

Senate Bill No. 1091

Passed the Senate August 26, 2016

Secretary of the Senate

Passed the Assembly August 24, 2016

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day
of _____, 2016, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to add Sections 10231.3 and 10235.9a to the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 1091, Liu. Long-term care insurance.

Under existing law, the Department of Insurance, headed by the Insurance Commissioner, licenses and regulates insurers. Existing law divides insurance into various classes, including long-term care insurance, which includes an 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. Existing law defines “policy” for these purposes.

This bill would, among other things, define “alternate plan of care” as a plan of care developed by a licensed health care practitioner that includes a specification of long-term care services required by an insured that are not specifically defined as a covered service under the policy. The bill would also define “alternate-plan-of-care provision” to mean a provision in a policy, rider, endorsement, or amendment that allows benefits for services specified in an alternate plan of care.

The bill would authorize, for policies issued on or after January 1, 2017, the insured or an insurer to propose an alternate plan of care. The bill would also prohibit the maximum benefit available under the contract from being changed based on an insured utilizing an alternate plan of care but would authorize the maximum benefit to be reduced by the amount of any benefits paid under an alternate plan of care. The bill would also require coverage for services under an alternate plan of care to be in addition to, not in lieu of, coverage for services specifically defined as covered services under the policy. The bill would also require an insurer, within 60 days, to provide a written explanation to the policyholder or certificate holder as to the specific reason an agreement cannot be reached for policies or certificates that contain an alternate plan of care provision, as specified.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Long-term care insurance is a vital lifeline for many of California's aging population.

(b) Ensuring that the insurance available to consumers is fair and accessible is essential to our aging community's quality of life.

(c) Because long-term care insurance is often purchased many years before a claim is anticipated, it is necessary to give insurers and insureds the flexibility needed to adapt policy coverage to meet contemporary needs.

(d) An alternate plan of care may provide insureds access to benefits for services not available at the time the policy was purchased and insurers a way to offer cost-effective alternatives to the benefits explicitly covered under the policy.

SEC. 2. It is the intent of the Legislature to ensure that insurance products provide appropriate benefits that fit consumers' needs.

SEC. 3. Section 10231.3 is added to the Insurance Code, to read:

10231.3. (a) For the purposes of this section, the following definitions apply:

(1) An "alternate plan of care" means a plan of care developed by a licensed health care practitioner that includes a specification of long-term care services required by an insured that are not specifically defined as covered services under the policy.

(2) An "alternate-plan-of-care provision" means a provision in a policy, rider, endorsement, or amendment that allows benefits for services specified in an alternate plan of care.

(3) "Licensed health care practitioner" means a physician, registered nurse, licensed social worker, or other individual whom the United States Secretary of the Treasury may prescribe by regulation.

(4) "Plan of care" means a written description of the insured's needs and a specification of the type, frequency, and providers of all formal and informal long-term care services required by the insured and the cost, if any.

(b) An alternate-plan-of-care provision shall provide for all of the following:

(1) An alternate plan of care may be proposed by the insured or the insurer. Adoption, amendment, or replacement of an alternate plan of care shall be agreed to by the insured, the insurer, and a licensed health care practitioner that is independent of the insurer. Consent or agreement to an alternate plan of care shall be free and mutual.

(2) The maximum benefit available under the contract shall not change based on an insured utilizing an alternate plan of care, but that benefit will be reduced by the amount of any benefits paid under an alternate plan of care.

(3) Coverage for services under an alternate plan of care shall be in addition to, not in lieu of, coverage for services that are specifically defined as covered services under the policy. The insured may switch between services that are specifically defined as covered services under the policy and services under the alternate plan of care and back if there is agreement from the licensed health care practitioner and the insurer.

(c) Nothing in this section shall be construed to require an insurer to include a provision authorizing an alternate plan of care.

(d) This section shall apply to policies issued on or after January 1, 2017.

SEC. 4. Section 10235.9a is added to the Insurance Code, immediately following Section 10235.9, to read:

10235.9a. For policies or certificates issued on or after January 1, 2017, that contain an alternate plan of care provision pursuant to Section 10231.3, if an insurer and insured cannot agree on the terms of an alternate plan of care, the insurer shall provide a written explanation to the policyholder or certificate holder as to the specific reason or reasons why the agreement cannot be reached. The insurer shall provide the written explanation within 60 days of the insurer's determination that an agreement cannot be reached.

Approved _____, 2016

Governor