State of Arkansas
77th General Assembly
Regular Session, 1989 SENATE BILL 491
By: Senators Kinard and Moore

"AN ACT TO PROVIDE MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE; AND FOR OTHER PURPOSES."

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Purpose. The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance to facilitate public understanding and comparison of long-term care insurance policies and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

SECTION 2. Scope. The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed or offered as long-term care insurance or nursing home insurance need not meet the requirements of this Act.

SECTION 3. Short title. This Act may be known and cited as the "Long-Term Care Insurance Act".

SECTION 4. Definitions. Unless the context requires otherwise, the definitions in this section apply throughout this Act. (a) "Long-term care insurance" means any insurance policy, contract certificate, rider, or other

evidence of coverage issued, issued for delivery, advertised, marketed, or offered in this State to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies, contracts, certificates or riders issued by insurers, fraternal benefit societies, nonprofit hospital, and medical service corporations, health maintenance organizations or any similar organization. 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 protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(b) "Applicant" means:

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

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

(c) "Certificate" means, for the purposes of this Act, any certificate of insurance or evidence of coverage issued to a resident of this State regardless of the state in which the policy was issued.

(d) "Commissioner" means the insurance commissioner of this State.

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

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or 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 organization; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(A) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(B) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy or contract within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of one hundred (100) persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one (1) year; and have a constitution and by-laws which provide that:

(A) the association or associations hold regular meetings not less than annually to further purposes of the members;

(B) except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) the members have voting privileges and representation on the governing board and committees.

Thirty (30) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in Subsections (e)(1), (e)(2) and (e)(3), subject to a finding by the commissioner that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged.

(f) "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, certificate, rider or endorsement or other evidence of coverage delivered or issued for delivery in this state by an issurer; fraternal benefit society; nonprofit hospital, or medical service corporation;

prepaid health plan; health maintenance organization or similar organization.

SECTION 5. Group long-term insurance. No group long-term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in Section 4(e)(4), unless the Commissioner has determined that the group policy meets the requirements of Section 4(e)(4).

SECTION 6. Disclosure and performance standards for long-term care insurance.

(a) The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

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

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

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

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

(c) Preexisting condition:

(1) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4(e)(1) shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the

effective date of coverage of an insured person.

(2) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4 (e)(1) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in Sections 6(c)(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the applicant's answers on that application, conduct underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6(c)(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Section 6(c)(2).

(d) Prior hospitalization/institutionalization:

(1) Effective one year from the effective date of this act no long-term care insurance policy or certificate may be delivered or issued for delivery in this State if such policy or certificate:

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

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

(2) Effective one year from the effective date of this act a long term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited above in sub-paragraph (1) shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of

confinement.

(a) A long-term care insurance policy or certificate containing a benefit advertised, marketed or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.

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

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

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

(f) Right to return - free look.

(1) Individual long-term care insurance policyholders or certificate holders shall have the right to return the policy/certificate within thirty (30) days of its delivery and to have the entire premium refunded if, after examination of the policy/certificate, the policyholder/certificate holder is not satisfied for any reason. Individual long-term care insurance policies and certificates shall be accompanied by a notice prominently printed stating in substance that the policyholder or certificate holders shall have the right to return the policy/certificate within thirty (30) days of its delivery and to have the entire premium refunded if, after examination of the policy/certificate, the policyholder is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within thirty (30) days of its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall be accompanied by a notice prominently printed stating in substance that the insured person shall have the right to return

the policy within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(g) (1) A written outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation with a notice which prominently directs the attention of the recipient to the document and its purpose.

(A) The Commissioner shall prescribe a standard format for such outline, including style, arrangement, overall appearance, and content.

(B) In the case of agent solicitations, an agent must deliver the outline of coverage to the applicant prior to the presentation of an application or enrollment form.

(C) In the case of direct response solicitations, the outline of coverage must be presented to the applicant in conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

(A) A description of the prinicipal benefits and coverage provided in the policy or certificate;

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

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

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

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

(F) A brief description of the relationship of cost of care to benefits.

(h) A certificate issued pursuant to a group long-term care insurance policy shall include:

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

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

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

(i) No policy or contract may be advertised, marketed or offered as long-term care or nursing home insurance in this state unless it complies with the provisions of this Act.

SECTION 7. Administrative procedures. Regulations adopted pursuant to this Act shall be in accordance with the provisions of Arkansas Code Annotated §23-61-108 and Arkansas Code Annotated §25-15-201 et seq.

SECTION 8. All provisions of this act of a general and permanent nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code Revision Commission shall incorporate the same in the Code.

SECTION 9. Emergency. It is hereby found and determined by the General Assembly that the laws of this State concerning the insurance matters covered in the subject of this Act are inadequate for the protection of the public and the immediate passage of this Act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is hereby declared to exist and this act being necessary for the preservation of the public peace, health and safety shall be in full force and effect from and after its passage and approval.