

AMENDED IN ASSEMBLY AUGUST 16, 1999

AMENDED IN ASSEMBLY JULY 8, 1999

AMENDED IN SENATE MAY 19, 1999

AMENDED IN SENATE MAY 6, 1999

AMENDED IN SENATE APRIL 26, 1999

SENATE BILL

No. 870

Introduced by Senator Vasconcellos

February 25, 1999

An act to amend Sections 10232.1, 10232.2, 10232.3, 10232.4, ~~10232.8, 10233.2, 10233.5, 10234.87, 10234.95, 10233.2, 10235.2, 10235.8, 10235.30, 10235.40, 10235.50, 10235.52, 10237.1, 10237.4, and 10237.5~~ of, to add Sections ~~10232.81, 10232.91, 10232.94, 10232.97~~ and 10235.94 to, ~~to repeal Section 10235.10 of,~~ and to repeal and add Sections *Section* 10232.92, ~~10232.95, and 10237.2~~ of, the Insurance Code, relating to long-term care insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 870, as amended, Vasconcellos. Long-term care insurance.

Existing law prescribes various requirements and conditions governing the delivery or issuance for delivery in this state of individual or group long-term care insurance.

This bill would make various changes to those provisions, including changes clarifying an insurer's obligations to file, offer, and market policies intended to be federally qualified

and policies that are not intended to be federally qualified; changes mandating coverage for care in a residential care facility ~~and for respite care~~; changes relating to coverage for preexisting conditions; ~~changes relating to eligibility for benefits; changes relating to elimination or deductible periods in every policy or certificate~~; changes regarding prohibited policy provisions and prohibited insurer actions in connection with policies; ~~changes clarifying policy replacements~~; and changes regarding the right of a policy or certificate holder to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursements.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

1 SECTION 1. Section 10232.1 of the Insurance Code is
2 amended to read:

3 10232.1. (a) Every policy that is intended to be a
4 qualified long-term care insurance contract as provided
5 by Public Law 104-191 shall be identified as such by
6 prominently displaying and printing on page one of the
7 policy form and the outline of coverage and in the
8 application the following words: “This contract for
9 long-term care insurance is intended to be a federally
10 qualified long-term care insurance contract and may
11 qualify you for federal and state tax benefits.” Every
12 policy that is not intended to be a qualified long-term care
13 insurance contract as provided by Public Law 104-191
14 shall be identified as such by prominently displaying and
15 printing on page one of the policy form and the outline
16 of coverage and in the application the following words:
17 “This contract for long-term care insurance is not
18 intended to be a federally qualified long-term care
19 insurance contract.”

20 (b) Any policy or certificate in which benefits are
21 limited to the provision of institutional care shall be called
22 a “nursing facility and residential care facility only”
23 policy or certificate and the words “Nursing Facility and
24 Residential Care Facility Only” shall be prominently



1 displayed on page one of the form and the outline of
2 coverage. The commissioner may approve alternative
3 wording if it is more descriptive of the benefits.

4 (c) Any policy or certificate in which benefits are
5 limited to the provision of home care services, including
6 community-based services, shall be called a “home care
7 only” policy or certificate and the words “Home Care
8 Only” shall be prominently displayed on page one of the
9 form and the outline of coverage. The commissioner may
10 approve alternative wording if it is more descriptive of
11 the benefits.

12 (d) Only those policies or certificates providing
13 benefits for both institutional care and home care may be
14 called “comprehensive long-term care” insurance.

15 SEC. 2. Section 10232.2 of the Insurance Code is
16 amended to read:

17 10232.2. (a) Every insurer that offers policies or
18 certificates that are intended to be federally qualified
19 long-term care insurance contracts, including riders to
20 life insurance policies providing long-term care coverage,
21 shall fairly and affirmatively concurrently file, offer, and
22 market long-term care insurance policies or certificates
23 not intended to be federally qualified, as described in
24 subdivision (a) of Section 10232.1, ~~that contain the same~~
25 ~~benefits and coverages as policies and certificates that are~~
26 ~~intended to be federally qualified long-term insurance~~
27 ~~contracts.~~

28 (b) All long-term care insurance contracts, including
29 riders to life insurance contracts providing long-term
30 care coverage, approved after the effective date of this
31 section shall meet all of the requirements of this chapter.

32 (c) Until ~~January~~ July 1, 2001, or 90 days after approval
33 of contracts submitted for approval pursuant to
34 subdivision (b), whichever comes first, insurers may
35 continue to offer and market previously approved
36 long-term care insurance contracts.

37 (d) Group policies issued prior to January 1, 1997, shall
38 be allowed to remain in force and not be required to meet
39 the requirements of this chapter, as amended during the
40 1997 portion of the 1997–98 Regular Session, unless those



1 policies cease to be treated as federally qualified
2 long-term care insurance contracts. If a policy or
3 certificate issued on a group policy of that type ceases to
4 be a federally qualified long-term care insurance contract
5 under the grandfather rules issued by the United States
6 Department of the Treasury pursuant to Section
7 7702B(f)(2) of the Internal Revenue Code, the insurer
8 shall offer the policy and certificate holders the option to
9 convert, on a guaranteed-issue basis, to a policy or
10 certificate that is federally tax qualified if the insurer sells
11 tax-qualified policies.

12 SEC. 3. Section 10232.3 of the Insurance Code is
13 amended to read:

14 10232.3. (a) All applications for long-term care
15 insurance except that which is guaranteed issue, shall
16 contain clear, unambiguous, short, simple questions
17 designed to ascertain the health condition of the
18 applicant. Each question shall contain only one health
19 status inquiry and shall require only a “yes” or “no”
20 answer, except that the application may include a request
21 for the name of any prescribed medication and the name
22 of a prescribing physician. If the application requests the
23 name of any prescribed medications or prescribing
24 physicians, then any mistake or omission shall not be used
25 as a basis for the denial of a claim or the rescision of a policy
26 or certificate.

27 (b) The following warning shall be printed
28 conspicuously and in close conjunction with the
29 applicant’s signature block:

30 “Caution: If your answers on this application are
31 misstated or untrue, the insurer may have the right to
32 deny benefits or rescind your coverage.”

33 (c) Every application for long-term care insurance
34 shall include a checklist that enumerates each of the
35 specific documents which this chapter requires be given
36 to the applicant at the time of solicitation. The documents
37 and notices to be listed in the checklist include, but are
38 not limited to, the following:

39 (1) The “Important Notice Regarding Policies
40 Available” pursuant to Section 10232.25.



1 (2) The outline of coverage pursuant to Section
2 10233.5.

3 (3) The HICAP notice pursuant to paragraph (8) of
4 subdivision (a) of Section 10234.93.

5 (4) The long-term care insurance shoppers guide
6 pursuant to paragraph (9) of subdivision (a) of Section
7 10234.93.

8 (5) The “Long-Term Care Insurance Personal
9 Worksheet” pursuant to subdivision (c) of Section
10 10234.95.

11 (6) The “Notice to Applicant Regarding Replacement
12 of Accident and Sickness or Long-Term Care Insurance”
13 pursuant to Section 10235.16 if replacement is not made
14 by direct response solicitation or Section 10235.18 if
15 replacement is made by direct response solicitation.
16 Unless the solicitation was made by a direct response
17 method, the agent and applicant shall both sign at the
18 bottom of the checklist to indicate the required
19 documents were delivered and received.

20 (d) If an insurer does not complete medical
21 underwriting and resolve all reasonable questions arising
22 from information submitted on or with an application
23 before issuing the policy or certificate, then the insurer
24 may only rescind the policy or certificate or deny an
25 otherwise valid claim, upon clear and convincing
26 evidence of fraud or material misrepresentation of the
27 risk by the applicant. The evidence shall:

28 (1) Pertain to the condition for which benefits are
29 sought.

30 (2) Involve a chronic condition or involve dates of
31 treatment before the date of application.

32 (3) Be material to the acceptance for coverage.

33 (e) No long-term care policy or certificate may be field
34 issued.

35 (f) The contestability period as defined in Section
36 10350.2 for long-term care insurance shall be two years.

37 (g) A copy of the completed application shall be
38 delivered to the insured at the time of delivery of the
39 policy or certificate.



1 (h) Every insurer shall maintain a record, in
2 accordance with Section 10508, of all policy or certificate
3 rescissions, both state and countrywide, except those
4 voluntarily initiated by the insured, and shall annually
5 furnish this information to the commissioner in a format
6 prescribed by the commissioner.

7 SEC. 4. Section 10232.4 of the Insurance Code is
8 amended to read:

9 10232.4. (a) No long-term care insurance policy or
10 certificate other than a group policy or certificate, as
11 described in subdivision (a) of Section 10231.6, shall use
12 a definition of preexisting condition which is more
13 restrictive than a condition for which medical advice or
14 treatment was recommended by, or received from a
15 provider of health care services, within six months
16 preceding the effective date of coverage of an insured
17 person.

18 (b) Every long-term care insurance policy or
19 certificate shall cover preexisting conditions that are
20 disclosed on the application no later than six months
21 following the effective date of the coverage of an insured,
22 regardless of the date the loss or confinement begins.

23 (c) The definition of preexisting condition does not
24 prohibit an insurer from using an application form
25 designed to elicit the complete health history of an
26 applicant, and on the basis of the answers on that
27 application, from underwriting in accordance with that
28 insurer's established underwriting standards. Unless
29 otherwise provided in the policy or certificate a
30 preexisting condition, regardless of whether it is disclosed
31 on the application, need not be covered until the waiting
32 period described in subdivision (b) expires. Unless a
33 waiver or rider has been specifically approved by the
34 commissioner, no long-term care insurance policy or
35 certificate may exclude or use waivers or riders of any
36 kind to exclude, limit, or reduce coverage or benefits for
37 specifically named or described preexisting diseases or
38 physical conditions beyond the waiting period described
39 in subdivision (b).



1 ~~SEC. 5. Section 10232.8 of the Insurance Code is~~
2 ~~amended to read:~~

3 ~~10232.8. (a) Every long-term care policy, certificate,~~
4 ~~or rider issued or delivered on or after January 1, 2000,~~
5 ~~that is not intended to be a federally qualified long-term~~
6 ~~care insurance contract under Public Law 104-191 shall~~
7 ~~establish benefits as follows:~~

8 ~~(1) The contract shall include a provision establishing~~
9 ~~eligibility for benefits that is at least as permissive as the~~
10 ~~following:~~

11 ~~“HOW TO QUALIFY FOR BENEFITS:~~

12 ~~We will pay for the long-term care services covered by~~
13 ~~this policy (certificate) when one of the following criteria~~
14 ~~is met:~~

15 ~~(A) You are impaired in two out of seven activities of~~
16 ~~daily living and need human assistance or continual~~
17 ~~supervision due to a loss of functional capacity, or~~

18 ~~(B) You have a cognitive impairment.~~

19 ~~The definitions for the following terms will help explain~~
20 ~~how you qualify for benefits under this policy:~~

21 ~~(i) Activities of daily living.~~

22 ~~(ii) Cognitive impairment.~~

23 ~~(iii) Long-term care services.”~~

24 ~~(2) The policy or certificate may provide for lesser but~~
25 ~~not greater eligibility criteria. The commissioner, at his or~~
26 ~~her discretion, may approve other criteria or~~
27 ~~combinations of criteria to be substituted, if the insurer~~
28 ~~demonstrates that the interest of the insured is better~~
29 ~~served.~~

30 ~~(3) “Activities of daily living” shall include eating,~~
31 ~~bathing, dressing, ambulating, transferring, toileting, and~~
32 ~~continence.~~

33 ~~The following definitions shall be used verbatim to~~
34 ~~define “activities of daily living” in the benefit eligibility~~
35 ~~provision of the contract:~~

36 ~~(A) Eating, which shall mean reaching for, picking up,~~
37 ~~and grasping a utensil and cup; getting food on a utensil,~~
38 ~~and bringing food, utensil, and cup to mouth;~~
39 ~~manipulating food on plate; and cleaning face and hands~~
40 ~~as necessary following meals.~~



1 ~~(B) Bathing, which shall mean cleaning the body using~~
2 ~~a tub, shower, or sponge bath, including getting a basin~~
3 ~~of water, managing faucets, getting in and out of tub or~~
4 ~~shower, and reaching head and body parts for soaping,~~
5 ~~rinsing, and drying.~~

6 ~~(C) Dressing, which shall mean putting on, taking off,~~
7 ~~fastening, and unfastening garments and undergarments~~
8 ~~and special devices including back or leg braces, corsets,~~
9 ~~elastic stockings or garments, and artificial limbs or~~
10 ~~splints.~~

11 ~~(D) Toileting, which shall mean getting on or off a~~
12 ~~toilet or commode and emptying a commode, managing~~
13 ~~clothing and wiping and cleaning the body after toileting,~~
14 ~~and using and emptying a bedpan and urinal.~~

15 ~~(E) Transferring, which shall mean moving from one~~
16 ~~sitting or lying position to another sitting or lying position;~~
17 ~~for example, from bed to or from a wheelchair or sofa,~~
18 ~~coming to a standing position, or repositioning to~~
19 ~~promote circulation and to prevent skin breakdown.~~

20 ~~(F) Continence, which shall mean the ability to~~
21 ~~control bowel and bladder as well as use ostomy or~~
22 ~~catheter receptacles, and apply diapers and disposable~~
23 ~~barrier pads.~~

24 ~~(G) Ambulating, which shall mean walking or moving~~
25 ~~around inside or outside the home regardless of the use~~
26 ~~of cane, crutches, or braces.~~

27 ~~(4) The following definitions shall be used verbatim to~~
28 ~~define the terms used in the benefit eligibility provision~~
29 ~~of the contract:~~

30 ~~(A) Cognitive impairment means a deterioration or~~
31 ~~loss of intellectual capacity either due to organic mental~~
32 ~~disease, including Alzheimer's disease or related illnesses,~~
33 ~~or due to nonorganic mental or emotional disease or~~
34 ~~disorder, that requires continual supervision to protect~~
35 ~~oneself or others.~~

36 ~~(B) "Long-term care services" means necessary~~
37 ~~diagnostic, preventative, therapeutic, curing, treating,~~
38 ~~mitigating, and rehabilitative services, and maintenance~~
39 ~~or personal care services which are needed to assist you~~
40 ~~with the disabling conditions that cause your loss of~~



1 functional capacity. “Maintenance or personal care
2 services” means any care the primary purpose of which
3 is the provision of needed assistance with any of the
4 disabilities resulting from your loss of functional capacity,
5 including the protection from threats to the health and
6 safety of yourself or others due to cognitive impairment.

7 (b) Every long-term care policy, certificate, or rider
8 issued or delivered on or after January 1, 2000, that is
9 intended to be a federally qualified long-term care
10 insurance contract under Public Law 104-191 shall
11 establish eligibility for benefits as follows:

12 (1) The contract shall include a provision establishing
13 eligibility for benefits, to be used verbatim unless
14 modified by regulation as provided in paragraph (2), as
15 follows:

16 **“HOW TO QUALIFY FOR BENEFITS:**

17 We will pay for the qualified long-term care services
18 covered by this policy (certificate) if:

19 (A) You are a chronically ill individual; and

20 (B) The qualified long-term care services are
21 prescribed for you in a written plan of care.

22 You will be considered a chronically ill individual when
23 one of the following criteria is met:

24 (A) You are unable to perform, without standby
25 assistance or hands-on assistance from another individual,
26 two activities of daily living due to a loss of functional
27 capacity and this loss of functional capacity is expected to
28 last at least 90 days.

29 (B) You have a severe cognitive impairment requiring
30 substantial supervision to protect you from threats to
31 health and safety.

32 The certification that you are a chronically ill individual
33 must be made by a licensed health care practitioner,
34 independent of us, within the preceding 12 months and
35 must be renewed at least every 12 months. The services
36 to be paid by this policy must be prescribed in a written
37 plan of care prepared by a licensed health care
38 practitioner, independent of us, after a face-to-face
39 assessment of your long-term care needs.



1 All services covered by this policy are qualified
2 long-term care services.

3 The definitions for the following terms will help explain
4 how you qualify for benefits under this policy:

5 Activities of daily living.

6 Standby assistance.

7 Hands-on assistance.

8 Severe cognitive impairment.

9 Substantial supervision.

10 Licensed health care practitioner.

11 Plan of care.

12 Qualified long-term care services.”

13 (2) Other criteria shall be used in establishing
14 eligibility for benefits if federal law or regulations allow
15 other types of disability to be used applicable to eligibility
16 for benefits under a long-term care insurance policy. If
17 federal law or regulations allow other types of disability
18 to be used, the commissioner shall promulgate
19 emergency regulations to add those other criteria as a
20 third threshold to establish eligibility for benefits.
21 Insurers shall submit policies for approval within 60 days
22 of the effective date of the regulations. With respect to
23 policies previously approved, the department is
24 authorized to review only the changes made to the policy.
25 All new policies approved and certificates issued after the
26 effective date of the regulation shall include the third
27 criterion. No policy shall be sold that does not include the
28 third criterion after one year beyond the effective date of
29 the regulations. An insured meeting this third criterion
30 shall be eligible for benefits regardless of whether the
31 individual meets benefit eligibility requirements of
32 paragraph (1).

33 (3) The contract shall include a provision for
34 assessment and development of a plan of care as follows:
35 A licensed health care practitioner, independent of the
36 insurer, shall certify that the insured meets the definition
37 of “chronically ill individual” as defined under Public
38 Law 104-191. In the event a health care practitioner
39 makes a determination, pursuant to this section, that an
40 insured does not meet the definition of “chronically ill



1 individual,” the insurer shall notify the insured that the
2 insured shall be entitled to a second assessment by a
3 licensed health care practitioner, upon request, who shall
4 personally examine the insured. The requirement for a
5 second assessment shall not apply if the initial assessment
6 was performed by a practitioner who otherwise meets the
7 requirements of this section and who personally
8 examined the insured. The assessments conducted
9 pursuant to this section shall be performed promptly with
10 the certification completed as quickly as possible to
11 ensure that an insured’s benefits are not delayed. The
12 written certification shall be renewed every 12 months.
13 A licensed health care practitioner, independent of the
14 insurer, shall develop a written plan of care after
15 personally examining the insured. The costs to have a
16 licensed health care practitioner certify that an insured
17 meets, or continues to meet, the definition of “chronically
18 ill individual,” or to prepare written plans of care shall not
19 count against the lifetime maximum of the policy or
20 certificate. In order to be considered “independent of the
21 insurer,” a licensed health care practitioner shall not be
22 an employee of the insurer and shall not be compensated
23 in any manner that is linked to the outcome of the
24 certification. It is the intent of this subdivision that the
25 practitioner’s assessments be unhindered by financial
26 considerations.

27 (4) The “activities of daily living” shall include eating,
28 bathing, dressing, transferring, toileting, and continence.

29 The following definitions shall be used to define the
30 “activities of daily living” in the benefit eligibility
31 provision of the contract until the time that these
32 definitions may be superseded by federal law or
33 regulations:

34 (A) Eating, which shall mean feeding oneself by
35 getting food in the body from a receptacle (such as a
36 plate, cup, or table) or by a feeding tube or intravenously.

37 (B) Bathing, which shall mean washing oneself by
38 sponge bath or in either a tub or shower, including the act
39 of getting into or out of a tub or shower.



1 ~~(C) Contenance, which shall mean the ability to~~
2 ~~maintain control of bowel and bladder function; or when~~
3 ~~unable to maintain control of bowel or bladder function;~~
4 ~~the ability to perform associated personal hygiene~~
5 ~~(including caring for a catheter or colostomy bag).~~

6 ~~(D) Dressing, which shall mean putting on and taking~~
7 ~~off all items of clothing and any necessary braces,~~
8 ~~fasteners, or artificial limbs.~~

9 ~~(E) Toileting, which shall mean getting to and from~~
10 ~~the toilet, getting on and off the toilet, and performing~~
11 ~~associated personal hygiene.~~

12 ~~(F) Transferring, which shall mean the ability to move~~
13 ~~into or out of bed, a chair or wheelchair.~~

14 ~~The commissioner may approve the use of definitions~~
15 ~~of “activities of daily living” that differ from the verbatim~~
16 ~~definitions of this subdivision if these definitions would~~
17 ~~result in more policy or certificate holders qualifying for~~
18 ~~long-term care benefits than would occur by the use of~~
19 ~~the verbatim definitions of this subdivision. In addition,~~
20 ~~the following definitions may be used without the~~
21 ~~approval of the commissioner: (1) the verbatim~~
22 ~~definitions of eating, bathing, dressing, toileting,~~
23 ~~transferring, and continence in subdivision (g); or (2) the~~
24 ~~verbatim definitions of eating, bathing, dressing,~~
25 ~~toileting, and continence in this subdivision and a~~
26 ~~substitute, verbatim definition of “transferring” as~~
27 ~~follows: “transferring,” which shall mean the ability to~~
28 ~~move into and out of a bed, a chair, or wheelchair, or~~
29 ~~ability to walk or move around inside or outside the home,~~
30 ~~regardless of the use of a cane, crutches, or braces.~~

31 ~~In addition to the verbatim definitions, the~~
32 ~~commissioner may approve additional descriptive~~
33 ~~language to be added to the definitions, if the additional~~
34 ~~language is (1) warranted based on federal or state laws,~~
35 ~~federal or state regulations, or other relevant federal~~
36 ~~decision, and (2) strictly limited to that language which~~
37 ~~is necessary to ensure that the definitions required by this~~
38 ~~section are not misleading to the insured.~~

39 ~~(5) The following definitions shall be used verbatim to~~
40 ~~define the terms in the benefit eligibility provision of the~~



1 ~~contract in policies and certificates intended to be~~
2 ~~federally qualified long-term care insurance unless~~
3 ~~changes are made in Public Law 104-191 or regulations.~~
4 ~~If changes are made in federal law or regulations, the~~
5 ~~federal definitions may be used in place of the following~~
6 ~~definitions:~~

7 (A) ~~“Standby assistance” means the presence of~~
8 ~~another person within arm’s reach of you that is necessary~~
9 ~~to prevent, by physical intervention, injury to you while~~
10 ~~you are performing an activity of daily living, such as~~
11 ~~being ready to catch you if you fall while getting into or~~
12 ~~out of the bathtub or shower as part of bathing, or being~~
13 ~~ready to remove food from your throat if you choke while~~
14 ~~eating.~~

15 (B) ~~“Hands-on assistance” means the physical~~
16 ~~assistance of another person without which you would be~~
17 ~~unable to perform the activity of daily living.~~

18 (C) ~~“Severe cognitive impairment” means a loss or~~
19 ~~deterioration in intellectual capacity that:~~

20 (i) ~~Is comparable to and includes Alzheimer’s disease~~
21 ~~and similar forms of irreversible dementia; and~~

22 (ii) ~~Is measured by clinical evidence and standardized~~
23 ~~tests that reliably measure impairment in the person’s~~
24 ~~short-term or long-term memory, orientation as to~~
25 ~~people, places, or time, and deductive or abstract~~
26 ~~reasoning.~~

27 (D) ~~“Substantial supervision” means continual~~
28 ~~supervision, which may include cueing by verbal~~
29 ~~prompting, gestures, or other demonstrations, by another~~
30 ~~person that is necessary to protect a person who has~~
31 ~~severe cognitive impairment from the threats to his or~~
32 ~~her health or safety, as may result from wandering.~~

33 (E) ~~“Licensed health care practitioner” means any~~
34 ~~physician and any registered professional nurse, licensed~~
35 ~~social worker, or other individual who meets such~~
36 ~~requirements as may be prescribed by the Secretary of~~
37 ~~the Treasury.~~

38 (F) ~~“Plan of care” means a written individualized plan~~
39 ~~of services prescribed by a licensed health care~~
40 ~~practitioner, which specifies the type, frequency, and~~



1 providers of all paid and unpaid long-term care services
2 required for the individual, and the cost, if any, of any
3 formal long-term care services prescribed. Changes in
4 the plan of care must be supported by documentation
5 that indicates alterations are required by changes in the
6 client's medical situation, by changes in the client's
7 functional, cognitive, or behavioral abilities, by changes
8 in the availability of social supports or providers, or by
9 changes in the client's preferences for the type,
10 frequency, or providers of services.

11 (G) "~~Qualified long-term care services~~" means
12 necessary diagnostic, preventative, therapeutic, curing,
13 treating, mitigating, and rehabilitative services, and
14 maintenance or personal care services, which are needed
15 to assist you with the disabling conditions that cause you
16 to be a chronically ill individual. "Maintenance or
17 personal care services" means any care the primary
18 purpose of which is the provision of needed assistance
19 with any of the disabilities as a result of which you are a
20 chronically ill individual, including the protection from
21 threats to health and safety due to severe cognitive
22 impairment.

23 SEC. 6. Section 10232.81 is added to the Insurance
24 Code, to read:

25 10232.81. (a) The elimination or deductible period in
26 every policy or certificate may not be more restrictive
27 than the following:

28 (1) The elimination or deductible period shall be met
29 either counting each day of disability or each day on
30 which a service covered by the policy or certificate is
31 received and paid for by the policy or certificate holder
32 or paid on behalf of the policy or certificate holder by
33 Medicare, other insurance, or any other third party.

34 (2) Each day of disability, or each day on which a
35 service covered by the policy or certificate but paid by
36 the insured or any other party is received prior to or after
37 the filing of a claim for benefits shall count toward
38 meeting the elimination period if the insured can
39 establish the benefit eligibility criteria of the policy or
40 certificate was met before the claim was filed.



1 ~~(3) The insured may not be required to meet more~~
2 ~~than one elimination or deductible period.~~

3 ~~(4) In the event the existing coverage is increased as~~
4 ~~provided by Section 10235.51 or the existing coverage is~~
5 ~~converted to, or replaced by, a new or other policy or~~
6 ~~certificate issued by the same insurer, the insured shall~~
7 ~~not be required to meet a new elimination or deductible~~
8 ~~period if the elimination or deductible period of the~~
9 ~~existing or previous policy or certificate has been met.~~

10 ~~(5) If the elimination or deductible period is based on~~
11 ~~days of paid care, any day on which the insured received~~
12 ~~paid care covered by the policy during a period no less~~
13 ~~than two years prior to the filing of a claim for benefits~~
14 ~~must be counted toward meeting the elimination or~~
15 ~~deductible requirements of the policy or certificate.~~

16 ~~(b) Respite care, if paid by the policy or certificate~~
17 ~~prior to meeting the elimination or deductible period of~~
18 ~~the policy or certificate, is not required to be counted~~
19 ~~toward meeting the elimination or deductible period.~~

20 ~~SEC. 7. Section 10232.91 is added to the Insurance~~
21 ~~Code, to read:~~

22 ~~10232.91. Every long term care policy or certificate~~
23 ~~that covers home care benefits shall include a respite care~~
24 ~~benefit with the following features:~~

25 ~~(a) No less than 21 days of care must be covered in~~
26 ~~each policy year.~~

27 ~~(b) Eligibility shall be at least as permissive as the~~
28 ~~criteria of Section 10232.8.~~

29 ~~(c) No elimination or waiting period shall apply.~~

30 ~~(d) The same benefits and benefit amounts must be~~
31 ~~payable for any home and community based services~~
32 ~~defined in Section 10232.9, assisted living benefit defined~~
33 ~~in Section 10232.92, or institutional care covered by the~~
34 ~~policy or certificate.~~

35 ~~SEC. 8.~~

36 ~~SEC. 5. Section 10232.92 of the Insurance Code is~~
37 ~~repealed.~~

38 ~~SEC. 9.~~

39 ~~SEC. 6. Section 10232.92 is added to the Insurance~~
40 ~~Code, to read:~~



1 10232.92. Every long-term care policy or certificate
2 and every benefit covering confinement in a nursing
3 facility shall also include a provision with the following
4 features:

5 (a) Care in a residential care facility must be covered.
6 “Residential care facility” means a facility licensed as a
7 residential care facility for the elderly or a residential care
8 facility as defined in the Health and Safety Code. Outside
9 California, eligible providers are facilities that are
10 engaged primarily in providing ongoing care and related
11 services sufficient to support needs resulting from
12 impairment in activities of daily living or impairment in
13 cognitive ability and which also provide care and services
14 on a 24-hour basis, have a trained and ready-to-respond
15 employee on duty in the facility at all times to provide
16 care and services, provide three meals a day and
17 accommodate special dietary needs, have agreements to
18 ensure that residents receive the medical care services of
19 a physician or nurse in case of emergency, and, have
20 appropriate methods and procedures to provide
21 necessary assistance to residents in the management of
22 prescribed medications.

23 (b) The benefit amount payable for care in a
24 residential care facility shall be no less than 70 percent of
25 the benefit amount payable for institutional confinement.

26 (c) All expenses incurred by the insured while
27 confined in a residential care facility, for ~~services~~
28 ~~described in paragraph (4) of subdivision (a) and~~
29 ~~paragraph (7) of subdivision (f) of Section 10232.8,~~ shall
30 *long-term care services that are necessary diagnostic,*
31 *preventative, therapeutic, curing, treating, mitigating,*
32 *and rehabilitative services, and maintenance or personal*
33 *care services, needed to assist the insured with the*
34 *disabling conditions that cause the insured to be a*
35 *chronically ill individual, shall be covered and payable, up*
36 *to but not to exceed the maximum daily residential care*
37 *facility benefit of the policy or certificate. There shall be*
38 *no restriction on who may provide the service or the*
39 *requirement that services be provided by the residential*
40 *care facility, and no restriction on the type of service,*



1 supply, or expenses incurred that are covered or the
2 amounts that are reimbursable as long as the expenses are
3 incurred while the insured is confined in a residential
4 care facility and the reimbursement does not exceed the
5 maximum daily residential care facility benefit of the
6 policy or certificate.

7 (d) In policies or certificates that are not intended to
8 be federally qualified, the threshold establishing
9 eligibility for care in a residential care facility shall be the
10 same as for home care benefits, as defined in subdivision
11 (a) of Section 10232.8, and the definitions of impairment
12 in activities of daily living and impairment of cognitive
13 ability shall be the same as for home care benefits, as
14 defined in subdivisions (a) and (g) of Section 10232.8. In
15 policies or certificates that are intended to be federally
16 qualified, the threshold establishing eligibility for care in
17 a residential care facility shall be the same as for home
18 care benefits, as defined in subdivision (b) of Section
19 10232.8, and the definitions of impairment in activities of
20 daily living and impairment in cognitive ability shall be
21 the same as those for home care benefits as defined in
22 subdivisions (b), (c), (d), (e), and (f) of Section 10232.8.

23 ~~SEC. 11. Section 10232.94 is added to the Insurance~~
24 ~~Code, to read:~~

25 ~~10232.94. Every policy, certificate, or rider shall~~
26 ~~include a waiver of premium provision that is at least as~~
27 ~~permissive as the following: the premium shall be waived~~
28 ~~within no more than 30 days during any period when~~
29 ~~benefits are being received for care in a residential or~~
30 ~~nursing facility; a pro rata refund shall be made of any~~
31 ~~premium already paid for coverage during the period~~
32 ~~when the premium waiver is in effect.~~

33 ~~SEC. 12. Section 10232.95 of the Insurance Code is~~
34 ~~repealed.~~

35 ~~SEC. 13.~~

36 ~~SEC. 7. Section 10232.95 10232.97 is added to the~~
37 ~~Insurance Code, to read:~~

38 ~~10232.95. (a)~~

39 ~~10232.97. In every long-term care policy or certificate~~
40 ~~that covers care in a nursing facility, the threshold~~



1 establishing eligibility for nursing facility care shall be no
2 more restrictive than a provision that the insured will
3 qualify if either one of two criteria are met:

4 ~~(1)~~

5 (a) Impairment in two activities of daily living.

6 ~~(2)~~

7 (b) Impairment in cognitive ability.

8 ~~(b) A provision shall be included that all expenses~~
9 ~~incurred by the insured while confined in a nursing~~
10 ~~facility, for services described in paragraph (4) of~~
11 ~~subdivision (a) and paragraph (7) of subdivision (f) of~~
12 ~~Section 10232.8, shall be covered and payable, up to the~~
13 ~~maximum daily facility benefit of the policy or certificate.~~
14 ~~There shall be no restriction on who may provide the~~
15 ~~service or the requirement that services be provided by~~
16 ~~the nursing facility, and no restriction on the type of~~
17 ~~service, supply, or expenses incurred that are covered or~~
18 ~~the amounts that are reimbursable as long as the expenses~~
19 ~~are incurred while the insured is confined in a nursing~~
20 ~~facility and the reimbursement does not exceed the~~
21 ~~maximum daily nursing facility benefit of the policy or~~
22 ~~certificate.~~

23 ~~SEC. 14.~~

24 ~~SEC. 8.~~ Section 10233.2 of the Insurance Code is
25 amended to read:

26 10233.2. Long-term care insurance may not:

27 (a) Be canceled, nonrenewed, or otherwise
28 terminated on the grounds of the age or the deterioration
29 of the mental or physical health of the insured individual
30 or certificate holder.

31 (b) Contain a provision establishing a new waiting
32 period in the event existing coverage is converted to, or
33 replaced by, a new or other form within the same insurer,
34 except with respect to an increase in benefits voluntarily
35 selected by the insured individual or group policyholder.

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

39 ~~(d) Limit or deny benefits to a policyholder or~~
40 ~~certificate holder requiring human supervision to protect~~



1 ~~self or others because of a loss or deterioration in~~
2 ~~intellectual capacity due to mental or emotional diseases~~
3 ~~or disorders, neurosis, psychoneurosis, psychopathy, or~~
4 ~~psychosis.~~

5 ~~(e)~~

6 ~~(d) Provide for payment of benefits based on a~~
7 ~~standard described as “usual and customary,”~~
8 ~~“reasonable and customary,” or words of similar import.~~

9 ~~(f) Describe the insurer’s willingness to consider a~~
10 ~~policy or certificate holder request to pay for benefits not~~
11 ~~otherwise covered under the policy or certificate as a~~
12 ~~benefit nor include language that could mislead the~~
13 ~~policy or certificate holder to expect the insurer will~~
14 ~~easily or routinely approve such a request. Any~~
15 ~~alternative payment provision shall clearly state that the~~
16 ~~approval of a request for payment of benefits, not~~
17 ~~otherwise covered, is solely at the discretion of the insurer~~
18 ~~and is not likely to be granted unless the insurer~~
19 ~~determines the alternative service is appropriate and a~~
20 ~~cost-effective alternative to the benefits covered by the~~
21 ~~policy or certificate.~~

22 ~~(g) Contain a provision to restore benefits.~~

23 ~~(h)~~

24 ~~(e) Terminate a policy, certificate, or rider, or contain~~
25 ~~a provision that allows the premium for an in-force policy,~~
26 ~~certificate, or rider, to be increased due to the divorce of~~
27 ~~a policyholder or certificate holder.~~

28 ~~(i) Pay different benefit amounts depending on~~
29 ~~whether or not a provider or service selected by the~~
30 ~~insurer is used. Making access available at point-of-service~~
31 ~~to providers with superior quality or discounted services~~
32 ~~is not restricted, provided the policy or certificate holder~~
33 ~~is not precluded from using providers other than those~~
34 ~~selected by the insurer.~~

35 ~~(j)~~

36 ~~(f) Include an additional benefit for a service with a~~
37 ~~known market value other than the statutorily required~~
38 ~~home- and community-based service benefits in Section~~
39 ~~10232.9, the assisted living benefit in Section 10232.92, or~~
40 ~~a nursing facility benefit, unless the additional benefit~~



1 provides for the payment of ~~a at least 60 percent of the~~
2 ~~actual cost of the additional covered service and the~~
3 ~~dollar value at least five times the daily benefit and the~~
4 ~~dollar value~~ of the additional benefit is disclosed in the
5 schedule page of the policy.

6 ~~SEC. 15. Section 10233.5 of the Insurance Code is~~
7 ~~amended to read:~~

8 ~~10233.5. (a) An outline of coverage, which has~~
9 ~~previously been filed with and approved by the~~
10 ~~commissioner, shall be delivered to a prospective~~
11 ~~applicant for long term care insurance at the time of~~
12 ~~initial solicitation through means which prominently~~
13 ~~direct the attention of the recipient to the document and~~
14 ~~its purpose.~~

15 ~~(b) In the case of agent solicitations, an agent shall~~
16 ~~deliver the outline of coverage prior to the presentation~~
17 ~~of an application or enrollment form.~~

18 ~~(c) In the case of direct response solicitations, the~~
19 ~~outline of coverage shall be presented in conjunction with~~
20 ~~any application or enrollment form.~~

21 ~~(d) The outline of coverage shall be a freestanding~~
22 ~~document, using no smaller than 10 point type.~~

23 ~~(e) The outline of coverage shall contain no material~~
24 ~~of an advertising nature.~~

25 ~~(f) Use of the text and sequence of the text of the~~
26 ~~outline of coverage set forth in this section is mandatory,~~
27 ~~unless otherwise specifically indicated.~~

28 ~~(g) Text which is capitalized or underlined in the~~
29 ~~outline of coverage may be emphasized by other means~~
30 ~~which provide prominence equivalent to capitalization~~
31 ~~or underlining.~~

32 ~~(h) The outline of coverage shall be in the following~~
33 ~~form:~~

34



~~“(COMPANY NAME)”~~

~~(ADDRESS — CITY AND STATE)~~

~~(TELEPHONE NUMBER)~~

~~LONG-TERM CARE INSURANCE~~

~~OUTLINE OF COVERAGE~~

~~(Policy Number or Group Master Policy and
Certificate Number)~~

~~1. This policy is (an individual policy of insurance) ((a group policy) which was issued in the (indicate jurisdiction in which group policy was issued)).~~

~~2. 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 (OR CERTIFICATE) CAREFULLY!~~

~~3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.~~

~~(a) Provide a brief description of the right to return “free look” provision of the policy.~~

~~(b) Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains those provisions, include a description of them.~~



1 ~~4. THIS IS NOT MEDICARE SUPPLEMENT~~
2 ~~COVERAGE. If you are eligible for Medicare, review the~~
3 ~~Medicare Supplement Buyer's Guide available from the~~
4 ~~insurance company.~~

5 ~~(a) (For agents) Neither (insert company name) nor~~
6 ~~its agents represent Medicare, the federal government or~~
7 ~~any state government.~~

8 ~~(b) (For direct response) (insert company name) is~~
9 ~~not representing Medicare, the federal government or~~
10 ~~any state government.~~

11 ~~5. LONG TERM CARE COVERAGE. Policies of this~~
12 ~~category are designed to provide coverage for one or~~
13 ~~more necessary or medically necessary diagnostic,~~
14 ~~preventive, therapeutic, rehabilitative, maintenance, or~~
15 ~~personal care services, provided in a setting other than an~~
16 ~~acute care unit of a hospital, such as in a nursing home, in~~
17 ~~the community, or in the home.~~

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

23 ~~6. BENEFITS PROVIDED BY THIS POLICY.~~

24 ~~(a) (Covered services, related deductible(s), waiting~~
25 ~~periods, elimination periods, and benefit maximums.)~~

26 ~~(b) (Institutional benefits, by skill level.)~~

27 ~~(c) (Noninstitutional benefits, by skill level.)~~

28 ~~(Any benefit screens must be explained in this section.~~
29 ~~If these screens differ for different benefits, explanation~~
30 ~~of the screen should accompany each benefit description.~~
31 ~~If an attending physician or other specified person must~~
32 ~~certify a certain level of functional dependency in order~~
33 ~~to be eligible for benefits, this too must be specified. If~~
34 ~~activities of daily living (ADLs) are used to measure an~~
35 ~~insured's need for long-term care, then these qualifying~~
36 ~~criteria or screens must be explained.)~~

37 ~~7. LIMITATIONS AND EXCLUSIONS.~~

38 ~~(Describe:~~

39 ~~(a) Preexisting conditions.~~

40 ~~(b) Noneligible facilities/provider.~~



1 ~~(c) Noneligible levels of care (e.g., unlicensed~~
2 ~~providers, care or treatments provided by a family~~
3 ~~member, etc.):~~

4 ~~(d) Exclusions/exceptions:~~

5 ~~(e) Limitations.)~~

6 ~~(This section should provide a brief specific description~~
7 ~~of any policy provisions which limit, exclude, restrict,~~
8 ~~reduce, delay, or in any other manner operate to qualify~~
9 ~~payment of the benefits described in (6) above.)~~

10 ~~THIS POLICY MAY NOT COVER ALL THE~~
11 ~~EXPENSES ASSOCIATED WITH YOUR LONG-TERM~~
12 ~~CARE NEEDS.~~

13 ~~8. RELATIONSHIP OF COST OF CARE AND~~
14 ~~BENEFITS. Because the costs of long-term care services~~
15 ~~will likely increase over time, you should consider~~
16 ~~whether and how the benefits of this plan may be~~
17 ~~adjusted. (As applicable, indicate the following:~~

18 ~~(a) That the benefit level will NOT increase over time.~~

19 ~~(b) Any automatic benefit adjustment provisions.~~

20 ~~(c) Whether the insured will be guaranteed the option~~
21 ~~to buy additional benefits and the basis upon which~~
22 ~~benefits will be increased over time if not by a specified~~
23 ~~amount or percentage.~~

24 ~~(d) If there is a guarantee, include whether additional~~
25 ~~underwriting or health screening will be required, the~~
26 ~~frequency and amounts of the upgrade options, and any~~
27 ~~significant restrictions or limitations.~~

28 ~~(e) And finally, describe whether there will be any~~
29 ~~additional premium charge imposed, and how that is to~~
30 ~~be calculated.)~~

31 ~~9. TERMS UNDER WHICH THE POLICY (OR~~
32 ~~CERTIFICATE) MAY BE CONTINUED IN FORCE OR~~
33 ~~DISCONTINUED.~~

34 ~~(a) Describe the policy renewability provisions.~~

35 ~~(b) For group coverage, specifically describe~~
36 ~~continuation/conversion provisions applicable to the~~
37 ~~certificate and group policy.~~

38 ~~(c) Describe waiver of premium provisions or state~~
39 ~~that there are no waiver of premium provisions.~~



1 (d) State whether or not the company has a right to
2 change premium, and if that right exists, describe clearly
3 and concisely each circumstance under which the
4 premium may change.

5 ~~10. ALZHEIMER’S DISEASE AND OTHER~~
6 ~~ORGANIC BRAIN DISORDERS.~~

7 (State that the policy provides coverage for insureds
8 clinically diagnosed as having Alzheimer’s Disease or
9 related degenerative and dementing illnesses.
10 Specifically describe each benefit screen or other policy
11 provision that provides preconditions to the availability
12 of policy benefits for that insured.)

13 ~~11. PREMIUM.~~

14 (a) State the total annual premium for the policy.

15 (b) If the premium varies with an applicant’s choice
16 among benefit options, indicate the portion of annual
17 premium which corresponds to each benefit option.

18 ~~12. ADDITIONAL FEATURES.~~

19 (a) Indicate if medical underwriting is used.

20 (b) Describe other important features.

21 ~~13. INFORMATION AND COUNSELING.~~ The
22 California Department of Insurance has prepared a
23 Consumer Guide to Long-Term Care Insurance. This
24 guide can be obtained by calling the Department of
25 Insurance toll-free telephone number. This number is
26 ~~1-800-927-HELP.~~ Additionally, the Health Insurance
27 Counseling and Advocaey Program (HICAP)
28 administered by the California Department of Aging,
29 provides long-term care insurance counseling to
30 California senior citizens. Call the HICAP toll-free
31 telephone number 1-800-434-0222 for a referral to your
32 local HICAP office.”

33 SEC. 15.5. Section 10234.87 of the Insurance Code is
34 amended to read:

35 10234.87. (a) Every policy or certificate shall include
36 a provision that if the insurer replaces a policy or
37 certificate that it has previously issued, the insurer shall
38 recognize past insured status by granting premium
39 credits toward the premiums for the replacement policy
40 or certificate. The premium credits shall equal five



1 percent of the annual premium of the prior policy or
2 certificate for each full year the prior policy or certificate
3 was in force. The premium credit shall be applied toward
4 all future premium payments for the replacement policy
5 or certificate, but the cumulative credit allowed need not
6 exceed 50 percent. No credit need be provided if a claim
7 has been filed under the original policy or certificate. The
8 premium credit, if any, shall be shown on the application
9 and on the policy or certificate.

10 (b) The cumulative credits allowed need not reduce
11 the premium for the replacement policy or certificate to
12 less than the premium of the original policy or certificate.

13 (c) A replacement policy or certificate shall be issued
14 with the same benefit coverage amounts as those in force
15 in the policy or certificate being replaced, after
16 adjustment for increases due to any inflation protection
17 features. The premium for the replacement policy or
18 certificate will be calculated based on the amount of
19 coverage in force at the time the policy or certificate
20 being replaced was issued, the current attained age of the
21 insured, and a premium discount in recognition of past
22 insured status as provided in subdivision (a).

23 (d) This section shall not apply to life insurance
24 policies that accelerate benefits for long-term care.

25 SEC. 16. Section 10234.95 of the Insurance Code is
26 amended to read:

27 10234.95. (a) Every insurer or other entity
28 marketing long-term care insurance shall:

29 (1) Develop and use suitability standards to determine
30 whether the purchase or replacement of long-term care
31 insurance is appropriate for the needs of the applicant.

32 (2) Train its agents in the use of its suitability
33 standards.

34 (3) Maintain a copy of its suitability standards and
35 make them available for inspection upon request by the
36 commissioner.

37 (b) The agent and insurer shall develop procedures
38 that take into consideration, when determining whether
39 the applicant meets the standards developed by the
40 insurer, the following:



1 ~~(1) The ability to pay for the proposed coverage and~~
2 ~~other pertinent financial information related to the~~
3 ~~purchase of the coverage.~~

4 ~~(2) The applicant's goals or needs with respect to~~
5 ~~long-term care and the advantages and disadvantages of~~
6 ~~insurance to meet these goals or needs.~~

7 ~~(3) The value, benefits, and costs of the applicant's~~
8 ~~existing insurance, if any, when compared to the values,~~
9 ~~benefits, and costs of the recommended purchase or~~
10 ~~replacement.~~

11 ~~(e) The issuer, and where an agent is involved, the~~
12 ~~agent, shall make reasonable efforts to obtain the~~
13 ~~information set out in subdivision (b). The efforts shall~~
14 ~~include presentation to the applicant, at or prior to~~
15 ~~application, of the "Long-Term Care Insurance Personal~~
16 ~~Worksheet," contained in the most current Long-Term~~
17 ~~Care Insurance Model Regulations of the National~~
18 ~~Association of Insurance Commissioners. The personal~~
19 ~~worksheet used by the insurer shall contain, at a~~
20 ~~minimum, the information in the NAIC worksheet in not~~
21 ~~less than 12-point type. In the "Premium Section" of the~~
22 ~~personal worksheet, the insurer shall disclose all rate~~
23 ~~increases and rate increase requests for any prior policies~~
24 ~~it has sold in any state. The insurer may request the~~
25 ~~applicant to provide additional information to comply~~
26 ~~with its suitability standards. A copy of the issuer's~~
27 ~~personal worksheet shall be filed and approved by the~~
28 ~~commissioner.~~

29 ~~(d) A completed personal worksheet shall be returned~~
30 ~~to the issuer prior to the issuer's consideration of the~~
31 ~~applicant for coverage, except the personal worksheet~~
32 ~~need not be returned for sale of employer group~~
33 ~~long-term care insurance to employees and their spouses~~
34 ~~and dependents.~~

35 ~~(e) The sale or dissemination outside the company or~~
36 ~~agency by the issuer or agent of information obtained~~
37 ~~through the personal worksheet is prohibited.~~

38 ~~(f) The issuer shall use the suitability standards it has~~
39 ~~developed pursuant to this section in determining~~



1 ~~whether issuing long-term care insurance coverage to an~~
2 ~~applicant is appropriate.~~

3 ~~(g) Agents shall use the suitability standards~~
4 ~~developed by the insurer in marketing long-term care~~
5 ~~insurance.~~

6 ~~(h) If the issuer determines that the applicant does not~~
7 ~~meet its financial suitability standards, or if the applicant~~
8 ~~has declined to provide the information, the issuer may~~
9 ~~reject the application. Alternatively, the issuers shall send~~
10 ~~the applicant a letter similar to the “Long-Term Care~~
11 ~~Insurance Suitability Letter” contained in the~~
12 ~~Long-Term Care Insurance Model Regulations of the~~
13 ~~National Association of Insurance Commissioners.~~
14 ~~However, if the applicant has declined to provide~~
15 ~~financial information, the issuer may use some other~~
16 ~~method to verify the applicant’s intent. Either the~~
17 ~~applicant’s returned letter or a record of the alternative~~
18 ~~method of verification shall be made part of the~~
19 ~~applicant’s file.~~

20 ~~(i) The insurer shall report annually to the~~
21 ~~commissioner the total number of applications received~~
22 ~~from residents of this state, the number of those who~~
23 ~~declined to provide information on the personal~~
24 ~~worksheet, the number of applicants who did not meet~~
25 ~~the suitability standards, and the number who chose to~~
26 ~~conform after receiving a suitability letter.~~

27 ~~(j) This section shall not apply to life insurance policies~~
28 ~~that accelerate benefits for long-term care.~~

29 ~~SEC. 17.~~

30 ~~SEC. 9.~~ Section 10235.2 of the Insurance Code is
31 amended to read:

32 10235.2. No long-term care insurance policy
33 delivered or issued for delivery in this state shall use the
34 terms set forth below, unless the terms are defined in the
35 policy and the definitions satisfy the following
36 requirements:

37 (a) “Medicare” shall be defined as ~~“The Health the~~
38 ~~“Health Insurance for the Aged Act, Act,”~~ Title XVIII of
39 the Social Security Amendments of 1965 as then
40 constituted or later amended,” ~~or “Title amended, or~~



1 *Title* I, Part I of Public Law 89-97, as enacted by the 89th
2 Congress of the United States of America and popularly
3 known as the Health Insurance for the Aged Act, as then
4 constituted and any later amendments or substitutes
5 thereof,” *thereof*, or words of similar import.

6 (b) “Skilled nursing care,” “intermediate care,”
7 “home health care,” and other services shall be defined
8 in relation to the level of skill required, the nature of the
9 care and the setting in which care is required to be
10 delivered.

11 (c) All providers of services, including, but not limited
12 to, skilled nursing facilities, intermediate care facilities,
13 and home health agencies shall be defined in relation to
14 the services and facilities required to be available and the
15 licensure or degree status of those providing or
16 supervising the services. The definition may require that
17 the provider be appropriately licensed or certified.

18 ~~SEC. 17.3.~~

19 *SEC. 10.* Section 10235.8 of the Insurance Code is
20 amended to read:

21 10235.8. No policy may be delivered or issued for
22 delivery in this state as long-term care insurance if the
23 policy limits or excludes coverage by type of illness,
24 treatment, medical condition, or accident, except as to
25 the following:

26 (a) Preexisting conditions or diseases.

27 (b) Alcoholism and drug addiction.

28 (c) Illness, treatment, or a medical condition arising
29 out of any of the following:

30 (1) War or act of war, whether declared or undeclared.

31 (2) Participation in a felony, riot, or insurrection.

32 (3) Service in the armed forces or units auxiliary
33 thereto.

34 (4) Suicide, whether sane or insane, attempted
35 suicide, or intentionally self-inflicted injury.

36 (5) Aviation in the capacity of a non-fare-paying
37 passenger.

38 (d) Treatment provided in a government facility,
39 unless otherwise required by law, services for which
40 benefits are available under Medicare or other



1 governmental programs (except Medi-Cal or medicaid),
2 any state or federal workers' compensation, employer's
3 liability or occupational disease law, or any motor vehicle
4 no fault law, services provided by a member of the
5 covered person's immediate family, and services for
6 which no charge is normally made in the absence of
7 insurance.

8 This section does not prohibit exclusions and limitations
9 by type of provider or territorial limitations.

10 ~~SEC. 17.5. Section 10235.10 of the Insurance Code is~~
11 ~~repealed.~~

12 ~~SEC. 18.~~

13 *SEC. 11.* Section 10235.30 of the Insurance Code is
14 amended to read:

15 10235.30. (a) No insurer may deliver or issue for
16 delivery a long-term care policy in this state unless the
17 insurer offers at the time of application an option to
18 purchase a shortened benefit period nonforfeiture
19 benefit with the following features:

20 (1) Eligibility begins no later than after 10 years of
21 premium payments.

22 (2) The lifetime maximum benefit is no less than the
23 dollar equivalent of three months of care at the nursing
24 facility per diem benefit contained in the policy ~~and a~~
25 ~~proportionately larger lifetime maximum benefit is~~
26 ~~payable depending on the number of years that~~
27 ~~premiums are paid. or the amount of the premiums paid,~~
28 *whichever is greater.*

29 (3) The same benefits covered in the policy and any
30 riders at the time eligibility begins are payable for a
31 qualifying claim.

32 (4) The lifetime maximum benefit may be reduced by
33 the amount of any claims already paid.

34 (5) Cash back, extended term, and reduced paid-up
35 forms of nonforfeiture benefits shall not be allowed.

36 (6) The lifetime maximum benefit ~~and all covered~~
37 ~~policy benefits continue to increase in the same manner~~
38 ~~and amount as any inflation protection feature that is in~~
39 ~~force when eligibility begins. amount increases~~



1 *proportionally with the number of years of premium*
2 *payment.*

3 (b) This section shall not apply to life insurance
4 policies that accelerate benefits for long-term care.

5 ~~SEC. 19.~~

6 *SEC. 12.* Section 10235.40 of the Insurance Code is
7 amended to read:

8 10235.40. (a) No individual long-term care policy or
9 certificate shall be issued until the applicant has been
10 given the right to designate at least one individual, in
11 addition to the applicant, to receive notice of lapse or
12 termination of a policy or certificate for nonpayment of
13 premium. The insurer shall receive from each applicant
14 one of the following:

15 (1) A written designation listing the name, address,
16 and telephone number of at least one individual, in
17 addition to the applicant, who is to receive notice of lapse
18 or termination of the policy or certificate for nonpayment
19 of premium.

20 (2) A waiver signed and dated by the applicant
21 electing not to designate additional persons to receive
22 notice. The required waiver shall read as follows:

23

24 “Protection Against Unintended Lapse.

25

26 I understand that I have the right to designate at least one
27 person other than myself to receive notice of lapse or
28 termination of this long-term care insurance policy for
29 nonpayment of premium. I understand that notice will
30 not be given until 30 days after a premium is due and
31 unpaid. I elect not to designate any person to receive the
32 notice.

33

34

35

Signature of Applicant

Date”

36

37 (b) The insurer shall notify the insured of the right to
38 change the written designation, no less often than once
39 every two years.



1 (c) When the policyholder or certificate holder pays
2 the premium for a long-term care insurance policy or
3 certificate through a payroll or pension deduction plan,
4 the requirements contained in subdivision (a) need not
5 be met until 60 days after the policyholder or certificate
6 holder is no longer on that deduction payment plan. The
7 application or enrollment form for a certified long-term
8 care insurance policy or certificate shall clearly indicate
9 the deduction payment plan selected by the applicant.

10 (d) No individual long-term care policy or certificate
11 shall lapse or be terminated for nonpayment of premium
12 unless the insurer, at least 30 days prior to the effective
13 date of the lapse or termination, gives notice to the
14 insured and to the individual or individuals designated
15 pursuant to subdivision (a), at the address provided by
16 the insured for purposes of receiving notice of lapse or
17 termination. Notice shall be given by first-class United
18 States certified mail, postage prepaid, ~~with a return~~
19 ~~receipt indicating proof of delivery to be signed by the~~
20 ~~insured or individuals designated pursuant to subdivision~~
21 ~~(a)~~; not less than 30 days after a premium is due and
22 unpaid.

23 (e) Each long-term care insurance policy or certificate
24 shall include a provision which, in the event of lapse,
25 provides for reinstatement of coverage, if the insurer is
26 provided with proof of the insured's cognitive
27 impairment or the loss of functional capacity. This option
28 shall be available to the insured if requested within five
29 months after termination and shall allow for the
30 collection of *a* past due premium, where appropriate. The
31 standard of proof of cognitive impairment or loss of
32 functional capacity shall not be more stringent than the
33 benefit eligibility criteria on cognitive impairment or the
34 loss of functional capacity contained in the policy
35 certificate.

36 ~~SEC. 20.~~

37 *SEC. 13.* Section 10235.50 of the Insurance Code is
38 amended to read:

39 10235.50. Every policy or certificate shall include a
40 provision that gives the policyholder or certificate holder



1 the following rights to reduce coverage and lower
2 premiums:

3 (a) A right, exercisable any time after the first year, to
4 retain a policy or certificate while lowering the premium
5 in no fewer than the following three ways:

6 (1) Reducing the lifetime maximum benefit.

7 (2) Reducing the nursing facility per diem and
8 reducing the home- and community-based service
9 benefits of a home care only policy and of a
10 comprehensive long-term care policy.

11 (3) Converting a “comprehensive long-term care”
12 policy or certificate to a “Nursing Facility Only” or a
13 “Home Care Only” policy or certificate, if the insurer
14 issues those policies or certificates for sale in the state.

15 (b) The premium for the policy or certificate that is
16 reduced in coverage will be based on the age of the
17 insured at issue age and the premium rate applicable to
18 the amount of reduced coverage at the original issue date.

19 (c) If the contract in force at the time a reduction in
20 coverage is made provides for benefit adjustments for
21 anticipated increases in the costs of long-term care
22 services, then the reduced nursing facility per diem,
23 lifetime maximum benefit, and daily, weekly, or monthly
24 home care benefits shall be adjusted in the same manner
25 and in the same amount as the contract in force prior to
26 the reduction in coverage.

27 (d) In the event a policy or certificate is about to lapse,
28 the insurer shall provide written notice to the insured of
29 the options in subdivision (a) to lower the premium by
30 reducing coverage and of the premiums applicable to the
31 reduced coverage options. The insurer may include in the
32 notice additional options to those required in subdivision
33 (a). The notice shall provide the insured at least 30 days
34 in which to elect to reduce coverage and the policy shall
35 be reinstated without underwriting if the insured elects
36 the reduced coverage.

37 (e) In the event of a premium increase, the insured
38 shall be offered the option to lower premiums and reduce
39 coverage.

40 ~~SEC. 21.~~



1 SEC. 14. Section 10235.52 of the Insurance Code is
2 amended to read:

3 10235.52. (a) Every policy shall contain a provision
4 that, in the event the insurer develops new benefits or
5 benefit eligibility or new policies with new benefits or
6 benefit eligibility not included in the previously issued
7 policy, the insurer will grant current holders of its policies
8 who are not in benefit or within the elimination period
9 the following rights:

10 (1) The policyholder will be notified of the availability
11 of the new benefits or benefit eligibility or new policy
12 within 12 months. *The insurer's notice shall be filed with*
13 *and approved by the department at the same time as the*
14 *new policy or rider.*

15 (2) The insurer shall offer the policyholder new
16 benefits or benefit eligibility in one of the following ways:

17 (A) By adding a rider to the existing policy and paying
18 a separate premium for the new benefit or benefit
19 eligibility based on the insured's attained age. The
20 premium for the existing policy will remain unchanged
21 based on the insured's age at issuance.

22 (B) By replacing the existing policy or certificate in
23 accordance with Section 10234.87.

24 (C) By replacing the existing policy or certificate with
25 a new policy or certificate in which case consideration for
26 past insured status shall be recognized by setting the
27 premium for the replacement policy or certificate at the
28 issue age of the policy or certificate being replaced.

29 (b) The insured may be required to undergo new
30 underwriting, but the underwriting can be no more
31 restrictive than if the policyholder or certificate holder
32 were applying for a new policy or certificate.

33 (c) The insurer of a group policy as defined under
34 subdivisions (a) to (c), inclusive, of Section 10231.6 must
35 offer the group policyholder the opportunity to have the
36 new benefits and provisions extended to existing
37 certificate holders, but the insurer is relieved of the
38 obligations imposed by this section if the holder of the
39 group policy declines the issuer's offer.



1 ~~(d) The notices to policyholders regarding the~~
2 ~~availability of new benefits, new eligibility, or a new~~
3 ~~policy required by subdivision (a) shall be filed with and~~
4 ~~approved by the commissioner at the same time as the~~
5 ~~new policy or rider is filed for approval.~~

6 ~~SEC. 22.~~

7 *SEC. 15.* Section 10235.94 is added to the Insurance
8 Code, to read:

9 10235.94. Every policy or certificate shall include a
10 provision giving the policyholder or certificate holder the
11 right to appeal decisions regarding benefit eligibility,
12 care plans, services and providers, and reimbursement
13 payments.

14 ~~SEC. 23.~~

15 *SEC. 16.* Section 10237.1 of the Insurance Code is
16 amended to read:

17 10237.1. No insurer may deliver or issue for delivery
18 a long-term care insurance policy or certificate in this
19 state unless the insurer offers to each policyholder and
20 certificate holder, in addition to any other inflation
21 protection, the option to purchase a long-term care
22 insurance policy or certificate that provides for benefit
23 levels and benefit maximums to increase to account for
24 reasonably anticipated increases in the costs of long-term
25 care services covered by the policy. Insurers shall offer to
26 each policyholder and certificate holder, at the time of
27 purchase, the option to purchase a long-term care
28 insurance policy or certificate containing an inflation
29 protection feature which is no less favorable than one that
30 does one or more of the following:

31 (a) Increases benefit levels annually in a manner so
32 that the increases are compounded annually at a rate of
33 not less than 5 percent.

34 (b) Guarantees the insured individual the right to
35 periodically increase benefit levels without providing
36 evidence of insurability or health status and without
37 regard to claim status or history so long as the option for
38 the previous period has not been declined. The amount
39 of the additional benefit shall be no less than the
40 difference between the existing policy benefit and that



1 benefit compounded annually at a rate of at least 5
2 percent for the period beginning with the purchase of the
3 existing benefit and extending until the year in which the
4 offer is made.

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

8 (d) *The insurer of a group long-term care insurance*
9 *policy as defined in subdivision (a), (b), or (c) of Section*
10 *10231.6, shall offer the holder of the group policy the*
11 *opportunity to have the inflation protection pursuant to*
12 *this section extended to existing certificate holders, but*
13 *the insurer is relieved of the obligations imposed by this*
14 *section if the holder of the group policy declines the*
15 *insurer's offer.*

16 ~~SEC. 24. Section 10237.2 of the Insurance Code is~~
17 ~~repealed.~~

18 ~~SEC. 25. Section 10237.2 is added to the Insurance~~
19 ~~Code, to read:~~

20 ~~10237.2. The inflation protection feature, if any, that~~
21 ~~applies to the benefit levels and benefit maximum of the~~
22 ~~policy or certificate shall also apply to the benefit levels~~
23 ~~and benefit maximums of any rider or amendments~~
24 ~~issued in conjunction with the policy or certificate.~~

25 ~~SEC. 26.~~

26 *SEC. 17. Section 10237.4 of the Insurance Code is*
27 *amended to read:*

28 10237.4. (a) Inflation protection benefit increases
29 under a policy that contains these benefits shall continue
30 without regard to an insured's age, claim status or claim
31 history, or the length of time the person has been insured
32 under the policy.

33 (b) An offer of inflation protection that provides for
34 automatic benefit increases shall include an offer of a
35 premium which the insurer expects to remain constant.
36 The offer shall disclose in a conspicuous manner that the
37 premium may change in the future unless the premium
38 is guaranteed to remain constant.



1 (c) The inflation protection benefit increases under a
2 policy or certificate that contains an inflation protection
3 feature shall not be reduced due to the payment of claims.

4 ~~SEC. 27.~~

5 SEC. 18. Section 10237.5 of the Insurance Code is
6 amended to read:

7 10237.5. (a) An inflation protection provision that
8 increases benefit levels annually in a manner so that the
9 increases are compounded annually at a rate not less than
10 5 percent shall be included in a long-term care insurance
11 policy unless an insurer obtains a rejection of inflation
12 protection signed by the policyholder.

13 (b) The rejection, to be included in the application or
14 on a separate form, shall state:

15
16 “I have reviewed the outline of coverage and the graphs
17 that compare the benefits and premiums of this policy
18 with and without inflation protection. Specifically, I have
19 reviewed the plan, and I reject 5 percent annual
20 compound inflation protection.

21
22 _____
23 Signature of Applicant Date”

