Guideline for California Long-Term Care Insurance Policies

This outline is intended as a guide for companies filing federally qualified long-term care insurance products. It is not a complete list of all legal requirements and does not replace a thorough review of the law. If there are any discrepancies between this outline and the applicable statutes and regulations, the statutes and regulations shall govern. The requirements in this outline apply to any long-term care policy and any long-term care benefit that is supplemental to a life insurance policy or annuity contract, except as otherwise noted. Additional requirements may apply to policies certified by the California Partnership for Long-Term Care. All references are to the California Insurance Code unless otherwise stated.

I. Long-Term Care Insurance, defined - Ins. Code, § 10231.2

Long-term care insurance includes:

A. Any insurance policy, certificate, or rider advertised, marketed, offered, solicited, or designed to provide coverage for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital.

B. All products containing coverage for care in a Nursing Facility or Residential Care Facility, home care, or community-based services.

II. Policy Requirements

A. First Page. The first page of a policy must include:
   1. A prominent label, if the policy benefits are limited to "Nursing Facility and Residential Care Facility Only" or "Home Care Only." Only policies providing benefits for both institutional care and home care may be labeled "comprehensive long-term care" insurance. Ins. Code, § 10232.1(b)-(d).
   2. A verbatim statement on "Federally Qualified" policies. Ins. Code, § 10232.1(a).
   3. A verbatim statement on the California Partnership. Cal. Code Regs., tit. 22, § 58050(g).
   4. A verbatim notice to buyer regarding policy limitations. Ins. Code, § 10234.93(a)(5).
   5. A renewability provision. Ins. Code, §§ 10235.14(a), 10236.
   6. A provision stating the insured's right to return the policy (not required for group long-term care insurance as described in section 10231.6 (a) and (b)). Ins. Code, § 10232.7.

B. Triggers of Coverage - Ins. Code, §§ 10232.8(b), 10232.92(d), 10232.97
   A Licensed Health Care Practitioner must certify that the insured meets either one of two criteria:
   1. The insured is unable to perform at least two activities of daily living without hands-on assistance or standby assistance for a period of at least 90 days, due to a loss of functional capacity. Ins. Code, § 10232.8(b)-(d); Pub. L. 104-191 § 321(a) (codified at 26 U.S.C. § 7702B(c)(2)).
      a. Certification requirement shall not be longer than 90 days. Ins. Code, § 10232.8(c).
      b. "Hands-on assistance" means physical assistance of another person without which the individual would be unable to perform the activity of daily living. Ins. Code, § 10232.8(e); IRS Notice 97-31, issued May 6, 1997.
      c. "Standby assistance" means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the activity of daily living. Ins. Code, § 10232.8(e); IRS Notice 97-31.
      d. "Activities of daily living" includes eating, bathing, continence, dressing, toileting, and transferring, as those activities are defined in Ins. Code, § 10232.8(f).

2. The insured needs substantial supervision due to severe cognitive impairment. Ins. Code, § 10232.8 (b) and (d).
    a. "Substantial supervision" means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such as may result from wandering). Ins. Code, § 10232.8(e); IRS Notice 97-31.
    b. "Severe cognitive impairment" means a loss or deterioration in intellectual capacity that is (1) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (2) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory; orientation as to people, places, or time; and deductive or abstract reasoning. Ins. Code, § 10232.8(e); IRS Notice 97-31.

C. Written Certification and Plan of Care
    1. Written certification must be renewed every 12 months. Ins. Code, § 10232.8(c).
    2. Certification must be provided by a Licensed Health Care Practitioner (LHCP) who is independent of the insurer: The LHCP shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification. Ins. Code, § 10232.8(c).
    3. If an LHCP determines that the insured is not chronically ill, and the LHCP did not personally examine the insured, the insured is entitled to a second assessment. Ins. Code, § 10232.8(c).
    4. A plan of care is a written description of the insured's needs and the type, frequency, providers, and cost (if any) of all long-term care services required by the insured, which is developed by an LHCP after personally examining the insured. Ins. Code, § 10232.8 (c) and (d).
    5. The costs to certify the insured or develop a plan of care shall not count against the lifetime maximum of the policy. Ins. Code, § 10232.8(c).
    6. Option to agree to an Alternate Plan of Care - Ins. Code, §§ 10231.3, 10235.9a. Coverage for services under an Alternate Plan of Care shall be in addition to, not in lieu of, covered services.

D. Required Coverages
    1. Nursing Facility and Residential Care Facility Coverage
        a. A policy covering care in a Nursing Facility must also cover care in a Residential Care Facility. Ins. Code, § 10232.92.
        b. Nursing Facility coverage must include per diem expenses and costs of ancillary supplies and services, up to any maximum daily Nursing Facility benefit. Ins. Code, § 10232.95.
        c. Any maximum daily, weekly, or monthly Residential Care Facility benefit must be at least 70% of the corresponding maximum Nursing Facility benefit. Ins. Code, § 10232.92(b).
        d. All expenses for Qualified Long-Term Care Services that are incurred by the insured while confined in a Residential Care Facility are covered and payable. Ins. Code, § 10232.92(c).
    2. Home Care and Community-Based Services
        a. Every policy offering home care or community-based services must include at least Home health care, Adult day care, Personal care, Homemaker services, Hospice services, and Respite care. Ins. Code, § 10232.9(a). Policy definitions must be no more restrictive than the definitions in Ins. Code, § 10232.9(b).

b. A daily, weekly, or monthly home care and community-based services benefit must be at least 50% of any daily, weekly, or monthly benefit for institutional care, and no less than $50 per day. Ins. Code, § 10232.9(d). (Does not apply to products for residents in a Continuing Care Retirement Community.)

E. Required Provisions
   1. Maximum Lifetime Benefit - Ins. Code, § 10232.93: Must be defined as a single dollar amount that may be used interchangeably for any covered services. No limits are allowed except for a daily, weekly, or monthly limit set for home- and community-based care, care in a Residential Care Facility, and care in a Nursing Facility.
   2. Offer to purchase shortened benefit period nonforfeiture benefit (not required in a life insurance policy that accelerates benefits for long-term care) - Ins. Code, § 10235.30
   3. Offer to purchase inflation protection (not required in a life insurance policy that accelerates benefits for long-term care) - Ins. Code, § 10237.1
      a. Inflation protection benefits must continue without regard to age, claim status, claim history, or the length of time insured under the policy. Ins. Code, § 10237.4(a).
      b. Increases shall not be reduced due to the payment of claims. Ins. Code, § 10237.4(c).
      c. Does not apply to group long-term care insurance under section 10231.6 (a), (b), or (c), or group insurance issued to a Continuing Care Retirement Community, if the inflation protection is offered to the group policyholder and the offer is declined. Ins. Code, § 10237.2.
   4. Continuation of confinement benefits after termination - Ins. Code, § 10235.10
   5. Reinstatement of coverage after lapse if insured is chronically ill - Ins. Code, § 10235.40(e)
   6. Right to reduce coverage and lower premiums - Ins. Code, § 10235.50
   7. Right to increase coverage - Ins. Code, § 10235.51
   8. Notification of new benefits, policies with new benefits or new eligibility (not required for group long-term care insurance as described in section 10231.6 (a), (b), or (c), if an offer is made to the group policyholder and the offer is declined) - Ins. Code, § 10235.52
   9. Right to appeal - Ins. Code, § 10235.94
   10. Compulsory provisions – Ins. Code, §§ 10350 to 10350.11. (*See* Cal. Code Regs., tit. 10, §§ 2232.17 to 2232.28, for compulsory provisions applicable to group policies.)

F. Prohibited Terms and Provisions
   1. Generally prohibited provisions - Ins. Code, § 10233.2
      a. Cancellation, nonrenewal, or termination due to age or deterioration of mental or physical health.
      b. Providing for a new waiting period after conversion or replacement of existing coverage (except for voluntary benefit increases).
      c. Coverage for skilled nursing care only, or significantly more coverage for skilled care than lower levels of care.
      d. Payment of benefits based on a standard described as “usual and customary,” “reasonable and customary,” or words of similar import.
      e. Termination or premium increase due to divorce.
      f. Including an additional benefit (a benefit not required by statute) with a known market value, unless the additional benefit provides for payment of at least five times the daily benefit and the value of the additional benefit is stated in the schedule page of the policy.

2. Prohibited provisions relating to home care benefits - Ins. Code, § 10232.9(c)
    a. Requiring a need for care in a nursing home if home care services are not provided.
    b. Requiring that skilled services be used before or with unskilled services.
    c. Requiring the existence of an acute condition.
    d. Limiting benefits to services provided by Medicare-certified providers or agencies.
    e. Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, unless certification or licensure is required by law.
    f. Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.
    g. Requiring "medical necessity" or similar standard as a criteria for benefits.
3. Prohibited provisions relating to Residential Care Facilities - Ins. Code, § 10232.92(c). A policy must not restrict who may provide Qualified Long-Term Care Services while the insured is confined.

G. Exclusions and Limitations - Ins. Code, § 10235.8. A policy is not permitted to limit or exclude coverage by type of illness, treatment, medical condition, or accident, except for:
    1. Preexisting conditions or diseases (subject to Ins. Code, § 10232.4).
    2. Alcoholism or drug addiction.
    3. Illness, treatment, or a medical condition arising out of: war or act of war; participation in a felony, riot, or insurrection; service in the Armed Forces or units auxiliary thereto; suicide, attempted suicide, or intentionally inflicted injury; aviation, if a non-fare-paying passenger.
    4. Treatment provided in a government facility (unless otherwise required by law).
    5. Services available under Medicare or other governmental programs (except Medi-Cal or Medicaid), state or federal workers' compensation, employer's liability or occupational disease law, or a motor vehicle no-fault law.
    6. Services provided by a member of the covered person's immediate family.
    7. Services for which no charge is normally made in the absence of insurance.
    8. Exclusions and limitations by type of provider or territorial limitations.

H. Group Requirements
    1. Group certificate requirements - Ins. Code, § 10233.6
    2. Continuation or conversion coverage - Ins. Code, § 10236.5

I. Group Exceptions
    1. Group long-term care insurance under section 10231.6 (a) and (b) is exempt from the right to return provided under section 10232.7.
    2. Group long-term care insurance under section 10231.6 (a), (b), and (c) is exempt from section 10235.52, if the new benefit, policy, or eligibility is offered to the group policyholder and the offer is declined.
    3. Group long-term care insurance under section 10231.6 (a), (b), and (c), and group insurance issued to a Continuing Care Retirement Community, is exempt from section 10237.1, if the group policyholder is offered inflation protection and declines the offer.

J. Supplemental Life Exceptions. For long-term care insurance that is supplemental to life insurance, the following provisions do not apply:
    1. Premium credits towards replacement policies - Ins. Code, § 10234.87
    2. Suitability standards - Ins. Code, § 10234.95
    3. Shortened benefit period non-forfeiture benefit - Ins. Code, § 10235.30
    4. Certain requirements after approval of a rate increase - Ins. Code, § 10236.15
    5. Option to purchase inflation protection - Ins. Code, §§ 10237.1, 10237.3

III. Required Notices and Forms

A. Application for Long-Term Care Insurance
   1. Each health question must: be clear, unambiguous, short, and simple; contain no more than one health inquiry; and require no more than a yes/no answer - Ins. Code, § 10232.3(a)
   2. Must include a verbatim statement on "Federally Qualified" policies - Ins. Code, § 10232.1(a)
   3. Must include a verbatim "Caution" statement - Ins. Code, § 10232.3(b)
   4. Must include a list of documents to be given to the applicant - Ins. Code, § 10232.3(c)
   5. Must include a rejection of inflation protection with signature line - Ins. Code, § 10237.5
   6. Must include a Replacement Notice (may be a separate form) - Ins. Code, § 10235.16 or § 10235.18

B. Personal Worksheet (not required for a life insurance policy that accelerates benefits for long-term care) - Ins. Code, § 10234.95(c). Use the current version at Appendix B, pp. 76-79, of the Long-Term Care Insurance Model Regulations of the NAIC, available at www.naic.org/store/free/MDL-641.pdf

C. Outline of Coverage. Must be in the form stated in Ins. Code, § 10233.5 and include:
   1. A prominent label, if policy benefits are limited to "Nursing Facility and Residential Care Facility Only" or "Home Care Only" - Ins. Code, § 10232.1(b)-(d)
   2. A verbatim statement on "Federally Qualified" policies - Ins. Code, § 10232.1(a)
   3. A verbatim notice to buyer regarding policy limitations - Ins. Code, § 10234.93(a)(5)
   4. A graphic comparison of benefit levels - Ins. Code, § 10237.6

D. Protection Against Unintended Lapse - Ins. Code, § 10235.40(a)

IV. Other References

A. California Insurance Code: leginfo.legislature.ca.gov/faces/codes.xhtml

B. California Code of Regulations: govt.westlaw.com/calregs

C. IRS Notice 97-31: www.irs.gov/pub/irs-irbs/irb97-21.pdf

D. California Partnership for Long-Term Care: More information about the California Partnership for Long-Term Care can be found at Welf. & Inst. Code, §§ 22000 through 22011, Cal. Code Regs., tit. 22, §§ 58000 through 58082, and www.dhcs.ca.gov.

Appendix

Qualified Long-Term Care Services - Ins. Code, § 10232.92(c); Pub. L. 104-191 § 321(a) (codified at 26 U.S.C. § 7702B(c)(1)). Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, 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.

Licensed Health Care Practitioner - Ins. Code, § 10232.8(d); Pub. L. 104-191 § 321(a) (codified at 26 U.S.C. § 7702B(c)(4)); Social Security Act § 1861(r)(1) (codified at 42 U.S.C. § 1395x(r)(1)). Any doctor of medicine or osteopathy authorized to practice medicine and surgery in the state where such action is performed, and any registered professional nurse, licensed social worker, or other individual designated by the United States Secretary of the Treasury.

Nursing Facility - Includes:

- A licensed health facility that is certified to participate as a provider of care either as a skilled nursing facility in the federal Medicare Program under Title XVIII of the Social Security Act (42 U.S.C. § 1395 *et seq*.) or as a nursing facility in the federal Medicaid Program under Title XIX of the Social Security Act (42 U.S.C. § 1396 *et seq*.), or as both. Health & Safety Code, § 1250(k).
- A skilled nursing facility, meaning a licensed health facility that provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis, and provides for 24-hour inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program. Ins. Code, § 10235.2(c); Health & Safety Code, § 1250(c); Cal. Code Regs., tit. 22 § 72103.
- An intermediate care facility, meaning a licensed health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care. Ins. Code, § 10235.2(c); Health & Safety Code, § 1250(d).
- A nursing home, meaning any institution, facility, place, building, or agency, or portion thereof, licensed as a licensed skilled nursing facility or intermediate care facility. Ins. Code, § 10235.2(c); Health & Safety Code, § 1426.2(a)(4).
- An inpatient hospice facility, meaning a licensed health facility with a capacity of no more than 24 beds that provides routine care, continuous care, inpatient respite care, and inpatient hospice care, and is operated by a licensed provider of hospice services and certified as a hospice pursuant to Part 418 of Title 42 of the Code of Federal Regulations. Ins. Code, § 10235.2(c); Health & Safety Code, § 1250(n).

Residential Care Facility - Ins. Code, § 10232.92(a), 10235.2(c); Health & Safety Code, § 1569.2(p). In California, a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code. Outside of California, a facility that is licensed, as required, and engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in activities of daily living or impairment in cognitive ability and which also provide care and services on a 24-hour basis, have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services, provide three meals a day and accommodate special dietary needs, have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency, and, have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

Continuing Care Retirement Community - Health & Safety Code, § 1771(c). A facility located within the State of California which promises to provide nursing, medical, or other health-related services, protection or supervision, or assistance with the personal activities of daily living to an elderly resident for the duration of his or her life or for a term in excess of one year.