CONVERSION CHECKLIST FOR PARTNERSHIP POLICIES:

How to convert a long-term care policy that has been approved under the Insurance Code into a policy that is eligible for certification by the California Partnership for Long-Term Care

Last revised: December 2019

This checklist is intended for use when amending a long-term care policy that has been approved by the California Department of Insurance (CDI) under the standards of the California Insurance Code, so as to meet requirements for certification by the California Partnership for Long-Term Care (the Partnership). This is not a complete list of all legal requirements. Standards applicable to tax-qualified long-term care policies under the Insurance Code are summarized on the CDI website, at this link: http://www.insurance.ca.gov/0250-insurers/0300-insurers/0100applications/pab/upload/GuidelineForCaliforniaLongTermCareInsurancePolicies.pdf. The checklist in this document summarizes Partnership requirements that add to or differ from standards found in the Insurance Code.

Note: Forms that were previously approved by CDI under the standards of the Insurance Code should be updated to comply with any changes in the law that were effective after the date of the previous approval. Insurers should also closely review the Partnership requirements located in 22 Cal. Code Regs. §§ 58000–58062. Forms should be submitted in SERFF to CDI, which will coordinate review with the Partnership.

MINIMUM COVERAGE

The policy must provide a daily benefit (or monthly equivalent) of at least $100 per day and a lifetime maximum benefit of at least $73,000. Welf. & Inst. Code § 22005.1(c)(1).	☐
An applicant must be offered a policy that provides a daily benefit (or monthly equivalent) of at least 70% of the average daily private pay rate for a nursing facility and a lifetime maximum benefit that is at least 365 times 70% of the average daily private pay rate for a nursing facility. Welf. & Inst. Code § 22005.1(c)(2).	☐
The policy must provide inflation protection and an applicant must be offered an option with an annual increase of 5% compound and a lower cost option. Welf. & Inst. Code § 22005.1(b)(3).	☐
The policy must include Care Management, as defined in 22 Cal. Code Regs. § 58005, that is provided by a Partnership-approved Care Management Provider Agency. Welf. & Inst. Code § 22005.1(b)(1); 22 Cal. Code Regs. § 58059(f).	☐
The elimination period must be defined as specified in 22 Cal. Code Regs. § 58010 and must comply with the restrictions stated in § 58059(h).	☐
Respite care must not be subject to the elimination period and must cover at least 21 days in any calendar year for care in a facility or in the home, payable at the daily and monthly maximum benefit amounts applicable for the type of service being used to provide the respite care. 22 Cal. Code Regs. § 58059(i).	☐
Severe cognitive impairment must be measured by The Mental Status Questionnaire and the Folstein Mini Mental State Examination, as described in 22 Cal. Code Regs. § 58059(g).	☐

ADDITIONAL FORM REQUIREMENTS

The Partnership logo must appear on all policy forms, applications, and sales materials. 22 Cal. Code Regs. § 58052.	☐
The outline of coverage, application, and policy must include a verbatim notice on Medi-Cal eligibility, as specified in 22 Cal. Code Regs. § 58052(c)(2)(C). § 58060(e).	☐
The application must indicate that the applicant received: a description of the Partnership, a copy of the Partnership shopper's guide, a statement regarding Medi-Cal eligibility, and a graphic comparison of 5% compound inflation protection to a policy without an inflation adjustment. 22 Cal. Code Regs. § 58052(c)(2).	☐
The application must include an authorization to release information, as stated in 22 Cal. Code Regs. § 58052(c)(2).	☐
The policy must explain that benefits may not be paid in excess of actual charges. 22 Cal. Code Regs. § 58060(a).	☐
The policy must explain that LTC services may not be delivered by a member of the individual's family, unless the family member is a regular employee of an organization which is providing the services, the organization receives the payment for the services, and the family member receives no compensation other than the normal compensation for employees in his or her job category. 22 Cal. Code Regs. § 58060(b).	☐
The policy must explain that benefits shall only be paid after the payment of all other benefits to which the Policy or Certificate holder is otherwise entitled, excluding Medi-Cal. 22 Cal. Code Regs. § 58060(d).	☐
The policy must contain a right to a partial refund of premiums paid or reduction in future premiums in the event a non-Medicaid national or state long-term care program duplicates policy benefits. 22 Cal. Code Regs. § 58060(f).	☐
The policy must contain a provision for a waiver of premium as specified in 22 Cal. Code Regs. § 58065(d).	☐
Each of the following is prohibited: a restoration of benefits, second elimination period, and any daily or weekly limit on home and community-based care benefits. 22 Cal. Code Regs. § 58063.	☐

MANDATORY VERBATIM DEFINITIONS AND DEFINITIONS WITH ADDITIONAL CRITERIA

Benefit eligibility must be defined as stated in 22 Cal. Code Regs. § 58003, and the policy must include the following definitions: Activities of Daily Living (§ 58000), Severe Cognitive Impairment (§ 58035), Hands-on Assistance (§ 58012), Standby Assistance (§ 58037), Substantial Supervision (§ 58038), Licensed Health Care Practitioner (§ 58021), Plan of Care (§ 58027), and Qualified Long-Term Care Services (§ 58029). § 58059(g).	☐
Covered long-term care services must be defined in accordance with the following: Residential Care Facility (22 Cal. Code Regs. § 58032), Home Health Care (§ 58013), Adult Day Health/Social Care (§ 58001), Personal Care Services (§ 58026), Homemaker Services (§ 58017), Hospice Care (§ 58018), and Respite Care (§ 58033). § 58059(e).	☐
The following terms are defined in the Partnership regulations but not in the Insurance Code: Care Management Provider Agency (22 Cal. Code Regs. § 58006), Care Management/Care Coordination (§ 58005), Care Management Supervisor (§ 58007), Care Manager/Coordinator (§ 58008), Medi-Cal Asset Protection (§ 58023), Long-Term Care Services Countable Toward Medi-Cal Property Exemption (§ 58022), Medi-Cal Property Exemption (§ 58024), Qualified Official Designee of a Care Management Provider Agency (§ 58030), and Service Summary (§ 58034).	☐