shall not apply to any of the following trusts:
(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c (a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.
(B) A trust established in a State for the benefit of an individual if—
(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),
(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter; and
(iii) the State makes medical assistance available to individuals described in section 1396a (a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a (a)(10)(C) of this title.
(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c (a)(3) of this title) that meets the following conditions:
(i) The trust is established and managed by a non-profit association.
(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c (a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.
(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.
(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.
(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.
(e) Disclosure and treatment of annuities

(1) In order to meet the requirements of this section for purposes of section 1396a (a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)

(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f) Disqualification for long-term care assistance for individuals with substantial home equity

(1)

(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a (a)(1) of this title (relating to statewideness) and section 1396a (a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term “assets”, with respect to an individual, includes all income and resources of the individual and of the individual’s spouse, including any income or resources which the individual or such individual’s spouse is entitled to but does not receive because of action—
(A) by the individual or such individual’s spouse,
(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual’s spouse, or
(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual’s spouse.
(2) The term “income” has the meaning given such term in section 1382a of this title.
(3) The term “institutionalized individual” means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a (a)(10)(A)(ii)(VI) of this title.
(4) The term “non-institutionalized individual” means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.
(5) The term “resources” has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

Title 26, Subtitle F, Chapter 79, § 7702B

Treatment of Qualified Long-Term Care Insurance

(a) In general
For purposes of this title—
(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,
(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213 (d)),
(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,
(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213 (d)(1)(D), and
(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816 (e).
(b) Qualified long-term care insurance contract
For purposes of this title—
(1) In general
The term “qualified long-term care insurance contract” means any insurance contract if—
(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,
(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,
(C) such contract is guaranteed renewable,
(D) such contract does not provide for a cash surrender value or other money that can be—
(i) paid, assigned, or pledged as collateral for a loan, or
(ii) borrowed,
other than as provided in subparagraph (E) or paragraph (2)(C),
(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and
(F) such contract meets the requirements of subsection (g).
(2) Special rules
(A) Per diem, etc. payments permitted
A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) 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.
(B) Special rules relating to medicare
(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

(C) Refunds of premiums

Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

(c) Qualified long-term care services

For purposes of this section—

(1) In general

The term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

(A) are required by a chronically ill individual, and

(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2) Chronically ill individual

(A) In general

The term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as—

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

(B) Activities of daily living

For purposes of subparagraph (A), each of the following is an activity of daily living:

(i) Eating.

(ii) Toileting.

(iii) Transferring.

(iv) Bathing.

(v) Dressing.

(vi) Continence.

A contract shall not be treated as a qualified long-term care insurance contract unless the determination of whether an individual is a chronically ill individual described in subparagraph (A)(i) takes into account at least 5 of such activities.

(3) Maintenance or personal care services

The term "maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(4) Licensed health care practitioner

The term "licensed health care practitioner" means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

(d) Aggregate payments in excess of limits

(1) In general

If the aggregate of—

(A) the periodic payments received for any period under all qualified long-term care insurance contracts which are treated as made for qualified long-term care services for an insured, and

(B) the periodic payments received for such period which are treated under section 101 (g) as paid by reason of the death of such insured,

exceeds the per diem limitation for such period, such excess shall be includible in gross income without regard to section 72. A payment shall not be taken into account under subparagraph (B) if the insured is a terminally ill individual (as defined in section 101 (g)) at the time the payment is received.

(2) Per diem limitation

For purposes of paragraph (1), the per diem limitation for any period is an amount equal to the excess (if any) of—

(A) the greater of—
(i) the dollar amount in effect for such period under paragraph (4), or
(ii) the costs incurred for qualified long-term care services provided for the insured for such period, over
(B) the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long-term care services provided for the insured during such period.

(3) Aggregation rules

For purposes of this subsection—
(A) all persons receiving periodic payments described in paragraph (1) with respect to the same insured shall be treated as 1 person, and
(B) the per diem limitation determined under paragraph (2) shall be allocated first to the insured and any remaining limitation shall be allocated among the other such persons in such manner as the Secretary shall prescribe.

(4) Dollar amount

The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

(5) Inflation adjustment

In the case of a calendar year after 1997, the dollar amount contained in paragraph (4) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213 (d)(10).

(6) Periodic payments

For purposes of this subsection, the term “periodic payment” means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

(e) Treatment of coverage provided as part of a life insurance contract

Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract—

(1) In general

This title shall apply as if the portion of the contract providing such coverage is a separate contract.

(2) Application of section 7702

Section 7702 (c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—
(A) by the sum of any charges (but not premium payments) against the life insurance contract’s cash surrender value (within the meaning of section 7702 (f)(2)(A)) for such coverage made to that date under the contract, less
(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702 (f)(1)).

(3) Application of section 213

No deduction shall be allowed under section 213 (a) for charges against the life insurance contract’s cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72 (e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

(4) Portion defined

For purposes of this subsection, the term “portion” means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

(f) Treatment of certain State-maintained plans

(1) In general

If—
(A) an individual receives coverage for qualified long-term care services under a State long-term care plan, and
(B) the terms of such plan would satisfy the requirements of subsection (b) were such plan an insurance contract,
such plan shall be treated as a qualified long-term care insurance contract for purposes of this title.

(2) State long-term care plan

For purposes of paragraph (1), the term “State long-term care plan” means any plan—
(A) which is established and maintained by a State or an instrumentality of a State,
(B) which provides coverage only for qualified long-term care services, and
(C) under which such coverage is provided only to—
(i) employees and former employees of a State (or any political subdivision or instrumentality of a State),
(ii) the spouses of such employees, and
(iii) individuals bearing a relationship to such employees or spouses which is described in any of subparagraphs (A) through (G) of section 152 (d)(2).

(g) Consumer protection provisions
(1) In general
The requirements of this subsection are met with respect to any contract if the contract meets—
(A) the requirements of the model regulation and model Act described in paragraph (2),
(B) the disclosure requirement of paragraph (3), and
(C) the requirements relating to non-forfeitability under paragraph (4).
(2) Requirements of model regulation and Act
(A) In general
The requirements of this paragraph are met with respect to any contract if such contract meets—
(i) Model regulation The following requirements of the model regulation:
(I) Section 7A (relating to guaranteed renewal or non-cancel-ability), and the requirements of section 6B of the model Act relating to such section 7A.
(II) Section 7B (relating to prohibitions on limitations and exclusions).
(III) Section 7C (relating to extension of benefits).
(IV) Section 7D (relating to continuation or conversion of coverage).
(V) Section 7E (relating to discontinuance and replacement of policies).
(VI) Section 8 (relating to unintentional lapse).
(VII) Section 9 (relating to disclosure), other than section 9F thereof.
(VIII) Section 10 (relating to prohibitions against post-claims underwriting).
(IX) Section 11 (relating to minimum standards).
(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.
(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).
(ii) Model Act The following requirements of the model Act:
(I) Section 6C (relating to preexisting conditions).
(II) Section 6D (relating to prior hospitalization).

(B) Definitions
For purposes of this paragraph—
(i) Model provisions The terms “model regulation” and “model Act” mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).
(ii) Coordination Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.
(iii) Determination For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.
(3) Disclosure requirement
The requirement of this paragraph is met with respect to any contract if such contract meets the requirements of section 4980C (d).
(4) Non-forfeiture requirements
(A) In general
The requirements of this paragraph are met with respect to any level premium contract, if the issuer of such contract offers to the policyholder, including any group policyholder, a non-forfeiture provision meeting the requirements of subparagraph (B).
(B) Requirements of provision
The non-forfeiture provision required under subparagraph (A) shall meet the following requirements:
(i) The non-forfeiture provision shall be appropriately captioned.
(ii) The non-forfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the appropriate State regulatory agency for the same contract form.
(iii) The non-forfeiture provision shall provide at least one of the following:
(I) Reduced paid-up insurance.
(II) Extended term insurance.
(III) Shortened benefit period.
(IV) Other similar offerings approved by the appropriate State regulatory agency.

(5) Cross reference
For coordination of the requirements of this subsection with State requirements, see section 4980C (f).

304.14-642 Kentucky Long-Term Care Partnership Insurance Program -- Policy component requirements -- Administrative regulations.

(1) The Kentucky Long-Term Care Partnership Insurance Program is established as a partnership between the Department for Medicaid Services and the Office of Insurance to:
(a) Provide incentives for an individual to insure against the cost of providing for his or her long-term care needs;
(b) Increase utilization of long-term care insurance policies;
(c) Assist in alleviating the financial burden of Kentucky's Medicaid program by encouraging the use of private insurance; and
(d) Provide a mechanism for individuals to qualify for Medicaid services for costs of long-term care without exhausting all of their assets and resources.
(2) A long-term care partnership insurance policy shall:
(a) Provide coverage for expenses for at least twelve (12) months for each covered person on an expense-incurred, indemnity, or prepaid basis for one (1) or more long-term care services provided in a setting other than an acute care unit of a hospital;
(b) Be qualified under Section 7702B(b) of the Internal Revenue Code of 1986;
(c) Provide coverage for long-term care services for a policyholder who is a resident of a state with a qualified long-term care partnership program when coverage first became effective; and
(d) Not be issued prior to the effective date of an approved amendment to the State Medicaid Plan.
(3) The Office of Insurance shall have responsibility to approve, pursuant to KRS 304.14-120, any long-term care partnership insurance policy available in Kentucky that meets and continues to meet all applicable federal and state laws and regulations. The state shall not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with the partnership.
(4) The Office of Insurance shall ensure that any agent who sells a long-term care partnership insurance policy can demonstrate an understanding of long-term care partnership insurance and how it relates to other public and private coverage of long-term care expenses. The Department for Medicaid Services shall provide consultation, materials, and other information to the Office of Insurance to enable the Office of Insurance to facilitate the development and issuance of uniform training materials for agents who sell long-term care insurance policies. The Office of Insurance may contract with another entity to conduct agent training and testing. Training and certification may be conducted at the expense of the insurance agent.
(5) Within sixty (60) days of notice of approval of the amendment to the State Medicaid Plan required under KRS 205.619, the Office of Insurance shall Page 2 of 2 promulgate an administrative regulation pursuant to KRS Chapter 13A to implement the Kentucky Long-Term Care Partnership Insurance Program.
(6) The Office of Insurance and the Department for Medicaid Services shall report no later than September 30 each year to the Interim Joint Committee on Banking and Insurance and the Interim Joint Committee on Health and Welfare on the number of partnership insurance policies sold in Kentucky, utilization of the partnership insurance policies, and expenditures and cost savings associated with implementation, utilization, and maintenance of the partnership program. If national data reporting standards become available, the report submitted to the federal agency shall meet the requirements of this subsection.

304.14-600 Definitions for KRS 304.14-600 to 304.14-625.

As used in KRS 304.14-600 to 304.14-625, unless the context requires otherwise:
(1) "Incidental" indicates that the value of the long-term care benefits provided in a policy is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. Policies may include life insurance, disability insurance, and annuities. These values shall be measured as of the date of issue.
(2) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital unless the hospital or unit is licensed or certified to provide long-term services. This term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. This term includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. This term also includes qualified long-term care insurance contracts as defined in 26 U.S.C. sec. 7702B(b). Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit hospital, medical-surgical, dental, and health service corporations, health maintenance organizations, or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense

coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one (1) or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Any product advertised, marketed, or offered as long-term care insurance or nursing home insurance which otherwise meets the definition of long-term care insurance shall be subject to the provisions of KRS 304.14-600 to 304.14-625.

(3) "Applicant" means:
(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and
(b) In the case of a group long-term care insurance policy, the proposed certificate holder.
(4) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in Kentucky, except as provided in KRS 304.14-610.
(5) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in Kentucky by an insurer, fraternal benefit society, nonprofit health service corporation, or health maintenance organization, and which is issued to:
(a) One (1) or more employers or labor organizations, or to a trust or to the trustees of a fund established by one (1) or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the labor organizations;
(b) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association:
1. Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and
2. Has been maintained in good faith for purposes other than obtaining insurance;
(c) An association or a trust or the trustee of a fund established, created, or maintained for the benefit of members of one (1) or more associations. Prior to advertising, marketing, or offering the policy within Kentucky, the insurer of the association shall file with the executive director evidence that the association has at the outset a minimum of one hundred (100) persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one (1) year, and has a constitution and bylaws which provide:
1. The association holds regular meetings not less than annually to further the purposes of the members;
2. Except for credit unions, the association collects dues or solicits contributions from members; and
3. The members have voting privileges and representation on the governing board and committees.
The association shall be deemed to satisfy the organizational requirements unless the executive director makes a finding that the association does not satisfy those organizational requirements within the time set forth in KRS 304.14-120; or
(d) A group other than that described in paragraphs (a), (b), and (c) of this subsection, subject to a finding by the executive director that:
1. The issuance of the group policy is not contrary to the best interest of the public;
2. The issuance of the group policy would result in economies of acquisition or administration; and
3. The benefits are reasonable in relation to the premiums charged.
(6) "Policy" means any policy, contract, subscriber, agreement, enrollment agreement, rider, or endorsement delivered or issued for delivery in Kentucky.

304.14-640 Definitions for KRS 205.619 and 304.14-640 to 304.14-644.

As used in KRS 205.619 and 304.14-640 to 304.14-644, unless the context requires otherwise:
(1) "Asset disregard" means a one dollar ($1) increase in the amount of assets the policyholder may own and retain for each one dollar ($1) of benefit paid under a long-term care partnership insurance policy qualified under KRS 205.619 and 304.14-640 to 304.14-644 when the policyholder applies for benefits of the Medicaid program;
(2) "Kentucky Long-Term Care Partnership Insurance Program" means a joint Kentucky Medicaid and private long-term care insurance program established by KRS 205.619 and 304.14-640 to 304.14-644 that incorporates asset disregard and exempts a policyholder from estate recovery requirements of the Medicaid program up to the amount of the asset disregard if the policyholder receives Medicaid benefits while or after accessing the benefits of the qualified long-term care partnership policy;
(3) "Long-term care" means necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital unless the hospital or unit is licensed or certified to provide long-term care services; and

(4) "Long-term care partnership insurance" means insurance coverage or an insurance policy that meets the requirements of KRS 304.14-642. Long-term care partnership insurance benefits shall not include payment of coinsurance, deductibles, or premiums for services covered by other insurance policies, services covered by other insurance policies, or services covered by Parts A, B, or D of the Medicare program specified by
42 U.S.C. sec. 1395 et seq.

304.14-644 Required disclosure of availability of Kentucky Long-Term Care Partnership Insurance Program.

(1) Each insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, shall provide each prospective applicant a Partnership Program Notice disclosing the availability of the Kentucky Long-Term Care Partnership Insurance Program as authorized in Section 6021 of the Deficit Reduction Act of 2005 and outlining the requirements and benefits of a partnership policy.
(2) The manner and content of the disclosure described in subsection (1) of this section shall be established through promulgation of administrative regulations by the Office of Insurance in coordination with the Cabinet for Health and Family Services.

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

RELATES TO: KRS 304.1-040, 304.2-310, 304.6-070, 304.6-130-180, 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 Executive Director 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 Executive Director 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 Executive Director 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 Executive Director of Insurance to promulgate reasonable administrative regulations necessary for the proper administration of KRS Chapter 304.32. KRS 304.38-150 authorizes the Executive Director 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) Non-institutional 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) Renew ability. The terms "guaranteed renewable" and "non-cancelable" 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 "non-cancelable."

(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 "non-cancelable" 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 insurance 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.

1. An individual long-term care policy or certificate shall not be issued until the insurer has received from the applicant a written:

a. 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

b. Waiver:

1. Dated and signed by the applicant; and

2. Electing not to designate additional persons to receive notice.

3. Designation shall not constitute acceptance of any liability of the third party for services provided to the insured.

4. The form used for the written designation shall provide space clearly designated for listing at least one (1) person.

5. The designation shall include each person's full name and home address.

6. If an applicant elects not to designate an additional person, the waiver shall contain the language as established in HIPMC-LTC-10.

7. 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 non-home 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. Renew ability 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 non-forfeiture 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. Renew ability;

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. Non-forfeiture 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% 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 non-forfeiture 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. Renew ability;

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. Non-forfeiture 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. Non-forfeiture 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 non-forfeiture benefit.

(a) The offer of a non-forfeiture benefit may be in the form of a rider, which is attached to the policy.

(b) If a policyholder or certificate holder declines the non-forfeiture 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 non-forfeiture 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 non-forfeiture benefits;

(b) Be the benefit described in subsection (7) of this section; and

(c) Be in writing if the non-forfeiture 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 non-forfeiture benefit; and

2. A group policy without a non-forfeiture benefit.

(b) If a group policyholder elects to make the non-forfeiture benefit an option to the certificate holder, a certificate shall provide either the non-forfeiture 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 non-forfeiture 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 non-forfeiture 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 non-forfeiture 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 non-forfeiture credit for that duration.

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

4. The calculation of a non-forfeiture 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 non-forfeiture 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 non-forfeiture 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 non-forfeiture 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 non-forfeiture 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 non-forfeiture 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 non-forfeiture benefit offered by an insurer shall:

(a) Be appropriately captioned;

(b) Indicate that the non-forfeiture 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.
(5) 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% 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;
(h) "Outline of Coverage, HIPMC-LTC-7", 09/2008;
(i) "Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-term Care Insurance, HIPMC-LTC-8", 09/2008;
(j) "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-term Care Insurance, HIPMC-LTC-9", 09/2008;
(k) "Disclosures and Language for Long-term Care Policies and Certificates, HIPMC-LTC-10", 09/2008; and
(l) "Long-term Care insurance replacement and lapse reporting form, HIPMC-LTC-11", 09/2008.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.
(3) Forms may also be obtained on the department's Web site at http://insurance.ky.gov. (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.)

806 KAR 17:085. Minimum standards for short-term nursing home insurance policies.

RELATES TO: KRS 304.14-650-304.14-675
STATUTORY AUTHORITY: KRS 304.2-110(1), 304.14-660
NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the Executive Director of Insurance to promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.14-660 requires the Executive Director of Insurance to promulgate administrative regulations establishing requirements for short-term nursing home insurance policies. This administrative regulation establishes minimum standards for short-term nursing home insurance policies.

Section 1. Definitions. (1) "Applicant" means:

(a) For an individual short-term nursing home insurance policy, the person who seeks to contract for benefits; and

(b) For a group short-term nursing home insurance policy, the proposed certificate holder.

(2) "Attained age rating" means a schedule of premiums starting from the issue age which increases 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" means any certificate issued under a group short-term nursing home insurance policy, which has been delivered or issued for delivery in Kentucky.

(4) "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.

(5) "Commissioner" is defined by KRS 304.1-050.

(6) "Compensation" means pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of short-term nursing home insurance or certificates, including bonuses, gift, prizes, awards, and finders fees.

(7) "Elimination period" means the time that shall elapse before benefits commence under a short-term nursing home insurance policy or certificate.

(8) "Insurer" means an entity authorized to issue short-term nursing home insurance in Kentucky.

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

(10) "Policy" means any policy, contract, subscriber agreement, enrollment agreement, rider, or endorsement delivered or issued for delivery in Kentucky.

(11) "Short-term nursing home insurance policies" is defined in KRS 304.14-650.

Section 2. Policy Requirements. A short-term nursing home insurance policy delivered or issued for delivery in Kentucky shall not use the terms set forth below unless the terms are defined in the policy as follows:

(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. The individual requires frequent monitoring by medical professionals, such as 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 can benefit from care in a group setting outside the home.

(4) "Bathing" means washing oneself by sponge bath; or in either 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 judgement as it relates to safety awareness.

(6) "Continence" means the ability to maintain control of bowel and bladder function; if, when 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 (such as a plate, cup, or table) or by a feeding tube or intravenously.

(9) "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) 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, provided to ill, disabled or infirm persons in their residences. The services may include homemaker services, assistance with activities of daily living, and respite care services.

(11) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of PL 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 words of similar import.

(12) "Mental or nervous disorder" shall not be defined to include more than 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.

Section 3. Policy Practices and Provisions. (1) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual short-term nursing home insurance policy without further explanatory language in accordance with the disclosure requirements of Section 5 of this administrative regulation.

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

(b) The term "guaranteed renewable" may be used only if the insured has the right to continue the short-term nursing home insurance in force by the timely payment of premiums and if the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(c) The term "noncancellable" may be used only if the insured has the right to continue the short-term nursing home insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the scheduled premium rate.

(d) The term "level premium" may only be used if the insurer does not have the right to change the premium.

(2)(a) Limitations and exclusions. A policy shall not be delivered or issued for delivery in Kentucky as a short-term nursing home 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 as defined in Section 5(7) through (9) of this administrative regulation;

2. Mental or nervous disorders, but this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease;

3. Alcoholism and drug addiction;

4. Illness, treatment, or medical condition arising out 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 (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

e. Aviation (this exclusion shall apply only to nonfare-paying passengers);

5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability, or occupational disease law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

(b) This subsection shall not prohibit exclusions and limitations by type of provider or territorial limitations.

(3) Continuation or conversion.

(a) Group short-term nursing home insurance issued in Kentucky on or after the effective date of this administrative regulation shall provide:

1. A covered individual with a basis for continuation or conversion of coverage without underwriting upon termination of coverage; and

2. A converted policy or continued coverage including benefits identical to or benefits determined by the executive director to be substantially similar to or in excess of those provided under the group policy from which conversion or continued coverage is made.

(b) Written application for the converted policy or continued coverage shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days following notice of continuation or conversion rights under the group policy.

(4) The premium charged to an insured for short-term nursing home insurance shall not increase due to either:

(a) The increasing age of the insured at ages beyond sixty-five (65); or

(b) The duration the insured has been covered under the policy.

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

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

(a) Designation of at least one (1) person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or

(b) Waiver, dated and signed by the applicant, electing not to designate additional persons to receive notice.

(2) Lapse or termination for nonpayment of premium:

(a) An individual short-term nursing home 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 to those persons designated pursuant to subsection (1)(a) of this section, at the address provided by the insured for purposes of receiving notice of lapse or termination; and

(b) Notice shall:

1. Be given by first class United States mail, postage prepaid;

2. Not be given until thirty (30) days after a premium is due and unpaid; and
3. Be deemed to have been given as of five (5) days after the date of mailing.

Section 5. Required Information and Disclosure Provisions. (1) Renewability.
(a) Individual short-term nursing home insurance policies shall contain a renewability provision.
(b) The provision 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.
(c) All short-term nursing home policies or certificates issued in the commonwealth of Kentucky shall state in (16) sixteen point bold type print on the front page of the policy the following statement: This is a short-term nursing home product that offers benefits for less than twelve (12) months. This is not a long-term care policy.
(2) Riders and endorsements.
(a) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual short-term nursing home insurance policy, riders or endorsements added to an individual short-term nursing home insurance policy after date of issue or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured.
(b) After the date of policy issue, a rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law.
(c) If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.
(3) Payment of benefits. A short-term nursing home insurance policy or certificate shall clearly define how benefits will be paid.
(4) Limitations. If a short-term nursing home insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations".
(5) Other limitations or conditions on eligibility for benefits. A short-term nursing home insurance policy or certificate containing any limitations or conditions for eligibility including any elimination period shall be clearly defined in the policy or certificate and shall be labeled the paragraph "Limitations or Conditions on Eligibility for Benefits".
(6) A provider of service shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.
(7) Short-term nursing home policies or certificates shall not use a definition of preexisting condition which is more restrictive than the following: "Preexisting condition means a condition for which medical services or treatment was recommended by, or received from, a provider of health care services within six (6) months preceding the effective date of coverage of an insured person."
(8) A short-term nursing home policy or certificate shall not exclude coverage for a loss or confinement which is the result of a preexisting condition unless that loss or confinement begins within six (6) months following the effective date of coverage of the insured person.
(9) A short term nursing home policy or certificate shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting conditions or physical conditions beyond the preexisting condition periods described in subsections (7) and (8) of this section.
(10) Insurers shall disclose whether or not inflation protection is offered with any short-term nursing home policy or certificate.
(11) Short-term nursing home policies shall contain on the front page of the policy or certificate the following statement: Notice to buyer: This policy may not cover all of the costs associated with nursing home care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.
(12) An elimination period shall be calculated based upon consecutive calendar days, beginning the first day eligible services are received by the individual, and ending the first day benefits are payable.

Section 6. Prohibition Against Postclaims Underwriting. (1)(a) If an application for short-term nursing home insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list all medication that has been prescribed.
(b) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.
(2)(a) The following language, or language substantially similar to the following, shall be set out conspicuously on the short-term nursing home insurance policy or certificate no later than when it is delivered: "Caution: The issuance of this short-term nursing home insurance (policy or certificate) is based upon your responses to the questions on your application. A copy of your (application or

enrollment form) (is enclosed or was retained by you when you applied). If your answers, to the best of your knowledge and belief, are incorrect or untrue, the insurer may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the insurer at this address: (insert address)."

(3) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than when the policy or certificate is delivered unless it was retained by the applicant at the time of application.

Section 7. Reserve Standards. (1)(a) If short-term nursing home insurance benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, policy reserves for these benefits shall be determined in accordance with KRS 304.6-130 to 304.6-180.

(b) Claim reserves shall also be established if the policy or rider is in claim status.

(c) In the development and calculation of reserves for policies and riders subject to the requirements of this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs.

(d) Any 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 short-term nursing home benefits are provided other than as in subsection (1) of this section, reserves shall be determined in accordance with KRS 304.6-070.

Section 8. Loss Ratio. (1) Rate filings shall follow the filing procedures contained in 806 KAR 14:007 and 806 KAR 17:070.

(2) Initial premium rate schedules shall be calculated such that the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the present value of future projected earned premiums times sixty (60) percent.

(3) Premium rate schedule increases shall be calculated such 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, will not be less than the sum of the following:

(a) The accumulated value of the initial earned premiums times sixty (60) percent;

(b) Eighty-five (85) percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(c) The present value of future projected initial earned premiums times sixty (60) percent; and

(d) Eighty-five (85) percent of the present value of future projected premiums not in paragraph (c) of this subsection on an earned basis.

(4) All present and accumulated values used to determine rates shall use the maximum valuation interest rate for contract reserves as specified in 806 KAR 6:080. The actuary shall disclose as part of the actuarial memorandum required by 806 KAR 17:070, Section 3, the use of any appropriate averages.

Section 9. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates. If a short-term nursing home insurance policy or certificate replaces another short-term nursing home or long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new short-term nursing home insurance policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy. (29 Ky.R. 1441; Am. 1797; eff. 1-16-2003; TAm eff. 8-9-2007.)

806 KAR 9:220. Continuing education.

RELATES TO: KRS 304.9-230, 304.9-260, 304.9-295, 304.14-642, 304.15-700(3), Pub.L. 108-264 sec. 207

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.9-295(5), (7), 304.14-642(5), 304.15-720, Pub.L. 108-264 sec. 207

NECESSITY, FUNCTION, AND CONFORMITY: EO 2008-507, signed June 6, 2008, and effective June 16, 2008, created the Department of Insurance, headed by the Commissioner of Insurance. KRS 304.2-110(1) authorizes the Executive Director of Insurance to promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.9-295(5) and (7) authorize the executive director to limit the number of continuing education hours carried forward to the subsequent biennium. KRS 304.14-642(5) requires the executive director to promulgate an administrative regulation to implement the Kentucky Long-Term Care Partnership Program. KRS 304.15-720 requires the executive director to promulgate administrative regulations to implement KRS 304.15-700 to 304.15-720, Kentucky's Life Settlement Law. Pub.L. 108-264 sec. 207 requires the Administrator of the Federal Emergency Management Agency to establish minimum training and education requirements for all insurance agents who sell flood insurance policies in cooperation with state insurance regulators. This administrative regulation establishes procedures for approval of agent and life settlement broker continuing education courses and obtaining credit for attending continuing education courses.

Section 1. Definitions. (1) "Commissioner" means the Commissioner of the Department of Insurance.

(2) "Department" means the Department of Insurance.

(3) "Provider" means the sponsor of a continuing education course.

Section 2. Continuing Education Course Requirements. (1) A continuing education course shall be offered by a provider approved by the commissioner, pursuant to this section:

(a) The application for approval of a provider shall be submitted on the "Provider Approval Application" form incorporated by reference, in 806 KAR 9:340; and

(b) The information shall show that the provider is qualified, through knowledge or experience, to provide prelicensing or continuing education courses and that the provider is properly authorized to charge a course fee, if any.

(2)(a) A continuing education course shall be filed with and approved by the commissioner at least sixty (60) days in advance of advertising unless the commissioner, waives the sixty (60) day period.

(b) In determining whether to grant a waiver, the commissioner shall consider whether the failure to file and approve the continuing education course within the time period specified in paragraph (a) of this subsection was due to circumstances which would reasonably justify failure to comply.

(3)(a)1. All applications for approval of a continuing education course shall be submitted on the "Course Approval Application" form incorporated by reference, in 806 KAR 9:340, which shall be accompanied by the "Filing Fee Submission Form" incorporated by reference, in 806 KAR 9:340, and a nonrefundable initial fee of ten (10) dollars.

2. Notwithstanding the requirements in paragraph (a)1 Of this subsection, application for approval of a continuing education course being offered in more than one (1) state, may be submitted on the Nation Association of Insurance Commissioners' "Uniform Continuing Education Reciprocity Course Filing Form" incorporated by reference in 806 KAR 9:340.

(b) After review and assignment of the number of credit hours, the commissioner shall notify the provider of the additional fee of five (5) dollars per credit hour due pursuant to 806 KAR 4:010.

(c) A continuing education course shall not be approved until all fees are paid.

(4) The commissioner shall approve a continuing education course if it meets the following requirements:

(a) The continuing education course shall contribute directly, at a professional level, to the competence of the licensee including the following subjects:

1. Insurance, annuities, and risk management;
2. Insurance laws and administrative regulations;
3. Mathematics, statistics, and probability;
4. Economics;
5. Business law;
6. Finance;
7. Taxes;
8. Business environment, management, or organization;
9. Ethics; and
10. Other topics approved by the commissioner which contribute directly at a professional level to the competence of the licensee; and

(b) Course development and presentation:

1. The continuing education course shall have substantial intellectual or practical content to enhance and improve the knowledge and professional competence of participants;
2. The course shall be developed by persons who are qualified in the subject matter and instructional design;
3. Material shall be current, relevant, accurate, and include valid reference materials, graphics, and interactivity;
4. The course shall have clearly defined objectives and course completion criteria;
5. Each course shall have a written outline and study materials or texts;
6. Information shall show that the instructors are qualified, through training or experience, to instruct the continuing education course competently and shall be submitted on the "Instructor Approval Application" incorporated by reference, in 806 KAR 9:340, and shall be accompanied by the "Filing Fee Submission Form" incorporated by reference, as in 806 KAR 9:340;
7. The number of participants and physical facilities shall be consistent with the teaching method specified; and
8. All courses shall include some means of evaluating quality.

(5) Continuing education credit shall not be provided for:

(a) Any course used to prepare for taking an examination required pursuant to KRS Chapter 304;

(b) Committee service of professional organizations;

(c) Computer training to develop functional skills

(d) Motivational or sales training courses; and

(e) Any course not in accordance with Section 2(4) of this administrative regulation.

(6) Any material change in a continuing education course shall be filed with and approved by the commissioner prior to use. The material change shall not be approved until the filing fees are paid in accordance with subsection (3) of this section.

(7) Biennially, providers shall renew approval of continuing education courses and instructors. Providers shall file applicable information with and pay the applicable fee specified in 806 KAR 4:010 to the commissioner prior to June 30 of even-numbered years.

Section 3. Measurement of Credit Hours. Continuing education courses shall be measured according to course type and calculated in the following manner:

(1) Classroom courses. Each credit hour of a continuing education course shall include at least fifty (50) minutes of continuous instruction or participation.

(2) Self-Study Courses. Each credit hour of a continuing education course completed online or by correspondence shall be calculated in accordance with the National Association of Insurance Commissioner's "Recommended Guidelines for Online Courses."

(3) A continuing education course, regardless of whether it is offered as a classroom course, online course, by correspondence, or self-study, shall not be credited for continuing education by a licensee more than once per continuing education biennium.

Section 4. Reasons for Withdrawal. The commissioner may withdraw approval of a continuing education course, provider, or instructor for any of the following reasons:

(1) The continuing education course teaching methods or course content:

(a) No longer meet the requirements of:

1. KRS 304.9-295; or

2. Sections 2 and 3 of this administrative regulation; or

(b) The course has been materially changed without being filed with and approved by the commissioner, in accordance with Section 2 of this administrative regulation;

(2) The continuing education course provider has certified to the commissioner that a licensee has satisfactorily completed the course when, in fact, the licensee has not done so;

(3) The continuing education course provider fails to certify to the commissioner that a licensee has satisfactorily completed the course when, in fact, the licensee has done so; or

(4) Unethical conduct of a provider or instructor.

Section 5. Product Specific Continuing Education and Training Requirements. (1) Any resident licensee selling, soliciting, or negotiating insurance products that qualify under the Long-Term Care Partnership Insurance Program, as described in KRS 304.14-462, shall complete eight (8) hours of initial long-term care training, and four (4) hours of additional training for each biennial continuing education compliance period.

(2) Any resident licensee licensed with Property and Casualty lines of authority selling federal flood insurance shall complete three (3) hours of training in accordance with the Flood Insurance Reform Act of 2004, as set forth in Pub.L. 108-264, Section 207.

(3) The training requirements in subsections (1) and (2) of this section may apply toward fulfillment of a licensee's continuing education requirement as set forth in KRS 304.2-295 and 304.15-700(3), if the training has been approved as a continuing education course in accordance with Section 2 of this administrative regulation and proof of completion is made in accordance with Section 6 of this administrative regulation.

Section 6. Proof of Completion. (1)(a) Within thirty (30) days of completion of a continuing education course, the provider shall certify to the commissioner the names of all licensees who satisfactorily completed the continuing education course.

(b) The provider shall maintain the "Continuing Education Course Attendance Roster" form, incorporated by reference in 806 KAR 9:340, for at least five (5) years and shall be subject to random audits to ensure compliance with this requirement.

(c) The certification of completion required by this section for a classroom course shall be submitted electronically on the "Continuing Education Course Attendance Roster" form, incorporated by reference in 806 KAR 9:340, through the Department of Insurance Web site, https://doi.ppr.ky.gov/kentucky/secured/Eservices/default.aspx.

(d)1. The certification of completion required by this section for a self-study course shall be submitted on the "Continuing Education Certificate of Completion" Form, incorporated by reference in 806 KAR 9:340.

2. The provider shall:

a. Forward the form to the licensee for signature; and

b. Instruct the licensee to file the form with the commissioner.

3. In addition, the information may be submitted electronically by the provider to the commissioner through the Department of Insurance Web site, https://doi.ppr.ky.gov/kentucky/secured/Eservices/default.aspx

(2)(a) The provider of the continuing education course shall furnish to the licensee attending the course a certificate and the licensee shall retain the certificate for at least five (5) years.

(b) The certification required by this subsection shall be on the "Continuing Education Certificate of Completion" Form, incorporated by reference in 806 KAR 9:340.

(c) The provider of the continuing education course shall retain a copy of the certificate for at least five (5) years.

(d) Providers of continuing education courses and licensees shall make available to the commissioner's designee copies of these certificates upon the request of the commissioner.

(3) Pursuant to KRS 304.9-295(2) and (9), every licensee shall be responsible for ensuring that the licensee's continuing education certificates of completion are timely filed with the department even if the provider does not fulfill its responsibilities under this administrative regulation.

(4)(a) At least six (6) hours of total credit earned per biennium shall be directly related to any one (1) or more of the lines of authority for which the agent is actively licensed.

(b) At least three (3) hours of total credit earned per biennium shall be in ethics.

(c) Hours may be classroom, self-study, or a combination of both.

(5) Each self-study course shall require successful completion of a written examination or the submission of a statement by the licensee made under oath that the course was completed within the biennium.

(6) Licensees may carry forward up to twelve (12) excess credit hours to the subsequent continuing education biennium.

Section 7. Cancellation and Reinstatement of Licenses. (1) Proof of fulfillment of a resident licensee's continuing education requirement shall be received in conjunction with license renewal in accordance with KRS 304.9-260 and 304.9-295.

(2) If the department does not receive proof of the fulfillment of a licensee's continuing education requirements on or before the deadline, pursuant to KRS 304.9-295. the commissioner shall:

(a) Make information of the deficiency available to the licensee; and

(b) Terminate the license if proof of completion of the deficient hours on the "Continuing Education Course Attendance Roster" Form incorporated by reference, in 806 KAR 9:340, or the "Continuing Education Certificate of Completion" Form incorporated by reference, in 806 KAR 9:340, is not received by the department on or before the deadline in accordance with KRS 304.9-295.

(3) Within twelve (12) months after a license is terminated for failing to submit certification of continuing education, the license may be reissued if the licensee:

(a) Satisfies the delinquent continuing education requirements;

(b) Submits a new application with required attachments for a license; and

(c) Submits the applicable fees.

(4) If the continuing education delinquency remains unsatisfied for twelve (12) months or longer, the former licensee shall satisfy all of the licensing requirements specified in KRS Chapter 304, Subtitle 9.

Section 8. Requests for an Extension of Time.from Continuing Education. (1) An agent exempted from continuing education requirements on the basis of a supporting affidavit that the agent license is maintained for the sole purpose of receiving renewals or deferred commissions may withdraw the continuing education exemption and may have all restrictions against selling, soliciting, and negotiating insurance removed from the agent license by:

(a) Completing the continuing education requirements for the immediate preceding continuing education biennium;

(b) Providing a certification of completion of those continuing education requirements; and

(c) Providing a signed, written statement withdrawing the affidavit.

(2) Use of a supporting affidavit that the agent license is maintained for the sole purpose of receiving renewals or deferred commissions for any reason, including an extension for completion of continuing education requirements for a continuing education biennium, shall be a violation of KRS 304.9-295 and shall subject the affiant to suspension or revocation of the agent license.

(3) Members of the Armed Forces who have been mobilized or deployed in support of their duties may:

(a) Request an extension of time for completion of continuing education requirements, in accordance with KRS 304.9-260(3), by filing with the department form, "Request for Waiver of Renewal Procedures or Exemption from Examination or Extension for Continuing Education Due to Active Military Service Deployment," incorporated by reference in 806 KAR 9:340; or

(b) Request a waiver for continuing education requirements in accordance with KRS 304.9-260(3).

Section 9. Limited lines of authority as identified in KRS 304.9-230 shall be exempt from all continuing education requirements.

Section 10. Incorporation by reference. (1) "Recommended Guidelines for Online Courses", 2005 National Association of Insurance Commissioners, is incorporated by reference.

(2) This material may be inspected, copied or obtained, subject to applicable copyright law, at the Kentucky Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (17 Ky.R. 803; eff. 10-14-90; Am. 18 Ky.R. 803; eff. 11-8-91; 21 Ky.R. 2797; 22 Ky.R. 58; reprinted 675; eff. 7-6-95; 27 Ky.R. 1594; 2254; eff. 2-15-2001; 29 Ky.R. 2358; 2689; eff. 5-13-2003; 32 Ky.R. 318; 906; 1619; eff. 3-31-06; 35 Ky.R. 1023; 1468; eff. 1-5-2009.)

907 KAR 1:585. Estate recovery.

RELATES TO: KRS 205.520, 205.619, 304.14-640[-~~304.14-644~~], 42 C.F.R. 430.10, 435.236, 42 U.S.C. 1396p(b)(1)-(4)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. 42 U.S.C. 1396p(b)(1)-(4) establishes minimum requirements for state plans for estate recovery actions. This administrative regulation establishes provisions relating to estate recovery.

Section 1. Definitions. (1) "Aged institutionalized individual" means a recipient age fifty-five (55) or older who received nursing facility (NF) services, intermediate care facility for individuals with mental retardation or a developmental disability (ICF/MR/DD) services, home and community based (HCB) waiver services, supports for community living (SCL) services, acquired brain injury (ABI) waiver services, ABI long-term care waiver services, or Michelle P. waiver services with payment for these services made, wholly or in part, by the Medicaid Program.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Estate" means:

(a) All real and personal property or other assets owned by the deceased recipient that would be included as probate property under Kentucky law; and

(b) All real and personal property or other assets in which the deceased recipient had legal title or interest at the time of death, to the extent of the recipient's interest, whether the asset was conveyed to a survivor, heir or assign of the deceased recipient through joint tenancy, tenancy in common survivorship, life estate, living trust or other arrangement.

(4) "Estate representative" means the court appointed fiduciary or the fiduciary's attorney, the recipient family member or other interested party who represents to the department in writing that he or she is the representative for the estate.

(5) "Long-term care partnership insurance" is defined by KRS 304.14-640(4).

(6) "Long-term care partnership insurance policy" means a policy meeting the requirements established in KRS 304.14-642(2).

(7) "Period of institutionalization" means the period of time an aged institutionalized or permanently institutionalized individual received Medicaid services.

(8) "Permanently institutionalized" means residing in a nursing facility or intermediate care facility for individuals with mental retardation or a developmental disability for six (6) months or more.

(9) "Recipient family member" means the surviving spouse, child or sibling of a deceased recipient.

(10) "State plan" is defined by 42 C.F.R. 400.203.

(11) "Surviving child" means a living child under age twenty-one (21)[,] or a child who is blind or disabled as defined in 42 U.S.C. 1382c.

Section 2. Recovery. (1) The department shall seek recovery from the estate of a deceased recipient for a period of institutionalization.

(2) The amount recovered shall not exceed the amount paid by the Medicaid Program on behalf of the deceased recipient for services received during a period of institutionalization.

(3) The amount subject to recovery shall include:

(a) The expenditures for:

1. NFservices pursuant to 907 KAR 1:022;
2. ICF/MR/DD services pursuant to 907 KAR 1:022;
3. Home and community based (HBC) waiver services pursuant to 907 KAR 1:160;
4. Supports for community living (SCL) services pursuant to 907 KAR 1:145;
5. Acquired brain injury (ABI) waiver services pursuant to 907 KAR 3:090;
6. ABI long-term care waiver services pursuant to 907 KAR 3:210; or
7. Michelle P. waiver services pursuant to 907 KAR 1:835; or[~~and~~]

(b) Other costs for:

1. Related prescription drugs, hospital services, and related physician services; or
2. Medicare cost [-]sharing or Medicare premiums.

(4) The amount subject to recovery shall include a capitation payment made by the Medicaid Program to a managed care organization on behalf of the deceased recipient.

Section 3. Exemptions and Limitations. (1) Recovery shall not be made from the estate if the estate representative can verify to the department's satisfaction that there is a:

(a) Surviving spouse; or

(b) Surviving child.

(2) Recovery shall not be made from the estate on any resources protected from consideration during the eligibility determination process based on payment issued by a long-term care partnership insurance policy.

(3) The department shall waive estate recovery to the extent the recovery would work an undue hardship.

(a) Undue hardship shall exist if an asset subject to recovery is the sole income-producing asset, for example a family farm or business, conveyed to the surviving recipient family member. A sole income-producing asset shall not include residential real property producing income through a lease or rental arrangement.

(b) The estate representative shall apply for an undue hardship exemption by:

1. Making a written request to the department within thirty (30) days of receipt of the notice provided in accordance with Section 7[4](3)(a) of this administrative regulation; and

2. Verifying to the department's satisfaction that the criteria specified in paragraph (a) of this subsection exists for an undue hardship.

(c) The department shall issue a decision on an undue hardship exemption request within thirty (30) days of receipt of the request and supporting documentation.

(d)1. If the department denies the estate representative's request for an undue hardship exemption, the estate representative may request an appeal.

2. If an appeal is requested, an administrative hearing shall be conducted in accordance with 907 KAR 1:563, Section 4, and KRS Chapter 13B.

(e) The department shall not conclude that an undue hardship exists if the deceased recipient created the hardship by resorting to estate planning methods under which the recipient illegally divested assets to avoid estate recovery.

(4)[~~(3)~~](a) The department may waive recovery if it is not cost effective to recover from the estate.

(b) The department shall not consider it to be cost effective to recover from an estate if the total date-of-death value of the estate subject to recovery is:

1. Less than the administrative cost of recovering from the estate; or

2. $10,000 or less.

(5)[~~(4)~~](a) The department may grant an exemption of the recovery provisions on a case-by-case basis to the extent of the anticipated cost of continuing education or health care needs of an estate heir.

(b) The estate representative shall submit to the department a written request for an exemption and provide verification to the satisfaction of the department.

(6)[~~(5)~~](a) A deceased recipient's estate shall be subject to recovery of Medicaid Program expenditures to the extent it is adjudicated through a final administrative appeal process or court action that the recipient qualified for Medicaid fraudulently.

(b) If the recipient qualified for Medicaid fraudulently, the exemptions or limitations established in this section shall not apply.

Section 4. Notification. (1) A general written notice regarding estate recovery shall be provided by the department to an aged institutionalized or permanently institutionalized individual, or an authorized representative acting on his or her behalf, at the time the individual requests coverage of NF services, ICF/MR/DD services, HCB waiver services, SCL services, ABI waiver services, ABI long-term care waiver services, or Michelle P. waiver services services under the Medicaid Program.

(2) When an aged institutionalized or permanently institutionalized individual who is receiving NF services, ICF/MR/DD services, HCB waiver services, SCL services, ABI waiver services, ABI long-term care waiver services, or Michelle P. waiver services under the Medicaid Program dies, the Medicaid provider from which the recipient was receiving institutionalized services at the time of death shall be responsible for reporting the death to the local Department for Community Based Services office within ten (10) days of the date of death.

(3)(a) Upon receipt of the notice of death specified in subsection (2) of this section, the department shall prepare and serve written notice of its intent to recover upon the estate representative.

(b) The estate representative shall be responsible for notifying individuals who are affected by the proposed recovery.

(c) If no estate representative exists, notice shall be provided to the family members or heirs if the recipient has provided the department with this information through the eligibility application process.

(4) The notice of intent to recover shall include:

(a) The action the department intends to initiate;

(b) The reason for the action;

(c) Exemptions and limitations to estate recovery as specified in Section 3 of this administrative regulation;

(d) Conditions that are considered an undue hardship exemption as specified in Section 3(3)[~~(2)~~] of this administrative regulation;

(e) Procedures for applying for an undue hardship exemption as specified in Section 3(3)[~~(2)~~] of this administrative regulation;

(f) The total amount subject to recovery; and
(g) The procedure for appealing a denial of an undue hardship exemption request.

907 KAR 1:645. Resource standards for Medicaid.

RELATES TO: KRS 205.520, 42 C.F.R. Part 435, 38 U.S.C. 5503, 42 U.S.C. 1396a, 1396b, 1396d, 1397jj(b), 1397p
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 435.840, 435.843, and 42 U.S.C. 1396a(l)(3), 1396d
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the resource standards for determining eligibility for Medicaid.

Section 1. Definitions. (1) "ABD" means an individual who is aged, blind, or has a disability.
(2) "Department" means the Department for Medicaid Services or its designee.
(3) "Homestead" means property which an individual:
(a) Has an ownership interest in; and
(b) Uses as his or her principal place of residence.
(4) "Individual development account" means an account containing funds for the purpose of continuing education, purchasing a first home, business capitalization, or other purposes allowed by federal regulations or clarifications which meets the criteria established in 921 KAR 2:016.
(5) "K-TAP" means Kentucky's version of the federal block grant program of Temporary Assistance for Needy Families (TANF), a money payment program for children who are deprived of parental support or care due to:
(a) Death;
(b) Continued voluntary or involuntary absence;
(c) Physical or mental incapacity of one (1) parent or stepparent if two (2) parents are in the home; or
(d) Unemployment of one (1) parent if both parents are in the home.
(6) "Liquid resource" means cash, savings accounts, checking accounts, money market accounts, certificates of deposit, bonds and stocks.
(7) "Medicaid works individual" means an individual who:
(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B) would be considered to be receiving supplemental security income;
(b) Is at least sixteen (16), but less than sixty-five (65), years of age;
(c) Is engaged in active employment verifiable with:
1. Paycheck stubs;
2. Tax returns;
3. 1099 forms; or
4. Proof of quarterly estimated tax;
(d) Meets the income standards established in 907 KAR 1:640; and
(e) Meets the resource standards established in this administrative regulation.
(8) "Permanent institutionalization" means residing in a nursing facility or intermediate care facility for the mentally retarded and developmentally disabled for six (6) months or more.
(9) "Poverty level guidelines" means the poverty income guidelines updated annually in the Federal Register by the United States Department of Health and Human Services, under authority of 42 U.S.C. 9902(2).
(10) "Real property" means land or an interest in land with an improvement, permanent fixture, mineral, or appurtenance considered to be a permanent part of the land, and a building with an improvement or permanent fixture attached.
(11) "Resources" mean cash money and other personal property or real property that:
(a) An individual:
1. Owns; and
2. Has the right, authority, or power to convert to cash; and
(b) Is not legally restricted for support and maintenance.
(12) "SSI" means the Social Security Administration Program called supplemental security income.

Section 2. Resource Limitations. (1) For the medically needy, as established in 907 KAR 1:011 the upper limit for resources for a family size of one (1) and for a family size of two (2) shall be $2,000 and $4,000 respectively, with fifty (50) dollars for each additional member.

(2) For a pregnant woman or a child meeting the following criteria, resources shall be disregarded for:

(a) A child under age one (1);

(b) A child who is at least age one (1) but under age six (6);

(c) A child who is at least age six (6) but under age nineteen (19) who is eligible under federal poverty level guidelines; or

(d) A targeted low income child, as defined in 42 U.S.C. 1397jj(b), from birth to age nineteen (19).

(3) For a qualified Medicare beneficiary, specified low-income Medicare beneficiary, qualified working disabled individual, or a Medicare qualified individual, resources shall be limited to twice the allowable amount for the SSI Program.

(4) For a pass-through recipient, as established in 907 KAR 1:640, a person with hemophilia who received a settlement in a class action lawsuit as described in 907 KAR 1:011, or a child who lost supplemental security income eligibility due to the change in definition of childhood disability as established in 907 KAR 1:011 resources shall be limited to the allowable amounts for the SSI Program.

(5) For an AFDC-related Medicaid case, the resource limit shall be $1,000.

(6) In accordance with 42 U.S.C. 1396p, an individual shall not be eligible for Medicaid nursing facility services or other Medicaid long-term care services if the individual's equity interest in his or her home exceeds $500,000 unless:

(a) The individual has a spouse who is lawfully residing in the individual's home;

(b) The individual has a child under the age of twenty-one (21) who is lawfully residing in the individual's home; or

(c) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home.

(7) Resources for a Medicaid works individual shall not exceed $5,000 per individual or $10,000 per couple.

Section 3. Resource Exclusions. (1)(a) A homestead, household or personal effects, and farm equipment shall be excluded from consideration without limitation on value.

(b) After permanent institutionalization, property shall cease to be a homestead unless:

1. A spouse or other dependent family member continues to reside there; or

2. A signed statement verifies that the permanently-institutionalized individual intends to return to the homestead.

The statement shall:

a. Be signed by:

(i) The permanently-institutionalized individual;

(ii) A representative payee;

(iii) A person who has power of attorney for the individual;

(iv) The individual's guardian; or

(v) Another legal representative; and

b. Require annual renewal.

(2) For an adult Medicaid case or a Medicaid works individual:

(a)1. Equity of $6,000 in income-producing, nonhomestead real property, business or nonbusiness, essential for self-support, shall be excluded from consideration.

2. The value of property, including the tools of a tradesperson or the machinery or livestock of a farmer, shall be excluded from consideration as a resource if the property:

a. Is essential for self-support for the individual or spouse, or family group in the instance of a family with a child; and

b. Is used in a trade or business or by the individual or member of the family group as an employee.

(b) Except as provided in paragraph (c) of this subsection, equity of $4,500 in automobiles shall be excluded from consideration.

(c) If an automobile is used as a home, for employment, to obtain medical treatment of a specific or regular medical problem, or is specially equipped for use by an individual with a disability, the total value of the automobile shall be excluded.

(d) A payment or benefit from a federal statutory program, other than an SSI benefit, shall be excluded from consideration as a resource if precluded from consideration in an SSI determination of eligibility by the specific terms of the statute.

(3) For an ABD Medicaid case:

(a) Real property or nonreal property shall be excluded from consideration if it can be demonstrated the individual is making a reasonable effort to sell the property at fair market value or for other valuable consideration.

(b)1. Nonhome property, which was previously the homestead property of a permanently-institutionalized individual, shall be excluded for six (6) months if there is a verified effort to sell the property at fair market value.

2. Additional time to sell the property may be allowed, on a case-by-case basis, if it can be demonstrated that a reasonable effort to sell the property at fair market value within the specified time frame has failed.

3. Reasonable effort to sell the property shall consist of:

a. Listing the property with a real estate agent if the agent:

1. Places a "For Sale" sign on the property which is clearly visible from the nearest public road; and

2. Advertises the property in the local newspaper or on local television or radio stations; or

b. A combination of at least two of the following actions:

1. Advertising the property in the local newspaper or on local television or radio stations;

2. Placing a "For Sale" sign on the property which is clearly visible from the nearest public road;

3. Distributing fliers advertising the property for sale;

4. Posting notices regarding availability of the property on community bulletin boards; or

5. Showing the property to interested parties on a continuing basis.

(c) Proceeds from the sale of a home shall be excluded from consideration for three (3) months from the date of receipt if used to purchase another home.

(4) For an AFDC-related Medicaid case, $1,000 in resources shall be excluded from consideration.

(5) A burial reserve of up to $1,500 per individual, which may be in the form of a burial agreement, prepaid burial or similar arrangement, trust fund, life insurance policy, savings account, checking account, or other identifiable fund, shall be excluded from consideration.

(a) For an adult Medicaid case, the cash surrender value of life insurance shall be considered if determining the total value of burial reserves.

(b) If a burial fund is commingled with another fund, the applicant shall have thirty (30) days to separately identify the burial reserve amount.

(c) Interest or other appreciation of value of an excluded burial reserve or space shall be excluded as a resource if the amount is left to accumulate as a part of the burial reserve or space.

(6) A burial trust, burial space, plot, vault, crypt, mausoleum, urn, casket, or other repository which is customarily and traditionally used for the remains of a deceased person shall be excluded from consideration as a countable resource without regard to value.

(7) For a family-related or an AFDC-related Medicaid case, proceeds from the sale of a home shall be excluded from consideration for six (6) months from the date of receipt if used to purchase another home.

(8) Resources of an individual who is blind or has a disability shall be excluded if the resources are included in an approved plan for achieving self-support (PASS).

(9) An individual development account up to a total of $5,000, excluding interest accruing, shall be excluded from consideration as a resource for an AFDC-related Medicaid case.

(10) Disaster relief assistance shall be excluded from consideration.

(11) Cash or in-kind replacement for repair or replacement of an excluded resource shall be excluded from consideration if used to repair or replace the excluded resource within nine (9) months of the date of receipt.

(12) A life interest that a Medicaid applicant or recipient has in real estate or other property shall be excluded from consideration as an available resource.

(13) Real property other than the homestead shall be excluded from consideration if:

(a) The property is jointly owned and its sale would cause loss of housing for the other owner or owners;

(b) Its sale is barred by a legal impediment; or

(c) The owner's reasonable efforts to sell by informing the public of his intention to sell the property at fair market value have been unsuccessful.

(14) A cash payment intended specifically to enable an applicant or recipient to pay for a medical or social service shall not be considered as a resource in the month of receipt or for one (1) calendar month following the month of receipt. If the cash is still being held at the beginning of the second month following its receipt, it shall be considered a resource.

(15) An amount received which is a result of an underpayment or a retroactive payment of benefits from retirement, survivors, and disability insurance (RSDI) benefits or SSI shall be excluded as a resource for the first six (6) months following the month in which the amount is received.

(16) A federal Republic of Germany reparation payment shall not be considered as an available resource.

(17) An amount received from a victim's compensation fund established by a state to aid victims of crime shall be:

(a) Completely excluded as a resource if the individual can show that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime; or

(b) Excluded as a resource for nine (9) months if the individual can show that the amount was paid for pain and suffering.

(18) An Austrian social insurance payment based on a wage credit granted under Sections 500-506 of the Austrian General Social Insurance Act shall be excluded from resource consideration.

(19) An individual retirement account, Keogh plan, or other tax deferred asset shall be excluded as a resource until withdrawn.

(20) A payment made from a fund established by a settlement in the case of Susan Walker v. Bayer Corporation or payment made for release of claims in this action shall be excluded from consideration as an available resource.

(21) A payment received from a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation" shall be excluded from consideration as an available resource.

(22) An annuity that is irrevocable and cannot be sold or transferred shall be excluded from consideration as a resource.

Section 4. Resource Exemptions. (1) A resource which is exempted from consideration for purposes of computing eligibility for the SSI Program shall be exempted from consideration by the department.

(2) For an AFDC-related or a family-related Medicaid case, all nonliquid resources shall be exempted.

907 KAR 1:650. Trust and transferred resource requirements for Medicaid.

RELATES TO: KRS 205.520, 205.619, 205.6322, 304.14-640, 304.14-642, 42 U.S.C. 1396p(b)-f

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6322, 42 C.F.R. 435, 42 U.S.C. 1396a, 1396p

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services has responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provisions of medical assistance to Kentucky's indigent citizenry. KRS 205.6322 requires the cabinet to promulgate administrative regulations to prohibit the sheltering of assets in medical assistance long-term [-]care cases. This administrative regulation establishes trust and transferred resource requirements for Medicaid eligibility determinations.

Section 1. Definitions. (1) "Baseline date" means the date the institutionalized individual was institutionalized and applied for Medicaid.

(2) "Cabinet" means the Cabinet for Health and Family Services.

(3) "Fair market value" means an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred.

"Income" means money received from:

(a) Statutory benefits, for example social security, Veterans Administration pension, black lung benefits, or railroad retirement benefits;

(b) Pension plans;

(c) Rental property;

(d) Investments; or

(e) Wages for labor or services.

(5) "Institutionalized individual" means an individual with respect to whom payment is based on a level of care provided in a nursing facility (NF) and who is:

(a) An inpatient in:

1. A nursing facility (NF);

2. An intermediate care facility for individuals with mental retardation or a developmental disability (ICF-MR-DD); or

3. A medical institution; or

(b) Receiving home and community based services (HCBS).

(6) "Long-term care partnership insurance" is defined by KRS 304.14-640(4).

(7) "Long-term care partnership insurance policy" means a policy meeting the requirements established in KRS 304.14-642(2).

(8) "Qualifying Income Trust" or "QIT" means an irrevocable trust established for the benefit of an identified individual in accordance with 42 U.S.C. 1396p(d)(4)(B).

(9) "Resources" mean money and other personal property or real property that an institutionalized individual or institutionalized individual's spouse:

(a) Owns;

(b) Has the right, authority or power to convert to cash; and

(c) Is not legally restricted from using for support and maintenance.

(10)"Transferred resource factor" means an amount that is:

(a) Equal to the average monthly cost of nursing facility services in the state at the time of application. The average monthly cost shall be the average of the private pay rates for semi-private rooms of all Medicaid-participating nursing facilities; and

(b) Adjusted annually.

(11) "Trust" means a legal instrument or agreement valid under Kentucky state law in which:

(a) A grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee or trustees for the benefit of the grantor or certain designated individuals or beneficiaries; and

(b) A trustee holds a fiduciary responsibility to manage the trust's corpus and income for the benefit of the beneficiaries.

(12) "Uncompensated value" means the difference between the fair market value at the time of transfer, less any outstanding loans, mortgages, or other encumbrances on the asset, and the amount received for the asset.

Section 2. Transferred Resources. (1) Transfer of resources on or before August 10, 1993.

(a) If an institutionalized individual applies for Medicaid, a period of ineligibility shall be computed if during the thirty (30) month period immediately preceding the application, but on or before August 10, 1993, the individual or the spouse disposed of property for less than fair market value.

(b) The period of ineligibility shall begin with the month of the transfer and shall be equal to the lesser of:

1. Thirty (30) months; or

2. The number of months derived by dividing the total uncompensated value of the resources transferred by the transferred resource factor at the time of the application.

(2) Transfer of resources after August 10, 1993 and before February 8, 2006.

(a) If an institutionalized individual applies for Medicaid, a period of ineligibility for NF or ICF-MR-DD services, or HCBS shall be computed if:

1. During the thirty-six (36) month period immediately preceding the baseline date, but after August 10, 1993, and before March 9, 2007 assets were transferred; or

2. During the sixty (60) month period immediately preceding the baseline date, but after August 10, 1993, and before March 9, 2007, a trust was created whereby the individual or the spouse disposed of property for less than fair market value.

(b) The period of ineligibility shall:

1. Begin with the month of the transfer; and

2. Be equal to the number of months derived by dividing the total uncompensated value of the resources transferred by the transferred resource factor at the time of the application.

(3) Transfer of resources on or after February 8, 2006.

(a) If an institutionalized individual applies for Medicaid, a period of ineligibility for NF or ICF-MR-DD services, or HCBS shall be computed if:

1. During the sixty (60) month period immediately preceding the baseline date, but on or after February 8, 2006, assets were transferred; or

2. During the sixty (60) month period immediately preceding the baseline date, but on or after February 8, 2006, a trust was created whereby the individual or the spouse disposed of property for less than fair market value.

(b) The period of ineligibility shall:

1. Begin with the month of Medicaid eligibility for NF or ICF-MR-DD services, or HCBS; and

2. Be equal to the number of months derived by dividing the total uncompensated value of the resources transferred by the transferred resource factor at the time of application.

(4) Jointly held resources shall be considered pursuant to 42 U.S.C. 1396p(c)(3).

(5) the addition of another individual's name to a deed shall constitute a transfer of resources.

(6) If a spouse transfers resources that result in an ineligibility period for the institutionalized spouse, the ineligibility period shall be apportioned between the spouses if the spouse is subsequently institutionalized and a portion of the ineligibility period against the first institutionalized spouse remains. If one (1) spouse is no longer subject to the ineligibility period, the remaining ineligibility period applicable to both spouses shall be served by the remaining spouse.

(7) The requirements of this subsection shall apply to an agreement in which an individual, prior to institutionalization, employed another person as a caregiver and made payment for all services provided by the caregiver prior to the individual's entry in a nursing facility.

(a) The caregiver agreement shall have:

1. Been notarized;

2. Identified and specified the cost of each caregiver service;

3. Specified that payment shall not have:

a. Been made for a service not recognized in the agreement as a caregiver service; or

b. Duplicated a service provided by another source; and

4. Included a provision that required payment to be made by the caregiver to the individual for the cost of each caregiver service not provided in accordance with the agreement.

(b) The cost of each caregiver service that was not provided in accordance with the agreement and not repaid by the caregiver shall be considered a transfer of resources.

(8)(a) The requirements of this subsection shall apply to resources sold by contractual agreement, including land contracts or contract for deeds.

(b) The contract shall:

1. Be actuarially sound;

2. Not contain balloon payments; and

3. Be without forgiveness of debt if there is termination of the sell.

(c) A contract that does not meet the requirements established in paragraph (b) of this subsection shall be treated as the disposal of assets for less than fair market value.

(9) The requirements of this subsection shall be applicable with regard to annuities. A determination shall be completed with regard to the purpose of the purchase of an annuity in order to determine if resources were transferred for less than fair market value.

(a) If the expected return on the annuity is commensurate with the life expectancy of the beneficiary, the annuity shall be actuarially sound and shall not be considered a transfer of resources for less than fair market value.

(b) In accordance with 42 U.S.C. 1396p(c)(1)(F), the purchase of an annuity occurring on or after February 8, 2006 shall be treated as the disposal of assets for less than fair market value unless the cabinet is named:

1. As the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

2.a. A beneficiary in the second position after the community spouse or a minor or disabled child; and

b. A beneficiary in the first position if the community spouse or a representative of the child disposes of any remainder for less than fair market value.

(10)The purchase of an annuity shall be considered a transfer of resources if:

(a) The expected return on the annuity is not commensurate with the life expectancy of the beneficiary, thus making the annuity not actuarially sound; and

(b) The annuity does not provide substantially equal monthly payments and has a balloon or deferred payment of principal or interest. Payments shall be considered substantially equal if the total annual payment in any year varies by five (5) percent or less from the payment in the previous year.

(11)The policies in this subsection shall apply regarding the transfer of home property.

(a) Transfer of home property to an individual listed in this paragraph shall not constitute a transfer of resources for less than fair market value. Home property may be transferred to:

1. The spouse;

2. A child who is:

a. Under age twenty-one (21); or

b. Blind or disabled;

3. A sibling who has:

a. Equity interest in the home and

lived with the institutionalized individual for one (1) year prior to institutionalization; or

b. A child who:

(i) Resided with the institutionalized individual for two (2) years prior to institutionalization; and

(ii) Provided care to the individual to prevent institutionalization.

(b) Transfer of home property to any individual not listed in paragraph (a) of this subsection shall constitute a transfer of resources for less than fair market value.

(12) (a) For multiple or incremental transfers prior to February 8, 2006, the ineligibility periods shall accrue and run consecutively beginning with the month of the initial transfer.

(b) For multiple or incremental transfers made on or after February 8, 2006, the ineligibility period shall begin with the month of Medicaid eligibility for NF or ICF-MR-DD services, or HCBS.

(13) An individual shall not be ineligible for Medicaid or an institutional type of service:

(a) By virtue of subsections (1) to (10) of this section to the extent that the conditions specified in 42 U.S.C. 1396p(c)(2)(B), (C) and (D) or 907 KAR 1:655 are met; or

(b) Due to transfer of resources for less than fair market value except in accordance with this section.

(14) Disposal of a resource.

(a) The disposal of a resource, including liquid assets, at less than fair market value shall be presumed to be for the purpose of establishing eligibility unless the individual shows the transfer was in accordance with 42 U.S.C. 1396p(c)(2)(B) or (C) or presents convincing evidence that the disposal was exclusively for some other purpose.

(b) The value of the transferred resource shall be disregarded if:

1. The transfer is in accordance with 42 U.S.C. 1396p(c)(2)(B) or (C);

2. It is for some reason other than to qualify for Medicaid; or

3. The transferred resource was not a homestead and was considered an excluded resource at the time it was transferred.

(c) If the resource was transferred for an amount equal to the assessed value for tax purposes, the resource shall be considered as being disposed of for fair market value.

(d) If the assessed agricultural value is used for tax purposes, the transfer shall be required to be for an amount equal to the fair market value.

(15)(a) After determining that the purpose of a transfer was to become or remain Medicaid eligible, the cabinet shall add the uncompensated equity value of the transferred resource to other currently held resources to determine if retention of the property would have resulted in ineligibility. For this purpose, the resource considered available shall be the type of resource it was prior to transfer,

e.g., if nonhomestead property was transferred, the uncompensated equity value of the transferred property shall be counted against the permissible amount for nonhomestead property.

(b) If retention of the resource would not have resulted in ineligibility, the value of the transferred resource shall be disregarded.

(c) If retention would result in ineligibility, the cabinet shall compute a period of ineligibility for Medicaid or an institutional type of service as provided for in subsections (1) to (10) of this section.

(16) The uncompensated value shall be excluded from consideration if good cause or undue hardship exists. A waiver of consideration of the uncompensated amount shall be granted subject to the criteria established in this subsection.

(a) Good cause shall be determined to exist if an expense or loss was incurred by the individual or family group due to:

1. A natural disaster, for example fire, flood, storm or earthquake;
2. Illness resulting from accident or disease;
3. Hospitalization or death of a member of the immediate family; or
4. Civil disorder or other disruption resulting in vandalism, home explosions, or theft of essential household items.

(b) Undue hardship shall be determined to exist if:

1. Application of transferred resource penalties deprive an individual of:
a. Medical care which shall result in an endangerment to the individual's health or life; or
b. Food, clothing, shelter, or other necessities of life; or
2. The cabinet determines that:
a. The transfer of resources is not recoverable;
b. The transfer of resources was not intended by the applicant to result in Medicaid coverage;
c. The transfer of resources was made in circumstances beyond the applicant's control; or
d. The applicant would be unable to receive necessary medical care unless an undue hardship exemption is granted.

(c)1. The exclusions shall not exceed the amount of the incurred expense or loss.

2. The amount of the uncompensated value to be excluded shall not include any amount which is payable by Medicaid, Medicare, or other insurance.

(d) If an institutionalized individual is subject to a period of ineligibility because the individual or individual's spouse disposed of property, assets, or resources for less than fair market value, the cabinet shall notify the individual in writing and include an explanation of:

1. The criteria upon which an undue hardship waiver may be granted;
2. The process for seeking an undue hardship waiver; and
3. How to appeal an adverse action in accordance with Section 5[4] of this administrative regulation.

(e) Upon consent of the institutionalized individual or individual's personal representative, the facility in which the individual resides may:

1. Request an undue hardship waiver on behalf of the institutionalized individual;
2. Present information to the cabinet regarding the institutionalized individual's case; and
3. File an appeal in accordance with Section 5[4] of this administrative regulation on behalf of the institutionalized individual if the cabinet denies the facility's request for an undue hardship waiver.

(f) If the cabinet suspends or terminates a recipient's eligibility because the cabinet discovers that the recipient or recipient's spouse transferred resources for less than fair market value and an undue hardship waiver is requested on behalf of the recipient, the cabinet shall provide payments for nursing facility services in order to hold the bed at the facility for up to, but not more than, thirty (30) days from the date of suspension or termination.

(g) If the cabinet decides in favor of a recipient's request for an undue hardship waiver and reverses its previous decision to suspend or terminate eligibility, the cabinet shall cover the recipient's nursing facility services at the facility's full rate for the period the individual is eligible under the undue hardship waiver.

(17) Disclaiming of an inheritance by an individual entitled to the inheritance shall be considered a transfer of resources.

Section 3. Treatment of Resources for a Long-Term Care Applicant who has Long-Term Care Partnership Insurance.

(1) The amount of benefits paid by the long-term care partnership insurance policy as a direct reimbursement to providers for long-term care expenses or benefits paid on a per diem basis issued directly to the individual shall be used during the eligibility determination process to determine the amount of resources the applicant shall have excluded from the eligibility determination and protected from estate recovery in accordance with 907 KAR 1:645.

(2) If the applicant disposed of a resource for less than fair market value resulting in a transfer penalty, the applicant may choose to apply the allowable exclusion, dollar-for-dollar, to the transferred resources for the purpose of avoiding a penalty.

Section 4. Treatment of Trusts. (1) Regarding a Medicaid qualifying trust created on or before August 10, 1993, if an individual, or the spouse for the individual's benefit, creates, other than by will, a trust or similar legal device with amounts payable to the same

individual, the trust shall be considered a "Medicaid qualifying trust" if the trustee of the trust is permitted to exercise discretion as to the amount of the payments from the trust to be paid to the individual.

(a) Except as provided by paragraph (b) of this subsection, the amount considered available to the trust beneficiary shall be the maximum amount the trustee may, using the trustee's discretion, pay in accordance with the terms of the trust, regardless of the amount actually paid.

(b) The cabinet may consider as available only that amount actually paid if to do otherwise would create an undue hardship upon the individual in accordance with Section 2(16)(b) of this administrative regulation.

(2) For purposes of determining eligibility in accordance with Section 2(1) to (10) of this administrative regulation regarding trust agreements, the rules provided for under 42 U.S.C. 1396p(d)(3) shall be met and shall apply to a trust created after August 10, 1993 and established by an individual subject to 42 U.S.C. 1396p(d)(4).

(a) An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the individuals described under 42 U.S.C. 1396p(d)(2)(A)(i), (ii), (iii), and (iv) established the trust other than by a will.

(b) If the corpus of a trust includes income or resources of any other person or persons, the trust rules shall apply to the portion of the trust attributable to the income or resources of the individual. In determining countable income and resources, income and resources shall be prorated based on the proportion of the individual's share of income or resources.

(c) Subject to 42 U.S.C. 1396p(d)(4), the trust provisions in 42 U.S.C. 1396p(d) shall be applied in a manner consistent with 42 U.S.C. 1396p(d)(2)(C).

(d) Payments made from revocable or irrevocable trusts to or on behalf of an individual shall be considered as income to the individual with the exception of payments for medical costs. Payments for medical care or medical expenses shall be excluded as income.

(e) A trust which is considered to be irrevocable and terminates if action is taken by the grantor shall be considered a revocable trust.

(f) An irrevocable trust which may be modified or terminated by a court shall be considered a revocable trust.

(g) If payment from a revocable or irrevocable trust may be made under any circumstance, the amount of the full payment that could be made shall be considered as a resource including amounts that may be disbursed in the distant future.

(h) Placement of an excluded resource into an irrevocable trust shall not change the excluded nature of the resource.

(i) Placement of a countable resource into an irrevocable trust shall constitute a transfer of resources for less than fair market value.

(3) The treatment of trusts established in this section of this administrative regulation shall be waived if undue hardship criteria is met as established in Section 2(15)(b) of this administrative regulation.

(4) Regarding subsection (1), (2), or (3) of this section, for trusts created on or prior to August 10, 1993, any resources transferred into a previously established trust after August 10, 1993 shall be considered a transfer of resources and subject to an ineligibility period as provided for under Section 2 of this administrative regulation using the thirty-six (36) month transfer rules.

(5) An individual may create a qualifying income trust, in accordance with this subsection, to establish financial eligibility for Medicaid.

(a) A transfer of resources shall not apply to a qualifying income trust if:

1. The trust is established in Kentucky for the benefit of an individual;

2. The trust is composed solely of the income of the individual, including accumulated interest in the trust;

3. Upon the death of the individual, the department receives all amounts remaining in the trust, up to an amount equal to the total medical assistance paid on behalf of the individual by Medicaid; and

4. The trust is irrevocable.

(b) The money in a qualifying income trust shall:

1. Be maintained in a separate account; and

2. Not be commingled with other checking or savings accounts.

(c) The corpus of a qualifying income trust and interest generated by the trust shall not be counted as available income for an individual for the determination of Medicaid eligibility.

(d) A qualifying income trust shall state that the funds may only be used for:

1. Valid medical expenses, including patient liability; or

2. The community spouse income allowance established in accordance with 907 KAR 1:655.

(e) All expenditures from a qualifying income trust shall require verification by the department that they are allowable expenditures.

(f) Allowable payments from a qualifying income trust shall be made:

1. Every month; or

2. By the end of the month following the month the funds were placed in the trust.

(g) If payments by the qualifying income trust are made for medical care, the individual shall be considered to have received fair market value for income placed in the trust.

Section 5.[4.] Appeal Rights. An appeal of a department decision regarding Medicaid eligibility of an individual based upon application of this administrative regulation shall be in accordance with 907 KAR 1:560.

907 KAR 1:655. Spousal impoverishment and nursing facility requirements for Medicaid.

RELATES TO: KRS 194A.505, 205.520, 38 U.S.C. 5503

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. Part 435, 42 U.S.C. 1396a, d, r-5, EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes spousal impoverishment and nursing facility requirements for Medicaid eligibility determinations.

Section 1. Definitions. (1) "Assigned support right" means the assignment of the support right of an institutionalized individual to the state or Medicaid Program.

(2) "Community spouse" means the spouse of an institutionalized spouse, who remains at home in the community and is not living in a medical institution or nursing facility or participating in a home and community based services (HCBS) waiver program.

(3) "Community spouse maintenance standard" means the income standard to which a community spouse's otherwise available income is compared for purposes of determining the amount of the allowance used in the posteligibility calculation.

(4) "Continuous period of institutionalization" means thirty (30) or more consecutive days of institutional care in a medical institution or nursing home or both and may include thirty (30) consecutive days of receipt of HCBS or a combination of both.

(5) "Countable resources" means resources not subject to exclusion in the Medicaid Program.

(6) "Department" means the Department for Medicaid Services or its designee.

(7) "Dependent child" means the couple's child, including a child gained through adoption, who lives with the community spouse and is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(8) "Dependent parent" means a parent of either member of a couple who lives with the community spouse and is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(9) "Dependent sibling" means a brother or sister of either member of a couple, including a half-brother, half-sister or sibling gained through adoption, who resides with the community spouse and is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(10) "Excess shelter allowance" means an amount equal to the difference between the community spouse's verified shelter expenses and the minimum shelter allowance.

(11) "Gross income" means nonexcluded income which would be used to determine eligibility prior to income disregards.

(12) "Income" means money received from statutory benefits (Social Security, Veterans Administration pension, black lung benefits, railroad retirement benefits), pension plans, rental property, investments or wages for labor or services.

(13) "Institutionalized individual" means an individual with respect to whom payment is based on a level of care provided in a nursing facility and who is:

(a) An inpatient in:

1. A nursing facility (NF);

2. An intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD); or

3. A medical institution; or

(b) Receiving home and community based services (HCBS).

(14) "Institutionalized spouse" means an institutionalized individual who is in a medical institution or nursing facility, or participates in an HCBS waiver program, with a spouse who:

(a) Has a spouse who is not an institutionalized individual; and

(b) Is likely to remain institutionalized for at least thirty (30) consecutive days while the community spouse remains out of a medical institution or nursing facility or HCBS waiver program.

(15) "Medical institution or nursing facility" means a hospital, nursing facility, or intermediate care facility for the mentally retarded and developmentally disabled.

(16) "Minimum shelter allowance" means an amount that is thirty (30) percent of the standard maintenance amount.

(17) "Minor" means the couple's minor child who:

(a) Is under age twenty-one (21);

(b) Lives with a community spouse; and

(c) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(18) "Monthly income allowance" means an amount:

(a) Deducted in the posteligibility calculation for maintenance needs of a community spouse or other family member; and

(b) Equal to the difference between a spouse's and other family member's income and the appropriate maintenance needs standards.

(19) "Other family member" means a relative of either member of a couple who is a:

(a) Minor or dependent child;

(b) Dependent parent; or

(c) Dependent sibling.

(20) "Other family member's maintenance standard" means an amount equal to one-third (1/3) of the difference between the income of the other family member and the standard maintenance amount.

(21) "Otherwise available income" means income to which the community spouse has access and control, including gross income that would be used to determine eligibility under Medicaid without benefit of disregards for federal, state and local taxes; child support payments; or other court ordered obligation.

(22) "Resources" mean money and personal property or real property that an institutionalized individual or institutionalized individual's spouse:

(a) Owns;

(b) Has the right, authority or power to convert to cash; and

(c) Is not legally restricted from using for support and maintenance.

(23) "Resource assessment" means the assessment, at the beginning of the first continuous period of institutionalization of the institutionalized spouse upon request by either spouse, of the joint resources of a couple if a member of the couple enters a medical institution or nursing facility or becomes a participant in an HCBS waiver program.

(24) "Significant financial duress" means a member of a couple establishes to the satisfaction of a hearing officer that the community spouse needs income above the level permitted by the community spouse maintenance standard to provide for medical, remedial, or other support needs of the community spouse to permit the community spouse to remain in the community.

(25) "Spousal protected resource amount" means resources deducted from a couple's combined resources for the community spouse in an eligibility determination for the institutionalized spouse.

(26) "Spousal share" means one-half (1/2) of the amount of a couple's combined countable resources, up to a maximum of $60,000 to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g).

(27) "Spouse" means a person legally married to another under state law.

(28) "Standard maintenance amount" means one-twelfth (1/12) of the federal poverty income guideline for a family unit of two (2) members, with revisions of the official income poverty guideline applied for Medicaid provided during and after the second calendar quarter that begins after the date of publication of the revisions, multiplied by 150 percent.

(29) "State spousal resource standard" means the amount of a couple's combined countable resources determined necessary by the department for a community spouse to maintain himself in the community.

(30) "Support right" means the right of an institutionalized spouse to receive support from a community spouse under state law.

(31) "Undue hardship" means that Medicaid eligibility of the institutionalized spouse cannot be established on the basis of assigned support rights and the spouse is subject to discharge from the medical institution, nursing facility, or HCBS waiver program due to inability to pay.

Section 2. Resource Assessment. (1) Pursuant to 42 U.S.C. 1396r-5(c)(1)(B), an assessment of the joint resources of an institutionalized spouse and the community spouse shall be made upon request of either spouse at the beginning of a continuous period of institutionalization of the institutionalized spouse and upon receipt of relevant documentation of resources.

(2) The assessment shall contain the total value of the joint resources and computation of the spousal share.

(3) The department shall complete the assessment within forty-five (45) days following submission of complete documentation or verification.

(4) Upon completion of the resource assessment, each spouse shall:

(a) Receive a copy of the assessment; and

(b) Be notified that the right of appeal of the assessment shall exist at the time the institutionalized spouse applies for Medicaid.

Section 3. Protection of Income and Resources of the Couple for Maintenance of the Community Spouse.

(1) The following income provisions shall apply for an individual beginning a continuous period of institutionalization on or after September 30, 1989:

(a) Except as provided in paragraph (b) of this subsection, during a month in which an institutionalized spouse is in the institution, income of the community spouse shall not be deemed available to the institutionalized spouse.

(b) In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined or redetermined to be eligible for Medicaid, the provisions of 42 U.S.C. 1396r-5(b)(2) shall apply.

(2) The following resource provisions shall apply for an individual beginning a continuous period of institutionalization on or after September 30, 1989.

(a) Except as provided in subsection (4)(b) of this section, in calculating the resources of an institutionalized spouse at the time of an initial eligibility determination for a benefit under Medicaid, the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse.

(b) The following protected amounts shall be deducted from a couple's combined countable resources at the time of the determination of initial eligibility of the institutionalized spouse:

1. The greater amount of:

a. The spousal share which shall not exceed a maximum of $60,000 to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g); or

b. The state resource standard; and

2.a. If applicable, an additional amount transferred under a court support order; or

b. If applicable, an additional amount designated by a hearing officer.

(c) The institutionalized spouse shall not be ineligible by reason of resources determined under paragraphs (a) and (b) of this subsection to be available for the cost of care in the following circumstances:

1. The institutionalized spouse has assigned to the department his right to support from the community spouse;

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment and the state has the right to bring a support proceeding against a community spouse without the assignment; or

3. The department determines that denial of eligibility would work an undue hardship.

(d) Separate treatment of resources after eligibility for benefits is established.

1. During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for a Medicaid benefit, the resources of the community spouse shall not be deemed available to the institutionalized spouse.

2. Resources of the institutionalized spouse protected for the needs of the community spouse shall be considered available to the institutionalized spouse if the resources are not transferred to the community spouse within six (6) months of the initial eligibility determination.

(e) The equity value of an automobile in excess of the limits established by 907 KAR 1:645 shall not be included as a countable resource.

(3) The following provisions shall apply with regard to protecting income for the community spouse:

(a) After an institutionalized spouse is determined or redetermined to be eligible for Medicaid, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

1. A personal needs allowance of forty (40) dollars plus a mandatory withholding from income, including a mandatory payroll deduction that is a condition of employment and federal, state and local taxes that the government requires the payer to deduct before payment is made to the payee;

2. A community spouse monthly income allowance to the extent income of the institutionalized spouse is made available to, or for the benefit of, the community spouse;

3. A family allowance determined in accordance with the definition of other family member's maintenance standard; and

4. An amount for incurred expenses for medical or remedial care for the institutionalized spouse.

(b) Establishment of the community spouse income allowance.

1. The community spouse income allowance shall be the sum of the standard maintenance amount and the excess shelter allowance, not to exceed the community spouse maintenance standard.

2. The community spouse maintenance standard shall be set at $1,500 per month, to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g).

(c) If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse income allowance for the spouse shall not be less than the amount ordered.

(4) The following provisions shall apply with regard to a transfer of resources from an institutionalized spouse:

(a) An institutionalized spouse may, without regard to the usual prohibition against disposal of assets for less than fair market value, transfer to the community spouse, or to another for the sole benefit of the community spouse, an amount equal to the spousal protected resource amount to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse. The transfer shall be made as soon as practicable after the initial determination of eligibility, taking into account the time necessary to obtain a court order under paragraph (c) of this subsection.

(b) Establishment of the spousal protected resource amount.

1. The spousal protected resource amount shall be the greater of:

a. The spousal share which shall not exceed a maximum of $60,000 to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g); or

b. The state spousal resource standard.

2. The state spousal resource standard shall be set at $20,000;

3. For an individual, the spousal protected resource amount may be a higher amount established by a hearing officer, or a higher amount transferred under a court order as specified in paragraph (c) of this subsection.

(c) If a court has entered an order against an institutionalized spouse for the support of a community spouse, the usual prohibition against disposal of assets for less than fair market value shall not apply to the amount of resources transferred pursuant to the order for the support of the spouse.

(5) Except for a transfer of resources to the community spouse as specified in subsection (4) of this section, the transfer of resource policies established by 907 KAR 1:650 shall apply.

(6)(a) The department shall send the notice specified in paragraph (b) of this subsection to both spouses upon a:

1. Determination of eligibility for Medicaid of an institutionalized spouse; or

2. Request by:

a. The institutionalized spouse;

b. The community spouse; or

c. A representative acting on behalf of either spouse.

(b) The notice shall state:

1. The amount of the community spouse monthly income allowance;

2. The amount of a family allowance, if any;

3. The method of computing the amount of the community spouse resources allowance; and

4. The spouse's right to a fair hearing in accordance with 907 KAR 1:560.

(7)(a) Both the institutionalized spouse and community spouse shall be entitled to a fair hearing in accordance with 907 KAR 1:560 if the spouse is dissatisfied with the action of the agency including determination of the following:

1. The community spouse monthly income allowance;

2. The amount of monthly income determined to be otherwise available to the community spouse;

3. The attribution of resources at the time of the initial eligibility determination; or

4. The determination of the community spouse resource allowance.

(b) If either the institutionalized spouse or community spouse establishes during the hearing that the community spouse needs income above the level otherwise provided by the monthly maintenance needs allowance, due to an exceptional circumstance resulting in significant financial duress, an amount adequate to provide the necessary additional income shall be substituted for the monthly maintenance needs allowance.

(c) If either spouse established during the hearing process that the community spouse resource allowance, in relation to the amount of income generated by an allowance, is inadequate to raise the community spouse's income to the monthly maintenance needs allowance, there shall be substituted for the community spouse resource allowance an amount adequate to provide the monthly maintenance needs allowance.

Section 4. Specified Individuals in Nursing Facilities. For an individual who is aged, blind, or has a disability and who is in a medical institution or nursing facility but does not have a community spouse, the following requirements with respect to income limitations and treatment of income shall apply:

(1) In determining eligibility, the appropriate medically needy standard or special income level, disregards, and exclusions from income shall be used. In determining patient liability for the cost of institutional care, gross income shall be used as provided in subsections (2) and (3) of this section.

(2) Income protected for basic maintenance shall be forty (40) dollars monthly plus mandatory withholdings. Mandatory withholdings shall:

(a) Include minimum state and federal taxes; and

(b) Not include court-ordered child support, alimony, or similar payment resulting from an action by the recipient.

(3) An amount excluded under a plan to achieve self-support (PASS), as an income related work expense (IRWE) or blind work expense (BWE) shall be considered an increased personal needs allowance for a Medicaid recipient except a recipient for whom a quarterly spenddown process as established in 907 KAR 1:640 is applicable.

(4) Income in excess of the amount protected for basic maintenance shall be applied to the cost of care except as follows:

(a) Available income in excess of the basic maintenance allowance shall be first conserved as needed to provide for the needs of a minor child up to the appropriate family size amount from the scale as established by 907 KAR 1:640, Section 2(1).

(b) Remaining available income shall be applied to the incurred costs of medical and remedial care that are not subject to payment by a third party (except that the incurred costs may be reimbursed under another public program of the state or political subdivision of the state), including Medicare and health insurance premiums or medical care recognized under state law but not covered under the state's Medicaid plan.

(5) The basic maintenance standard allowed the individual during the month of entrance into or exit from the nursing facility shall take into account the home maintenance costs.

(6) If an individual loses eligibility for a supplementary payment due to entrance into a participating nursing facility, and the supplementary payment is not discontinued on a timely basis, the amount of an overpayment shall be considered as available income to offset the cost of care to the Medicaid Program.

(7) A supplemental security income (SSI) or state supplementation payment received by a specified institutionalized Medicaid eligible individual in accordance with 42 U.S.C. 1382(e)(1)(G) shall be excluded from consideration as either income or a resource. The payment shall not be used in the posteligibility process to increase the patient liability.

(8) Ninety (90) dollars of Veteran's Administration (VA) benefits received by a veteran or the spouse of a veteran shall be excluded from consideration as income. The ninety (90) dollars shall not be counted in the eligibility or the posteligibility calculation.

(9) Veterans Administration payments for unmet medical expenses (UME) and aid and attendance (A&A) shall be excluded in a Medicaid eligibility determination for a veteran or the spouse of a veteran residing in a nursing facility.

(a) Veterans Administration payments for unmet medical expenses (UME) and aid and attendance (A&A) shall be excluded in the posteligibility determination for a veteran or the spouse of a veteran residing in a nonstate-operated nursing facility.

(b) Veterans Administration payments for unmet medical expenses (UME) and aid and attendance (A&A) shall not be excluded in the posteligibility determination process for a veteran or the spouse of a veteran residing in a state-operated nursing facility.

(10) Income placed in a qualifying income trust established in accordance with 42 U.S.C. 1396p(d)(4) and 907 KAR 1:650, Section 3(5), shall be counted in the posteligibility determination.

Section 5. Special Needs Contributions for Institutionalized Individuals. A voluntary payment made by a relative or other party on behalf of a nursing facility resident or patient shall not be considered as available income if made to obtain a special privilege, service, or item not covered by the Medicaid Program. A special service or item shall include television or telephone service, private room or bath, or a private duty nursing service. (23 Ky.R. 4035; Am. 24 Ky.R. 607; eff. 8-20-97; 28 Ky.R. 970; 1417; eff. 12-19-2001; 30 Ky.R. 743; 1270; eff. 11-25-03.)