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CHAPTER ONE

Introduction and Overview

Defining Long-Term Care

10231.2 of the California Insurance Code states that "Long-term care insurance" includes 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. Long-term care insurance includes all products containing any of the following benefit types: coverage for institutional care including care in a nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility, or personal care home; home care coverage including home health care, personal care, homemaker services, hospice, or respite care; or community-based coverage including adult day care, hospice, or respite care. Long-term care insurance includes disability based long-term care policies but does not include insurance designed primarily to provide Medicare supplement or major medical expense coverage.

Long-term care policies, certificates, and riders are regulated under Chapter 2.6 of the California Insurance Code. The commissioner reviews and approves individual and group policies, certificates, riders, and outlines of coverage. Other applicable laws and regulations are also supposed to apply to long-term care insurance so they do not conflict with the provisions of Chapter 2.6. Long-term care benefits are also designed to provide coverage of 12 months or more that are contained in or amended to Medicare supplement or other disability policies and certificates must be regulated by Chapter 2.6 of the California Insurance Code.

The term long-term care encompasses the organization, delivery, and financing of a broad range of services and assistance to people who are severely limited in their ability to function independently on a daily basis over a relatively long period of time (i.e., 90 or more days). Long-term care is the assistance or supervision you may need when you are not able to do some of the basic "activities of daily living" (ADLs) like bathing, dressing or moving from a bed to a chair. Long-term care services can be provided in one's own home or in a community program like an Adult Day Care Center, in an assisted living facility licensed as a Residential Care Facility for the Elderly (RCFE), or in a nursing home. Long-term care is not necessarily "long term." Some people only need long-term care for a few months while recovering at home from a broken hip, while others may need care for the rest of their life. One's personal risk of needing long-term care depends on many factors.

Functional dependency can result from either physical or mental limitations and is defined in terms of the inability to perform essential activities of daily living (ADLs), such as eating, bathing, dressing, using the toilet, getting into or out of bed, and moving about the house, or activities necessary to remain independent, known as instrumental activities of daily living (IADLs), such as shopping, cooking, doing laundry, managing household finances, and housekeeping.

Overview

The country's elderly population is expected to double in the next 30 years. It is estimated that more than 1.3 million elderly and non-elderly individuals in California have already been afflicted with debilitating functional limitations. Any number of these require assistance in the activities of daily living, such as eating, bathing, dressing, getting in and out of bed and even going to the bathroom. This extraordinary demographic shift will affect almost all Americans and will create increasing pressure to understand and meet the needs of older people. This segment of the population is growing as the general population is living longer. Elderly women were more likely to be widowed (59%) than elderly men (22%) and the percent of elderly women living alone was doubled that for elderly men (45% vs. 22%). The most common ADL for which assistance was received by elderly patients was bathing or showering (55%), followed by dressing (47%), transferring (35%), using the toilet (27%), and eating (12%).

Clinically

The “clinical” definition of LTC as used by the State of California could be stated as follows. California’s Welfare and Institutions Code, Chapter 1637, 1984 Statutes, Division 8.5, Section 9390.1(c) defines long term care in a broader sense. Long-term care means a coordinated continuum of preventive, diagnostic, supportive, therapeutic, rehabilitative, and maintenance services which address three areas of need that individuals who have restricted self-care capabilities may have: *health, social and personal*. . . Services must be designed to recognize the positive capabilities of the individual and maximize the potential for the optimum level of physical, social and psychological independence in the least restrictive environment. The emphasis must be placed on seeking alternative services other than institutionalization. Services may be by formal or informal support systems and may be continuous or intermittent.

Per California

The California Insurance Code 10232.8 states the following: In every Long-Term Care policy or certificate that is not intended to be a federally qualified Long-Term Care Insurance contract and provides home care benefits, the threshold establishing eligibility for home care benefits shall be at least as permissive as a provision that the insured will qualify if either one of two criteria are met:

- Impairment in two out of seven activities of daily living;
- Impairment of cognitive ability.

The policy or certificate may provide for lesser but not greater eligibility criteria. The commissioner, at his or her discretion, may approve other criteria or combinations of criteria to be substituted, if the insurer demonstrates that the interest of the insured is better served.

The California Insurance Code 10232.8 continues with the following explanation of the “Activities of Daily Living. “Activities of daily living” in every policy or certificate intended to be a federally qualified Long-Term Care insurance contract includes eating, bathing, dressing, transferring, toileting, and continence; “impairment in activities of daily living” means the insured needs “substantial assistance” either in the form of “hands-on assistance” or “standby assistance,” due to a loss of functional capacity to perform the activity; “impairment of cognitive ability” means the insured needs substantial supervision due to severe cognitive impairment; “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.

The Public Policy Issues Pertaining To LTC in California

Long-term care has become an increasingly urgent policy issue. The number of elderly Americans and their proportion of the nation’s population are growing. Some of the public policy issues that plague LTC has to do with policy offerings by employers and others who refuse to having any offerings for employees. More and more employers are offering long-term care insurance as an employee benefit, with over 3,000 employers making it available to employees, retirees, their spouses and parents. With the percentage participation rates are lower than expected in this segment of the market. Increased employer support and active promotion may provide the most optimal opportunity to expand coverage in the employer market.

Another public policy issue is the cost of long-term in California. An individual’s age is a primary factor in determining its cost because the younger an individual is when a policy is purchased, the cheaper the premiums will be. A policy that costs \$800 annually when one is 55 will cost nearly twice as much if one were to wait to buy it until he or she is 65. Of course, the individual also will be paying those premiums for a longer period of time before taking any benefits. According to the American Health Care Association (AHCA), a good time to buy long-term care insurance is between ages 50 and 55.

The debate over long-term care by policymakers with the general public has ebbed and flowed over the past two to three decade as more and more Americans and their leaders fact the dilemma of how to meet the needs of the elderly and the families of the elderly. Many of these individuals in every state of the Union are burdened with chronic disabilities. Policymakers are struggling to define the roles of the

federal and state governments and the private sector in financing and delivering care to elderly people with disabilities.

Conditions Resulting in The Need For Care

10232.8(c) of the California Insurance Code states that a licensed health care practitioner, independent of the insurer, must certify that the insured meets the definition of a "chronically ill individual" as defined under Public Law 104-191. If a health care practitioner makes a determination that an insured does not meet the definition of "chronically ill individual," the insurer has to notify the insured that he or she is entitled to a second assessment by a licensed health care practitioner, upon request, who personally examines the insured. The requirement for a second assessment does not apply if the initial assessment was performed by a practitioner who meets the requirements and who has personally examined the insured.

The assessments are to be performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. The written certification is to be renewed every 12 months. A licensed health care practitioner develops a written plan of care after personally examining the insured. The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual," or to prepare written plans of care does not count against the lifetime maximum of the policy or certificate. In order to be considered "independent of the insurer," a licensed health care practitioner cannot be an employee of the insurer and cannot be compensated in any manner that is linked to the outcome of the certification. The practitioner's assessments are to be unhindered by financial considerations and apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract.

Long-term care services can become necessary because of a sudden, serious illness or accident, or a slow progression of chronic conditions. Long-term care services are needed when a person cannot perform certain "activities of daily living" (ADLs); or is cognitively impaired because of senile dementia or Alzheimer's disease. Most commonly the ADLs used to determine the need for services include bathing, dressing, transferring from one place to another place such as the bed to the chair. Other ADLs which determine the need for services include toileting, eating, and continence. Mental and Cognitive Impairment results in the need for supervision and monitoring.

Acute, life-threatening traumas and diseases also cause lengthy and costly hospitalizations and many times permanent disability to the young or mid-age individuals. This, along with the elderly living longer, has resulted in the increasing need and demand for long-term care services. The likelihood is that any individual or a family member of that individual will need long-term assistance due to a prolonged illness, a disability, or general deterioration of health and ability to perform routine daily activities some time in their life.

Acute vs. Chronic Conditions

According to Random House Webster dictionary the term acute is an adjective with the following definition: 1. sharp or severe in effect; intense. 2. (of disease) brief and severe (distinguish from chronic). Where as chronic: chronic-adj. 3. having long had a disease, habit, weakness, or the like: a chronic invalid. 4. (of disease) having long duration (distinguish from acute). These differences have serious implications for the lifestyle and care needs of older persons. Acute problems generally can be cured in a short period of time, after which the afflicted individual can return to the lifestyle enjoyed prior to the episode. Treatment for most acute health problems is financed by public and private insurance.

Chronic diseases, however, usually cannot be cured, and thus are likely to continue to affect a person until his or her death. Chronic disease also may lead to some degree of disability, which is far more prevalent among the elderly than among younger persons. Measuring the extent of an individual's functional impairment against the standard of handicap and disability is a primary assessment needed to determine care needs. The most frequently used measure of disability is the "activities of daily living" (ADL).

The Services and Providers of Care

Long-term care services can be provided in a wide range of settings: informally by family, friends, neighbors, and volunteers; at home through home length care agencies and homemaker services or other community based services such as adult day care center; and through institutions such as nursing home and assisted living facilities.

- *Home Health Care;*
- *Adult Day Care;*
- *Personal Care;*
- *Homemaker Services;*
- *Hospice Services;*
- *Respite Care.*

The amount or type of long-term care that a patient receives depends on the kind of facility that he or she is staying at. a skilled nursing facility provides both custodial care and skilled nursing care. But a residential care facility for the elderly provides only custodial care. Custodial care (or personal care) refers to assistance with activities of daily living such as bathing, dressing, toileting and eating. Skilled nursing care refers to care that must be given or supervised by registered nurses and rehabilitative staff such as injections, tube feeding and physical therapy. Assisted Living facilities are state-licensed facilities that provide a range of services, but they are not skilled nursing facilities. The distinction is important because agents must understand the places where a particular policy will pay benefits, and where it will not.

Who Needs Care and Why

10232.8. (a) of the California Insurance Code states that in every long-term care policy or certificate that is not intended to be a federally qualified long-term care insurance contract but provides home care benefits, the threshold establishing eligibility for home care benefits is at least as permissive as a provision that the insured will qualify if either one of two criteria are met:

- Impairment in two out of seven activities of daily living.
- Impairment of cognitive ability.

The policy or certificate may provide for lesser but not greater eligibility criteria. The commissioner, at his or her discretion, may approve other criteria or combinations of criteria to be substituted, if the insurer demonstrates that the interest of the insured is better served. "Activities of daily living" in every policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits including eating, bathing, dressing, ambulating, transferring, toileting, and continence; "impairment" means that the insured needs human assistance, or needs continual substantial supervision. "Impairment of cognitive ability" means deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that require continual supervision to protect oneself or others.

In every long-term care policy approved or certificate issued after the effective date of this addition, that is intended to be a federally qualified long-term care insurance contract, the threshold establishing eligibility for home care benefits must provide that a chronically ill insured will qualify if either one of two criteria are met or if a third criterion is met:

- Impairment in two out of six activities of daily living;
- Impairment of cognitive ability.

Other criteria used in establishing eligibility for benefits if federal law or regulations allow other types of disability to be used applicable to eligibility for benefits under a long-term care insurance policy. If federal law or regulations allow other types of disability to be used, the commissioner transmits emergency regulations to add those other criteria as a third threshold to establish eligibility for benefits. Insurers submit policies for approval within 60 days of the effective date of the regulations. With respect to policies previously approved, the department is authorized to review only the changes made to the policy. All new policies approved and certificates issued after the effective date of the regulation include the third criterion. No policy is to be sold that does not include the third criterion after one year beyond the effective date of the regulations. An insured meeting this third criterion is eligible for benefits regardless of whether the individual meets the impairment requirements regarding activities of daily living and cognitive ability.

It's estimated that more than 1.3 million elderly and non-elderly Californians already have debilitating functional limitation that require assistance in the activities of daily living, such as eating, bathing, dressing, getting in and out of bed, and going to the bathroom. Of Californians who are age 65-74, some 17% have one or more limitations. Of those aged 75-84, 28% are functionally limited but of those age 85 and older, almost one-half suffer from functional limitation. *{Source: Data National Center for Health Statistics, Health Interview Survey}*

Most long-term care services are used by the elderly, however, young adults, children, and even infants are in need of long-term care as a result of chronic illness, disability or an injury from an accident. Cancer is one of the terminal illnesses which needs extended care and can affect the young as well as the elderly. Approximately two million people worldwide live with a spinal cord injury (SCI) with 11,000 new injuries reported every year in the United States. A new SCI occurs every 49 minutes. More than half of all SCI injuries occurs between the ages of 16 and 30. Eight years after the injury, 63% of SCI individuals are unemployed. There are approximately 10 to 11 million blind and visually impaired people in North America. Sometimes babies are born blind with macular degeneration, but most become blind later on. Symptoms of Retinitis pigmentosa (RP) are most often recognized in adolescents and young adults, with progression of the disease usually continuing throughout an individual's life. As many as 3 out of every 100 people in the country have mental retardation and over 614,000 children ages 6 to 21 have some level of mental retardation and need long-term care in some form or other.

The triggers for LTC benefits have been limited to two options—cognitive impairment, such as Alzheimer's, Parkinson's, etc., and necessity for help with activities of daily living. The individual must be designated as a "chronically ill individual" to be eligible for benefits under the two remaining triggers. So disabling diseases or conditions of the young or the elderly are all reasons for individuals to be in need of LTC. Two out of every five Americans will need long term care at some point in their lives. Seniors are the fastest growing segment of population and the heaviest users of long-term care and health care services. In California, the elderly population is expected to grow more than twice as fast as the total population. The elderly age group will increase an average of 112% during the period 1990-2020.

Women are disproportionately affected by long-term care partly because they live longer than men and so are more likely to develop the functional ailments requiring long-term care. Another reason why long-term care is needed is that families are scattered farther apart so the time and travel expenses make it impossible to provide care to the individual with a progressive illness.

How Services are Provided and Paid For

Long-term care services are provided for individuals with Medicare nursing home benefit, after spending a minimum of three full days in an acute care hospital within 30 of an admission to a nursing home. This individual must also need skilled nursing care seven days a week, and/or rehabilitation services at least five days a week. Medicare will not pay for a stay if skilled nursing or rehabilitation therapy is needed only once a week. Besides those qualifications, the longest nursing home stay that Medicare will pay for completely is 20 days. After the first 20 days, if skilled care is required, Medicare will pay only a part of the nursing home bill leaving the patient with the responsibility of a co-payment for each day of the next 80 days. For 2007, the co-payment amount is \$124.00.

Ninety two percent of all long term nursing care costs are paid by the individual who is needing care or else by Medicaid. This is the largest unfounded liability in the country. Overall, Medicare pays eight percent of the total costs of long-term care. {Source: HCFA, www.hcfa.gov 2000} "Most long-term care is furnished in nursing homes to people with chronic, long-term illnesses or disabilities where they receive personal custodial care. Medicare does not pay for custodial care. Medicare pays less than 10% of all nursing home costs.

Information on the risks of needing and financing care should be fairly presented and not overstated to the client so as to enable an individual to realize the accurate possibility of needing long-term care. The truth is that no one knows if he or she will need long-term care in their elder years. But statistics show that the possibility of that need is high.

The Availability of LTC Services and Facilities

All Long-Term Care Insurance policies must comply with Chapter 2.6 of the CIC § 10233.7 which states that no policy may be advertised, marketed, or offered as long-term care or nursing home insurance unless it complies with all regulations of the California Insurance Code. 10232.9 (a) of the California Insurance code states that every long-term care policy or certificate that purports to provide benefits of home care or community-based services, shall provide at least the following:

- Home health care;
- Adult day care;
- Personal care;
- Homemaker services;
- Hospice services;
- Respite care.

10232.9 (b) of the California Insurance Code states that the policy definitions of these benefits may be no more restrictive than the following definitions:

- "Home health care" is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.
- "Adult day care" is medical or nonmedical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.
- "Personal care" is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. "Instrumental activities of daily living" include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

- "Homemaker services" is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- "Hospice services" are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- "Respite care" is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home. This is a separate benefit with its own conditions for eligibility and maximum benefit levels. Home care benefits shall not be limited or excluded by any of the following:
 - Requiring a need for care in a nursing home if home care services are not provided;
 - Requiring that skilled nursing or therapeutic services be used before or with unskilled services;
 - Requiring the existence of an acute condition;
 - Limiting benefits to services provided by Medicare-certified providers or agencies.
 - Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law;
 - 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;
 - Requiring "medical necessity" or similar standard as a criteria for benefits.

Every comprehensive long-term care policy or certificate that provides for both institutional care and home care and that sets a daily, weekly, or monthly benefit payment maximum, must pay a maximum benefit payment for home care that is at least 50% of the maximum benefit payment for institutional care, and in no event shall home care benefits be paid at a rate less than fifty dollars (\$50) per day. Insurance products approved for residents in continuing care retirement communities are exempt from this provision. Every such comprehensive long-term care policy or certificate that sets a durational maximum for institutional care, limiting the length of time that benefits may be received during the life of the policy or certificate, is to allow a similar durational maximum for home care that is at least one-half of the length of time allowed for institutional care.

Continuum of Care

Long-term care is generally provided along a continuum of care, from minor supporting services such as assistance with the basic Instrumental Activities of Daily Living (IADLs) to extensive nursing and therapeutic services, depending upon the individual's condition and needs at a particular time. Ideally, individuals needing long-term care would receive an appropriate mix of services in an appropriate environment that permits maximum independence. Reflecting this evolutionary process, Activities of Daily Living fall into two categories: those activities that can be performed on a scheduled basis, and those that must be taken care of on demand.

The distinction between scheduled and on-demand ADL needs is important to note. The demands on caregivers and the cost of services today are extensive and varied. When ADL needs are limited to those that can be scheduled an individual can often live at home and be cared for by a family member or friend. If outside services are necessary, they may be limited to one to two hours per day. When ADL needs are on demand, care must be provided on a continuous 24 hour basis, and if done through outside services, the cost can be prohibitively expensive. Long-Term Care provides a full spectrum of care and services through an informal or formal health care delivery system. Depending upon the level of care needed, long-term care services are often classified into three phases of life due to the existence of a terminal disease:

- Skilled Care,
- Intermediate Care
- Custodial Care.

Skilled Care -- Skilled Care is medically necessary care provided continuously, day in and day out, by licensed medical professionals working under the order of, or direct supervision of, a physician.

Intermediate Care -- Intermediate Care is nursing and rehabilitation services with supervision by a physician required. Licensed personnel, RNs and therapists, are required for some intermediate care services, but maybe not on a continuous or daily basis. Other intermediate care services may be provided by Licensed Practical Nurses (LPNs) and nurse's aids.

Custodial Care -- Custodial Care is assistance care primarily for the purpose of meeting daily living requirements; getting in and out of bed, dressing, walking, bathing, eating or taking medication. Licensed medical personnel are not required.

LTC Services Available

There is a wide range of LTC services available on the market place. They range from skilled services by highly skilled personnel such as physical therapist to a lower level of care such as a personal care attendant, which is delivered by unskilled personnel.

Evolutionary Process of Chronic Conditions

The evolutionary process of chronic conditions relates directly to how care is delivered and how services are provided for the elderly or for the non-elderly. “Terminal illness” is defined as an incurable condition caused by injury or disease from which there is no reasonable prospect of a temporary or permanent recovery. Whether the condition or the disease is terminal or not, the condition is most likely progressive. Because of this the services that are provided must be progressing. Agents need to understand the continuing evolution of long-term care services and providers in the context of relating those changes to both old and new policy language for RCFEs and adult day care centers. The services that some Residential Care Facilities provide is a progressive services as an individual becomes less mobile and less able to administer his or her own medication.

The extraordinary life-sustaining measures would only serve to postpone the moment of death of the patient. “Extraordinary life-sustaining treatment” is any medical intervention, which serves only to prolong the process of dying for terminally ill patients but does not cure the illness on either a temporary or permanent basis. An example is the respirator that is connected to a patient to assist him or her to breathe. In certain terminal conditions, a respirator artificially prolongs the life of a terminally ill patient.

Palliative care, also called “comfort care,” is primarily meant to provide relief to a terminally ill person by managing symptoms and pain. The goal is not to cure, but to provide comfort and maintain the highest possible quality of life for as long as life remains addressing mental health and spiritual needs.

As a person approaches the dying process, a natural slowing down of the body’s physical and mental systems occur. This process is different for each individual and may vary from hours to days, weeks, and even months. There are some signs and symptoms that may indicate that death is near. There is a period of time of waiting that always happens when someone is about to be diagnosed or waiting the results of a test or the outcome of an intervention.

Obtaining Information On These Services

There are various websites and hardcopy locations to get information regarding long-term care services and facilities in California. The website of Ombudsman, <http://www.acombuds.org/> is one location where invaluable information on many fronts is available. Also the website, <http://www.calnhs.org>, from The California HealthCare Foundation and the University of California San Francisco discuss long-term care services in California. The information on this website is designed for consumers, caregivers, providers, discharge planners, and advocates.

The website, <http://www.pascenter.org>, has a variety of information regarding Long-Term Care in California.

Location Where Formal Care Is Provided

There are a variety of locations where formal long-term care is provided. Some of the locations are set up to give care only to the terminally disabled individuals. So if someone has a disease or a condition that is disabling but he or she can still do some things without assistance, another location would be a better choice. Below are listed a variety of locations where a variety of care ranging from complete to minimal is provided.

Nursing Homes

In California, most skilled, intermediate and custodial care is received in nursing homes that are licensed as “skilled nursing facilities”. All long-term care policies except Home Care Only cover this kind of care. Policies sold after October, 2001 (except Home Care Only policies) are required to include a benefit to cover care in an assisted living facility licensed as a Residential Care Facility for the Elderly (RCFE). Some insurance policies sold before October, 2001 also include this benefit.

The number of nursing home beds is growing, but occupancy rates are declining (82% in 1998). In 1999, California had 1,441 licensed, freestanding nursing facilities with almost 132,000 beds, including 261

hospital-based facilities and eight facilities operated by the U.S. Veterans Administration. The total expenditure for nursing facilities in California was \$5 billion in FY 1998-99; Medi-Cal paid for 45% of the cost for individuals with low incomes.

Residential Care Facilities (RCF)

Residential Care Facilities (RCFs) provide personal care and safe housing for people who may need supervision for medication and some assistance with daily living but who do not require 24-hour a day 7-days a week care. RCFs are not nursing homes, but living arrangements where a person can also receive personal care or supervision. In California, there are two types of classifications for Residential Care Facilities:

- **Residential Care Facility for the Elderly (RCFE)** means a housing arraignment chosen voluntarily by the residents, or the resident's guardian, conservator or other responsible person; where 75% of the residents are at least sixty-two years of age. They may be younger but have needs compatible with other residents as specified in section 87582 and as agreed to at time of admission or as determined necessary as subsequent times of reappraisal.
- **Residential Care Facility for the Chronically Ill (RCF-CI)** means a housing arrangement with a maximum capacity of 25 residents that provides a range of services to residents who have chronic, life-threatening illnesses.

Some RCFs are large retirement homes, others small group homes. Those who need care beyond what they can receive at home but not requiring the level of care provided by a nursing home may find that they can receive the help they need in assisted living or other residential care facilities. Some are structured so that individuals have their own apartments and often provide a more homelike atmosphere but still receive assistance with housekeeping, meals and personal care.

Continuing Care Retirement Communities (CCRC/LCC)

Continuing Care Retirement Communities are master planned, age restricted developments that offer a variety of living arrangements and levels of services. The object of a Continuing Care Retirement Community (CCRC) is to allow residents to "age in place" by providing independent living, congregate living, assisted living, and skilled nursing care at a single location. Residents may move from one level to another as their needs change. Some CCRC's are fully licensed, while others are only licensed as a RCFE to provide ambulatory and personal care. The skilled nursing component must be licensed by the State Department of Health to offer skilled nursing services. When looking into this type of lifestyle, you must clarify the type of contract and care that is included in your agreement.

Continuing Care Retirement Communities offer a specified number of days per year of additional care only and may require the resident to relocate out of the community to a separate nursing facility. The contract for care in such communities normally remains in effect for more than one year and more commonly for the rest of one's lifetime thus representing the long-term commitment to provide continuing care to a community resident. These contracts cover housing, services, and nursing care - usually in one location - coordinated or directly managed by a single administrator who is accountable to the community's board of directors. Hospital care, medical service, and physician visits are rarely included, though the community may schedule appointments and provide transportation. Continuing care contracts often, although not always, require an entrance fee, accommodation fee, or endowment, plus monthly fees that cover, in advance, some or all services and care as a form of insurance for one's later years.

Types of Adult Day Care Facilities

The California Insurance Code 10232.9 states that the adult day care is medical or non-medical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs of eating, bathing, dressing, ambulating, transferring, toileting, and medications. Adult Day Care offers structured, comprehensive programs providing a variety of health, social, and other related support serviced in a protective setting during any part of a day, but less than 24-hour care. Adult Day Care facilities are medical or social care in a daytime program 5 days a week in a licensed facility which provides personal care, supervision, protection, or assistance in the following: eating, bathing, dressing, moving about and taking medications. Adult day centers generally operate programs during normal business hours with some offering services in the evenings and on weekends.

Adult day care centers provide daily supervision and limited health care in a group setting for elderly and disabled people who live at home with relatives who cannot care for them during the day. Adult day care typically provides social interactions, therapeutic activities, preventive health services, and nutritious meals. Adult Day Care facilities are a place when LTC policies are continually changing so current updates alter the face of this care center. Earlier policies restricted benefit payment to only those facilities that provided Adult Day Health care, a much more restrictive definition.

The California Insurance Code 10232.9 states that Hospice Services are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Hospice Services are services in a residence designed to provide physical, emotional, social and spiritual support when a terminal illness has been diagnosed. Some policies will pay for these services in an institutional setting as well. Under California law, the services (like Personal Care) that can be provided by a skilled or unskilled person, so long as they are required in a Plan of Care developed by the doctor or a team of health care workers under medical direction.

A hospice provides comfort and care for terminally ill patients and their families, either in a special facility or sometimes at home.

The California Insurance Code states that "Respite Care" is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home. Respite Care is provided in respite facilities where temporary care is provided for an elderly or disabled person. They are designed to provide some time off for the primary caregiver (typically a relative). Respite care can be offered in a nursing home or other facility, or at home through the services of a home health aide. This is a separate benefit with its own conditions for eligibility and maximum benefit levels.

How and Where to Locate the Facilities

RCFE's – The local District Office of Community Care Licensing can provide a listing of facilities. You can also inspect facility files that will contain the annual survey report and any citations for poor care. Some Ombudsman Programs also have listings, offer pre-placement services, and provide access to licensing reports. Contact the Senior Information and Referral (I&R) Program in one's area (1-800-510-2020, statewide elder services locator number) for assistance in contacting the licensing office or the Ombudsman Program. (Source: CANHR)

Licensing Requirements of all LTC Facilities

California's oversight of long-term care facilities is the most specific and rigorous in the nation and the most comprehensive in all categories of all agencies. The department of health services, the department of social services, the department of mental health and the department of developmental services each plays a role in licensing and regulating care providers. Assisted Living facilities are state-licensed facilities that provide a range of services, but they are not skilled nursing facilities. The distinction is important because agents must understand the places where a particular policy will pay benefits, and where it will not.

Federal, State, and Local agencies such as the Federal Health Care Financing Administration, State Departments of Aging, Justice and Consumer Affairs and the Office of the State Fire Marshal are involved with licensing and regulating.

All levels of care facilities must demonstrate compliance with hundreds of very detailed regulations. Nursing facilities are subject to an extensive set of standards set forth in California state licensing law as well as federal Medicare/Medicaid certification requirements. To ensure compliance with these standards, California state surveyors annually conduct thorough inspections of each facility and spend hundreds of hours enforcing the regulations. The Health and Human Services agencies, State Country Fire Marshals, Cal-OSHA, and the Department of Consumer Affairs have important roles in the oversight of long-term care in California.

There is a difference between the Board and Care facility and the Assisted Living facility. 10232.92 of the California Insurance Code states that every long-term care policy or certificate covering confinement in a nursing facility is to include a provision with the following features:

- "Residential care facility" means 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 California, eligible providers are facilities that meet applicable licensure standards, if any, and are 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.
- The benefit amount payable for care in a residential care facility shall be no less than 70% of the benefit amount payable for institutional confinement.
- All expenses incurred by the insured while confined in a residential care facility, for long-term care services that are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, needed to assist the insured with the disabling conditions that cause the insured to be a chronically ill individual and regulations are to be covered and payable, up to but not to exceed the maximum daily residential care facility benefit of the policy or certificate. There are no restriction on who may provide the service or the requirement that services be provided by the residential care facility, as long as the expenses are incurred while the insured is confined in a residential care facility, the reimbursement does not exceed the maximum

daily residential care facility benefit of the policy or certificate, and the services do not conflict with federal law or regulation for purposes of qualifying for favorable tax consideration.

In policies or certificates that are not intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility is no more restrictive than that for home care benefits and the definitions of impairment in activities of daily living and impairment of cognitive ability shall be the same as for home care benefits. In policies or certificates that are intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility is no more restrictive than that for home care benefits and the definitions of impairment in activities of daily living and impairment in cognitive ability the same as those for home care benefits

Board and Care

This term originated through the Department of Social Services for Residential Care Facility for the Elderly (RCFE), and applies primarily to small converted single-family homes. Board and Care homes are small, private residential facilities licensed to accommodate up to six residents providing basic room meals, help with money management, setting up health care and other appointments, and/or reminders to take medications for people who cannot live on their own but do not need 24-hour nursing home services. These group homes tend to have 20 or fewer residents and may not be appropriate for individuals who need the level of care available in a nursing home, since nursing and medical attention are usually not provided on the premises.

This type of facility does not require either nurses or doctors to be on staff but they provide meals and activities for residents, as well as some help with dressing, eating and hygiene. In most of these facilities, residents must be ambulatory. Board and Care Homes generally work better for people who have more personal care needs, are more forgetful, suffer dementia or simply prefer a home-like environment. Help is always close at hand. In some cases, private long-term care insurance and certain other types of assistance programs may help pay for this type of living arrangement.

Housing must be licensed and can provide “hands on” assistance, and is for individuals who are unable to live alone but do not warrant skilled nursing care. Board and Care Homes provide a more home-like atmosphere for residents to “age in place”. They provide assistance with personal hygiene, grooming and bedside care during periods of minor or temporary illness. They may also provide some recreational and social activities. In California, Board and Care facilities are classified as RCFEs and licensed as such.

Assisted Living

Assisted living offers a wide range of services with a wide range of monthly fees. If an elderly individual needs assistance getting through the day, but does not require the intensive supervision and medical services of a nursing home, assisted living may be the answer. Services, staffing, and philosophy of this type of housing vary enormously. It is very important that an individual determines exactly what is offered in each home. Look for a place that encourages residents to be active.

People who have been loners all their lives are unlikely to adapt well to congregate living, and a mentally alert person does not belong in a small home with cognitively impaired people. An individual has the right to know who makes the decision regarding transfers when a resident’s health declines.

Change or Improvements to Services and Facilities

Agents need to understand the continuing evolution of long-term care services and providers in the context of relating those changes to both old and new policy language. RCFE can be an example of a place of care that insurers are increasingly willing to cover in the policy, or are willing to consider for the payment of benefits when it is not specifically covered along with Adult Day Care. Earlier policies restricted benefit payment to only those facilities that provided Adult Day Health care, a much more restrictive definition. Another example could be policies that cover home care, but do require that services were needed because the person would require institutional care without them. The changes that the agent should be aware of include the:

- Changes in covered services related to definitions in policies;
- Changes in providers (licensed or not) related to definitions in policies.

Home Care Providers of Home Health Care

Home care is appropriate whenever a person prefers to stay at home but needs some kind of ongoing care by various agencies or individuals. Many elderly individuals elect to live independently, non-institutionalized lives, and are successfully receiving home care as their physical capabilities diminish. Home care includes health care, personal care, nutrition, homemaking, social and safety needs encompassing a wide range of available treatments and assistance with Activities of Daily Living (ADL)

10232.8(d)-(g) of the California Insurance Code states and clarifies the meaning of various types of care and caregivers and how they are included in a Long-Term Care Insurance Policy. It states that "Activities of daily living" in every policy or certificate intended to be a federally qualified long-term care insurance contract includes eating, bathing, dressing, transferring, toileting, and continence; "impairment in activities of daily living" means the insured needs "substantial assistance" either in the form of "hands-on assistance" or "standby assistance," due to a loss of functional capacity to perform the activity; "impairment of cognitive ability" means the insured needs substantial supervision due to severe cognitive impairment; "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; and "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.

Until the time that these definitions may be superseded by federal law or regulation, the terms "substantial assistance," "hands-on assistance," "standby assistance," "severe cognitive impairment," and "substantial supervision" shall be defined according to the safe-harbor definitions contained in Internal Revenue Service Notice 97-31, issued May 6, 1997. The definitions of "activities of daily living" to be used in policies and certificates that are intended to be federally qualified long-term care insurance shall be the following until the time that these definitions may be superseded by federal law or regulations:

- Eating, which shall mean feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- Bathing, which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.
- Continence, which shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- Dressing, which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Toileting, which shall mean getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- Transferring, which shall mean the ability to move into or out of bed, a chair or wheelchair.

The use of definitions of "activities of daily living" that differ from the verbatim definitions can be approved if they would result in more policy or certificate holders qualifying for long-term care benefits. The following definitions stand as approved:

- Definitions of eating, bathing, dressing, toileting, transferring, and continence in or
- Definitions of eating, bathing, dressing, toileting, and continence in this subdivision and a substitute, verbatim definition of "transferring" which means the ability to move into and out of a bed, a chair, or wheelchair, or ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.

The definitions to be used in policies and certificates for impairment in activities of daily living, "impairment in cognitive ability," and any third eligibility criterion adopted by regulation pursuant to subdivision (b) shall be the verbatim definitions of these benefit eligibility triggers allowed by federal regulations.

Additional definitions can be added to the current definitions, if the additional language is:

- Warranted based on federal or state laws, federal or state regulations, or other relevant federal decision, and
- Strictly limited to that language which is necessary to ensure that the definitions required by this section are not misleading to the insured.

The definitions of "activities of daily living" to be used in policies and certificates that are not intended to qualify for favorable tax treatment are as follows:

- Eating, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.
- Bathing, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying;
- Dressing, which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints;
- Toileting, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal;
- Transferring, which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown;
- Continence, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads;
- Ambulating, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

Difference Between Home and Home Health Care

Agents must be aware that newer policies cannot require the use of a state-licensed provider unless the state also requires a license for that provider. Insurance companies are permitted to make exceptions when the care specified in the policy can be delivered appropriately, and often for less money, in a place that may not be specifically described in that contract. Agents must be taught to read older policies and understand why the services may be more restrictive than those described in the newer policies. They should be able to explain this when an older policy is replaced, and be able to accurately identify the reason for replacement and whether it constitutes a material improvement in the agent certification statement on the application.

- "Home health care" is skilled nursing or other professional services in the residence, including part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.
- "Personal care" is assistance with the activities of daily living, including the instrumental activities of daily living, using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction;
- "Homemaker services" is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

Historical Development

In the beginning, The National Association of Insurance Commissioners (NAIC) Model Legislation adopted the Long-Term Care Insurance Model Act in 1986 and the Long-Term Care Insurance Model Regulation in 1987. Both have been amended a number of times and have been widely, though not universally adopted. As of July 1993, 45 states had adopted all or most of the Model Act, and 38 states had adopted the Model Regulation. The Model Act and Model Regulation included the following key provisions:

- Alzheimer's Disease must be covered;
- Individual policies must be guaranteed renewable or non-cancelable;
- Coverage for pre-existing conditions may be excluded for only six months;
- Policyholders must be provided with an outline of coverage;
- Individual policies must have an expected loss ratio of at least 60%

1987 to 1992 --Amendments:

- Policy may not cover skilled care only or provide higher benefits for skilled care than for lower levels of care;
- Benefits may not be conditional or prior hospitalization;
- Inflation protection must be offered;
- Minimum standards specified for home health benefits.

Recent regulatory attention has been focused on three areas. These three areas are:

- Non forfeiture Benefits;
- Rate Stabilization;
- Suitability of Coverage.

1993 -- California Long-Term Care Insurance

California passed one of the most prolific long-term insurance laws in the country, referred to as (SB 1943). This law was responsible for redefining long-term care insurance from nursing home and home health care to nursing home and home care. In addition to home care benefits, the SB 1943 law introduces seven ADLs from the previous five ADL models by adding two which are bathing and ambulating.

1994 -- California Launches The Partnership Program

The California Partnership for Long-Term Care is an innovative alliance between consumers, the State of California and private insurers who offer policies meeting stringent, state approved standards. Three of the major goals of the partnership are:

- To educate consumers on their risk and the costs of needing long-term care and the available financing options;
- To improve the quality of long-term care insurance policies; and
- To offer Californians most at risk of becoming impoverished by long-term care expenses protection against having to exhaust a lifetime of savings or losing control of their financial independence in order to pay for long-term care.
- The California Partnership will be discussed in greater detail later in this course.

1996 -- The Health Insurance Portability and Accountability Act

On August 21, 1996, President Clinton signed into law "The Health Insurance Portability and Accountability Act of 1996," P.L. 104-191, POPULARLY KNOWN AS THE Kennedy-Kessalbaum Bill, after its chief senate sponsors. This new legislation provides the strongest endorsement yet for private long-term care insurance. With the tax incentives, product requirement and consumer protection standards, insurance companies and their produces now have the tools to meet their clients need for protection from the high cost of long-term care. LTC policies issued on or after 1/1/97, will need to conform to standards outlined in the new law to qualify for federal tax-preferred status. Some of these standards still need clarification, and will be subject to yet to be developed federal regulations due to the standards outlined in the new federal law, California's SB 1943 (LTC Insurance Law) did not comply and therefore California policies would not be "tax qualified" or NTQ (Non Tax Qualified). It is because of this conflict that the State of California has amended SB 1943 (Chapter 2.6, Part, Division 2 of the LIC) by adding SB 1052, SB 527 and AB 1483.

1997 -- California Long-Term Care Insurance -- SB 1052 (Vasconcelles)

This bill would require every policy that is intended to be a qualified long-term care insurance contract as provided by federal law to be identified as such with a specified disclosure statement, and similarly would require every policy that is not intended to be a qualified long-term care insurance contract as provided by federal law to be identified as such. It would require insurers that offer policies or certificates that are intended to be federally qualified long-term (A) contracts, including riders to life insurance policies providing long-term care coverage, (A) to fairly and affirmatively concurrently offer and market and sell policies and certificates that are not intended to be federally qualified long-term care.

10232.1.(a) of the California Insurance Code states that every policy that is intended to be a qualified long-term care insurance contract be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for federal and state tax benefits." Every policy that is not intended to be a qualified long-term care insurance contract is identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract."

Any policy or certificate in which benefits are limited to the provision of institutional care shall be called a "nursing facility and residential care facility only" policy or certificate and the words "Nursing Facility and Residential Care Facility Only" is to be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

Any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, are referred to as "home care only" policy or certificate and the words "Home Care Only" must be prominently displayed on page one of the form and the outline of coverage. Only those policies or certificates providing benefits for both institutional care and home care are referred to as "comprehensive long-term care" insurance.

10232.2.(a) of the California Insurance Code states that every insurer that offers policies or certificates that are intended to be federally qualified long-term care insurance contracts, including riders to life insurance policies providing long-term care coverage, shall fairly file, offer, and market long-term care insurance policies or certificates not intended to be federally qualified as described previously. All long-term care insurance contracts, including riders to life insurance contracts providing long-term care coverage, approved after the effective date of this section shall meet all of the requirements.

Until October 1, 2001, or 90 days after approval of contracts submitted for approval, whichever comes first, insurers may continue to offer and market previously approved long-term care insurance contracts. Group policies issued prior to January 1, 1997, are allowed to remain in force and not be required to meet the current requirements, as amended during the 1997 portion of the 1997-98 Regular Session. This is true unless those policies cease to be treated as federally qualified long-term care insurance contracts.

If a policy or certificate issued on a group policy of that type ceases to be a federally qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury the insurer shall offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies. It is the intent of the Legislature that the commissioner approve by July 1, 2001, all accurate and complete contracts submitted for approval. It is the further intent of the Legislature that insurers submit contracts for approval and resolve further outstanding issues in a timely manner in order for the commissioner to approve the contracts by July 1, 2001.

Definition of LTC Insurance Terms

LTC of integrated pool of money is often based on benefit type and not length of stay. Most policies today offer a full range of care services from home care to adult day care and assisted living facilities, to nursing home care. These are called “integrated or Pool of Funds” policies. Special attention to coverage for assisted living facilities (sometimes called alternative care facilities) should be noted. These are increasingly popular since they provide help with activities of daily living or supervision for the cognitively impaired while encouraging independence and privacy in a home-like setting. Choosing a policy with flexible benefits will give better options should one’s health require more care than can be managed at home

Applicant

10231.4 of the California Insurance Code defines "Applicant" to mean either of the following:

- In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.
- In the case of a group long-term care insurance policy, the proposed certificate holder.

Certificate

10231.5 of the California Insurance Code states that "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

Employer Group LTC Insurance

The employer provided insurance is one of the fastest growing segments of the private long-term care insurance market, with over 800 employer sponsored LTC insurance plans being introduced between 1995 and 1998. However, just between 1997 and 1998, the number of new employer groups increased by 39.2%. This market consisted of approximately 1,800 employers offering policies by the year 1998. Even though the employer group LTC insurance policies can vary widely in their plan structure and policy management features, the employer group plans generally resemble individual policies. Let’s highlight three important differences: (1) lower premiums; (2) oversight by the employer of their employee’s interests; (3). the greater access to coverage that many employer group plans make possible through guaranteed issue offerings or more limited underwriting.

Trade group

Because trade groups routinely lobby Congress to adopt or change regulations for economic advantage, a successful public risk analysis should account for private group pressures and private incentives. Trade Groups are defined for Wholesale Trade and for Retail Trade and are special aggregations of the industries within those sectors. The groupings reflect the needs of users and provide greater continuity of time series. Trade Groups, in various forms, have existed since the 1980’s. Trade Groups are mutually exclusive and exhaustive of the classes within the Wholesale and Retail Trade Sectors. Trade Groups are aggregated into Trade Group Sectors. The differences between North American Industry Classification System (NAICS) and Trade Groups emerge. That is, differences beyond simple grouping and re-sequencing.

In Wholesale Trade, the differences relate to the Trade Group Sectors: Food, Beverage and Tobacco Products; Personal and Household Goods; Building Materials; and Machinery and Electronic Equipment. Specifically, the differences reflect (1) grouping non-alcoholic beverages with food; (2) isolating pharmaceuticals; (3) isolating lumber and millwork; and (4) grouping the residual machinery and equipment category with machinery and equipment. In Retail Trade, the differences relate to the Trade Group Sectors: Automotive; Building and Outdoor Home Supplies Stores; Food and Beverage Stores; and Clothing and Accessories Stores. Specifically, the differences here reflect: (1) isolating new cars; (2) isolating furniture; (3) isolating computers; (4) isolating home centers and hardware stores; (5) isolating

supermarkets; (6) isolating beer, wine and liquor stores; (7) grouping clothing accessories with other accessory-type items; and (8) isolating department stores.

Association group

An association is typically hierarchical in nature with a board of directors or council as the highest or ultimate authority in matters of policy, finances, etc. The primary objectives of an association are detailed in the legal documentation necessary for an association to be established and registered by its country's government.

Discretionary Group

A discretionary group is one that does not fit into the traditional definition of true group as defined in the laws and regulations of the various states. Discretionary groups are often made up of customers of a financial institution, holders of a particular credit card and other affinity groups. Certain discretionary groups could include a contract issued to a group consisting of:

- Students of one or more universities or other educational institutions;
- Members or former members of the U.S. Armed Forces;
- Individuals for the payment of future funeral expenses;
- Other discretionary group as specified by the Commissioner;
- Employees treated as members.

In determining whether the group affiliation, the employees of a labor union, credit union, or association may be treated as members of a labor union group, a credit union group, or an association group, respectively. Class or classes of a group determined without regard to individual health. The Commissioner must investigate group's relationship to insurance

ERISA (Employee Retirement Income Security Act of 1974).

The Employee Retirement Income Security Act of 1974, commonly known as ERISA, is a United States federal statute which sets minimum standards for pension plans in private industry and provides for extensive rules on Federal income tax effects of dealings in connection with various employee benefit plans. ERISA was enacted to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

ERISA requires pension plans to provide for vesting of employees' pension rights after a specified minimum number of years and to meet certain funding requirements. It also establishes an entity, the Pension Benefit Guaranty Corporation (PBGC), that will provide some minimal benefits coverage in the event that a plan does not, on termination, have sufficient assets to provide all the benefits employees and retirees have earned. Later amendments to the Act require employers who are withdrawing from participation in a multiemployer pension plan that has insufficient assets to pay all of employees' vested benefits to pay their *pro rata* share of that unfunded vested benefits liability.

There have been a number of amendments to ERISA, expanding the protections available to health benefit plan participants and beneficiaries. One important amendment, the Consolidated Omnibus Budget Reconciliation Act (COBRA), provides some workers and their families with the right to continue their health coverage for a limited time after certain events, such as the loss of a job. Another amendment to ERISA is the Health Insurance Portability and Accountability Act (HIPAA) which provides important new protections for working Americans and their families who have preexisting medical conditions or might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health. Other important amendments include the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

Policy

10231.8 of The California Insurance Code states that "policy" means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit hospital service plan, or any similar organization, regulated by the commissioner.

General Provisions

The purpose of LTC insurance is to provide coverage for a succession of care giving services for the elderly, the chronically ill, the disabled, or the seriously injured. This care may be provided in a skilled nursing facility (SNF); a nursing home; a mental hospital; in a person's home with a registered nurse (RN), a licensed practical nurse (LPN), or nurse's aide; or even in an assisted living facility (ALF). It is important to note the societal changes responsible for the increased need for professional services to care for our loved ones. Although today's families are smaller and a number of women are working outside the home, the majority of LTC continues to be provided by unpaid, informal caregivers—family members and friends.

Long term care insurance will help preserve an estate. It can, because if an individual has to use their own personal savings to pay for long term care, in little or no time, all savings and investments can be gone. Estate planning includes techniques and considerations that individuals and families use to make sure that their assets are disposed of in the way they desire near and at the time of their death. Proper estate planning uses legal methods to assess the value of one's estate, acquire insurance such as long-term care insurance, prepare the appropriate legal documents, provide gifts to family members and charities, and minimize taxes.

Products Of Out-Of-State Groups

10232 of The California Insurance Code states that no group long-term care insurance coverage may be offered or sold to a resident of this state under a group policy issued in another state to a group unless the commissioner has determined that the requirements imposed by 10231.6 have been met. At least 30 days in advance of advertising, marketing, or offering coverage within this state, an insurer issuing a policy to a group described in 10231.6 shall accomplish an informational filing with the commissioner, which consists of the following materials:

- A specimen master policy and certificate.
- The corresponding outline of coverage.
- Representative advertising materials to be used in this state.

10232 of The California Insurance Code continues to state that at the option of the insurer, any other documentation can be used and may be required which the insurer believes will provide information sufficient to allow the commissioner to determine that the requirements have been met or which establishes that the insurance regulatory authority of another state has made a determination that the requirements have been met, or both.

The conversion policy contains limiting payment for benefits needed at the time of conversion to the same amount that would have been payable under the previous group coverage. Legislation also exists in California to address Out-of-State Groups or Associations that market long-term care insurance to their members in California. As with other insurers, these groups must register their advertising, an outline of coverage and a specimen policy with the Department of Insurance. Most important, however, regulators are looking to the purpose of these groups. Are they discretionary or have they been set up with a primary purpose to sell insurance to a specific group – the latter is not preferred and could violate state codes.

CHAPTER TWO

Statutory Policy Provisions, Requirements, and Terminology

Agent Responsibilities

Agents play a crucial role in presenting the long-term options to clients so they can choose an appropriate long-term care coverage. The policies that are presented to clients can make all the difference in the level of care policyholders will receive on down the road when they are needing to utilize the policy. At that point no one wants surprises. All the surprises should be weeded out while you're reviewing policy options. An agent's advice to a client should direct them to a policy that covers the benefits needed or replaces ones that are not needed. Older policies may exclude home care coverage or require only skilled home health workers; even though many home care services can be more cost effectively provided by unskilled aides. New policies also demonstrate a willingness by insurers to expand policy benefits and definitions. It has not been that long ago that Adult Day Care coverage was only available in connection with institutional care.

Agent should use the highest standards of reasonable care in marketing LTC, because it may be a client's most valuable coverage and the primary market that buys it – senior citizens – are particularly vulnerable to scare tactics such as loss of assets or lack of family support due to an LTC condition. New services such as residential care facilities may not have been addressed in older policies because RCFs are a relatively new option. Agents should review old policies to uncover restrictive eligibility and gaps in benefits and to explain these options to policyholders to identify “material improvement” by a new policy. The process of choosing a facility or provider is individual to the need and where he or she is in the evolution of any particular illness. It is vital for agents to understand these services in order to better advise prospects on policies and benefit options.

As a professional, it is an agent's duty to assess a client's needs and suggest appropriate product by recognizing that now all clients need comprehensive coverage. Some may need fewer benefits than others because they have substantial assets and/or a family support team and there will be the occasional one who does not need LTC Insurance at all. These are individuals who may not be able to afford premiums and/or be able to qualify for Medi-Cal or other publicly funded coverage. The advice an agent gives clients on choosing a specific insurance company is essential and critical because long-term care coverage may become the most important aspect of his or her life in 20, 30 or 40 years. Engaging in practices like *post claims underwriting* or simple *low balling* new issue rates only to raise them after issue are all illegal and unethical practices. *Policy lapses* are yet another sad tale in the marketing of insurance because too many insurers rely on the fact that people who buy LTC eventually drop it because they cannot afford it. Industry estimates are somewhere between 5 and 30% of all LTC policyholders drop their policies each year.

Requirements for Replacement Notice

Agents need to do a thorough comparison of a grandfathered LTC policy (one sold before 1/1/97) where a new, replacement contract is considered. The standard of material improvement must be assessed, including improved eligibility and benefit triggers, loss of qualified status, loss of favorable tax treatment, etc. Below are the requirements for the policy replacement notice.

- *Mandated Form of Notice*

"NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

Application Questions

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with long-term care insurance coverage to be issued by (company name) Insurance Company.

- *Notice of 30-day Free Look*

Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors, which may affect the insurance protection available to you under the new coverage.

- *Pre-existing Conditions Warning*

Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.

- *Contact Your Present Insurer*

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage. If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history.

- *Warning: Misstatement May Equal Rescission*

Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

- *Notice Delivered Before Policy Delivery*

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)"

- *Modify Notice if 30-Day Free Look Does Not Apply*

For group coverage not subject to the 30-day return provision of Section 10232.7, the notice shall be modified to reflect the appropriate time period in which the policy may be returned and premium refunded. The replacement notice shall include the following statement except when the replacement coverage is group:

- *Disclaimer By Agent and Insurer: COMPARISON TO YOUR CURRENT COVERAGE: Replacement materially improves your position – reasons must be listed*

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long-term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons: ___ Additional or different benefits (please specify) _____. ___ No change in benefits, but lower premiums. ___ Fewer benefits and lower premiums. ___ Other (please specify) _____.

(Signature of Agent and Name of Insurer)

(Signature of Applicant)

(Date)

Outline of Coverage (OOC)

10233.5 (a) of the California Insurance Code states that agents are required to provide a prospective applicant (the prospect) for long term care insurance an Outline of Coverage (OOC) *at the time of initial solicitation* in such a way as to prominently direct the attention of the prospect to the document and its purpose. It should be a freestanding document. If the agent solicited the prospect, the agent must deliver the Outline of Coverage prior to the presentation of an application or enrollment form. In the case of a direct response solicitation, the Outline of Coverage must be provided along with any application or enrollment form.

Company Responsibilities

Below are various responsibilities that an insurance company and the agent has to a client to make sure that they know all the ins and outs of a policy so that they can make a decision that will be the best for them in the years to come when they need long-term care

Mandatory OOC Freestanding Document, 10 point type

The Outline of Coverage is a mandatory, freestanding document (10 point or larger type) that should not include advertising and must provide the following information in the order in which it is given in the following section.

Minor Changes Are OK

Minor changes in the OCC are allowed, but it must clearly identify the name, address, and telephone number of the insurance company. It must identify the policy as an individual or group coverage. It must also show the policy number or group master policy and certificate number. On page one of the Outline of Coverage the following statement must be prominently displayed:

- No Advertising -- *The outline of coverage shall contain no material of an advertising nature*
- Mandatory OOC Form -- Use of the text and sequence of the text of the outline of coverage here is mandatory, unless otherwise specifically indicated. Text which is capitalized or underscored in the outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.

The outline of coverage shall be in the following form:

(COMPANY NAME)
(ADDRESS--CITY AND STATE)
(TELEPHONE NUMBER)
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE

(Policy Number or Group Master Policy and Certificate Number)

- Individual or Group -- This policy is (an individual policy of insurance) (a group policy) which was issued in the (indicate jurisdiction in which group policy was issued)).
- Purpose – “Read Your Policy Carefully!” -- This outline of coverage provides a very brief description of the important features of the policy. This outline of coverage should be compared to outlines of coverage for other policies available. 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. The warning that if the coverage is purchased, the client is to “READ YOUR POLICY (OR CERTIFICATE) CAREFULLY;” TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED
- Free Look Provision -- The new coverage provides 30-days within which to decide, without cost, whether the coverage is suitable to keep.
- Refund or Partial Refund of Premium -- 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
- “This is not Medicare Supplement Coverage” -- If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company. (For agents) Neither (insert company name) nor its agents represent Medicare, the federal government or any state government.(For direct response) (insert company name) is not representing Medicare, the federal government or any state government.
- Long-Term Care Coverage -- Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations) (waiting periods) and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)
- Explain Method of Benefit Payment (reimbursement, cash) -- Benefits, Waiting Periods, Maximums, Skill Levels, Triggers -- (a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.) (b) (Institutional benefits, by skill level.) Non-institutional benefits, by skill level.) Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)
- Limitations or Exclusions – Describe (a) Preexisting conditions; (b) Noneligible facilities/provider; (c) Noneligible levels of care (e.g., unlicensed providers, care or treatments provided by a family member, etc.); (d) Exclusions/exceptions; (e) Limitations.) This part should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits above.)
- **Relationship Of Cost Of Care And Benefits** -- Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. (As applicable, indicate the following:
 - That the benefit level will NOT increase over time.
 - Any automatic benefit adjustment provisions.
 - Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

- If there is a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.
- And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.)

Terms Under Which The Policy (Or Certificate) May Be Continued In Force Or Discontinued.

- Renewability, Conversion continuation, Premium Changes -- Describe the policy renewability provisions. For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy. Describe waiver of premium provisions or state that there are no waiver of premium provisions. State whether or not the company has a right to change premium, and if that right exists, describe clearly and concisely each circumstance under which the premium may change.
- Alzheimer's Disease Covered – It must be stated that the policy provides coverage for insureds clinically diagnosed with Alzheimer's Disease, organic disorders, or related degenerative illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for the insured.
- Premium -- State the total annual premium for the policy. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium, which corresponds to each benefit option.
- Additional Features. -- Indicate if medical underwriting is used. Describe other important features.
- Information and Counseling-- The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office."

Consumer Protection

California leads the nation in providing consumers and victims with meaningful protections and with tools to combat the crime's impact. One important new law took effect on July 1, 2003 requiring companies and state agencies to notify California residents of certain security breaches that may possibly end in identity theft. By law if an unauthorized person has acquired an individual's name and either Social Security number, driver's license number, or financial account number they are to have a notice to gives an individual the chance to take steps to protect against identity theft, such as putting a fraud alert on credit files.

Insurers, Brokers, and Agents: Duty of Honesty, Good Faith and Fair Dealing

10234.8 (a) of the California Insurance Code states that with regard to long-term care insurance, all insurers, brokers, agents, and others engaged in the business of insurance owe a policyholder or a prospective policyholder a duty of honesty, and a duty of good faith and fair dealing. The conduct of an insurer, broker, or agent during the offer and sale of a policy previous to the purchase is relevant to any action alleging a breach of the duty of honesty, and a duty of good faith and fair dealing.

Replacement of Long-Term Care Insurance Unnecessarily; Application

10234.85 of the California Insurance Code states that no insurer, broker, agent, or other person can cause a policyholder to replace a long term care insurance policy unnecessarily. Nothing is to be construed to allow an insurer, broker, agent, or other person to cause a policyholder to replace a long term care insurance policy that will result in a decrease in benefits and an increase in premium. It is to be presumed that any third or greater policy sold to a policyholder in any 12-month period is unnecessary. This does not apply to those instances in which a policy is replaced solely for the purpose of consolidating policies with a single insurer.

Replacement Sales and Lapse Rates: Maintenance of Agent Records: Reports

10234.86 (a) of the California Insurance Code states that every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. Every insurer shall report annually by June 30, the 10% of its agents in the state with the greatest percentage of lapses and replacements. Every insurer shall report annually by June 30, the number of lapsed policies as a percent of its total annual sales in the state, as a percent of its total number of policies in force in the state, and as a total number of each policy form in the state, as of the end of the preceding calendar year.

10234.86 (a) of the California Insurance Code continues to state that every insurer is to report annually by June 30, the number of replacement policies sold as a percent of its total annual sales in the state and as a percent of its total number of policies in force in the state as of the end of the preceding calendar year. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

Premium Credits Toward Replacement Policies or Certificates

10234.87 (a) of the California Insurance Code states that if an insurer replaces a policy or certificate that it has previously issued, the insurer shall recognize past insured status by granting premium credits toward the premiums for the replacement policy or certificate. The premium credits shall equal five percent of the annual premium of the prior policy or certificate for each full year the prior policy or certificate was in force. The premium credit shall be applied toward all future premium payments for the replacement policy or certificate, but the cumulative credit allowed need not exceed 50%. No credit need be provided if a claim has been filed under the original policy or certificate. The cumulative credits allowed need not reduce the premium for the replacement policy or certificate to less than the premium of the original policy or certificate. This does not apply to life insurance policies that accelerate benefits for long-term care.

Advertisements: Commissioner's review; Retention Period; Contact Through Cold Lead Device; Disclosures to Consumers

10234.9 (a) of the California Insurance Code states that every insurer providing long-term care coverage in California must provide a copy of any advertisement intended for use in California to the commissioner for review at least 30 days before dissemination. The advertisement must comply with all laws in California. In addition, the advertisement should be retained by the insurer for at least three years. An advertisement designed to produce leads must prominently disclose that "an insurance agent will contact you" if that is the case. An agent, broker, or other person who contacts a consumer as a result of receiving information generated by a cold lead device, shall immediately disclose that fact to the consumer.

Responsibilities of Insurers Regarding Marketing Procedures, Unfair Trade Practices

10234.93 (a) of the California Insurance Code states that every insurer of long-term care in California is to establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate and to establish marketing procedures to assure excessive insurance is not sold or issued. They are also responsible to submit to the commissioner within six months of the effective date of this act, a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions are to be updated at least semiannually. Provide the following training and require that each agent or other insurer representative authorized to solicit individual consumers for the sale of long-term care insurance shall satisfactorily complete the following training requirements that, for resident licensees, shall be part of, and not in addition to, the continuing education requirements.

For licensees issued a license after January 1, 1992, eight hours of training in each of the first four 12-month periods beginning from the date of original license issuance and thereafter and eight hours of training prior to each license renewal. For licensees issued a license before January 1, 1992, eight hours of training prior to each license renewal. For nonresident licensees that are not otherwise subject to the continuing education requirements the evidence of training must be filed with and approved by the commissioner. Licensees must complete the initial training requirements prior to being authorized to solicit individual consumers for the sale of long-term care insurance. The training consists of topics related to long-term care services and long-term care insurance, including California regulations and requirements, available long-term care services and facilities, changes or improvements in services or facilities, and alternatives to the purchase of private long-term care insurance. On or before July 1, 1998, the following additional training topics that are required were differences in eligibility for benefits and tax treatment between policies intended to be federally qualified and those not intended to be federally qualified, the effect of inflation in eroding the value of benefits and the importance of inflation protection, and NAIC consumer suitability standards and guidelines.

Display prominently on page one of the policy or certificate and the outline of coverage: *"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."* Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subdivision. Every insurer must provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent is to provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222. The agent is to provide a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each prospective applicant prior to the presentation of an application or enrollment form for insurance. In addition to other unfair trade practices, including those identified in this code, the following acts and practices are prohibited:

- *Twisting* -- Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
- *High pressure tactics* -- Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
- *Cold lead advertising* -- Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

Indemnity Contracts and Method of Payment

10232.95 of the California Insurance Code states that Every long-term care policy or certificate that provides reimbursement for care in a nursing facility shall cover and reimburse for per diem expenses, as well as the costs of ancillary supplies and services, up to but not to exceed the maximum lifetime daily facility benefit of the policy or certificate.

The Personal Worksheet

The recommended method to obtain this information includes a presentation to the applicant, at or prior to the application, of the “*Long Term Care Personal Worksheet*” contained in the Long Term Care Model Regulations of the National Association of Insurance Commissioners. The purpose of the NAIC worksheet is to gather sufficient information to determine if the client has sufficient income and assets to afford long term care insurance. The worksheet advises that if assets are less than \$30,000, or more than 7% of income will be used to pay for LTC premiums, the applicant should consider other options to finance the care. Agents may use suitability standards in their marketing.

The proposed worksheet used by the insurer in issuing and marketing and shall contain, at a minimum, the information in the NAIC worksheet in not less than 12-point type and be filed and approved by the Commissioner. A completed worksheet must be returned to the issuer by the agent prior to the issuer’s consideration of the application for coverage. Insurer’s must rely on the worksheet for appropriateness of coverage. Group long term care applicants and life riders are exempt from this worksheet requirement. Of course, any information on the worksheet is confidential and must not be disseminated outside the company or agency. If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has refused to provide the information, the application may be rejected.

Suitability Standards

Alternatively, issuers may send the applicant a letter similar to the “*Long Term Care Insurance Suitability Letter*” contained in the Long Term Care Model Regulations of the National Association of Insurance Commissioners. This letter documents the need for obtaining information and runs down a list of things applicants should know before buying long term care coverage. Unless the client chooses to sign and return the form to proceed with the application, the application is automatically suspended. If the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s intent. Either the applicant’s returned letter or a record of the alternative method of verification shall be made part of the applicant’s file. The insurer must report annually to the insurance commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter.

Replacement Coverage and Sales Commission Structure

10234.97 (a) of the California Insurance Code states that any time long-term care coverage is replaced, the sales commission that is paid by the insurer and that represents the percentage of the sale normally paid for first year sales of long-term care policies or certificates shall be calculated based on the difference between the annual premium of the replacement coverage and that of the original coverage. If the premium on the replacement product is less than or equal to the premium for the product being replaced, the sales commission is limited to the percentage of sale normally paid for renewal of long-term care policies or certificates. Replacement is contingent upon the insurer's declaration that the replacement policy materially improves the position of the insured. This provision does not apply to replacement coverage which is group insurance. "Commission or other compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate. This includes, but is not limited to, bonuses, gifts, prizes, awards, and finder's fees. Every long-term care insurer is required to file with the commissioner within six months of the effective date, its commission structure or an explanation of the insurer's compensation plan. Any amendments to the commission structure must be filed with the commissioner before implementation.

Group Policies Issued Before 1-1-97

Group policies issued prior to January 1, 1997, are allowed to remain in force and not be required to meet the requirements stated here unless those policies cease to be treated as federally qualified long-term care insurance contracts. If such a policy or certificate issued on such a group policy ceases to be a federally qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury of the Internal Revenue Code, the insurer is required to offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies.

Definition of Pre-existing Condition

10232.4 (a) of the California Insurance Code states that no long-term care insurance policy or certificate other than a group policy or certificate, as described in subdivision (a) of Section 10231.6, shall use a definition of preexisting condition which is more restrictive than a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person. Every long-term care insurance policy or certificate shall cover preexisting conditions that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.

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

Minimum Standards for Home Care

10232.9 (a) states that every long-term care policy or certificate that claims to provide benefits of home care or community-based services, shall provide at least the following types of care.

Six Mandated Elements of Home Care

- *Home Health Care* – This is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.
- *Adult Day Care* – This is medical or non-medical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.
- *Personal Care* – This is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. "Instrumental activities of daily living" include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.
- *Homemaker Services* – This is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- *Hospice Services* – These services are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- *Respite Care* -- is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home. This is a separate benefit with its own conditions for eligibility and maximum benefit levels.

Definitions of the Mandated Services

Home Health Care is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

Adult Day Care is medical or non-medical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.

Personal Care is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. "Instrumental activities of daily living" include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

Homemaker Services is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

Hospice Services are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

Prohibited Limitations

Home care benefits are limited or excluded by any of the following scenarios:

- Requiring a need for care in a nursing home if home care services are not provided;
- Requiring that skilled nursing or therapeutic services be used before or with unskilled services;
- Requiring the existence of an acute condition;
- Limiting benefits to services provided by Medicare-certified providers or agencies;
- Limiting benefits to those provided by licensed or skilled personnel except where prior certification or licensure is required by state law;
- 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;
- Requiring "medical necessity" or similar standard as a criteria for benefits.

Home Care Paid vs. Daily Nursing Home Benefit

Every comprehensive long-term care policy or certificate that provides for both institutional care and home care and that sets a daily, weekly, or monthly benefit payment maximum, is to pay a maximum benefit payment for home care that is at least 50% of the maximum benefit payment for institutional care, and in no event shall home care benefits be paid at a rate less than \$50 per day. Insurance products approved for residents in continuing care retirement communities are exempt from this provision. Every such comprehensive long-term care policy or certificate that sets a durational maximum for institutional care, limiting the length of time that benefits may be received during the life of the policy or certificate, allows a similar durational maximum for home care that is at least one-half of the length of time allowed for institutional care.

Nursing Facilities Benefit Must Cover "Ancillary Supplies and Services"

Every long-term care policy or certificate that provides reimbursement for care in a nursing facility shall cover and reimburse for per diem expenses, as well as the costs of ancillary supplies and services, up to but not to exceed the maximum lifetime daily facility benefit of the policy or certificate.

Insurer, Tax Consequences and "Material Modification"

When a policy or certificate holder of an insurance contract issued prior to December 31, 1996, requests a material modification to the contract as defined by federal law or regulations, the insurer, prior to approving such a request, is required to provide written notice to the policy or certificate holder that the contract change requested may constitute a material modification that jeopardizes the federal tax status of the contract and appropriate tax advice will be needed

Nursing Facility Benefit Triggers

In the benefits section of the policy the insured will find the terms as to what will have to happen before benefits start to flow. This is often referred to as the "benefit trigger" and is further defined in the policy as to what conditions must be met for the policy to pay benefits. In every long-term care policy or certificate that covers care in a nursing facility, the threshold establishing eligibility for nursing facility care shall be no more restrictive than a provision that the insured will qualify if either one of two criteria are met:

- *Impairment in Two Activities of Daily Living* -- Residential care facility coverage, for example, can be no more restrictive than home care benefit eligibility. Also, every LTC policy that covers care in a nursing facility must grant coverage for an insured who experiences impairment in two ADLs
- *Impairment in Cognitive Ability* -- means deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or other.

Insurers May Verify Necessity With Any Source of Independent Judgment

10232.8 (c) of the California Insurance Code states that a licensed health care practitioner, independent of the insurer, is to certify that the insured meets the definition of "chronically ill individual." If a health care practitioner makes a determination that an insured does not meet the definition of "chronically ill individual," the insurer notifies the insured that the insured is entitled to a second assessment by a licensed health care practitioner, upon request, who personally examines the insured. The requirement for a second assessment does not apply if the initial assessment was performed by a practitioner who otherwise meets the proper requirements and who personally examined the insured. The assessments conducted will be performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. The written certification will be renewed every 12 months.

A licensed health care practitioner should develop a written plan of care after personally examining the insured. The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual," or to prepare written plans of care shall not count against the lifetime maximum of the policy or certificate. In order to be considered "independent of the insurer," a licensed health care practitioner should not be an employee of the insurer nor be compensated in any manner that is linked to the outcome of the certification. The practitioner's assessments should be unhindered by financial considerations and apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract.

Precedent to the payment of benefits for any care covered by the terms of the policy, any insurer offering long-term care insurance may obtain a written declaration by a physician, independent needs assessment agency, or any other source of independent judgment suitable to the insurer that services are necessary.

Benefits for LTC Contracts and Other Contract Benefit

Providers will be required to provide an expanded explanation of LTC plan benefits, design and variations. As many new features have been included by the state and federal legislation as well as ancillary features not required by legislation.

10233.2. of the California Insurance Code states that long-term care insurance may not do the following.

- Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.
- Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.
- Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

- Provide for payment of benefits based on a standard described as "usual and customary," "reasonable and customary," or words of similar import.
- Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.
- Include an additional benefit for a service with a known market value other than the statutorily required home- and community-based service benefits, the assisted living benefit, or a nursing facility benefit, unless the additional benefit provides for the payment of at least five times the daily benefit and the dollar value of the additional benefit is disclosed in the schedule page of the policy.

10233.25. of the California Insurance Code states that no long-term care policy or certificate that is issued, amended, renewed, or delivered on and after January 1, 2002, must contain a provision that prohibits or restricts any health facilities' compliance with the requirements of Section 1262.5 of the Health and Safety Code. 10233.3. of the California Insurance Code states that if a policy or certificate replaces another long-term care policy or certificate, the replacing insurer is required to waive any time periods applicable to preexisting conditions and probationary periods to the extent that similar exclusions have been satisfied under the original policy or certificate. 10233.4. of the California Insurance Code states that no long-term care insurance benefits may be reduced because of out-of-pocket expenditures by the insured or on behalf of the insured by a family member of the insured or by any other individual.

Indemnity contracts/integrated contracts

Indemnity is compensation to the claimant for disability or illness suffered – security against loss. Indemnity contracts pay the entire pre-determined benefit on a daily or monthly basis. With indemnity plans, the health insurance consumer pays a set percentage of the total costs of the health care treatment, and the health insurance company pays the remaining percentage. The costs of medical treatment are defined by the health insurance provider and vary by doctor. Indemnity health plans allow health insurance consumers an opportunity to become actively involved in selecting the actual medical care professional or physicians.

There are three methods of pay reimbursement – (1) reimbursement, (2) cash, and (3) per diem. Policies or certificates that provide reimbursement for care in a nursing facility shall be triggered by impairment in either 2 ADL's or cognitive ability and cover and reimburse for per diem expenses as well as the costs of ancillary supplies and services, up to but not to exceed the maximum lifetime daily facility benefit of the policy or certificate. Also, there shall be no reduction in benefits where an insured incurs "out-of-pocket" expenditures.

The reimbursement/cash/perdiem limit for tax-free benefits vary from year to year. In 1999, the limit on tax-free benefits is \$190 per day, or \$69,350 per year, but this limit applies only to "per diem" products which pay benefits regardless of whether or not services have been performed. This limit does not apply to "reimbursement" products. In 2003 it was raised to \$220 in 2003.

Benefit Periods and Dollar Amounts

10232.93 of the California Insurance Code states that every long-term care policy or certificate defines the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any home- and community-based assisted living benefit or institutional care covered by the policy or certificate. There is no limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home- and community-based care and for assisted living care, and for the limits for institutional care. Nothing here is to be construed as prohibiting limitations for reimbursement of actual expenses and incurred expenses up to daily, weekly, and monthly limits.

10233.4 of the California Insurance Code states that no long-term care insurance benefits may be reduced because of out-of-pocket expenditures by the insured or on behalf of the insured by a family member of the insured or by any other individual.

Elimination Periods

The elimination period is the time a person must pay out-of-pocket for services before the insurance benefits begin. The choice of an elimination or waiting period depends on a client's needs and ability to cover the early costs in a chronic illness. It's also called a waiting period. With a 20-day elimination period the policy will begin paying benefits on the twenty-first day. Most policies offer a choice a deductible ranging from Elimination period generally run 30, 90 or 180 days with options to lengthen this time more in exchange for reduced premiums. The Elimination Period works like a deductible stated in time rather than dollars. The insured will not receive benefit payment for a certain number of days at the beginning of a period of care, even though they may be receiving services defined by the policy.

A policy with a 90-day elimination might cost \$300 per year less than a policy with 20-day elimination. After 20 years, a policyholder would save about \$6,000 in premiums, but with 5 percent inflation, the 70 additional days of care would cost over \$20,000.

- *Definition of "day" for home care purposes* -- Most policies define a day of elimination as meaning a day of care, but a few define elimination as a calendar day with no care required. Once the insured has been certified as being chronically ill each calendar day counts towards the elimination period, regardless of whether formal long-term care services are received.
- *Financial Examples* -- There are out of pocket costs and these are the costs counted with inflation protection. Even lower rates can be accomplished if the couple is confident that a higher elimination period can be "financed" by their assets. Your objective with these clients is to engineer premiums they can "live with". It does them no good to purchase coverage only to drop it in a few years because the payments get to be a "nuisance".

Financial Example: Earl, an elderly man in his early 70's is planning to sell his home in the country and move closer to Wiley and his wife in the big city. He does not want to burden them with any home care and he wants to be sure they will not have to "support" him in a nursing home. But, his income is modest at best. **LTC Suggestions** -- No one can guarantee that LTC insurance will always cover each and every cost or that Medi-Cal will be there to help when someone needs it. A possible suggestion to this client is that he do the best he can and purchase a lifetime benefit nursing home only policy with inflation protection. A critical issue is the daily benefit amount and whether it will be sufficient to pay the higher cost of nursing care in a big city. The reality of it is that it can cost two to three times as much as a rural facility. A full indemnity contract with a "pool of money" approach might help here but a client will have to be advised that the costs may exceed benefits. Further, he must expect rates to increase over time. Because his income is limited, he may have to reduce coverage to a 3, 4 or 5-year benefit period later on.

- *Nursing Home* -- If an Elimination Period of 60 days is chosen, an individual will be responsible for the cost of the first 60 days of care. If in a nursing home that charges \$100 per day, an individual will pay approximately \$6,000, before the policy starts paying. If one leaves the nursing home before the 60 days expires and the policy only pays for institutional care, it would pay nothing for that period of care.
- *Home Care* -- If an individual qualifies for benefits in a home care setting most long-term care insurance policies apply a day towards the Elimination Period for any day one actually receives care (or a home care visit). Therefore, if the plan of care only calls for 3 visits per week one will only have satisfied 3 days towards their Elimination Period. Some companies offer a more liberal interpretation of this definition. For example, the policy might say that if a person has one home care visit per calendar week, that satisfies 7 days towards one's Elimination Period.

Case Management (TQ vs. NTQ)

10232.8 (a) from the California Insurance Code states that in every long-term care policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits, the threshold establishing eligibility for home care benefits shall be at least as permissive as a provision that the insured will qualify if either one of two criteria are met:

- Impairment in two out of seven activities of daily living;
- Impairment of cognitive ability.

The policy or certificate may provide for lesser but not greater eligibility criteria. The commissioner, at his or her discretion, may approve other criteria or combinations of criteria to be substituted, if the insurer demonstrates that the interest of the insured is better served.

"Activities of daily living" in every policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits shall include eating, bathing, dressing, ambulating, transferring, toileting, and continence; "impairment" means that the insured needs human assistance, or needs continual substantial supervision; and "impairment of cognitive ability" means deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or others.

Case Management Agencies around the country assist frail persons of any age to remain independent in the community by screening and assessing need, developing client care plans, implementing plans, coordinating services, monitoring the treatment process, periodically reassessing the care plan, and acting as advocate for chronically ill, functionally impaired, and vulnerable adults to assist them in obtaining necessary services. All TQ policyholders have the benefit of having a qualified licensed health care professional evaluate their need for care, and, with the policy holder's input, to develop a customized plan of care. This is a plan of care necessary to help them maintain as much independence in an efficient way. The case management process starts through a comprehensive evaluation of each individual's needs: health, social, environmental, financial, and support systems. After this comprehensive evaluation, a plan of care tailored to the individual is developed that is realistic, obtainable, and affordable. Monitoring is also done to ensure that the individual is benefiting from the services and that the care plan is changed as the individuals needs change.

- **Assessment Process**

A face-to-face assessment of an individual's needs, health, social, environmental, financial and support systems should be performed by a care management agency, after which, a plan of care is designed for the individual that fits the specific needs he or she has in regard to the level of service and the costs of each service. The question of "who does the assessment for benefit eligibility and who is charged for the assessment is not answered under NTQ Regulations. The assessment process is not addressed in NTQ policies. A client could be charged for this assessment under NTQ.

- **Plan of Care Requirements**

"Plan of Care" is a written individualized plan of services approved by a health care practitioner which specifies the type, frequency, and providers of all formal and informal long-term care services required for the individual, and the cost of any formal long-term care services prescribed. The Plan of Care identifies the type, frequency, and providers of all formal and informal care providers including the costs incorporating the services covered by the LTC policy or any other coverage that applies to the needs the individual has. The Plan of Care is revised every six months as the assessment mandates. Each time that the Plan of Care is adjusted, the changes must be documented to show the alterations that were required. These alterations may have been necessary because of a client's medical situation, functional or cognitive abilities which have deteriorated, behavior abilities, or the availability of support services in their area.

A Care Advisor/coordinator is a health care professional or a social worker trained in long-term care who works with the insured, their family, and their care provider support system to assess the need and the options which are available to them. Expenses associated with Care Advisory services will not reduce total coverage amount. Care Advisors are based in the insured's area, so they know what local services and resources are available. The CalPERS Partnership plans provide dollar-for-dollar asset protection from Medi-Cal spend-down, offer a 30-day elimination period and integrated benefit allowance of either \$40,150 or \$80,300, and include 5% compounded inflation protection. The most popular plans are the comprehensive, lifetime with compounded inflation plans.

Bed Reservation Benefit

There is a 14 days Bed Reservation. Bed reservation applies if an insured goes home, the particular bed space is reserved in case he or she returns within a specified period for nursing homes, waiver of premium, respite care and survivorship benefit. If one is in a nursing home, assisted living facility, or hospice facility, and leaves that facility, some companies will pay for actual charges incurred to hold a space to enable the individual to return to that facility. The insurance company will not pay for more than the benefit that it would pay if the individual had been in the facility on those days. The majority of LTC policies will pay benefits for a stipulated period of time or days in order to maintain a bed in a nursing home should the insured be moved to a hospital with the intention of returning to the nursing facility. A typical number of days will range from 15-30 with some plans providing up to 60 days of bed reservation.

Assisted Living Benefit Offering

The California Assisted Living Association (CALA) represents more than 400 assisted living providers serving over 20,000 elderly and disabled individuals throughout the state. CALA members range from small independently operated communities, to those that specialize in caring for residents with dementia, to large campuses with multiple levels of licensed care. “Assisted living” refers to a special combination of housing, personalized supportive services and health-related care designed to respond to the individual needs of those who require help with activities of daily living in a non-institutional setting promoting maximum independence and dignity for each resident. Staff is available 24 hours a day to meet scheduled and unscheduled needs.

Assisted living communities in California are licensed Residential Care Facilities for the Elderly (RCFEs) and are regulated by the Department of Social Services. Inspections by state officials, staff training and certification requirements, family and community involvement and ongoing quality assurance efforts work together to help ensure quality care. Ongoing education and training programs provided by CALA and other education organizations, strive to reinforce standards and promote state-of-the-art programs and care delivery models. Responsiveness to consumer demand has resulted in a variety of options now available to consumers – options relating to services, special programs, activities, community size and amenities.

- *Place*
Because consumers’ preferences and needs vary widely, there is no single blueprint. Assisted living communities can range from a converted Victorian home, to a high-rise complex, to a multi-acre campus. Assisted living is an attractive option for consumers primarily because of the range of choices available, individualized service approach, security and home-like environment.
- *Daily Benefit*
Benefit triggers determine when, and whether, the benefits under a long-term care policy will begin to be paid and are therefore extremely significant. Assisted living services may include assistance with activities of daily living such as eating, bathing, dressing, toileting and mobility, medication management, social and recreational activities, housekeeping services, transportation, and other health-related services.
- *Out-Of-State*
Coverage continues even if an individual changes jobs, retires or moves out of state. Plan pays benefits anywhere in the United States and its possessions.

Restoration of Benefit

Any person who is restored to a position shall be considered as having been on leave of absence during the period of training or service in the armed forces of the United States and at the expiration of the period shall be entitled to be restored to his employment without loss of seniority, shall be entitled to participate in insurance or other benefits offered by the employer in accordance with established rules and practices relating to employees on leave of absence, and shall not be discharged from the position without cause within 1 year after restoration.

Home modification

Home modification and repair includes adaptations to homes that can make it easier and safer to carry out activities such as bathing, cooking, and climbing stairs and alterations to the physical structure of the home to improve its overall safety and condition. Home modification and repair can help prevent accidents such as falls. Sometimes a ramp, grab bars, special bed or other items can help an individual at home. In accordance with his or her Plan of Care, the company will pay the expenses he or she incurs for the purchase or rental of supportive equipment that allows them to stay at home for at least 90 days. The lifetime maximum for the benefit is 50 times the daily maximum. Research suggests that one-third to one-half of home accidents can be prevented by modification and repair and can allow people to remain in their homes. Over 60% of older persons live in homes more than 20 years old. Home modification and repair can accommodate lifestyle changes and increase comfort.

Caregiver Training

If the caregiver is a friend or family member, some policies allow for caregiver services and training under home care benefits. The daily benefit for informal care is typically one-half the home care benefit. A caregiver is the person who helps the individual accomplish the basic everyday activities one can no longer manage without assistance, due to illness, injury, or cognitive impairment. Caregiver training is training provided to an informal caregiver or a caregiver whose services are not covered under the policy. Caregiver training is included in most solid LTC plans. Caregiver training: benefits are limited to 7 days times the daily benefit amount in a lifetime. Informal Caregiver Training is when an individual needs someone to informally help him/her at home, such as a friend or family member, the company will pay the expenses of training this person or pay a percentage of the daily Home Care benefit for a pre-determined period of time.

Return of Premium

Return of Premium LTC Insurance is an attractive new rider offered by a select few insurance companies. Return of premium death benefit is included in most plans. This option provides for a percentage refund of the total premiums paid less any benefits paid or payable, should one die or terminate his or her coverage. While policy language varies by insurance company, the rider's purpose is to return any unused premium as a death benefit. In the event that the insured passes away without accessing policy benefits, a portion and in some cases the entire premium is returned to a named beneficiary. Today's LTC Insurance with return of premium, stay-at-home, direct cash, and modest benefit levels, may require a new look from those who have steered clear of insurance. Many advisers are changing their opinion of LTC Insurance, as benefits and features are geared toward home care and care delivered outside a nursing home. No return of premium is paid if death occurs at age 75 or older. The benefit is paid to the insured's spouse, if living, or to the estate. The return of premium option may be better suited to the policyholder who doubts he will use his coverage but still wants something out of the policy. He would have discretionary income and liquid assets to make the increased premiums. In essence, the cost of these additional options represent a potential loss in the time value of money.

Limited Pay Options

Limited pay options add to the premium amount, sometimes rather significantly. Some insurance companies offer payment options in which premiums are paid for a limited period of time, rather than over the life of the policy. Rather than paying premiums as long as the policy stays in force, payments are made for a predetermined number of years or up to a certain age. Common examples are:

- Single pay – one premium payment
- Ten pay – paying premiums for 10 years
- Twenty pay – paying premiums for 20 years, and
- To age 65 – paying premiums until insured turns 65

An individual can use cash, certificates of deposit (CDs), annuities, or other resources to buy a limited pay/long-term care policy. If one purchase a policy that offers a single premium payment, you are guaranteed that there won't be any additional premium charges. The policy includes a set amount of money for your long-term care needs. The longer one has the policy and doesn't file a claim, the more money he or she will have for future long-term care needs. These policies also pay a death benefit to heirs.

Waiver of Premium

Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if that institutionalization began while the long-term care insurance was in force and continues without interruption after termination. This extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

Though Waiver of Premium largely assures that a contract under benefit will remain in force while benefits are being received, there are instances in which it may not do so. There can be waiting periods of up to 90 days before this waiver takes effect, and it may not be available when home health care is obtained. If a policy waives premiums commencing six months after benefits are first payable, there remains the possibility that the insured might lapse his or her policy by failing to pay such premiums prior to the commencement of Waiver benefits. In this case, the LTC benefits would be payable as if the policy remained in-force. If the insured recovered prior to receiving maximum benefits, the policy would no longer be in-force and no further benefits would be due. Had the premiums been paid prior to the commencement of Waiver benefits, the policy would remain in-force and would return to active premium-paying status.

- *Facility or Home Care*

The waiver of premium provision waives one's need to make future premium payments once he or she has been in a nursing home or have received home care for a specified number of days. The company allows clients to stop paying premiums once they are receiving benefits.

Option – Non-forfeiture Benefits

10235.30. (a) of the California Insurance Code states that no insurer may deliver or issue for delivery a long-term care policy in this state unless the insurer offers at the time of application an option to purchase a shortened benefit period non-forfeiture benefit with the following features:

- Eligibility begins no later than after 10 years of premium payments;
- The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater;
- The same benefits covered in the policy and any riders at the time eligibility begins are payable for a qualifying claim;
- The lifetime maximum benefit may be reduced by the amount of any claims already paid;

- Cash back, extended term, and reduced paid-up forms of non-forfeiture benefits shall not be allowed;
- The lifetime maximum benefit amount increases proportionally with the number of years of premium payment;
- This does not apply to life insurance policies that accelerate benefits for long-term care.

Company Responsibilities

Terms and Conditions

10235.35. (a) of the California Insurance Code states that the commissioner may require the administration by an insurer of the contingent benefit upon lapse of the Long-Term Care Insurance Model Regulation by the National Association of Insurance Commissioners, as adopted in October 2000, as a condition of approval or acknowledgment of a rate adjustment for a block of business for which the contingent benefit upon lapse is not otherwise available. The insurer is to notify policyholders and certificate holders of the contingent benefit upon lapse when required by the commissioner in conjunction with the implementation of a rate adjustment. The commissioner may require an insurer who files for such a rate adjustment to allow policyholders and certificate holders to reduce coverage to avoid an increase in the policy's premium amount. The commissioner may also approve any other alternative mechanism filed by the insurer in lieu of the contingent benefit upon lapse.

Policy Terms

10235.2. of the California Insurance Code states that no long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

- "Medicare" is defined as the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended, or Title I, Part I of Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act;
- "Skilled nursing care," "intermediate care," "home health care," and other services is defined in relation to the level of skill required, the nature of the care and the setting in which care is required to be delivered;
- All providers of services, including, but not limited to, skilled nursing facilities, intermediate care facilities, and home health agencies are defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Permitted Exclusions And Limitations

10235.8 of the California Insurance Code states that no policy may be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as to the following:

- Preexisting conditions or diseases;
- Alcoholism and drug addiction;
- Illness, treatment, or a medical condition arising out of any of the following:
 - Aviation in the capacity of a non-fare-paying passenger;
 - Participation in a felony, riot, or insurrection;
 - Service in the armed forces or auxiliary units;
 - Suicide, whether sane or insane, attempted suicide, or intentionally self-inflicted injury;
 - War or act of war, whether declared or undeclared.

Treatment provided in a government facility, unless otherwise required by law, services for which benefits are available under Medicare or other governmental programs (except Medi-Cal or medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no fault law, services provided by a member of the covered person's immediate family, and

services for which no charge is normally made in the absence of insurance. This does not prohibit exclusions and limitations by type of provider or territorial limitations.

Permitted Pre-existing Condition

Permitted policy exclusions, however, may still include pre-existing conditions. In the same spirit as the prohibition of post claims underwriting, unique pre-existing limitations have been enacted for long term care insurance. Due to the quality of their underwriting, many carriers now cover pre-existing conditions from the date of issue, making this a somewhat academic regulatory requirement.

Claims Denial

10235.9 (a) of the California Insurance Code states that every insurer is to report annually by June 30 the total number of claims denied by each class of business in the state and the number of these claims denied for failure to meet the waiting period or because of a preexisting condition as of the end of the preceding calendar year. The insurer provides every policyholder or certificate holder whose claim is denied a written notice within 40 days of the date of denial of the reasons for the denial and all information directly related to the denial. Insurers annually report to the department the number of denied claims and upon request, the department makes available to the public the denial rate of claims by insurer.

Consumer/Policy Holder Right To Appeal

10235.94 of the California Insurance Code states that every policy or certificate shall include a provision giving the policyholder or certificate holder the right to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursement payments. If a person needs more information about his right to appeal, he should contact his local Social Security office, the Medicare intermediary or carrier, or the Peer Review Organization (PRO) in his state. Peer Review Organizations assign committees to conduct reviews involving Medicare and its decisions. There shall be no termination of coverage during a claim.

Renewability Provision in Individual Policies

10235.14 (a) of the California Insurance Code states that individual long-term care insurance policies contain a renewability provision. This provision must be appropriately captioned, appear on the first page of the policy, and clearly disclose the term of coverage for which the policy is initially issued, the terms and conditions under which the policy may be renewed, and whether or not the issuer has the right to change the premium. If this right exists, the policy provisions can clearly and concisely describe each circumstance under which the premium may change. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy require a signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term has to be agreed to in writing signed by the insured, unless the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, that premium charge is set forth in the policy, rider, or endorsement.

If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, those limitations are to appear as a separate paragraph of the policy or certificate and be labeled as "preexisting condition limitations." A long-term care insurance policy or certificate containing any limitations or conditions for eligibility must be in a separate paragraph of the policy or certificate a description of those limitations or conditions, including any required number of days of confinement, and that paragraph must be labeled, "Limitations or Conditions on Eligibility for Benefits."

Shortened Benefit Period

10235.30 (a) of the California Insurance Code states that no insurer may deliver or issue for delivery a long-term care policy in this state unless the insurer offers at the time of application an option to purchase a shortened benefit period non-forfeiture benefit with the following features:

- Eligibility begins no later than after 10 years of premium payments;
- The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater;
- The amount and frequency is the same as the original policy terms;
- The same benefits covered in the policy and any riders at the time eligibility begins are payable for a qualifying claim.
- The lifetime maximum benefit may be reduced by the amount of any claims already paid.
- Cash back, extended term, return of premium, and reduced paid-up forms of non-forfeiture benefits is not allowed.
- The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.
- Life riders accelerating benefits are exempt;

This section does not apply to life insurance policies that accelerate benefits for long-term care.

Forgetfulness

10235.40 (a) of the California Insurance Code states that no individual long-term care policy or certificate is to be issued until the applicant has been given the right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy or certificate for nonpayment of premium. The insurer receives from each applicant one of the following:

- A written designation listing the name, address, and telephone number of at least one individual, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium;
- A verbatim waiver signed and dated by the applicant electing not to designate additional persons to receive notice. The required waiver reads as follows:

"Protection Against Unintended Lapse.

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

Signature of Applicant

Date"

The insurer is required to notify the insured of the right to change the written designation, no less often than once every two years. When the policyholder or certificate holder pays the premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements need not be met until 60 days after the policyholder or certificate holder is no longer on that deduction payment plan. The application or enrollment form for a certified long-term care insurance policy or certificate must clearly indicate the deduction payment plan selected by the applicant.

No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the effective date of the lapse or termination, gives notice to the insured and to the individual or individuals designated at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice is to be given by first-class United States mail, postage prepaid, not less than 30 days after a premium is due and unpaid.

Each long-term care insurance policy or certificate is to include a provision, which, in the event of lapse, provides for reinstatement of coverage, if the insurer is provided with proof of the insured's cognitive impairment or the loss of functional capacity. This option must be available to the insured if requested within five months after termination and must be allowed for the collection of a past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity cannot be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy certificate.

Post Claims Underwriting Prohibited

Applications must ask “yes or no” health questions. Warning on application that misstatements may result in rescission. Since post claims underwriting is prohibited in California, all applications for long-term care insurance, except those that are guarantee issue, shall contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant. The California Insurance Code 10232.3 states the following regarding post claims underwriting. The applications must be delivered with each policy. Each question shall contain only one health status inquiry and shall require only a “yes” or “no” answer, except that an application may include a request for the name of any prescribed medication and the name of the prescribing physician. An omission here may be used as the basis for a denial of a claim or the rescission of a policy. The following warning shall be printed conspicuously and in close conjunction with the applicant’s signature block: “Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage.”

10232.3 of the California Insurance Code states that every application for long-term care insurance must include a checklist that enumerates each of the specific documents required to be given to the applicant at the time of solicitation. The documents and notices to be listed in the checklist include, but are not limited to, the following:

- The “Important Notice Regarding Policies Available” pursuant to Section 10232.25;
- The outline of coverage pursuant to Section 10233.5;
- The HICAP notice pursuant to paragraph (8) of subdivision (a) of Section 10234.93;
- The long-term care insurance shoppers guide pursuant to paragraph (9) of subdivision (a) of Section 10234.93;
- The “Long-Term Care Insurance Personal Worksheet” pursuant to subdivision (c) of Section 10234.95; (*See Attachment 6*)
- The “Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance” pursuant to Section 10235.16 if replacement is not made by direct response solicitation.

If medical underwriting not complete, insurer may rescind only for fraud or material misrepresentation. No LTC policy or certificate may be field issued. The contestability period for long-term care insurance has been shortened to two years. A copy of the completed application must be delivered to the insured at the time of delivery of the policy or certificate. Every insurer shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those voluntarily initiated by the insured, and annually must furnish this information to the commissioner in a format prescribed by the commissioner.

Eliminates Prior Hospital Stay Requirement

10232.5 of the California Insurance Code states that on or after January 1, 1990, no long-term care insurance policy may be delivered or issued for delivery in this state which does any of the following:

- Preconditions the availability of benefits on prior hospitalization;
- Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care;
- Preconditions the availability of benefits for community-based care, home health care, or home care on prior institutionalization;
- Conditions eligibility for non-institutional benefits on a prior institutional stay of more than 30 days.

30-Day Free Look

10232.7 (a) of the California Insurance Code states that an applicant for a long-term care insurance policy or a certificate, other than an applicant for a certificate issued under a group long-term care insurance policy issued to a group will have the right to return the policy or certificate by first-class United States mail within 30 days of its delivery and to have the premium refunded. It can be refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. The return of a policy or certificate voids the policy or certificate from the beginning and the parties are to be in the same position as if no policy, certificate, or contract had been issued. All premiums paid and any policy fee paid for the policy will be fully refunded directly to the applicant by the insurer within 30 days after the policy or certificate is returned. Long-term care insurance policies or certificates are required have a notice prominently printed on the first page of the policy or certificate, or attached to it, stating in substance the conditions.

Insurers Must Provide Residential Care Facilities for the Elderly (RCFE) Coverage

Insurers Must Provide Residential Care Facilities for the Elderly (RCFE) Coverage with facility and comprehensive LTC Policies. The benefit amount payable for care in a residential care facility shall be no less than 70% of the benefit amount payable for institutional confinement.

All expenses incurred by the insured while confined in a residential care facility, for long-term care necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services and maintenance or personal care services, needed to assist the insured with the disabling conditions that cause the insured to be a chronically ill individual and regulations adopted pursuant thereto, shall be covered and payable, up to but not to exceed the maximum daily residential care facility benefit of the policy or certificate.

Benefit eligibility is determined by the need for substantial supervision to prevent threats to safety or health as the result of severe cognitive impairment. Benefit eligibility is 2 out of 6 Activities of Daily Living or cognitive impairment. Some companies have paid for home care when a person needed services, regardless of whether the 2 out of 7 ADLs or cognitive impairment trigger had been met. These payments and other benefit triggers or standards such as “medical necessity” for benefit eligibility are not permitted in a tax-qualified contract.

Flexible Benefit Mandated

10232.93 of the California Insurance Code states that every long-term care policy or certificate is responsible for defining the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any home- and community-based services and assisted living benefit, or institutional care covered by the policy or certificate. Policy Lifetime maximum must be stated integrated pool of dollars. There is to be no limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home- and community-based care and for assisted living care, and for the limits for institutional care. This is not to be construed as prohibiting limitations for reimbursement of actual expenses and incurred expenses up to daily, weekly, and monthly limits.

Inflation Protection

10237.6 (a) of the California Insurance Code states that an insurer must include the following information in, or with the outline of coverage:

- A graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5% over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
- Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

An insurer may use a reasonable hypothetical or graphic demonstration for purposes of this disclosure.

Statutory Requirements

10237.1 of the California Insurance Code states that no insurer is to deliver or issue for delivery a long-term care insurance policy or certificate in this state unless the insurer offers to each policyholder and certificate holder, in addition to any other inflation protection, the option to purchase a long-term care insurance policy or certificate that provides for benefit levels and benefit maximums to increase to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers are to offer to each policyholder and certificate holder, at the time of purchase, the option to purchase a long-term care insurance policy or certificate containing an inflation protection feature which is no less favorable than one that does one or more of the following:

- Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5%.
- Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status and without regard to claim status or history so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.
- Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount limit.
- The insurer of a group long-term care insurance must offer the holder of the group policy the opportunity to have the inflation protection extended to existing certificate holders, but the insurer is relieved of the obligations if the holder of the group policy declines the insurer's offer.
- Applicant must be offered
- Applicant must sign statement refusing 5% annual compounded adjustments.

A graphic comparison of benefit levels of a policy with and without inflation protection over a 20-year period must be presented to applicants in the outline of coverage. This illustration must be reasonable and show expected premium increases necessary to pay for inflation protection.

Past Increases in California Long-Term Care Costs

The consumer price index (CPI) is the most highly recognized measure of inflation. Actually, the CPI measures only certain costs for goods and services purchased by urban consumers across the U.S. As you might expect, the year-to-year rise in the CPI for the nation varies from the rise in the cost of nursing facility care in California.

Average Annual Percent Increase In Nursing Facility Private Pay Rates Since 1980					
Year Period	Average Annual Increase	Average Daily N. F. Private Rate / Percentage Increase From Previous Year	Cost Per Year	LTC % Increase	CPI Increase
1980-1989	7.5	\$42.89/12.1%	1980	12.1%	12.5%
		--	1981	--	--
		--	1982	--	6.2
		--	1983	8.5%	3.2
		--	1984	5.8%	4.3
		\$62.20/7.0%	1985	7.4%	3.8
			1986	6.9%	1.9
			1987	6.4%	3.6
			1988	7.5%	4.1
			1989	7.0%	4.8
1990-1999	4.3	\$87.80/6.6%	1990	6.6%	6.1
		\$92.67/5.5%	1991	6.0%	4.1
		\$98.09/5.8%	1992	5.7%	3.0
		\$101.29/3.3%	1993	2.7%	3.0
		\$105.43/4.1%	1994	4.1%	2.6
		--	1995	5.1%	2.5
		--	1996	4.8%	3.3
		--	1997	4.5%	2.3
		--	1998		
		--	1999		
2000-2004	5.7	\$160.00/7.0%	2004		

Note: Average Daily Nursing Facility Private Pay Rate (ADPR) are the actual statewide average private pay rate for the year shown. The rates are extracted from the Office of Statewide Health Planning and Development's LTC Annual Financial Data Profile report. The rates for the years 2002-2004 are estimated as specified in California Code Regulations, Title 22 Section 58002.

Note: Partnership approved policies and certificates issued to 2004 must include a daily benefit (per diem) for nursing facility care of no less than \$110.00

Source: Office of Statewide Health Planning & Development

Source: California Office of Statewide Housing Planning & Development; Aggregate Long Term Care Facility Financial Data, 1982 – 1997.

US Bureau of Labor Statistics

Source: Office of Statewide Health Planning and Development, part of the California Health and Welfare Agency.

- *Compare annual increases in nursing home rates with consumer price index (CPI)*

In 2002, the cost of nursing home care in California averaged \$141 a day. Costs may be lower in rural areas and higher in suburban and urban areas. A short 30-day stay could cost \$4,230 or more; a 3-month stay, \$12,690 or more; and, a year stay, \$50,000 or more. The cost of care in the future will be much higher than it is today. California nursing home rates increased at an average rate of over 5% per year during the past twenty years and are likely in the future to continue to increase by at least 5% per year. A 5% annual increase means a year of care that costs \$50,000 today will cost twice that amount in 14 years, or \$100,000 a year.

- *Show that annual increases in recent years have trended downward toward 5%, but still exceed CPI*

Annual increases in recent years have trended downward toward the 5% but have still exceeded CPI. In the 1980s and 1990s, the rise in long-term care costs has been much greater than inflation in things that are included in the consumer price index. The average rate of private pay in a California nursing home was \$4,477/month in 2004.

Cost of Nursing Home Care Today

The average cost of NH care in California in 2004 was \$165 per day. The average daily cost of nursing care will grow to \$184 in 14 years if costs continue rising at a compounded rate of 5%. In 20 and 30 years, the average cost will be \$245 and \$399, respectively. For an average nursing home stay of 2.25 years the current cost of care could run \$75,000. In 20 years, this same stay will cost an astounding \$201,206 for one year.

- *Current nursing home daily rates in various California communities*

The rate that clients in a community pay may be quite different. In Orange County, California, a Santa Ana nursing home run by Catholic nuns charges \$87 per bed day which is lower than the state average rate. A few miles away in the City of Orange the rate moves to \$100 per day while a Laguna Niguel facility commands \$125. Rates will vary based on services needed, neighborhood location, the cost of labor in the area and the age, ownership and quality of the facility. A “bare bones” nursing home built in a rural area where land costs and labor are less will likely charge less than statewide averages.

Estimate Life Expectancy for Applicants at Different ages

Average Years of Life California population, 1998			
Age	Total Yrs.	Male	Female
50	36	33	38
55	31	29	33
60	27	25	29
65	24	22	25
70	20	18	21
75	17	15	18
80	14	13	15
85	12	11	12

Source: Department of Health Services, Vital Statistics

- Illustrate the average number of remaining years of life for different ages – using California data
- Point out half will live longer and half less than the average, but persons healthy enough to qualify for LTC insurance are expected to live longer than average

Project Future Nursing home Costs (NH) (for Daily Benefits and Average NH Stay of 2.25 years)

Out-of-Pocket Nursing Home Expenses Without Inflation Protection 5 Percent Compound Increase in Care				Out-of-Pocket Nursing Home Expenses Without Inflation Protection 5 Percent Simple Increase in Care			
Time Period	Daily Nursing Home Cost	Excess Cost Without Inflation Protection		Time Period	Daily Nursing Home Cost	Excess Cost Without Inflation Protection	
		Daily	Annual			Daily	Annual
Today	\$116	--	--	Today	\$116	--	--
14 yrs	\$229	\$113	\$40,680	14 yrs.	\$197	\$81	\$29,160
20 yrs	\$307	\$191	\$68,760	20 yrs.	\$232	\$116	\$41,760
30 yrs	\$501	\$307	\$138,600	30 yrs.	\$290	\$174	\$62,640

Inflation Escalator and Benefit Increases

This applies to all long-term care insurance policies delivered or issued for delivery in this state on or after January 1, 1991. Nursing home costs in California have grown faster than the average rate of inflation. The insurer must offer Inflation Protection at 5% which is compounded annually. Some years have seen huge jumps in the cost of nursing care; especially in the late 1980's and early 1990's where rates increased in the 8% to 10% range annually. Recent years have seen a decrease in the rate of increase but nursing home costs still outpace inflation. More to the point; nursing costs have nearly doubled in the past 10 years.

Insurer must offer Inflation Protection

Agents should review possibilities with clients to arrive at an informed decision to add or decline inflation protection. It is easy to see that inflation protection can be the most important feature in a long-term care policy. The real tragedy of the statistics is the amount of out-of-pocket expenses a client will incur if they do not buy inflation protection. When a client is on a fixed income, the value of having a policy with Inflation Protection is great.

Mandated Offer Goes to Group Policyholder

10237.3 of the California Insurance Code states that the offer in Section 10237.1 shall not be required of any of the following:

- Life insurance policies or riders containing accelerated long-term care benefits;
- Expense incurred long-term care insurance policies;

For purposes of this subdivision, "expense incurred" does not include policies paying a certain percentage of reasonable and customary charges up to a specified, indemnity-type maximum amount.

No Limits on Inflation Protection

10237.4 (a) of the California Insurance Code states that inflation protection benefit increases under a policy that contains these benefits continues without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy. An offer of inflation protection that provides for automatic benefit increases must include an offer of a premium which the insurer expects to remain constant. The offer is required to disclose in a conspicuous manner that the premium may change in the future unless it is guaranteed to remain constant. The inflation protection benefit increases under a policy or certificate that contains an inflation protection feature is not to be reduced due to the payment of claims.

Accelerated Benefits and Expenses incurred plans exempt

10237.3. of the California Insurance Code states that Section 10237.1 does not refer to any of the following:

- Life insurance policies or riders containing accelerated long-term care benefits.
- Expense incurred long-term care insurance policies. "Expense incurred" does not include policies paying a certain percentage of reasonable and customary charges up to a specified, indemnity-type maximum amount.

No Reduction of Inflation Benefit Increase Due to Payment of Claims

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

Insurer must Provide 5% Compounded Unless Applicant Signs Rejection

10237.5 (a) of the California Insurance Code states that an inflation protection provision that increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5% is to be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

Rejection, Verbatim

10237.5 (b) of the California Insurance Code states that the rejection, to be included in the application or on a separate form, shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject 5% annual compound inflation protection"

Signature of Applicant Date

OOB Must Include

10237.6 (a) of the California Insurance Code states that an insurer must include the following information in or with the outline of coverage:

- A graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5% over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
- Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.
- An insurer may use a reasonable hypothetical or graphic demonstration for purposes of this disclosure.

CHAPTER THREE

Statutory Provisions, Disclosures, and Prohibitions

Outline of Coverage (OOC)

The existing law for long-term care insurance prescribes various requirements and conditions governing the delivery or issuance for delivery in this state of individual or group long-term care insurance. SB 870 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; changes relating to coverage for preexisting conditions; changes regarding prohibited policy provisions and prohibited insurer actions in connection with policies; and changes regarding the right of a policy or certificate holder to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursements.

SB 870 SEC. 9. would amend 10233.5 of the California Insurance Code to read as follows.

OOC delivered at Solicitation

An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

Delivery Before Application (agents)

In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

Delivery With Application (direct response)

In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

Distinguish Between Groups and Individual Disclosure in Certificates

Group policies can be identical to individual policies, except that they are not required to meet the same regulations. Many people have private insurance when they reach age 65 that may be purchased through their employer or their spouse's current employer or union membership. If an individual has such coverage, he must determine whether the coverage can be continued when his spouse retires. Group health insurance that is continued after retirement usually has the advantage of having no waiting periods or exclusions for preexisting conditions. The coverage is usually based on group premium rates, which may be lower than the premium rates for individually purchased policies.

Under a group long-term care insurance policy, an individual qualifies for benefits when the doctor provides information that demonstrates that the policy holder needs personal assistance with two or three of the following activities of daily living: Bathing, continence, dressing, transferring, toileting, and eating needs.

Group long-term care coverage does, by design, help protect assets, lifestyle, and peace of mind by providing benefits for medical problems or chronic impairments which require long-term nursing care including nursing home care or home health care. California permits insurers to sell LTC to employer groups, trade groups, associations, small business alliances, or purchasing cooperatives to provide insurance to small companies in order to reduce the cost of group long-term care.

10233.6 of the California Insurance Code states that a certificate issued to a group long-term care insurance policy delivered or issued for delivery in California, is required to include all of the following:

- A description of the principal benefits and coverage provided in the policy;
- A statement of the principal exclusions, reductions, and limitations contained in the policy;
- A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums;
- A statement that the group master policy determines governing contractual provisions;
- An explanation of the insured's rights regarding continuation, conversion, and replacement.

Duty of Honest, Good Faith, Fair Dealing -

10234.8 (a) of the California Insurance Code states that the agents owe a policyholder or a prospective policyholder a duty of honesty, and a duty of good faith and fair dealing. Agents are prohibited from twisting, high pressure tactics, cold lead advertising. The first agent priority in any long term care sales presentation is the requirement that all insurers, brokers, agents, and other engaged in the business of insurance owe a policyholder a duty of honesty and a duty of good faith and fair dealing. In addition, he or she must make sure to avoid unfair practice, unfair methods of competition, or unfair and deceptive acts. Insurers, brokers, agents, and others engaged in the transaction of insurance owe a duty of honesty, good faith, and fair dealing to all prospective insureds who are 65 years of age or older. According to Consumer Protection/Agent Responsibilities page 104 the agent is to "owe a policyholder a duty of honesty, and a duty of good faith and fair dealing, especially if the agent sells less than lifetime coverage."

10234.8 is amended to include the following regulations to permit the commissioner to delegate the power to negotiate settlements but not the power to approve them. Unless specifically authorized by law, prohibits the commissioner from agreeing that:

- An insurer, agent, or broker will contribute to a nonprofit entity, or direct funds outside the state treasury system.
- Funds will be directed to another person or entity.
- Settlement proceeds will be used to produce materials using the commissioner's name, voice, or likeness.

This Senate Bill permits settlement payments only to those who may be due payment as a result of the wrongdoer's violations. It also requires all fines, penalties, assessments, costs, and sanctions be deposited in the state treasury.

No Unnecessary Replacement

In light of in-force rate increases, carriers are struggling financially so it may be best to develop some clear guidelines for agents when replacement is appropriate and when it is not appropriate. 10234.85 of the California Insurance Code states that no insurer, broker, agent, or other person is to cause a policyholder to replace a long term care insurance policy unnecessarily. Nothing here is to be construed to allow an insurer, broker, agent, or other person to cause a policyholder to replace a long term care insurance policy that will result in a decrease in benefits and an increase in premium. It shall be presumed that any third or greater policy sold to a policyholder in any 12-month period is unnecessary. This does not apply to those instances in which a policy is replaced solely for the purpose of consolidating policies with a single insurer.

Permitted commissions

10234.97. (a) of the California Insurance Code states that at any time long-term care coverage is replaced, the sales commission that is paid by the insurer and that represents the percentage of the sale normally paid for first year sales of long-term care policies or certificates shall be calculated based on the difference between the annual premium of the replacement coverage and that of the original coverage. If the premium on the replacement product is less than or equal to the premium for the product being

replaced, the sales commission is limited to the percentage of sale normally paid for renewal of long-term care policies or certificates. Replacement must be contingent upon the insurer's declaration that the replacement policy materially improves the position of the insured, according to Section 10235.16. This does not apply to replacement coverage which is group insurance as described in subdivision (a) of Section 10231.6.

“Commission or other compensation” includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards, and finder's fees. Every long-term care insurer shall file with the commissioner within six months of the effective date of this section, its commission structure or an explanation of the insurer's compensation plan. Any amendments to the commission structure shall be filed with the commissioner before implementation.

Replacement commissions –Dependent on Material Improvement’ -- In any replacement situation, agent commissions are limited to the difference between replacement and original coverage so long as the insurer declares that a “material improvement” in policy benefits has taken place. In the eyes of the law, a material change in a policy can be considered issuance of an entirely new contract, thus voiding Pre-1997 TQ status under federal “grandfather” rules. Examples of changes that could trigger this include any altering on the timing of benefits, premiums or non-forfeiture rights; a substitution of the insured or a change in the eligibility for membership in a group contract; or exchanging a Pre-97 policy for a new one. Simply exercising an option or right existing in a Pre-1997 contract is NOT material.

- *Includes Any Kind of Compensation* -- Commission or compensation includes remuneration of any kind, including, but not limited to bonuses, gifts, prizes, awards and finder’s fees.
- *Commission structure filed with commissioner within six months* -- Commission structures and any amendments must be filed with the commissioner before implementation or within six months of code changes.

Premium Credits for Replacement Policies: 5% of Prior Premium

10234.87 (a) of the California Insurance Code states that if an insurer replaces a policy or certificate that it has previously issued, the insurer is to recognize past insured status by granting premium credits toward the premiums for the replacement policy or certificate. The premium credits equal 5% of the annual premium of the prior policy or certificate for each full year the prior policy or certificate was in force. The premium credit must be applied toward all future premium payments for the replacement policy or certificate, but the cumulative credit allowed need not exceed 50%. No credit need be provided if a claim has been filed under the original policy or certificate. The cumulative credits allowed do not need to reduce the premium for the replacement policy or certificate to less than the premium of the original policy or certificate. This does not apply to life insurance policies that accelerate benefits for long-term care.

While replacement and lapses do not alone constitute a violation of insurance law, it is clear the DOI wants to monitor potential abuses. Recent legislation clearly targets the exposure of agents with higher-than normal policy replacements and lapses. Insurers are also required to “track and report” a list of the top 10% of agents with active policy lapse ratios. With mandatory premium credits in place it may be economically unfeasible for agents to consider or recommend aggressive replacement of previous policies unless warranted.

Premium Credit Example

Old Policy - Premium of \$1,000 annually -- New Policy - Premium of \$1,500 annually

Credit - 5% for each full year of premiums paid -- Had old policy for six years -

How it works: 6 years x .05 = .30

\$1,000 (old premium) x .30 = \$300 -- \$1,500 (new premium)

- \$300 (credit)

\$1,200 (new annual premium)

Carrier Ratings

The true financial health of a life insurance company cannot be determined merely by looking at its annual report or its size. A company's size and ratings are important factors to take into consideration when making your long-term care insurance choice. While an A+ rating is no guarantee the company will remain in business or not increase their premiums, companies with superior ratings are more likely to have the ability to pay future claims. However, the company's growth (or lack of growth) over a number of years can reveal some important information assessment of financial strength; the types of business written, the company's business trends over the years, its underwriting and investment strategies, the adequacy of its reserves or its ratio of policyholder's surplus to liabilities.

Every agent should consult one or more of the above rating services before selecting an LTC company for their client. The ratings issued by these companies represent their opinions of the insurer's financial condition and their ability to meet obligations to policyholders. As a minimum, however, the company should be licensed to sell LTC insurance in California and be rated by one of the major services like A.M. best, Standard & Poors, Moody's, Duff & Phelps or Weiss research. Providers must be able to explain the implications regarding the various rating as they relate to carrier financial standing and claims paying ability

AM Best

The *A. M. Best* company describes secure insurers as "having a strong or good ability long-term to meet their obligations to policyholder," and states: "Insurers classified in the secure rating categories maintain a level of financial strength that is not vulnerable to unfavorable changes in the business, economic or regulatory environment." Ratings within the secure categories range from A++ (Superior) to B+ (Very Good), while those companies judged to be vulnerable range from B (Adequate) to F (In Liquidation). In recent years, ratings have become an increasingly important factor in a consumer's decision to purchase insurance and in an agent's selection of plans to market. Based on analysis of insolvencies over a 15-year time period, *A. M. Best* has found that insurers rated B+ and above maintain secure financial strength. Therefore, an agent or consumer should not exclude from consideration insurers rated in the secure rating range when looking for a financially sound carrier.

Standard & Poor

Many insurers to seek ratings from companies such as *Standard & Poor's (S&P)*, *Moody's Investors Service (Moody's)* or *Duff & Phelps (D&P)*. These organizations have excellent reputations for providing objective ratings of a company's financial situation after a thorough examination of the accounting and investment records and after meeting with senior management. Although these companies are known for the *bond rating* services (based on systems of gradation for measuring the relative investment quality of bonds), they also rate insurers using symbols that range from the highest quality (least risk) to the lowest investment quality (greatest risk).

Moody's

All of Moody's insurance research services feature analyst access, credit opinions and in-depth analysis on individual companies, and industry wide outlooks and commentary. Moody's provides credit ratings on roughly 700 insurance companies worldwide along with rating the major reinsurers and financial guarantors. In addition, they provide performance ratings and supporting research on the Lloyd's syndicates through our Lloyd's Market Service.

Fitch

Fitch Ratings is one of the largest global credit rating agencies in the world with its rating opinions playing an important role in support of insurance company selection decisions for a broad range of constituencies. Since insurers are viewed as possessing a very strong capacity to meet policyholder and contract obligations, the risk factors are modest. Ratings in the "AA" through "CCC" categories may be amended with a (+) or (-) sign to show relative standing within the major rating category.

Weiss

Weiss Ratings is the source for accurate ratings that one can rely upon to make sound, informed financial decisions. Weiss accepts no compensation from the companies that are rated nor do they give the companies the opportunity to preview the ratings or suppress their publication. Weiss is totally independent and unbiased because their loyalty is to the customer with their insurance ratings proven to be more accurate than any of the other rating agencies.

Prohibited Provisions

No discrimination based on individual's health

10233.2 of the California Insurance Code states that long-term care insurance may not:

- Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.
- Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.
- Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- Provide for payment of benefits based on a standard described as "usual and customary," "reasonable and customary," or words of similar import.
- Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.
- Include an additional benefit for a service with a known market value other than the statutorily required home- and community-based service benefits, the assisted living benefit, or a nursing facility benefit, unless the additional benefit provides for the payment of at least five times the daily benefit and the dollar value of the additional benefit is disclosed in the schedule page of the policy.

Medical Necessity

Medical Necessity usually means a doctor has certified that a medical condition will deteriorate if an individual does not receive the care recommended. However, under California law, an insurer is not allowed to require that benefits also be “medically necessary” before the company will pay. Federal law prohibits the use of a medical necessity trigger in tax-qualified long-term care insurance policies. There is a very good reason for the tightening up of the access to benefits. California Policies (NTQ) are allowed to use at their discretion, a 3rd trigger (i.e. “Injury or sickness” or “Medical necessity” has been commonly used). Medical necessity is a common trigger under non-tax qualified policies but NOT under TQ plans. 10232.9 (c) 7 of the California Insurance Code states that home care benefits are not to be limited or excluded by requiring "medical necessity" or similar standard as a criteria for benefits.

Prohibited Termination Due to a Divorce

10233.2 (e) of the California Insurance Code states that long-term care insurance may not terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.

Distinguish Between Lifetime and Unlimited Benefits

10232.93 of the California Insurance Code states that every long-term care policy or certificate must define the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any home- and community-based services, assisted living benefit, or institutional care covered by the policy or certificate. There shall be no limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home- and community-based care and for assisted living care, and for the limits for institutional care. Nothing in this section shall be construed as prohibiting limitations for reimbursement of actual expenses and incurred expenses up to daily, weekly, and monthly limits.

No New Preexisting Conditions on Replacement Policies

10232.4 of the California Insurance Code states that no long-term care insurance policy or certificate other than a group policy or certificate is use a definition of preexisting condition which is more restrictive than a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person. Every long-term care insurance policy or certificate is to cover preexisting conditions that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.

No Benefit Reductions Because of Out-of-Pocket Expenditures

10233.4 of the California Insurance Code states that no long-term care insurance benefits may be reduced because of out-of-pocket expenditures by the insured or on behalf of the insured by a family member of the insured or by any other individual.

“Usual and Customary” Standard Prohibited

10233.2 of the California Insurance Code states that long-term care insurance may not provide for payment of benefits based on a standard described as "usual and customary," "reasonable and customary," or words of similar import.

Long Term Care Personal Worksheet

10508.5 of the California Insurance Code states that it shall be the obligation of each life, life and disability, and disability insurance agent and any other agent and insurer to preserve and maintain all applicable records defined in Section 10508 in his or her possession, in addition to those records transmitted to the insurer, at his or her principal place of business for a minimum of five years. The records shall be kept in an orderly manner so that the information therein is readily available, and shall be open to inspection or examination by the commissioner at all times.

The HIPAA and Gramm-Leach-Bliley Act are both statutes dealing with the financial privacy issues. Title II of HIPAA, the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The AS provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the US health care system. HIPAA's medical privacy regulations govern the use and release of a patient's personal health information. The statute imposes serious criminal restrictions on dissemination of certain protected health information. The Department of Health and Human Services adopted regulations implementing HIPAA that essentially took effect in April 2003.

A copy of the issuer's personal worksheet must be filed and approved by the commissioner. A new personal worksheet is also to be filed and approved by the commissioner each time a rate is increased in California and each time a new policy is filed for approval by the commissioner. The new personal worksheet discloses the amount of the rate increase in California and all prior rate increases in California as well as all prior rate increases and rate increase requests or filings in any other state. The new personal worksheet is used by the insurer within 60 days of approval by the commissioner in place of the previously approved personal worksheet.

Agent must return three completed Personal Worksheet to insurer. One copy is for the insurer, one copy is for the agent record keeping, and one copy is for the consumer. 10234.95 of the California Insurance Code states that a completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sale of employer group long-term care insurance to employees and their spouses and dependents. The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet is prohibited.

The issuer is to use the suitability standards it has developed in determining whether issuing long-term care insurance coverage to an applicant is appropriate. Agents are to use the suitability standards developed by the insurer in marketing long-term care insurance. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. Alternatively, the issuers shall send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the National Association of Insurance Commissioners. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the

applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification will be made part of the applicant's file.

Annual Report: number of applications, number who declined to provide worksheet information, number who failed to meet suitability standards, number who conformed after suitability letter. Life riders are exempt from this section. Rules governing replacement and consequences depend on when policy was issued.

Companies' Suitability Policy Guidelines

Suitability refers to the process of determining whether it makes good financial sense for someone to buy long-term care insurance. All states require insurance companies and agents to make a reasonable effort to determine the appropriateness of a recommended sale or replacement. One of the most difficult decisions a family can face is to place a spouse, parent or other elderly relative in a nursing home. This decision may cause financial hardship when the family must pay for formal long term care in a nursing home. People often underestimate the extent to which the need for LTC can rapidly deplete a family's assets, and they often believe that, if they have a couple of hundred thousand dollars saved up, they don't need additional coverage. There is emotional trauma accompanying this decision along with the financial hardship when the family must pay for formal long term care in a nursing home. An insurance professional can help to ease this burden by providing advice on the alternate means of funding long term care.

There are several reasons why people might want to think about buying long-term care (LTC) insurance. First, fundamental to all insurance purchases is the peace of mind derived from knowing (or at least believing) that all of life's major contingencies have been adequately prepared for. For anyone who is concerned about LTC as one of those contingencies, private insurance offers at least one decided advantage – its benefits could make the critical difference in gaining access to the facility of choice.

Suitability Standards

10234.95 (a) of the California Insurance Code states that every insurer or other entity marketing long-term care insurance shall:

- Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.
- Train its agents in the use of its suitability standards.
- Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

The agent and insurer shall develop procedures that take into consideration, when determining whether the applicant meets the standards developed by the insurer, the following:

- The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.
- The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.
- The value, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

The issuer, and where an agent is involved, the agent, shall make reasonable efforts to obtain the information. The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet," contained in the Long-Term Care Insurance Model Regulations of the National Association of Insurance Commissioners. The personal worksheet used by the insurer shall contain, at a minimum, the information in the NAIC worksheet in not less than 12-point type. The insurer may request the applicant to provide additional information to comply with its suitability standards.

In the premium section of the personal worksheet, the insurer must disclose all rate increases and rate increase requests for all policies, whether issued by the insurer or purchased or acquired from another insurer, in the United States on or after January 1, 1990. The premium section shall include a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990.

The premium section shall include a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov)."

If the personal worksheet is approved prior to the availability of the rate guide, the worksheet shall indicate that the rate guide will be available beginning December 1, 2000. A copy of the issuer's personal worksheet shall be filed and approved by the commissioner. A new personal worksheet shall be filed and approved by the commissioner each time a rate is increased in California and each time a new policy is filed for approval by the commissioner. The new personal worksheet shall disclose the amount of the rate increase in California and all prior rate increases in California as well as all prior rate increases and rate increase requests or filings in any other state. The new personal worksheet shall be used by the insurer within 60 days of approval by the commissioner in place of the previously approved personal worksheet.

A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sale of employer group long-term care insurance to employees and their spouses and dependents. The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet is prohibited. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate. Agents shall use the suitability standards developed by the insurer in marketing long-term care insurance. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. Alternatively, the issuers shall send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the National Association of Insurance Commissioners. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

The insurer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter. This section shall not apply to life insurance policies that accelerate benefits for long-term care.

Pre-1997 Policy

Pre-1997 policy means that the policy was issued before December 31, 1997. 10232.2 of the California Insurance Code states that group policies issued prior to January 1, 1997, will be allowed to remain in force and not be required to meet the requirements noted here, as amended during the 1997-98 Regular Session, unless those policies cease to be treated as federally qualified long-term care insurance contracts. If such a policy or certificate issued on such a group policy ceases to be a federally

qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury pursuant to Section 7702B(f)(2) of the Internal Revenue Code, the insurer shall offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies. Congress realized that there were many long-term care insurance policies issued prior to January 1, 1997, that would not comply with HIPAA. Either their benefit structures or payment mechanisms were inferior to its guidelines or in California, the benefit triggers were considered too generous. Legislators left it to the Department of the Treasury to establish guidelines for “grandfathered” policies. In its interim directive on tax qualified long-term care insurance (Notice 97-31, May 1997), the Department of the Treasury indicated that long-term care insurance policies issued prior to January 1, 1997, meeting “long-term care insurance requirements of the State in which the contract was ... issued” would be grandfathered for the purposes of tax qualification unless the policyholder made a “material change” to the policy. However, they did not define material change.

Eligibility Benefits

Eligibility triggers in pre-1997 policies may make it easier to qualify for benefits than required triggers in TQ policies. The definitions to be used in policies and certificates for impairment in activities of daily living, “impairment in cognitive ability,” and any third eligibility criterion adopted by regulation, are to be the verbatim definitions of these benefit eligibility triggers. There are tax consequences of making “material modifications” to existing policies. Final regulations issued in December 1998 identified criteria for which a material modification that would result in a policy losing its tax qualified status. Action that could be taken by the policyholder that is not material and would not jeopardize the policy’s grandfathered status can include the following:

- A change in method of premium payment
- A classwide increase or decrease in premiums for contracts that have been issued on a guaranteed renewable basis
- A reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder’s family
- A reduction in coverage (with correspondingly lower premium) made at the request of a policyholder
- A reduction in premiums because the policyholder becomes entitled to a discount under the issuer’s pre-1997 premium rate structure
- The addition without an increase in premiums of alternative forms of benefits that may be selected by the policyholder
- The addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were a separate contract.
- The effectuation of a continuation or conversion of coverage right under a group contract following an individual’s ineligibility for continued coverage under the group contract
- The substitution of one insurer for another in an assumption reinsurance transaction
- Expansion of coverage under a group contract caused by corporate merger or acquisition
- Extension of coverage to collectively bargained employees
- The addition of former employees

10232.96 of the California Insurance Code states that when a policy or certificate holder of an insurance contract issued prior to December 31, 1996, requests a material modification to the contract as defined by federal law or regulations, the insurer, prior to approving such a request, shall provide written notice to the policy or certificate holder that the contract change requested may constitute a material modification that jeopardizes the federal tax status of the contract and appropriate tax advice should therefore be sought.

Favorable Tax Treatment

Favorable tax treatment can be retained if the insurance contract specifically allows for the change in benefits requested by a policyholder by adding a non-forfeiture rider. Treasury guidelines allow changes

in these policies so long as they have been “built-in”, e.g., a nonforfeiture rider or inflation protection option. As a precaution against losing favorable tax status the California insurance code now requires that if a policy or certificate holder requests a material modification to his insurance contract, and the policy or certificate was issued prior to 12/31/96, the policyholder shall receive written notice that the contract changes requested may constitute a material modification that jeopardizes the federal tax status of the contract and to seek appropriate tax advice favorable tax treatment can be lost if the change materially modifies the existing contract. Legal consequences of making material modifications precludes insurers from making changes without notifying policy holder that such changes may jeopardize federal tax treatment.

Policy issued after new California legislation becomes effective (October 5, 1997). conversion when insurer offers new benefits or eligibility rules. The insurance agent must discuss circumstances under which policyholder would acquire the right to convert to new policy. 10235.C of the California Insurance Code states that by replacing the existing policy or certificate with a new policy or certificate in which case consideration for past insured status shall be recognized by setting the premium for the replacement policy or certificate at the issue age of the policy or certificate being replaced. The insured may be required to undergo new underwriting, but the underwriting can be no more restrictive than if the policyholder or certificate holder were applying for a new policy or certificate. The insurer of a group policy must offer the group policyholder the opportunity to have the new benefits and provisions extended to existing certificate holders, but the insurer is relieved of the obligations imposed by this section if the holder of the group policy declines the issuer's offer. This became operative on June 30, 2003.

Insured’s Options When Group Policy Terminates

If a group long-term care policy is replaced by another policy to the same master policyholder issued, the replacing insurer shall offer coverage to all persons covered under the replaced group policy on its date of termination. “Continuation coverage” means the maintenance of coverage under an existing group policy when that coverage would be or has been terminated and which is subject only to continued timely payment of the premium. “Conversion coverage” means an individual policy of long-term care insurance, issued by the insurer of the terminating group coverage, without considering insurability, containing benefits which are identical, or which have been determined by the commissioner to be at least substantially equivalent to the group coverage which would be or has been terminated for any reason. A new policy to replace a terminated group policy is not exclude coverage for pre-existing conditions if the terminating group coverage would provide benefits for those pre-existing conditions.

Before issuing conversion coverage, the insurer may require that the conversion policy contain a provision:

- for a reduction of benefits if the insured has existing long-term care insurance, payable on an expense-incurred basis, which, together with the conversion policy, would result in payment of more than 100% of incurred expenses;
- limiting the payment for a single claim, spell of illness, or benefit period occurring at the time of conversion, to the amount that would have been payable under the previous group coverage.

Before issuing conversion coverage, the insured must submit written application for a conversion policy within a reasonable period after termination of the group coverage, and the premium must be paid as directed by the insurer, for the conversion policy issued to be effective on the day following termination of group coverage. The individual also must have been continuously insured under the group policy for at least six months immediately prior to termination. If a group long-term care policy is replaced by another policy to the same master policyholder issued, the replacing insurer must provide benefits identical to the terminating coverage of benefits determined by the commissioner to be at least substantially equivalent to the terminating policy. Lesser or greater benefits may be provided if the commissioner determines the replacement coverage is the most advantageous choice for the beneficiaries.

Tax Treatment -- Policy does not qualify for favorable tax treatment unless exchanged for a new policy designed specifically to comply with both federal and state tax law and new California insurance law.

Insurer Procedures -- Most insurers promised purchasers they would be given option to convert once new policies become available.

Convert or Retain Existing Policy -- This depends on the particular situation of each consumer. Considerations are the same as for a consumer deciding now whether to purchase policy that is intended or not intended to be federally tax qualified.

Replacement Notice

The replacement notice should include the following statement except when the replacement coverage is group insurance as described in Section 10231.6:

COMPARISON TO YOUR CURRENT COVERAGE

I have reviewed your current long-term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

_____ Additional or different benefits (please specify) _____

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other (please specify) _____

Signature of Agent and Name of Insurer

Signature of Applicant

Date

Replacement Notice For Direct Response Insurers

10235.18 (a) of the California Insurance Code states that insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy or certificate. The required notice shall be provided in the following form:

"NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance coverage delivered herewith issued by (company name) Insurance Company. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy or certificate. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage. (To be included only if the application is attached to the policy or certificate). If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, read the copy of the application attached to your new coverage and be sure that all questions are answered fully and correctly

concerning your medical health history. . Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application. The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

For group coverage not subject to the 30-day return provision of Section 10232.7, the notice shall be modified to reflect the appropriate time period in which the policy may be returned and premium refunded.

Downgrading (amended 1999 SB 870)

10235.51 (a) of the California Insurance Code states that every policy or certificate is to include a provision that gives the insured the option to elect, no less frequently than on each anniversary date after the policy or certificate is issued, to pay an extra premium for one or more riders that increase coverage in any of the following ways:

- Increase the amount of the per diem benefits.
- Increase the lifetime maximum benefit.
- Increase the amount of both the nursing facility per diem benefit and the home- and community-based care benefits of a comprehensive long-term care insurance policy or certificate.

The premiums for the riders to increase coverage may be based on the attained age of the insured. The premium for the original policy or certificate will not be changed and will continue to be based on the insured's age when the original policy or certificate was issued. The insurer may require the insured to undergo new underwriting, in addition to the payment of an additional premium, to qualify for the additional coverage. The insurer may restrict the age for issuance of additional coverage and restrict the aggregate amount of additional coverage an insured may acquire to the maximum age and coverage the insurer allows when issuing a new policy or certificate.

Any premium adjustments will be based on the age of the insured at issue. And, any optional coverage's are reduced in step with the overall reduction of benefits (the exception is inflation protection which continues). If any policy is about to lapse or if a premium increase is anticipated, the insurer shall advise the insured of his options to lower the premium by reducing coverage by giving at least 30 days notice. In any downgrade option, premiums must be based on and issue date. In the event of a lapse, reinstatement shall be permitted if the insurer provides proof of cognitive impairment or loss of functional capacity. Further, where inflation protection has been purchased, it will continue in force. Every policy or certificate must allow lowering premium by:

- Reducing policy maximum
- Reducing daily, weekly, monthly benefit
- Converting to nursing facility only or home care only

Premium based on issue age and issue date

The younger the age when the policy is purchased the less expensive the premium. In addition, the premium cost is determined by age at the time the policy is issued (known as the "issue age") and does not increase because of age as the policyholder grows older. There is an advantage to buying younger and locking in at a lower issue age premium. This advantage would be lost if someone replaced coverage with another policy at a much older issue age. No policy may be terminated for non-payment unless 30 days prior written notice is given by the insurer.

Upgrading

10235.51 (a) of the California Insurance Code states that every policy or certificate shall include a provision that gives the insured the option to elect, no less frequently than on each anniversary date after

the policy or certificate is issued, to pay an extra premium for one or more riders that increase coverage in any of the following ways:

- Increase the amount of daily, weekly, monthly the per diem benefits;
- Increase the lifetime policy maximum benefit.
- Increase the amount of both the nursing facility per diem benefit and the home- and community-based care benefits of a comprehensive long-term care insurance policy or certificate.

The premiums for the riders to increase coverage may be based on the attained age of the insured. The premium for the original policy or certificate will not be changed and will continue to be based on the insured's age when the original policy or certificate was issued. The insurer may require the insured to undergo new underwriting, in addition to the payment of an additional premium, to qualify for the additional coverage. The insurer may restrict the age for issuance of additional coverage and restrict the aggregate amount of additional coverage an insured may acquire to the maximum age and coverage the insurer allows when issuing a new policy or certificate.

Updating (amended 1999 SB 870)

In an effort to provide California consumers with the most complete and updated coverage available and to address the ever-changing landscape of LTC insurance, it is important for the consumer to be assured that he or she will be introduced to new technologies, services and or benefits that would be an enhancement from previous policies. California policyholders must have the opportunity to upgrade their existing coverage.

10235.52 (a) of the California Insurance Code states that every policy shall contain a provision that, in the event the insurer develops new benefits or benefit eligibility or new policies with new benefits or benefit eligibility not included in the previously issued policy, the insurer will grant current holders of its policies who are not in benefit or within the elimination period the following rights:

- The policyholder will be notified of the availability of the new benefits or benefit eligibility or new policy within 12 months. The insurer's notice shall be filed with the department at the same time as the new policy or rider.
- The insurer shall offer the policyholder new benefits or benefit eligibility in one of the following ways:
 - By adding a rider to the existing policy and paying a separate premium for the new benefits or benefit eligibility based on the insured's attained age. The premium for the existing policy will remain unchanged based on the insured's age at issuance.
 - By replacing the existing policy or certificate in accordance with Section 10234.87.
 - By replacing the existing policy or certificate with a new policy or certificate in which case consideration for past insured status shall be recognized by setting the premium for the replacement policy or certificate at the issue age of the policy or certificate being replaced.

The insured may be required to undergo new underwriting for the update, but the underwriting can be no more restrictive than if the policyholder or certificate holder were applying for a new policy or certificate. The insurer of a group policy must offer the group policyholder the opportunity to have the new benefits and provisions extended to existing certificate holders, but the insurer is relieved of the obligations imposed by this section if the holder of the group policy declines the issuer's offer. This section became operative on June 30, 2003.

10235.91 of the California Insurance Code states that in the event a non-medicaid national or state long-term care program is created through public funding that substantially duplicates benefits covered by the policy or certificate, the policyholder or certificate holder will be entitled to select either a reduction in future premiums or an increase in future benefits. An actuarial method for determining the premium reductions and increases in future benefits will be mutually agreed upon by the department and insurers. The amount of the premium reductions and future benefit increases to be made by each insurer will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and claims experience. Each insurer's premium reduction and benefit increase plans have to be filed and approved by the department.

Individual Policy Is Guaranteed Renewable or Noncancelable.

10236 of the California Insurance Code states that every individual and group long-term care policy and certificate under a group long-term care policy shall be either guaranteed renewable or noncancelable. "Guaranteed renewable" means that the insured has the right to continue coverage in force if premiums are timely paid during which period the insurer may not unilaterally change the terms of coverage or decline to renew, except that the insurer may, in accordance with provisions in the policy, and in accordance with Section 10236.1, change the premium rates to all insureds in the same class. The "class" is determined by the insurer for the purpose of setting rates at the time the policy is issued. "Noncancelable" means the insured has the right to continue the coverage in force if premiums are timely paid during which period the insurer may not unilaterally change the terms of coverage, decline to renew, or change the premium rate. Every long-term care policy and certificate shall contain an appropriately captioned renewability provision on page one, which shall clearly describe the initial term of coverage, the conditions for renewal, and, if guaranteed renewable, a description of the class and of each circumstance under which the insurer may change the premium amount.

Continuation or Conversion of Group Coverage

10236.5 (a) of the California Insurance Code states that every certificate of group insurance issued or delivered in California shall provide for continuation or conversion coverage for the certificate holder if the group coverage terminates for any reason except the following reasons:

- The termination of group coverage resulted from the insured's failure to make any required payment of premium or contribution when due.
- The terminating coverage is replaced not later than 31 days after termination by new group coverage effective on the day following the termination and the replacement coverage meets both of the following criteria:
 - The replacement coverage provides benefits identical to, or benefits determined by the commissioner to be substantially equivalent to or in excess of, those provided by the terminating coverage.
 - The premium for the replacement coverage is calculated on the insured's age at the time of issue of the group certificate for the coverage which is being replaced. If the coverage being replaced has itself replaced previous group coverage, the premium for the newest replacement coverage is calculated on the insured's age at the time the previous group certificate was issued.

"Continuation coverage" means the maintenance of coverage under an existing group policy when that coverage would be or has been terminated and which is subject only to continued timely payment of the premium. Any insured individual whose eligibility for group coverage is based on his or her relationship to another person, shall be entitled to continuation coverage under the group policy if the qualifying relationship terminates by dissolution of marriage or death. **"Conversion coverage"** means an individual policy of long-term care insurance, issued by the insurer of the terminating group coverage, without considering insurability, containing benefits which are identical, or which have been determined by the commissioner to be at least substantially equivalent, to the group coverage which would be or has been terminated for any reason.

In determining whether benefits are substantially equivalent, the commissioner shall consider, if applicable, the relative advantages of managed care plans, which use restricted provider networks, considering items such as service availability, benefit levels, and administrative complexity. The premium for the converted policy shall be calculated on the insured's age at the time the group certificate was issued. If the terminating group coverage replaced previous group coverage, the premium for the converted policy shall be calculated on the insured's age at the time the previous group certificate was issued. Before issuing conversion coverage, the insurer may require, if adequate notice is provided to certificate holders in the certificate, that:

- The individual must have been continuously insured under the group policy, or any group policy which it replaced, for at least six months immediately prior to termination in order to be entitled to conversion coverage.
- The insured must submit written application for a conversion policy within a reasonable period after termination of the group coverage, and the premium paid as directed by the insurer, in order that the conversion policy be issued effective on the day following termination of group coverage.
- The conversion policy contains a provision for a reduction of benefits if the insured has existing long-term care insurance, payable on an expense-incurred basis, which, together with the conversion policy, would result in payment of more than 100% of incurred expenses. This provision shall not be included in the conversion policy unless the reduction in benefits is reflected in a premium decrease or refund.
- The conversion policy contains a provision limiting the payment for a single claim, spell of illness, or benefit period occurring at the time of conversion, to the amount that would have been payable had the group coverage remained in effect.

Requirements For Replacement Of Group Coverage

10236.8 of the California Insurance Code states that if a group long-term care policy is replaced by another policy to the same master policyholder issued, the replacing insurer is to:

- Provide benefits identical to the terminating coverage or benefits determined by the commissioner to be at least substantially equivalent to the terminating coverage. Lesser or greater benefits may be provided if the commissioner determines the replacement coverage is the most advantageous choice for the beneficiaries.
- Calculate the premium on the insured's age at the time of issue of the group certificate for the coverage which is being replaced. If the coverage being replaced has itself replaced previous group coverage, the premium for the newest replacement coverage shall be calculated on the insured's age at the time the previous group certificate was issued. If the replacement coverage adds new or increased benefits, the premium for the new or increased benefits may be calculated on the insured's age at the time of replacement.
- Offer coverage to all persons covered under the replaced group policy on its date of termination.
- Not exclude coverage for preexisting conditions if the terminating group coverage would provide benefits for those preexisting conditions.
- Not require new waiting periods, elimination periods, probationary periods, or similar preconditions related to preexisting conditions. The insurer is to waive any such time periods applicable to preexisting conditions to the extent that similar preconditions have been satisfied under the terminating group coverage.
- Not vary the benefits or the premium based on the insured's health, disability status, claims experience, or use of long-term care services.

Updating

In an effort to provide California consumers with the most complete and updated coverage available, 10235.52 was introduced into California regulations in 1997 under SB 1052. The goal was to address the ever-changing landscape of LTC insurance so if and when a carrier introduced new technologies, services and or benefits that would be an enhancement from previous policies. California policyholders would be given an opportunity to upgrade their existing coverage. Then 10235.52 of the California Insurance Code was amended by SB870 to read (a) Every policy shall contain a provision that, in the event the insurer develops new benefits or benefit eligibility or new policies with new benefits or benefit eligibility not included in the previously issued policy, the insurer will grant current holders of its policies who are not in benefit or within the elimination period the following rights:

Policy Provision Allow Insureds to Update With New Benefits or Eligibility

10235.52 (a) of the California Insurance Code states that every policy shall contain a provision that, in the event the insurer develops new benefits or benefit eligibility or new policies with new benefits or benefit eligibility not included in the previously issued policy, the insurer will grant current holders of policies who are not in benefit or within the elimination period these rights:

- The policyholder will be notified of the availability of the new benefits or benefit eligibility or new policy within 12 months. The insurer's notice shall be filed with the department at the same time as the new policy or rider.
- The insurer shall offer the policyholder new benefits or benefit eligibility in one of the following ways:
 - Insurer must notify within 12 months
 - Insurer must offer new benefits or benefit eligibility
 - By adding a rider to the existing policy and paying a separate premium for the new benefit or benefit eligibility based on the insured's attained age. The premium for the existing policy will remain unchanged based on the insured's age at issuance.
 - By replacing the existing policy or certificate;
 - By replacing the existing policy or certificate with a new policy or certificate in which case consideration for past insured status shall be recognized by setting the premium for the replacement policy or certificate at the issue age of the policy or certificate being replaced.
 - The insured may be required to undergo new underwriting, but the underwriting can be no more restrictive than if the policyholder or certificate holder were applying for a new policy or certificate.
 - The insurer of a group policy must offer the group policyholder the opportunity to have new benefits and provisions extended to existing certificate holders, but the insurer is relieved of the obligations imposed if the holder of the group policy declines a issuer's offer.
 - For future government LTC program, insureds may elect reduced premiums or increased benefits

Right to appeal (added in 1999 SB 870) -- 10235.94 of the California Insurance Code states that every policy or certificate shall include a provision giving the policyholder or certificate holder the right to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursement payments.

Reasonableness of benefits (added in 2000/SB898) -- Minimum Loss ratio – Because insurers have the right to raise premiums on LTCL, loss ratio requirements have been instituted as a counterweight in order to assure that benefits are paid at a known percentage of premium. Insurers can only institute rate increases if there is sufficient evidence that, over time, benefits paid out will exceed 60% of premiums collected. Within this requirement, insurers rights are further limited through the exclusion of investment losses as a basis for rate increases and through further requirements in the event premiums are raised. In the latter case, for example, that portion of the premium that represents the increase must pay out benefits equal to at least 85% of the increase. 10236.11 of the California Insurance Code is deemed reasonable in relation to premiums if the expected loss ratio is at least 60%, calculated in a manner that provides for adequate reserving of the long-term care insurance risk.

CHAPTER FOUR

Health Insurance Portability and Accountability Act (HIPAA) Specific to California

Overview of HIPAA

Health Insurance Portability and Accountability Act (HIPAA) is a Federal Health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits. It improves health insurance portability by building on the Consolidated Omnibus Budget Reconciliation Act (COBRA). The Act also mandates administrative simplification through the use of standard code sets, unique identifiers and standard EDI transactions sets. It prescribes privacy and security standards to safeguard the privacy of personal healthcare information. HIPAA clarified that for federal income tax purposes, LTC insurance is to be treated essentially the same as major medical insurance. More specifically HIPAA provided that:

- benefits from private LTC coverage, generally, are not taxable;
 - employers can deduct the costs of establishing an LTC insurance plan for employees and contributions toward premiums;
 - employer contributions to LTC premiums are excluded from the taxable income of employees; and,
 - LTC insurance premiums (and out-of-pocket costs for LTC services) can be applied toward meeting the 7.5% threshold in the federal tax code for medical expense deductions. (Limits, based on the policyholder's age, are still placed on the total premium amount that can be applied toward the 7.5% threshold.)
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- *Eligibility* -- Eligible employees or their dependents may not be denied coverage under a group health plan or insurance policy because of their health condition, medical history, or other evidence of insurability. An eligible employee or dependent may not be charged higher premiums or plan contributions based on his or her health condition. HIPAA does not prohibit, however, premium or plan contribution discounts as a health promotion incentive.
 - *Pre-Existing Exclusions* -- HIPAA defines a pre-existing condition as “a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received.” Under this law, group health plans and insurers can only apply pre-existing exclusions to late entrants which includes persons who have never had health insurance, persons who have been previously covered by health insurance for less time than the pre-existing exclusion period under the plan, or persons who have been uninsured for more than sixty-three days. Pre-existing exclusions are not allowed for newborns, adopted children or children placed for adoption, or pregnancy. If a pre-existing exclusion applies to a timely entrant, the maximum exclusion period allowed is twelve months following enrollment for conditions treated within six months prior to enrollment. For pre-existing exclusions applying to late entrants, the maximum exclusion period allowed is eighteen months following enrollment for conditions treated within six months prior to enrollment.

Insurers May Offer Non-TQ if They Offer TQ Products

There is an automatic repeal if California policies become TQ under federal law. Otherwise it sunsets July 1, 2001 (SB 527). All certificates and riders must comply with the regulations of this chapter on long-term care policies and insurance.

SB 527 – Chapter 701, Statutes of 1997 – Insurance: Long-Term Care reads as follows.

Provides that if an insurer provides Long-Term Care Insurance intended to qualify for favorable tax treatment under federal law, the insurer shall also offer coverage that conforms to the current state eligibility requirements, as specified.

Requires insurers to provide a specified notice at the time of solicitation, and a specified notice in the application form.

Disclosure: TQ or Not TQ on Policy, OOC and Application

As new legislation continues in California, the long term care application has become a complicated document. It has evolved well beyond a simple data gathering list for underwriting to a major legal document full of disclaimers and signed disclosures concerning issues like taxes, inflation protection, replacement and document tracking. Applications for long term care insurance must identify whether the policy is “tax qualified” or “non-tax qualified” using the following prominently displayed disclosures:

- This contract for long term care is intended to be a federally qualified long term care insurance contract and may qualify you for federal and state tax benefits. OR,
- This contract for long term care insurance is not intended to be a federally qualified long term care insurance contract.

Eligibility for care in a residential care facility shall be no more restrictive than it is for home care benefits for both tax qualified and non-tax qualified policies. Eligibility for nursing facilities shall be no more restrictive than impairment in two activities of daily living or impairment in cognitive ability. Every long term care policy covering confinement in a nursing facility must offer to the policyholder, at the time of application, *assisted living care* coverage in a residential care facility or a residential care facility for the elderly as defined in the Health and Safety Code.

- *Products must be called “Nursing Facility and Residential Care Facility.”* Care in a residential care facility must be covered. "Residential care facility" means a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code.
- *Products must be called “Home Care Only.”* 10232.1(c) of the California Insurance Code states that any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, shall be called a "home care only" policy or certificate and the words "Home Care Only" shall be prominently displayed on page one of the form and the outline of coverage.
- Products may be called “Comprehensive Long-Term Care” if both “Home Care and Comprehensive Long-Term Care” are included. 10232.1 (d) of the California Insurance Code states that only those policies or certificates providing benefits for both institutional care and home care may be called "comprehensive long-term care" insurance.

Tax qualified policies are more restrictive. There are 6 ADL's (activities of daily living) versus 7 for the non tax qualified (NTQ). The additional ADL of ambulating should provide quicker coverage overall. TQ policies require that care is required for at least 90 days- if not, benefits will not commence. This is not particularly onerous but, nonetheless, applies a restriction not evidenced in the NTQ policies.

Non-TQ Benefit Triggers

10232.8 (a) of the California Insurance Code states that in every long-term care policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits, the threshold establishing eligibility for home care benefits is at least as permissive as a provision that the insured will qualify if one of two criteria are met:

- Impairment in two out of seven activities of daily living;
- Impairment of cognitive ability.

The definition of the following activities is currently prescribed by federal law. Further, if the federal government expands these triggers, the Department of Insurance can issue emergency regulations. "Activities of daily living" in every policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits includes eating, bathing, dressing, ambulating, transferring, toileting, and continence; "impairment" meaning that the person be determined to be Chronically Ill. In establishing that the insured is Chronically Ill, either of these two criteria may be used:

- Impairment in two out of six activities of daily living, for a period of at least 90 days;
- Impairment of cognitive ability needing substantial supervision

Cognitive Impairment Defined

A cognitive impairment affects a person's ability to reason, understand, and learn. Cognitive disabilities are separated into two categories: learning disabilities and mental retardation. It is distinct from a learning disability insofar as it may have been acquired later in life as a result of an accident or illness. Cognitive Impairment may be changes in cognitive function caused by trauma or disease process. It is the loss of the ability to process, learn, and remember information. Cognitive Impairment is the deterioration or loss of intellectual capacity such as dementia, Alzheimer's Disease, and Parkinson's Disease. The eligibility for benefits under a long term care insurance policy is determined by clinical evidence or standardized tests, which judge the areas of memory, orientation and reasoning. It is important to have a separate trigger or means of access to a long term care policy for cognitive impairment. Some long term care insurance policies permit access to benefits only if the insured requires directional assistance or cueing in two or more ADLs.

Non-TQ Definitions of The Seven ADL's

The fact of the matter is that NTQ definitions, or lack thereof, are vague, ambiguous, non-specific and wrought with potential carrier abuse.

- Eating means reaching for picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.
- Bathing means cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucet's, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.
- Continence means the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diaper and disposable pads.
- Dressing means putting on, taking off, fastening and unfastening garments and under-garments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.
- Transferring means moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.
- Toileting means getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.
- Ambulating means walking or moving around inside or outside the home regardless of the uses of a cane, crutches or braces.

TQ Benefit Triggers

10232.8 (b) of the California Insurance Code states that in every long-term care policy or certificate that is intended to be a federally qualified Long-Term Care insurance contract to provide home care benefits, the threshold establishing eligibility for home care benefits is that the person be determined to be Chronically Ill. In establishing that the insured is Chronically Ill, either of these two criteria may be used:

- Impairment in two out of six activities of daily living, for a period of at least 90 days;
- Impairment of cognitive ability needing substantial supervision

Impairment in two out of six ADLs -- HIPAA complaint—consistent with the definition of a chronically ill individual for the purposes of deducting LTC expenses as a medical expense. Other criteria used in establishing eligibility for benefits if federal law or regulations allow other types of disability to be used applicable to eligibility for benefits under a long-term care insurance policy. If federal law or regulations allow other types of disability to be used, the commissioner must issue emergency regulations to add those other criteria as a third threshold to establish eligibility for benefits. Insurers shall submit policies for approval within 60 days of the effective date of the regulations. With respect to policies previously

approved, the department is authorized to review only the changes made to the policy. All new policies approved and certificates issued after the effective date of the regulation are to include the third criterion. No policy is to be sold that does not include the third criterion after one year beyond the effective date of the regulations. An insured meeting this third criterion is eligible for benefits regardless of whether the individual meets the impairment requirements.

TQ "Licensed Health Care Practitioner" Independent of Insurer

10232.8 (c) of the California Insurance Code states that if the initial assessment is performed by a practitioner, who personally examines the insured, the requirement for a second assessment does not apply. The assessments conducted are performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. In order to be considered "independent of the insurer," a licensed health care practitioner cannot be an employee of the insurer and nor be compensated in any manner that is linked to the outcome of the certification. It is the intent here that the practitioner's assessments be unhindered by financial considerations.

- *"Chronically ill individual"* -- A licensed health care practitioner, independent of the insurer, shall certify that the insured meets the definition of "chronically ill individual" as defined under Public Law 104-191. If a health care practitioner makes a determination that an insured does not meet the definition of "chronically ill individual," the insurer is to notify the insured that the insured is entitled to a second assessment by a licensed health care practitioner, upon request, who shall personally examine the insured.
- *Written Plan of care* -- A licensed health care practitioner must develop a written plan of care after personally examining the insured. The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual."
- *Renew Every 12 Months* -- *The written certification is renewed every 12 months.*
- *Insurer May Not Deduct Costs From Policy Maximum* -- Preparing written plans of care does not count against the lifetime maximum of the policy or certificate.
- *Applies Only to TQ Policies* -- This applies only to a policy or certificate intended to be a federally qualified long-term care insurance contract.

TQ Definitions

10232.8 (d) of the California Insurance Code states that "Activities of Daily Living" in every policy or certificate intended to be a federally qualified long-term care insurance contract as provided by Public Law 104-191 must include eating, bathing, dressing, transferring, toileting, and continence; "impairment in activities of daily living" means the insured needs "substantial assistance" either in the form of "hands-on assistance" or "standby assistance," due to a loss of functional capacity to perform the activity. ADLs exclude ambulating

- "Impairment of cognitive ability" means the insured needs substantial supervision due to severe cognitive impairment;
- "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; and
- "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.

The definitions of "activities of daily living" to be used in policies and certificates that are intended to be federally qualified long-term care insurance shall be the following until the time that these definitions may be superseded by federal law or regulations:

- Eating, which means feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- Bathing, which means washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.
- Contenance, which means the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- Dressing, which means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Toileting, which means getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- Transferring, which shall mean the ability to move into or out of bed, a chair or wheelchair.
- Ambulating is Not An ADL In TQ Long Term Care Plans.

The California commissioner may approve the use of definitions of "activities of daily living" that differ from the verbatim definitions if these definitions result in more policy or certificate holders qualifying for long-term care benefits than would occur by the use of the verbatim definitions. In addition, the following definitions may be used without the approval of the commissioner:

- the verbatim definitions of eating, bathing, dressing, toileting, transferring, and continence;
- the verbatim definitions of eating, bathing, dressing, toileting, and continence and a substitute, verbatim definition of "transferring" as follows:
 - "transferring," which means the ability to move into and out of a bed, a chair, or wheelchair, or ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.
- ADL impairment – This refers to “substantial assistance (either hands-on or standby) due to loss of functional capacity.”
- Cognitive impairment = ‘needs substantial supervision due to severe cognitive impairment’

A licensed health care practitioner, independent of the insurer, certifies that the insured meets the definition of "chronically ill individual" as defined under Public Law 104-191. If a health care practitioner makes a determination that an insured does not meet the definition of "chronically ill individual," the insurer must notify the insured that the insured is entitled to a second assessment by a licensed health care practitioner, upon request, who personally examines the insured. A licensed health care practitioner is to develop a written plan of care after personally examining the insured. The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual," or to prepare written plans of care does not count against the lifetime maximum of the policy or certificate. In order to be considered "independent of the insurer," a licensed health care practitioner 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.

Consumer Exchange Privileges

There are consumer exchange privileges in the event the federal Congress passes a law, or treasury rules on the taxation of benefits from non-tax qualified long-term care insurance. SB 1537 states that this legislation concerns IRS decisions on the taxability of long-term care policies. If the IRS issues a decision, declaring that the benefits paid under long-term care insurance policies or certificates, that are not intended to be federally qualified, are either taxable or nontaxable as income, insurers offering both forms of policies must offer a holder of either form of policy a one-time opportunity to exchange the policy from one form into the other form.

The bill provides for the emergency regulations to require insurers to allow exchanges to be made on a guaranteed issuance basis, but to allow insurers to lower or increase the premium, with the new premium based on the age of the policyholder at the time the holder was issued the previous policy, as specified. The bill also provides for the exchange to be made by rider to a policy at the discretion of the department, and provide that policies may not be exchanged if the holder is receiving benefits under the policy or would immediately be eligible for benefits as a result of an exchange. The bill also requires insurers to take certain actions to notify holders of these policies and certificates of the availability of the exchange option. Exchange must be made on a guaranteed issue basis at original issue age and the insurers would be allowed to adjust premiums if there is a disparity. Exchange can be facilitated by rider or new policy, but the exchange would not be made if the policyholder is receiving benefits.

Use IRO Notice 97-31 for TQ

IRS Notice 97-31 provides very specific guidance relating to qualified long term care services and *qualified* long term care insurance contracts under sections 213, 7702B and 4980C of the Internal Revenue Code. A few definitions that would be minimum requirements to establish tax qualified status for an LTC contract are listed below:

- **Substantial assistance** means hands-on assistance or standby assistance
- **Hands-on assistance** means the physical assistance of another person without which the individual would be unable to perform the ADL.
- **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 ADL
- **Substantial supervision** means continual supervision by another person that is necessary to protect a severely cognitively impaired individual from threats to his or her health or safety. The provider must be able to reflect the impact and implications of these definitions as they relate to TQ vs. NTQ and benefit eligibility in California. Provider must be able to empirically demonstrate the differences in benefit eligibility of TQ vs. NTQ if there is any differences.

Tax Qualified vs Non-tax Qualified Policies

The advent of HIPAA (Health Insurance Portability and Accountability Act) has created a new evaluation procedure for agents to make: tax-qualified or non-tax qualified contracts. The advent of more recent SB 870 legislation, has further clouded the lines between the two policies. The first order of comparison is for agents to help a client determine whether the tax breaks associated with a tax qualified policy are meaningful to him or her. Clients who itemize on their tax return have a potential need for tax deductions. The tax status of a client may change dramatically as he or she moves from full employment to retirement. Section 6.9 offers some very specific examples of these tax issues and how a client might be able to determine the value in a tax qualified policy versus NTQ.

The next order of analysis is benefits. Prior to SB 870 Guidelines from the IRS have also been helpful in establishing tax qualified status based on many “safe-harbor” definitions of terms like “substantial assistance”, “hands-on assistance”, “standby assistance”, “severe cognitive impairment” and “substantial supervision”. In general, tax qualified plans are considered more restrictive than non-tax qualified policies. The basis for this evaluation is the requirement that two out of six activities of daily living must be failed to qualify for a tax-qualified plan while many non-tax plans allow two out of seven.

Benefit Eligibility for TQ and Non-TQ

Eligibility for benefits under tax qualified long term care insurance plans is determined on the basis of either of two measures of the need for care: Activities of Daily Living or Cognitive Impairment. A person who suffers a sufficient loss in either the ADLs or Cognitive Impairment is known, under federal standards, as a Chronically Ill Individual. ADLs refers to the simple physical; tasks necessary to care for oneself. Under the federal standard, there are six such activities – bathing, dressing, eating, transferring, toileting and continence. In order to be eligible for benefits, a licensed health care practitioner (a doctor, nurse or social worker) must certify that the insured individual cannot perform two or more of these activities without substantial assistance (either hands on or standby) from another person, and it is expected that such assistance will be needed for a period of 90 days or more.

Cognitive impairment refers to a loss of mental capacity, as measured by a decline in short or long term memory; orientation to people, places or time; or the capacity for deductive or abstract reasoning. Benefit eligibility is determined by the need for substantial supervision to prevent threats to safety or health as the result of severe cognitive impairment. This means that benefit eligibility accommodates the need for care due to Alzheimer’s disease and other forms of dementia. Generally, benefits are payable under tax qualified policies when an individualized plan of care and services is prescribed by a doctor, nurse or social worker that appropriately meets long-term care needs resulting from the ADL or Cognitive loss. Benefits are first paid after an initial period of time, known as the elimination period, is met.

TQ Comparison Chart

*Non-Qualified ADL Definition (NTQ)
Section 10232.8(g)*

Eating which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.

Bathing -- This means cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucet's, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.

Continence -- This means the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diaper and disposable pads.

Dressing -- This means putting on, taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.

Transferring -- This means moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

Toileting -- This means getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

Ambulating -- This means walking or moving around inside or outside the home regardless of the uses of a cane, crutches or braces.

*Tax-Qualified ADL Definitions (TQ)
Section 10232.89(f)*

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

Bathing -- which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.

Continence -- which shall mean the ability to maintain bowel and bladder function; or when unable to maintain bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

Dressing -- which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Transferring -- which shall mean the ability to move into or out of bed, a chair or wheelchair.

Toileting -- which shall mean getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.

Ambulating -- Not An ADL In Tax-Qualified Long Term Care Plans.

CHAPTER FIVE

Statutory Rate Stabilization

Agent Responsibilities

Agent should use the highest standards of reasonable care in marketing LTC, because it may be a client's most valuable coverage. The primary market that buys it are senior citizens. They may be particularly vulnerable to scare tactics such as loss of assets or lack of family support due to an LTC condition. As a professional, it is your duty to assess your client's needs and suggest appropriate product. You must recognize that now all clients need comprehensive coverage. Some may need fewer benefits than others because they have substantial assets and/or a family support team. It is also likely, however, that you will meet clients who do not need a LTC policy.

Availability of a Consumer Rate Guide

10234.6 (a) The commissioner shall, by June 1 of each year, jointly design the format and content of a consumer rate guide for long-term care insurance with a working group that includes representatives of the Health Insurance Counseling and Advocacy Program, the insurance industry, and insurance agents. The commissioner shall annually prepare the consumer rate guide for long-term care insurance that shall include, but not be limited to, the following information:

- A comparison of the different types of long-term care insurance and coverages available to California consumers;
- A premium history of each insurer that writes long-term care policies for all the types of long-term care insurance and coverages issued by the insurer in California.

The consumer rate guide to be prepared by the commissioner must consist of two parts: a history of the rates for all policies issued in the United States on or after January 1, 1990, and a comparison of the policies, benefits, and sample premiums for all policies currently being issued for delivery in California. For the rate history portion of the rate guide required by this section, the department shall collect, and each insurer shall provide to the department, all of the following information for each long-term care policy, including all policies, whether issued by the insurer or purchased or acquired from another insurer, issued in the United States on or after January 1, 1990:

- Company name.
- Policy type.
- Policy form identification.
- Dates sold.
- Date acquired (if applicable).
- Premium rate increases requested.
- Premium rate increases approved.
- Dates of premium rate increase approvals.
- Any other information requested by the department.

For the policy comparison portion of the rate guide, the department must collect, and each insurer must provide to the department, the information needed to complete the following form, along with any other information requested by the department, for each long-term care policy currently issued for delivery in California, including all policies, whether issued by the insurer or purchased or acquired from another insurer. If an insurer does not offer a policy for sale that fits the criteria set forth in the sample premium portion of the policy comparison section of the rate guide, the department shall include in that section of the form for that policy a statement explaining that a policy fitting that criteria is not offered by the insurer and that the consumer may seek, from an agent, sample premium information for the insurer's policy that most closely resembles the policy in the sample.

The department uses the format set forth in this section for the policy comparison portion of the rate guide, unless the working group convened pursuant to subdivision (a) designs an alternative format and agrees that it should be used instead. In compiling the policy comparison portion of the rate guide, the department shall separate the group policies from the individual policies available for sale so that group policies for all insurers appear together in the guide and individual policies for all insurers appear together in the guide. The policy comparison portion of the rate guide shall contain a cross-reference for each policy form listed indicating the page in the rate guide where rate information on the policy form can be found. The department shall publish, on the department's Internet Web site, a premium history of each insurer that writes long-term care policies for all the types of long-term care insurance and coverages issued by the insurer in each state. Each insurer shall provide to the department all of the information listed in paragraph (1) of subdivision (b) for each long-term care policy, including all policies, whether issued by the insurer or purchased or acquired from another insurer, issued in the United States for the current year and for nine preceding years. Insurers shall provide the information required pursuant to subdivisions (b) and (c) no later than July 31 of each year, commencing in 2000. The consumer rate guide shall be published no later than December 1st of each year commencing in 2000, and shall be distributed using all of the following methods:

- Through Health Insurance Counseling and Advocacy Program (HICAP) offices – 1-800-434-0222).
- By telephone using CDI's consumer toll-free telephone number – 1-800-927-HELP (4357).
- On the department's Internet Web site – www.insurance.ca.gov.
- A notice in the Long-Term Care Insurance Personal Worksheet required by Section 10234.95.

Notwithstanding any other provision of law, the data submitted by insurers to the department pursuant to this section are public records, and shall be open to inspection by members of the public pursuant to the procedures of the California Public Records Act. However, a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, is not subject to this subdivision.

10234.7 of the California Insurance Code states that the commissioner's annual report to the Legislature, as required by Section 10234.6, shall be compiled in consultation with a task force designated by the commissioner for this purpose, which shall include insurance industry representatives, other individuals deemed appropriate by the commissioner, and one or more representatives from each of the following:

- The Health Insurance Counseling and Advocacy Program.
- The California Health Policy and Data Advisory Commission.

The commissioner shall have the responsibility, in consultation with the task force, to develop analytic methods and to select indicators for evaluation of the impact of long-term care insurance on the public share of costs for long-term care.

Rate Stability and LTCI

By law, LTCI is issued as a Guaranteed Renewable form. This gives insurers the right to raise premiums across a group of policyholders issued in the same “risk class” (generally, the policy form) if claim levels exceed those anticipated in the pricing assumptions. However, because of the product’s level premium structure and the typical age of policyholders, the consequences of a rate increase are often harshest on those most in need of the coverage and with the least financial capacity to absorb a large increase. As experience has shown, LTCI, unlike most forms of health insurance, does not respond well to a strategy of rate increases in order to meet increased costs and/or under-priced premiums. This is due to the considerably different pattern of premiums and claim expenses in LTCI in comparison to other forms of health insurance. With most health insurance, the claim costs associated with a given year’s premiums are realized in that year, making rate adjustments relatively straight-forward. However, with LTCI, the opposite is true. The bulk of claim costs are incurred well after the majority of premiums are collected (consider that the average age of purchase is 63 and the average age of claim is 79), making recovery from mis-pricing considerably trickier. This, in turn, leads to the need for large rate increases and thus the difficulties for consumers.

Many people believe, incorrectly, that the need for rate increases in LTCI is driven by the increased cost of nursing care. However, since almost all policies reimburse expenses up to a daily limit, and that limit is usually met, the actual cost of care doesn’t play a factor. Inadequate premiums are almost always the result of overly optimistic lapse assumptions, increased claim incidence and severity and low investment returns. Nonetheless, several insurers, now departed from the market, attempted to pursue a health insurance model with regard to pricing. Simply put, this business model dictates that when costs exceed those anticipated in pricing, they are passed onto the policyholder in the form of a rate increase. Among other things, this approach rationalizes pricing to market share, rather than to cost, and so suits aggressive marketing goals. As the failure of companies operating in this vein has shown, the health insurance model doesn’t work for anyone involved, neither the company nor the consumer. The departing companies lost money and many consumers now have to face rate increases of 50% to 100% or more. Sadly, those who are unable to keep their policies because of the increased cost represent a profit to the insurer, making for perverse, and potentially cynical, incentives on the part of insurers. It is due to these differences that stronger rate regulation is needed for LTCI than for other Guaranteed Renewable forms.

Approval of Premium Rate Schedules

10236.11 was added to the California Insurance Code by (2000) (SB898). It states that the premium rate schedules for all individual and group long-term care insurance policies issued in this state shall be filed with and receive the prior approval of the commissioner before the policy may be offered, sold, issued, or delivered to a resident of this state. All initial rate filings shall be subject to the following.

No approval for an initial premium schedule shall be granted unless the actuary performing the review for the commissioner certifies that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated. The certification may rely on supporting data in the filing. The actuary performing the review may request an actuarial demonstration that the assumptions the insurer has used are reasonable. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and creditable data from other studies, or both. The insurer shall submit to the commissioner for approval a rate filing for each policy form that includes at least all of the following information:

- An actuarial memorandum that describes the assumptions the insurer used to develop the premium rate schedule. The actuarial assumptions shall include, but not be limited to, a sufficiently detailed description of morbidity assumptions, voluntary lapse rates, mortality assumptions, asset investment yield rates, a description of all expense components, and plan and option mix assumptions. The memorandum shall also include the expected lifetime loss ratio and projections of yearly earned premiums, incurred claims, incurred claim loss ratios, and changes in contract reserves.
- An actuarial certification consisting of at least all of the following:
 - A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.
 - A statement that the policy design and coverage provided have been reviewed and taken into consideration.
 - A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.
 - A complete description of the basis for contract reserves that are anticipated to be held under the form, to include all of the following:
 - Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held.
 - A statement that the assumptions used for reserves contain reasonable margins for adverse experience.
 - A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted).
 - A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses, or if that statement cannot be made, a complete description of the situations in which this does not occur and the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subdivision (a) based on a standard age distribution.

A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. Premium rate schedules and new policy forms shall be filed by January 1, 2002, for all group long-term care insurance policies that an insurer will offer, sell, issue, or deliver on or after January 1, 2003, and for all previously approved individual long-term care insurance policies that an insurer will offer, sell, issue, or deliver on or after January 1, 2003, unless the January 1, 2002, deadline is extended by the commissioner. Insurers may continue to offer and market long-term care insurance policies approved prior to January 1, 2002, until the earlier of (1) 90 days after approval of both the premium rate schedules and new policy forms filed pursuant to this section or (2) January 1, 2003.

SB 898 and the NAIC

Over the past 15 years, the NAIC has worked to strengthen rate regulations as they apply to LTCI, and so incite companies to price responsibly from the outset. Originally, this was in the form of restrictions on the maximum percentage rates could increase as a function of the age of the insured. Later, this approach was abandoned in favor of one which dropped initial loss ratio requirements, set high loss ratio requirements for increased premiums and instituted extensive monitoring and projection of subsequent experience and regular reporting to the state. Additionally, the regulation requires a signed statement by the company actuary was that the increased premiums can be expected to stay level in the face of “moderately adverse experience”. Under the NAIC model, a rate increase request re-institutes loss ratio standards. A demonstration must be provided that the initial premiums and any rate increased premiums run, respectively, at a 58% and 85% loss ratio, unless the rate increase is justified due to unforeseen changes in law or regulation. In this case, the 85% may be reduced to 70%. All valuations must be performed at the maximum valuation interest rate and the actuary must certify that, even under moderately adverse conditions, no further rate increases will be necessary. Extensive documentation is required is coupled with five years of experience monitoring and reporting.

The last requirement, the “moderately adverse” vow, when set against the removal of initial loss ratio requirements, places considerable onus on the actuary by offering more latitude up front while requiring a much more comprehensive demonstration that increased rates can be expected to remain level for life. The intent was to put increased pressure on actuaries by creating more points of professional exposure and therefore focus their attention on the long term stability of their initial rates. Finally, companies are required to demonstrate parity between the rates being filed and those accompanying all other LTCI products, thus restricting the opportunity to offer “loss leaders.” California has gone beyond the NAIC by placing further restrictions on insurers’ rate increase opportunities. In particular, Section 10236.14 of the CIC institutes a five year “pooling experiment” (set to expire on January 1, 2008) that takes effect whenever any rate increase request, in combination with prior increases on the same form, exceeds 15%.

Under this section, an insurer will be required to demonstrate that all business issued during this period, when aggregated, meets the requirements for the approval of a rate increase. This provision expires in 2008 unless a later statute extends it. The intent of the rate increase provisions is clearly to limit the size and frequency of rate increases by mounting an ever higher standard of approval and documentation and, for the experimental period, to force profitable plans to subsidize the losses of unprofitable ones. How effective this approach is remains to be seen.

Requirements For Actuaries

10236.12 added to the California Insurance Code by 2000) (SB898) states that all actuaries used by the commissioner to review rate applications submitted by insurers pursuant to this chapter, whether employed by the department or secured by contract, shall be members of the American Academy of Actuaries with at least five years' relevant experience in long-term care insurance industry pricing. If the department does not have actuaries with the experience required by this section, the commissioner shall contract with actuaries to review all rate applications submitted by insurers pursuant to this chapter. If the department has actuaries that have experience required by this section, but not enough of those experienced actuaries to perform the volume of work required by this chapter, the commissioner may contract with independent actuaries, as necessary. If the commissioner contracts with independent actuaries, the commissioner shall promulgate regulations no later than January 1, 2002, to maintain the confidentiality of rate filings and proprietary insurer information and to avoid conflicts of interest.

Procedures For Premium Rate Schedule Increases

10236.13 was added to California Insurance Code by (2000) (SB898). It states that no insurer may increase the premium for an individual or group long-term care insurance policy or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner. The insurer shall submit to the commissioner for approval all proposed premium rate schedule increases, including at least all of the following information:

- Certification by an actuary, who is a member of the American Society of Actuaries and who is in good standing with that society, that:
 - If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated.
 - The premium rate filing is in compliance with the provisions of this section.

An actuarial memorandum justifying the rate schedule change request that includes all of the following:

- Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.
 - Annual values for the five years preceding and the three years following the valuation date shall be provided separately.
 - The projections shall include the development of the lifetime loss ratio.
 - For policies issued with premium rate schedules approved under Section 10236.11, the projections shall demonstrate compliance with subdivision (a) of Section 10236.14. For all other policies, the projections shall demonstrate compliance with Section 10236.1.
 - In the event the commissioner determines that a premium rate increase is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state, then:
 - The projected experience should be limited to the increases in claims expenses attributable to the changes in law or regulations.
 - In the event the commissioner determines that potential offsets to higher claims costs may exist, the insurer shall be required to use appropriate net projected experience.
- Disclosure of how reserves have been incorporated in this rate increase.
- Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary.
- A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration.
- In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates.

A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner;

Sufficient information for approval of the premium rate schedule increase by the commissioner;

The provisions of this section are applicable to all individual and group policies issued in this state on or after July 1, 2002.

10236.14 of the California Insurance Code amended by (2000) (SB898) states that approval of all premium rate schedule increases shall be subject to the following requirements:

- Premium rate schedule increases shall demonstrate that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

- The accumulated value of the initial earned premium times 58%.
- Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis.
- The present value of future projected initial earned premiums times 58%.
- Eighty-five percent of the present value of future projected premiums on an earned basis.

In the event the commissioner determines that a premium rate increase is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state, a premium rate schedule increase may be approved if the increase provides that 70% of the present value of projected additional premiums shall be returned to policyholders in benefits and the other requirements applicable to other premium rate schedule increases are met. All present and accumulated values used to determine rate increases should use the maximum valuation interest rate for contract reserves. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages. No approval for an increase in the premium schedule shall be granted unless the actuary performing the review for the commissioner certifies that if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated. The certification may rely on supporting data in the filing. These provisions are applicable to all policies issued in California on or after July 1, 2002 and became operative on January 1, 2008.

Requirements For Approved Premium Rate Schedule Increases

10236.15 amended by (2000) (SB898) of the California Insurance Code states that premium rate schedule increases that have been approved shall be subject to the following requirements.

For each rate increase that is implemented, the insurer must file for approval by the commissioner updated projections annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years. If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums that the commissioner may require the insurer to implement any of the following:

- Premium rate schedule adjustments.
- Other measures to reduce the difference between the projected and actual experience.

In determining whether the actual experience adequately matches the projected experience, consideration should be given to paragraph (5) of subdivision (b) of Section 10236.13, if applicable. If the commissioner demonstrates, based upon credible evidence, that an insurer has engaged in a persistent practice of filing inadequate premium schedules, the commissioner may, in addition to any other authority of the commissioner under this chapter, and after the insurer is afforded proper notice and due process, prohibit the insurer from filing and marketing comparable coverage for a period of up to five years or from offering all other similar coverages, and may limit marketing of new applications to the products subject to recent premium rate schedule increases. This does not apply to life insurance policies and certificates that accelerate benefits for long-term care. The provisions are applicable to all individual and group policies issued in California on or after July 1, 2002.

CDI/HICAP's Annually Prepared Consumer Rate Guide For LTC Insurance

The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance tollfree telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.

Different Kinds of LTC Insurance Coverage Available to consumers

Continuing Care Retirement Centers (CCRCs) -- Life Care Communities (LCCs) represent the one-stop shopping. Typically LCCs are 200-250 unit housing complexes combined with a package of social and medical services, including emergency medical care, long-term nursing care, meals, recreational programs, transportation services, housekeeping services, and other services. Residents may be required to be of a minimum age of 60. Entry fee is non-refundable after a limited period, though the trend has been towards guaranteeing a substantial, if not complete, refund upon death, departure, or nursing home confinement. In exchange for these fees and charges, the LCC provides the resident with a contract guaranteeing shelter and an array of services for life of the individual.

Annuities -- Annuities are a well established method of financial planning for an individual's retirement years. For that reason they should receive serious consideration as a mechanism for financing long-term care. Most life insurance companies offer two basic types of annuity contracts: immediate and deferred annuities. Group and individual contracts are also available. Traditional annuity contracts involve the assumption of investment and mortality risks by the insurance company. Annuities are an attractive option for long-term care because they permit the accumulation of funds, possess some flexibility, and under current law retain certain tax advantages.

Reverse Mortgage -- A reverse mortgage is a special type of loan used by older Americans to convert the equity in their homes into cash. The money from a reverse mortgage can provide seniors with the financial security they need to fully enjoy their retirement years. The reverse mortgage is aptly named because the payment stream is "reversed." Instead of making monthly payments to a lender, as with a regular first mortgage or home equity loan, a lender makes payments. While a reverse mortgage loan is outstanding, one continues to own the home and hold title to it. The money from a reverse mortgage can be used for anything: daily living expenses; home repairs and home modifications; medical bills and prescription drugs; pay-off of existing debts; continuing education; travel; long-term health care; prevention of foreclosure; and other needs.

Company Responsibilities

Rate stability is one of the most important regulatory issues in long term care insurance (LTCi). Unlike regular health insurance, LTCi prefunds an event that, for the most part, occurs once and later in life. Policyholders typically pay premiums for 15 years or more, before accessing benefits. Since many people are on fixed incomes when they need care, a large rate increase can often compromise their ability to retain coverage, laying waste to years of premium payments.

Though the NAIC has promulgated model regulations for rate stability, no state has enlarged on the NAIC rate provisions like California. While the NAIC Model places certain restrictions on rate increases, the provisions of SB898 have extended these to include additional requirements and sanctions when insurers exceed specific benchmark amounts. These and other requirements to certify the adequacy of initial rate filings and requests for rate increases makes California unique and at the forefront of consumer protection in rate stability.

Rate History for Company

The 1996 National Association of Insurance Commissioners (NAIC) Suitability Standards is required to be used by every insurer and other entity marketing LTC insurance. Providers shall include a copy of the LTC Insurance Personal Worksheet (ATTACHMENT—A-6). The model language must be described, and providers must explain what it means and how it applies to the agent and California consumer.

Unique Aspects of LTCi

California, like every other state, will be facing a Medicaid (MediCal) funding crisis as the Baby Boomers age and require long term care. In recognition of the need to include private financing options as part of the solution to this problem, the state has enacted a regulatory and legislative structure to enable the sale of LTC insurance. What makes California unique is the extent and complexity of its laws and regulations. In an ongoing attempt to balance consumer protection with product availability, the state has passed no less than 10 pieces of legislation in as many years to govern this market. Rate inadequacy will cause the LTCi policies to fail at times to meet the needs of the consumers. LTC in and of itself is fluid and difficult to calculate rates. There are so many variables to care and those who need the care that legislators may feel as if they are grasping at straws to walk the line of rating making.

CHAPTER SIX

California Department of Insurance Authority

Administration and Enforcement of The Commissioner's Authority

10234 of the California Insurance Code states that the commissioner is to adopt reasonable regulations, and amendments and additions, as are necessary to administer the rules and regulations as required here.

10234.7 of the California Insurance Code states that the commissioner's annual report to the Legislature, as required by Section 10234.6, is to be compiled in consultation with a task force designated by the commissioner for this purpose, which includes insurance industry representatives, other individuals deemed appropriate by the commissioner, and one or more representatives from each of the following:

- The Health Insurance Counseling and Advocacy Program.
- The California Health Policy and Data Advisory Commission.

The commissioner shall have the responsibility, in consultation with the task force, to develop analytic methods and to select indicators for evaluation of the impact of long-term care insurance on the public share of costs for long-term care.

Authority to Bring Actions, Assess Penalties

10234.2 (a) of the California Insurance Code states that In addition to all other powers and remedies vested in the commissioner by law, the commissioner shall have administrative authority to assess the penalties prescribed in this article for violation of any provision in this chapter against insurers, brokers, agents, and other entities which have been determined by the commissioner to be engaged in the business of insurance. 10234 (b) Upon a showing of a violation of this chapter in any civil action, a court may also assess the penalties prescribed in this article. The court shall award reasonable attorney's fees and costs to a prevailing plaintiff who establishes a violation of this chapter. The court awards reasonable attorney's fees and costs to a prevailing plaintiff who establishes a violation of this chapter. 10234 (c) of the California Insurance Code states that actions for injunctive relief, penalties prescribed in this article, damages, restitution, and all other remedies in law or equity, may be brought in superior court by the Attorney General, a district attorney, or city attorney on behalf of the people of the State of California for violation of any provision in this chapter. The court awards reasonable attorney's fees and costs to a prevailing plaintiff who establishes a violation according to rules and regulations stated here.

Penalties

Penalties For Agent Violations

10234.3 (a) of the California Insurance Code states that any broker, agent, or other entity determined by the commissioner to engage in the business of insurance, other than an insurer, who violates this chapter is liable for an administrative penalty of not less than \$250 for each first violation. The penalty for committing a subsequent or a knowing violation shall be not less than \$1,000 and not more than \$25,000 for each violation. The penalty for inappropriate replacement of long-term care coverage shall be not more than \$5,000 for each violation.

Penalties For Insurer Violations

10234.3 (b) of the California Insurance Code states that any insurer that violates this chapter is liable for an administrative penalty of not less than \$5,000 for each first violation. The penalty for committing a subsequent or knowing violation shall be not less than \$10,000 for each violation. The penalty for violating this chapter in a manner indicating a general business practice shall reflect the magnitude of the violation against the public interest and shall be not less than \$10,000 and not more than \$500,000.

Penalties Paid to the Insurance Fund

10234.3 (c) of the California Insurance Code states that penalties shall be paid to the Insurance Fund. Or, in other words, all the monies that is retrieved from the penalties is paid into this fund.

Non-penalty Remedies

10234.4 of the California Insurance Code states that in addition to the assessment of penalties and other applicable remedies, the commissioner may take the following actions upon determination that a violation of this chapter, or a regulation adopted pursuant to this chapter, has occurred:

- Suspend or revoke the license of any broker, agent, or other producer licensed by the department.
- Suspend an insurer's certificate of authority to transact disability insurance.
- Order any broker, agent, insurer, or other entity determined by the commissioner to be engaged in the business of insurance, to cease marketing in California a particular policy form of long-term care insurance, to cease marketing any long-term care insurance, or to take such actions as are necessary to comply with California rules and regulations.

Notice and Hearing

10234.5 (a) of the California Insurance Code states that any broker, agent, insurer, or other entity within the jurisdiction of the department who is charged with a violation of this chapter shall be afforded due process through proper notice and public hearing, if requested, before a penalty may be assessed under Section 10234.3, an order issued under Section 10234.4, or other remedy imposed by the commissioner.

(b) Written notice, served by registered mail, shall include:

- A summary of the facts establishing reasonable cause that a violation has occurred.
- Citation of the code section or other standard allegedly violated.
- A statement of the commissioner's intent to assess a penalty including the amount of the penalty, or to seek another remedy.
- A statement of the respondent's right to elect any of the following:
 - To accept assessment of the penalty or other remedy as stated in the notice.
 - To respond to the charge in writing, after which the commissioner may issue a final order or set a hearing.
 - To request, within 10 days of receipt of the notice, a public hearing.

10234.5 (c) of the California Insurance Code states that if timely requested by the respondent or ordered by the commissioner, a public hearing before the Administrative Law Bureau of the department shall be held within 30 days after the notice is served. Within 20 days after the hearing, the administrative law judge shall issue findings of fact and a proposed order. The commissioner shall issue his or her final order or the proposed order shall become the final order of the commissioner within 30 working days after the hearing unless reconsideration is granted for good cause by the administrative law judge. If the notice issued to the respondent assessed a penalty of one hundred thousand dollars (\$100,000) or more and the respondent has timely requested, the hearing shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

10234.5 (d) of the California Insurance Code states that the final order of the commissioner may contain one or more of the remedies set forth in this article. The amount of any penalty assessed need not be limited to the amount stated in the notice to the respondent. 10234.5 (e) of the California Insurance Code states that in addition to the penalties set forth in this section and any other penalties provided by law, the commissioner may suspend an insurer's certificate of authority under Section 704 or assess a penalty under Section 704.7 if the commissioner finds, after notice and hearing, that the insurer has violated this chapter or regulations adopted pursuant to this chapter or that the insurer has knowingly permitted any person or entity to do so.

Lapse & Replacement Data

10234.86 (a) of the California Insurance Code states that every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. 10234.86 (b) of the California Insurance Code states that every insurer shall report annually by June 30 the 10% of its agents in the state with the greatest percentage of lapses and replacements as measured by the quota 10234.86 (a). 10234.86 (c) of the California Insurance Code states that every insurer shall report annually by June 30, the number of lapsed policies as a percent of its total annual sales in the state, as a percent of its total number of policies in force in the state, and as a total number of each policy form in the state, as of the end of the preceding calendar year. 10234.86 (d) of the California Insurance Code states that every insurer shall report annually by June 30, the number of replacement policies sold as a percent of its total annual sales in the state and as a percent of its total number of policies in force in the state as of the end of the preceding calendar year. 10234.86 (e) of the California Insurance Code states that reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

CDI must send sample policy materials to HICAP

10233.9 of the California Insurance Code states that any insurer offering long-term care insurance must provide to the Department of Insurance, for the commissioner's conveyance to the Department of Aging, a copy of the following materials for all long-term care insurance coverage advertised, marketed, or offered by that insurer in this state:

- Specimen individual policy form or group master policy and certificate forms;
- Corresponding outline of coverage;
- Representative advertising materials to be used in this state.

Commissioner's Power To Waive Provisions In Best Interest of Insureds

10235.20 of the California Insurance Code states that the commissioner may waive a specific provision or provisions of this article with respect to a specific long-term care insurance policy or certificate upon making written findings as follows:

- The waiver would be in the best interest of the insureds.
- The underlying purposes of this article could not be effectively or efficiently achieved without the waiver.
- Any of the following:
 - The waiver is necessary to the development of an innovative and reasonable approach for insuring long-term care.
 - The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the waiver is reasonably related to the special needs or nature of such a community.
 - The waiver is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

The commissioner may condition any waiver upon compliance with alternative requirements to achieve these purposes.

Reporting Requirements

10234.93 (a) of the California Insurance Code states that every insurer of long-term care in California shall:

- Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;
- Establish marketing procedures to assure excessive insurance is not sold or issued;
- Submit to the commissioner within six months of the effective date of this act, a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance, updated at least semiannually;
- Provide the following training and require that each agent or other insurer representative authorized to solicit individual consumers for the sale of long-term care insurance shall satisfactorily complete the following training requirements that, for resident licensees, a part of the continuing education requirements in Section 1749.3:
 - For licensees issued a license after January 1, 1992, eight hours of training in each of the first four 12-month periods beginning from the date of original license issuance and thereafter and eight hours of training prior to each license renewal.
 - For licensees issued a license before January 1, 1992, eight hours of training prior to each license renewal.
 - For nonresident licensees that are not otherwise subject to the continuing education requirements set forth in Section 1749.3, the evidence of training required by this section shall be filed with and approved by the commissioner as provided in subdivision (g) of Section 1749.4.

Licensees shall complete the initial training requirements of this section prior to being authorized to solicit individual consumers for the sale of long-term care insurance. The training required by this section shall consist of topics related to long-term care services and long-term care insurance, including, but not limited to, California regulations and requirements, available long-term care services and facilities, changes or improvements in services or facilities, and alternatives to the purchase of private long-term care insurance. On or before July 1, 1998, the following additional training topics shall be required: differences in eligibility for benefits and tax treatment between policies intended to be federally qualified and those not intended to be federally qualified, the effect of inflation in eroding the value of benefits and the importance of inflation protection, and NAIC consumer suitability standards and guidelines.

Display prominently on page one of the policy or certificate and the outline of coverage: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations." Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance. Every insurer or entity marketing long-term care insurance must establish auditable procedures for verifying compliance.

Every insurer shall provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent is to provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222. Provide a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each prospective applicant prior to the presentation of an application or enrollment form for insurance.

10234.93 (b) of the California Insurance Code states that in addition to other unfair trade practices, including those identified in this code, the following acts and practices are prohibited:

- Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
- High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
- Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

CHAPTER SEVEN

Alternatives for Long-Term Care Insurance

Financial Considerations For Long-Term Care

According to the *American Medical Association*, the elderly paid out more money to cover nursing home expenses than any other aspect of their health care. While most of us may eventually have a need for long-term care, we may not all necessarily have a need for. Even so, a majority cannot meet the staggering costs on their own, and Medicare coverage is limited. The average cost of nursing home care in the United States, in 1997, ranged from \$30,000 on up per year. That breaks down to approximately \$2,500 per month or \$82 per day. It is easy to see how an extended period of long-term care can devastate a modest estate. Medicaid (Medi-Cal in California) is the only public assistance program, which will pay for long-term care. However, to qualify for Medi-Cal, one must be deemed indigent according to qualifying criteria set by state and federal regulations.

Faced with an average outlay of \$36,500 a year, and double or triple that in urban areas, many of the elderly in nursing homes watch a lifetime of savings evaporate within a few years. Standard health care policies currently pay less than 1% of LTC costs because they are designed to provide benefits for doctor, hospital, surgical or emergency medical care. Some policies may offer optional benefits for skilled nursing care or convalescent home care, but these benefits require prior hospitalization and are generally provided for a short time.

Life Insurance With Long Term Care Benefits

Life insurance that provides accelerated death benefits to pay medical expenses arrived in 1988 and are presently being offered by over 100 insurers. In 1994, these particular policies represented just under 12% of the total market. Companies are beginning to modify existing policies in order to add riders. These riders only increase the basic premium cost by 5-15%, although a riders can increase the cost of a basic policy 33%. A long-term care rider will pay some of the policy's death benefit while an individual is still alive and in recent years, insurers have been offering them as accelerated death benefits. Long-term care riders often pay *living benefits* when a serious illness occurs, even when no nursing home care is needed. Sometimes the policyholder can receive as much as 25% of the policy's face value up front, rather than in regular monthly payments. The limits to these riders are that they may not cover nursing home stays outside the United States or long-term care resulting from alcoholism, drug addiction, or attempted suicides. The long-term care riders usually cover nursing home care only after a stay in a hospital or in a skilled nursing home where medical treatment is dispensed. Most nursing home residents enter the homes directly, however. The money available for nursing home benefits on a long-term care rider is normally 2% of insurance coverage per month.

Some policies may place a limit on the monthly payment amount permitting the policyholder to collect 100% of the amount of the life insurance, while others cap it at 50% or the policy may require the policyholder to pay at least for the first 60 days of nursing home care before a long-term care rider kicks in. Some riders do not pay for custodial care while others will pay only after a specified number of days in a hospital or a specified number of weeks in a skilled care or an intermediate care home. The problems with funding long term care coverage through an accelerated death benefit policy are obvious :

Benefits may be slower than a stand-alone policy, benefit triggers can be tricky and there is typically no inflation protection other than by expensive inflation riders. Furthermore, the death benefits that could have gone to an insured's estate are usually "eaten-up" in long term care costs thus defeating the purpose of buying a life insurance policy.

Home Equity Conversion

Elderly Americans have an estimated \$650 billion in equity in their homes -- assets that have made the concept of home equity conversions attractive for the elderly. Home equity conversion (HEC) has many drawbacks and has slowly gained acceptance. There are three basic types of HEC programs:

- the reverse annuity mortgage (RAM);
- sale-leaseback;
- deferred payment loan.

After the set period, the loan must be repaid or renegotiated. The second type of HEC is the sale-leaseback program. In this arrangement, homeowners sell their homes to an investor, often for a discounted price. In return the seller is guaranteed the right of lifetime occupancy. The investor takes over all responsibility for taxes and maintenance, and when the seller dies the investor takes full possession of the home. The third type of HEC plan is a deferred payment loan. These plans are of no real practical use to elderly homeowners, since they are generally made a short-term loss.

For both the investor and the elderly homeowner the advantages of HECs are obvious. The investor receives the opportunity to make a profitable return on an investment. For a homeowner 65 years or older, such an arrangement could provide an additional income ranging from \$150 to \$700 per month, depending on age, sex, the value of the home, etc. Under a RAM agreement, the additional income would be tax free since it is technically a loan, and in a sale leaseback an elderly person could take advantage of the capital gains exemption.

Reverse Mortgages

Another form of possible income is through a reverse mortgage in which you can withdraw the equity in your home in the form of a loan and use the money for living expenses. Typically, the loan proceeds are paid out monthly, but other arrangements can be made. The loan balance increases each month as payments are received. Additionally, interest is added to the growing balance. Many seniors work diligently to make sure that when they retire they own their home "free and clear". If medical expenses start piling up, many can find themselves in a situation where they are house -rich but cash poor. The reverse mortgage is an excellent way for these older homeowners to convert home equity into needed cash without immediately selling the home. In the typical reverse mortgage transaction, a lender agrees to pay the homeowner a specified payment each month.

The balance owed the lender grows as more monies are disbursed to the homeowner. The total accumulated balance is considered a loan against the homeowner's equity but no repayment is required until the borrower dies, moves or sells the home. If there are two spouses who own the house, there is no repayment due until the last surviving borrower dies or sells or moves from the home. The maximum loan amount varies per locality, from \$67,500 in low-cost rural areas to \$151,725 in costlier housing markets. The amount also varies on the client's age. In addition to the full loan amount, the borrower is liable for fees, points, closing costs, insurance premiums, plus all interest. Interest and closing rates are generally higher than those in conventional mortgages. Liability to homeowners is limited to the value of his home, i.e., they can't be made to pay from other assets. Some reverse mortgage financing programs are FHA-insured, however, many lenders require no insurance -- they are simply banking on the owner's large "pot of equity" to secure the deal. The proceeds from a reverse mortgage can be used for long term care expenses as tax free to the homeowner.

Reverse Annuity Mortgages

The reverse annuity mortgage is a loan against the equity in a home, paid in monthly installments usually over a set period of time. Reverse Annuity Mortgage is an arrangement in which a homeowner borrows against the equity in his/her home and receives regular monthly tax-free payments from the lender. A reverse annuity mortgage is a mortgage where an elderly borrower (62 years old or older) may borrow against the equity in their home to receive a monthly payment, and/or lump sum payment of cash. In a typical mortgage, you make monthly principal and interest payments.

Over time, the loan balance decreases as you build up equity in your home, until at the loan's term you own the home. A reverse mortgage turns around this process. With a reverse mortgage, the borrower receives money for the equity in their home. As they receive money, the equity in their home declines and their loan balance increases. With a reverse mortgage, the homeowner continues to own their home.

While the amount of the homeowner's loan increases over time, a reverse mortgage cannot grow to more than the value of the house. In addition, a lender cannot seek payment for a reverse mortgage from anything other than the value of the house. Other assets and the assets of the borrower's heirs are protected by what is referred to as a "non-recourse" limit. RAMs involve important decisions and can be complicated. It is recommended that anyone contemplating using a RAM to generate income call the Elderly Services Division at the Dept. of Social Services to consult with an information and referral specialist to explore the wisdom of taking a RAM from a private lender

Savings and Private Investment

Many Californians have substantial savings set aside for their retirement and if the need for long-term care arises, they would be able to financially meet those needs and still maintain their existing lifestyle. If this were so, they would need \$500,000 or more in a retirement income. According to the NAIC's "Shoppers Guide to Long Term Care Insurance," approximately one-third of all nursing home expenses are paid out-of-pocket by individuals and their families. Many senior Californians have substantial savings set aside for their retirement in the form of passbook savings accounts, IRAs, annuities, CDs, and other investments such as stocks and bonds. Many seniors have incomes that fall below 125% of the poverty level. Years of savings quickly disappear due to the effects of inflation and expenses related to failing health. Often the death of a spouse, and the resulting loss of their income, makes the difference between a comfortable retirement and just barely getting by.

Annuities

Annuities are a well-established method of financial planning for an individual's retirement years. Most life insurance companies offer two basic types of annuity contracts: immediate and deferred annuities. For that reason they should receive serious consideration as a mechanism for financing long-term care. Traditional annuity contracts involve the assumption of investment and mortality risks by the insurance company. Variable annuities sometimes offer other optional features, which also have extra charges. One common feature, the guaranteed minimum income benefit, guarantees a particular minimum level of annuity payments, even if you do not have enough money in your account (perhaps because of investment losses) to support that level of payments. Other features may include long-term care insurance, which pays for home health care or nursing home care if an individual becomes seriously ill.

Long-Term Care Immediate Annuity -- A long-term care immediate annuity is a single premium annuity that can provide a larger monthly payment than a regular annuity due to underwriting of the annuitant's life expectancy to guarantee a monthly income stream for life to pay for nursing home, assisted living facility, home health care or other needs. Particular emphasis is placed on the role of underwriting in determining the price and size of the potential market for annuities and private long-term-care insurance sold separately, compared with the price and potential size of the market for a combined income and disability annuity.

Simulated premiums for a combined insurance policy are 3% to 5% lower than total simulated premiums for stand-alone annuity and disability insurance policies purchased separately. The potential market for the combined policy would increase to 98% of 65-year-olds compared to only 77% under current long-term care insurance underwriting practices. If the individuals purchasing a combined insurance policy are like all those eligible at age 65, they could expect to receive 18.0 years of annuity payments and 1.4 years of disability payments. Specifically, it appears that combining the two products could reduce the cost of both coverages and make them available to more persons by reducing adverse selection in the income annuity and removing the need for medical underwriting for the disability coverage.

Deferred Annuity Contracts -- Deferred annuities may be purchased with a single premium or with scheduled payments. The funds accumulate tax-free until payments are made under the contract. Benefit payments may commence upon the occurrence of a specified event, or at the end of a given number of years. Most deferred annuities contain the following features, which allow the owner various options in applying benefits for long-term care:

- **Benefit Options** -- Most contracts provide that the proceeds which are payable upon death, maturity or the occurrence of a specified event may be applied under the options contained in the policy;
- **Loans** -- Most contracts provide that the owner can borrow from the insurer an amount not exceeding the surrender value of the policy with fixed or variable interest rates;
- **Surrender** -- Most annuity contracts allow the owner the option to surrender the contract for cash value.

Deferred annuities have received some criticism in recent years and have been the subject of scrutiny by Congress, the Internal Revenue Service, the Securities and Exchange Commission (SEC), and state regulators.

Viatical Settlements

A viatical settlement, a transaction whereby a non-related party purchases all beneficial interest in a life insurance policy, is a method of insuring the life of a terminally ill person. More and more, people diagnosed with other terminal illnesses are turning to viatical settlements to meet their financial needs. The theory behind these transactions may sound gruesome but can be beneficial for both parties. The income realized from the sale of the life insurance policy can be a good financial move. The mechanics of the transaction involve a third party “broker” or viatical company who pays the terminally ill person a percentage of the death benefit and then becomes the owner and beneficiary of the policy. The terminally ill person receives a lump sum of money to use for medical expenses. When the individual dies, the proceeds of the policy go to the viatical company, which are usually funded through investors who buy all kinds of life insurance policies. The policy does have to be in force for at least two years and cannot be subject to a contestability period.

The viatical company may continue paying the premium on the policy to keep it current. A real boost to viatical settlements should also come as a result of HIPAA (The Health Insurance Portability and Accountability Act) of 1996, which allows people diagnosed with a terminal illness to sell their life insurance policies to viatical settlement companies for a tax free lump sum payment if the individual’s life expectancy is less than 24 months and the purchasing company must be licensed by the state in which the viator (seller) resides.

Medi-Cal

This is not to be confined to the concept that if a consumer does not buy LTC insurance, they will ultimately spend all their money and go on Medi-Cal. Let's look at the options available who should not purchase. Medi-Cal will pay for virtually all of the cost of nursing home care, but is subject to specific eligibility rules regarding assets and income. A person applying for assistance from Medi-Cal must first "spend-down" their assets to a level of legal impoverishment before Medi-Cal can assist in payment of their care. Medi-Cal is a combined federal and California State program designed to help pay for medical care for public assistance recipients and other low-income persons. Although Medi-Cal recipients often receive Medicare, the Medi-Cal program is not related to the Medicare program. Medi-Cal is a need-based program and is funded jointly with state and federal Medicaid funds.

The objective of the Medicaid program is to provide essential medical care and services to preserve health, alleviate sickness and mitigate handicapping conditions for individuals or families receiving public assistance, or whose income is not sufficient to meet their individual needs. Medi-Cal will pay for long-term care, but only after individuals have spend down most of their savings and income. To qualify, people are required to deplete their assets to be at or below the state's poverty level. Medi-Cal also imposes many restrictions on the type of care, and the choice of facilities and locales. One of the largest items in California's budget is Medi-Cal and one of the largest expenditures in the Medi-Cal budget is the cost of nursing home care for the elderly. Even though the largest group served by Medi-Cal is children, the expenses for the elderly are disproportionate to their numbers. This is a result of the high cost of services utilized by this population and not the size of the population.

Year 2007 Community Spousal Resource Limits

The California Department of Health Services' Medi-Cal Eligibility Branch has issued the year 2007 ruling. The California Department of Health Services' Medi-Cal Eligibility Branch has issued the year 2007 community spouse resource allowance and the minimum monthly maintenance needs allowance.

The year 2007 resource limits are:

- \$101,640 in assets;
- \$2,541 in monthly income.

The resource limits and income provisions work in the following way for a married couple when one spouse is in a nursing home and the other spouse is still at home:

- The spouse at home may keep up to \$101,640 in resources (property and other assets);
- The institutionalized spouse may keep \$2,000.

The spouse at home may keep all of the income received in his or her name, regardless of the amount. If the amount is below \$2,541 per month, the institutionalized spouse may allocate income to bring the at-home spouse's income up to the \$2,541 per month limit. The spouse in the nursing home is permitted to keep \$35 a month for personal needs. Single individuals remaining at home and getting Medi-Cal are permitted to retain \$2,000 in additions to any other exempt assets.

Informal Care by Family or Friends

In previous generations, older persons often lived with their children, and daughters or daughters-in-law cared for an aging parent. Things have changed today. A majority of daughters are working and mobility disperses family members geographically over great distances in California. In addition, today's older persons are living longer than their parents. Friends and family members still provide more than half of all long-term care informally at home. The traditional caregiver has been, still is, and will be in the future the female of the family. Because women work their career ahead of having a family, more and more women are electing to have children later on in their lives and may be in the midst of raising their own children when their own parents need assistance. An estimated 22.4 million U.S. households are providing informal (and often unpaid) care to a friend or relative over age fifty at a price tag of \$24 billion for such things as missed work, elder care services and travel expenses. Unfortunately, the expense of a nursing home is something that often must be planned for. Many nursing homes can cost as much as \$50,000 annually, and most health insurance companies do not cover this cost.

Considering Medi-Cal and Its Affect on California Long Term Care

Medi-Cal, California's Medicaid Program, is funded by both federal and state tax dollars and providing health care coverage for approximately six million eligible beneficiaries. The eligibility is based on being financial needy and being able to pay for health care services. Since there is no other payment source for custodial long-term care service, the Medi-Cal program has become the largest payor for these services when people cannot afford to pay. As is with many programs that were developed with "good intentions" to assist citizens during a time of need, the Medi-Cal Program has developed the stigma of being an extension of the social welfare system. The program was established to help those in need, those who were experiencing financial difficulty and for the aged, blind and disabled citizens that had no other way to access health care benefits. These individuals and especially the aged population are those at risk for needing long-term care services, primarily nursing home care, and are generally in the "Medically Needy" category. The program pays for 53% of all such services in the State.

Rules and Regulations For Medi-Cal

The Medi-Cal program has many rules and regulations and is very complex. It is best that you do not try to describe the whole program to an applicant but to at least familiarize yourself with the basic information so you can explain the risk involved based on the applicant's financial status. Also, make certain that you keep current on the property/asset and income allowances. You can get these updated figures each December for the following year from the local county Department of Social Services or the Departments of Health Services Eligibility Branch in Sacramento. Should an applicant have any additional questions, refer them to their local county Department of Social Services.

Just over 17% of the persons receiving Medi-Cal nursing home benefits in 1999 were married. In 2007, if a person is receiving Medi-Cal nursing home benefits, the spouse at home may keep all of the couple's income up to \$2,541 each month. The spouse at home may keep all of the income received in his or her name, regardless of the amount. If the amount is below \$2,541 per month, the institutionalized spouse may allocate income to bring the at-home spouse's income up to \$2,541 per month limit. The spouse in the nursing home is permitted to keep \$35 a month for personal needs and can retain \$2,000 in assets. We might hope we will still be married at the time we need long term care, and therefore, be able to take advantage of the above "spousal-impoverishment protection". However, less than 20% of all individuals receiving Medi-Cal nursing home benefits are married. Single individuals remaining at home, getting Medi-Cal or receiving care in a nursing home are permitted to retain \$2,000 in addition to any other exempt assets.

Medicare

Medicare is inextricably connected to long-term care by virtue of the fact that changes in the Medicare system of payments has lead to a boom in long-term care services. In essence, Medicare has promoted a system that gives hospitals an incentive to move patients out quickly, sometimes without regard to the patient's actual condition or need for continuing care. Medicare is a federal health insurance program. Medicare principally finances acute medical care for the elderly and the disabled. Medicare pays for hospital services (Part A) and physician services (Part B). Limited nursing home, home health care and hospice benefits are available.

LTCI and Medicare

About seven million people are covered by both Medicare and Medicaid. But these dual enrollees account for a much higher share of each program's spending -- 28% for Medicare and 35% for Medicaid. Like Social Security, Medicare represents a promise that the Nation has made to its senior citizens of an enduring obligation to keep. It pays for Medicare's premium and cost-sharing requirements, allowing enrollees to obtain needed care that they otherwise might not be able to afford because of premiums, deductibles, or coinsurance costs. The historic bipartisan agreement signed by President George W. Bush on December 8, 2003 will give all Medicare beneficiaries access to prescription drug coverage and preserve and expand private plan participation in Medicare. Seniors with no drug coverage and monthly drug costs of \$200 would save more than \$1,700 on drug costs each year. Seniors with no drug coverage and monthly drug costs of \$800 would save nearly \$5,900 on drug costs each year. Seniors would be protected again high out-of-pocket costs with Medicare covering 95% of drug costs over \$3,600 per year.

Medicare Coverage

Medicare is a federal health insurance program for people age 65 and older, people of any age with permanent kidney failure, and certain disabled people under age 65. Health Care Financing Administration (HCFA) administers Medicare, the nation's largest health insurance program, which covers 40-45 million Americans. Generally, one is eligible for Medicare if he or his spouse worked for at least 10 years in Medicare-covered employment and he is 65 years old and a citizen or permanent resident of the United States. The federal government from payroll tax contributions and general tax revenues funds this health insurance program. There are three Parts to Medicare – Part A, Part B, and Part C (new in 1998). Part A (Medicare Hospital Insurance) and Part B (Medicare Medical Insurance) combine to form what is commonly known as Medicare.

Hospitalization

Medicare Part A, Hospital Insurance is financed directly through Social Security taxes. The claims are submitted by the hospital or other providing agency to large insurance companies called intermediaries which have been designated by the Health Care Financing Administration. Medicare hospital insurance helps pay for necessary medical care and services furnished by Medicare-certified hospitals, skilled nursing facilities, home health agencies, and hospices.

Benefit Periods -- The number of days that Medicare covers care in hospitals and skilled nursing facilities is measured in benefit periods. A benefit period begins on the first day one receives services as a patient in a hospital or skilled nursing facility and ends after he has been out of the hospital or skilled nursing facility and has not received skilled care in any other facility for 60 days in a row. There is no limit to the number of benefit periods one can have.

<i>Understanding Medicare Benefits</i>	
Medicare Part A (Hospital Insurance Covers:	What Is Paid in 2007 in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, hospital services and supplies. This does not include private duty nursing, a television or telephone in a room, a private room, unless medically necessary. Inpatient mental health care coverage in a psychiatric	For each benefit period you pay: <ul style="list-style-type: none">• A total of \$992 for a hospital stay of 1-60 days.• \$248 per day for days 61-90 of a hospital stay.• \$496 per day for days 91-150 of a hospital stay.• All costs for each day beyond 150 days.

facility is limited to 190 days in a lifetime.	
Skilled Nursing Facility (SNF) Care**: Semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay).	For each benefit period you pay: <ul style="list-style-type: none"> • Nothing for the first 20 days. • Up to \$124.00 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary.
Home Health Care**: Part-time skilled nursing care, physical therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	You pay: <ul style="list-style-type: none"> • Nothing for home health care services. • 20% of approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary.
Hospice Care**: Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	You pay: <ul style="list-style-type: none"> • Copayment of up to \$5 for outpatient prescription drugs and a \$5 per day copayment for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The copayment can change depending on where you live. If you have questions about hospice care and conditions of coverage, call your regional Home Health Intermediary.
Blood: Given at a hospital or skilled nursing facility during a covered stay.	You pay: <ul style="list-style-type: none"> • For the first 3 pints of blood.

Home Health Care – If conditions are met, Medicare pays the full-approved cost of covered home health care services including part-time or intermittent skilled nursing services prescribed by a physician for treatment or rehabilitation of homebound patients. The insured pays a 20% coinsurance charge for home health care for medical equipment such as a wheelchair or walker. Home health services reimbursed by Medicare or Medicaid are very limited and must be prescribed by a physician. Agencies that provide only health aide and homemaker services (for help around the house and personal care) are not Medicare certified, because Medicare certifies only agencies that offer skilled nursing services. Personal care services may be covered by Medicare, if skilled nursing services are being provided. Home care often requires special equipment, such as a hospital bed, safety bars in the bathroom, raised toilet seats, or monitoring devices; Medicare and Medicaid cover some of these assistive devices if prescribed by a physician.

Hospice Care -- Medicare helps pay for hospice care for terminally ill beneficiaries who select the hospice care benefit.

Inpatient Hospital Care -- Medicare Part A helps pay for up to ninety days of inpatient hospital care in each benefit period covering semi-private room and meals, general nursing services, operating and recovery room costs, intensive care, drugs, laboratory tests, X-rays, and all other necessary medical services and supplies.

Skilled Nursing Facility Care -- Part A helps pay for up to 100 days in a participating skilled nursing facility in each benefit period if certain conditions are met. Medicare pays all approved charges for the first twenty days. An individual then pays a coinsurance amount for days 21 through 100.

Medicare Supplement

Medicare Part B, medical insurance, Supplementary Medical Insurance (SMI), is financed by payments from the federal government and by monthly premiums paid by people enrolled in the plan helping to pay for doctor's services, outpatient hospital services, ambulance transportation, diagnostic tests, laboratory services, some preventive care like mammography and Pap smear screening, outpatient therapy services, durable medical equipment and supplies, and a variety of other health services. Part B pays for home health care services for which Part A does not pay. Medicare Part B pays 80% of approved charges for most covered services.

Taking No Action To Provide For Elder Care

Some individuals may choose not to buy LTC insurance or due to medical conditions (in which they may not be eligible for coverage) or due to financial considerations (they may not be able to afford such coverage) they may have to simply rely on Medi-Cal if a long-term care event were to occur. Using personal savings is equivalent to self-insuring in that personal funds are put at risk in order to cover the potential cost of care. This is the position that most individuals are in, though few would choose to characterize it this way. Given how rarely people self-insure against the risk of large medical expenses or auto and property loss, it's curious how many seem willing to accept the long-term care risk.

Agents should be aware that the purchase of Long-Term Care policy will not necessarily ensure that someone will avoid Medi-Cal when they need Long-Term Care. Whether that is to their advantage or not depends upon the particular circumstances. People who are unlikely to be able to afford premiums, unable to absorb even a moderate increase are not appropriate purchaser, and the safety net of Medi-Cal may be their only option.

Referral to HICAP

HICAP, the Health Insurance Counseling and advocacy Program, offers consumers a resource, funded by the Department of Aging, to help them better understand their options with regard to the purchase of long term care insurance. HICAP assists individuals and families with Medicare problems and other health insurance concerns. Over 600 trained and registered volunteer counselors provide objective information on Medicare, Medicare supplement insurance, managed care, long-term care planning and health insurance. Community education and individual counseling are available in all 58 counties. Some agents may tend to misrepresent it in order to make a sale. HICAP is a counterbalance to this practice. The practice of misrepresentation was more pervasive in the past when there were few distributors and insurers in the market. Today, it is more difficult to get away with this practice, as increased competition for sales has made more resources available to consumers. HICAP's ability to monitor inappropriate sales and stay current is bolstered through notification requirements and the requirement that the DOI send copies of all approved marketing materials to the organization.

HICAP will help an individual file Medicare or other health insurance claims, understand his or her coverage and consumer rights, assist with managed care issues and long-term care planning, and evaluate his or her insurance or health care needs. HICAP serves current Medicare beneficiaries and those planning for future health and long term care needs with confidential and free of charge counseling.

A Short, Accurate Description of the Program

The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800- 927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the Department of Insurance toll-free telephone number for a referral to your local HICAP office or call 1-800-434- 0222. In a cooperative effort, the Department of Insurance sends sample Outlines of Coverage to HICAP for inspection by applicants. For group policies, the outline of coverage should disclose what applicants will find in the certificate including a description of benefits, exclusions, reductions, limitations, terms of the policy, certificate continuation, explanation of insured's rights regarding continuing, conversion and replacement. Also explained should be the fact that the group master policy determines and governs all contractual provisions of the long-term care coverage.

A Current List of Each Program

The programs which an agent presents to a client are to be no older than six months. You can refer to California Department of Aging (CDA) web site, where a current list is posted. Agents are required to know the name, address and telephone number of the local program in the area in which they are selling.

Medicaid and Long-Term Care

Medicaid is a federally aided, state-operated program of health care assistance for the poor who are aged, blind, disabled, or families with dependent children. Each state is allowed to make its own rules concerning Medicaid coverages along with loose federal guidelines. The services and medical care provided under a state's Medicaid program could be provided separately from Medicare, or in some instances, in conjunction with Medicare. Medicaid is the largest source of public money paying almost half of the nation's nursing home care but you must "spend down" all your assets to qualify for government assistance.

Assistance for the Elderly

Medicaid assistance becomes a necessity because of financial problems caused by payments for long-term nursing home care to many elderly individuals. The costs associated with an extended nursing home stay or the expenses associated with catastrophic illnesses can diminish personal savings quickly. Assistance for medical care under the Medicaid program is provided for people currently eligible for Medicare and also for people who receive Supplementary Security Income benefits from Social Security. For Medicare beneficiaries who are eligible for their state's Medicaid program, Medicaid will function as the secondary insurer. The general types of coverage that may be provided, depending upon the state, include:

- Doctors, surgeons, inpatient or outpatient, dentists, podiatrists, psychologists, and optometrists;
- Long-term care or mental health services; hospital care, inpatient and outpatient;
- Prescriptions, X-rays and lab service; medical supplies and equipment;
- Personal care assistance or rural health clinic services; hospice care or HMOs;
- Prostheses, hearing aids, eyeglasses, and braces;
- Transportation to services.

Limited Admission

There is strong evidence that Medicaid eligibles face substantially lower access to nursing home services than private payers and have more problems getting into nursing homes than higher paying private payers. An ample bed supply may go unfilled if Medicaid payment rates are too low to make it profitable to admit most Medicaid recipients. Private-pay patients can usually find a nursing home bed quickly. Waiting lists for Medicaid patients can stretch for several months, even a year or more. The only opening for a Medicaid patient may be in a facility that is not convenient to visitors, or that does not provide quality care.

Medicaid and Nursing Facilities

In 1995, the Department of Health and Human Services issued the toughest nursing home regulations in the history of the Medicare and Medicaid programs leading to measurable improvements in quality of care for nursing home residents. The Administration developed additional steps in July 1998 to further assure that all nursing home residents would receive quality care. About 1.6 million elderly and disabled Americans receive care in nearly 17,000 nursing homes across the United States. Under Medicaid programs, states have the primary responsibility for conducting on-site inspections and recommending sanctions against nursing homes that violate health and safety requirements. Additional steps have been announced to further strengthen state enforcement efforts to assure high-quality care in nursing homes and to give consumers more detailed. HCFA instructed states to impose immediate sanctions, such as fines, against nursing homes in more situations -- including any time that a nursing home is found to have caused harm to a resident on consecutive surveys.

CalPERS

California is also unique in that it has one of the few “self-funded” state LTC programs available to government employees and their families called CalPERS. CalPERS (the California Public Employees Retirement System) has issued more than 195,000 LTC contracts since its Program’s inception in March of 1995. CalPERS is dedicated to providing world-class customer service to approximately 1.5 million members and more than 2,500 public agency employers. The CalPERS Program is available to nearly 7 million people, including all active and retired California public employees, their spouses, parents and parents-in-law, and siblings age 18 and older, regardless of where they live in the U.S. and its possessions. Both Partnership and CalPERS policies started out as non-traditional policies with unique features and benefits but now they resemble traditional “tax qualified” policies with the added benefit of asset protection.

All California public employees, retirees, their spouses, parents, parents-in-law, and adult siblings are eligible for the CalPERS Long-Term Care Program. Those eligible to apply must be between the ages of 18 to 79. This includes members of CalPERS, teachers, school employees, University of California, and California State University employees and retirees, county and city employees and retirees, judges, legislators, and all other California public employees and retirees. Members of the Program can receive benefits anywhere in the nation. There are three basic plans in CalPERS LTC Program with several sub-options:

- CalPERS Comprehensive;
- CalPERS Nursing Home/Assisted Living Only; and the
- Partnership plans.

Each plan option offers a variety of daily benefit and total coverage amounts and flexibility on how the benefits are used. While some benefits vary by plan, the CalPERS LTC Program includes options for coverage of care at home, an adult day care center, a residential care facility, or a nursing home. The program also covers respite care to give family care-givers time off and Care Advisory Services to help one find quality providers of the care that is needed. CalPERS offers two ways to keep pace with inflation. An individual can choose a built-in automatic inflation protection option that increases coverage amounts by 5% each year (compounded annually). Or one can periodically increase coverage amounts and pay an additional premium for that increased amount at the time the increase is made.

CalPERS Comprehensive and Nursing Home / Assisted Living plans feature a 90-day elimination period and an integrated benefit allowance of either \$142,350 or lifetime. With inflation protection selected, all benefits increase by 5% (compounded annually). Otherwise, members have the opportunity to increase their benefit limits every third year without having to provide evidence of insurability. The CalPERS Partnership plans provide dollar-for-dollar asset protection from Medi-Cal spend-down, offer a 30- day elimination period and integrated benefit allowance of either \$40,150 or \$80,300, and include 5% compounded inflation protection. The most popular plans are the comprehensive, lifetime with compounded inflation plans. Premiums typically average 20% LESS than comparable private LTC plans. At age 65 the premium for the CalPERS Comprehensive plan with lifetime benefits and inflation protection is \$177 per month. Most of the savings result from the direct marketing and self-funded, not-for-profit aspects of the program. All CalPERS long-term care plans are federally qualified to provide tax advantages. Long-term care benefit payments are not subject to taxes and the premiums are tax-deductible under certain circumstances. Clients should always be advised to consult an accountant or tax expert for more information on these matters.

Enrollment	Employees	Dependents	Total Members
<i>State Employees – 61%</i>			
State Active	212,401	327,013	539,414
State Retired	132,471	83,128	215,599
State Total	344,872	410,141	755,013
<i>1,100 Public Agencies (Local Government Agencies & School Employees) – 39%</i>			
Public Agcy Active	165,542	215,866	381,408
Public Agcy Retired	62,887	34,422	97,309
Public Agcy Total	228,429	250,288	478,717
Active – 75%	377,943	542,879	920,822
Retired – 25%	195,358	117,550	312,908
HMO – 69%	381,143	471,401	852,544
PPO – 25%	166,383	140,452	306,835
Associations – 6%	25,775	48,576	74,351
Total Program	573,301	660,429	1,233,730

CalPERS Long-Term Care Program

Provides financial protection from the high cost of extended care, including nursing home care, that six of 10 Americans over age 65 will need Regular health insurance and Medicare do not cover long-term care Nursing home care averages \$65,000/year; home care averages \$20,000/year CalPERS' program is not-for-profit and self funded; began in January 1995 Over \$360 million in benefits paid since the program's inception All California public employees, retirees, their spouses, parents and parents-in-law, and adult siblings (age 18 and older) are eligible to apply More than 173,000 members Total annual premiums of approximately \$245 million Benefits paid in 2007: over \$15 million (through February 2007)

Alternative Living Settings/Arrangements

The array of long-term care services available today in California offers consumers more options than ever. Having many consumer choices may explain why our state has one of the lowest facility utilization in the nation – we rank 47th in the nation in the placement of people in nursing facilities. Of those entering nursing facilities, most stay less than three weeks. (California Association of Health Facilities,). Long-term care does not necessarily mean nursing home care. In fact, that is only the most intense, and expensive, level of support for an older person. Long-term care is any kind of care that helps an older person who can no longer lead a completely independent life. Depending upon the degree and the kind of help needed, long-term care can mean part-time home care, a residential care facility, or anything in between.

Retirement Homes/Assisted Living Facilities

Assisted living facilities and independent living facilities fill the gap for people who do not need the high supervision or medical care provided by a nursing home, but really should not or do not want to be living alone or can no longer drive. These facilities offer an array of services to assist the resident with their daily living needs, provide a social outlet, provide interaction in the community, and encourage the person to remain as independent as possible. As a person's needs grow, the amount of assistance can grow to meet their needs and keep them in their homes. The diversification of long-term care has brought rapid growth to the assisted living profession. With the growth of assisted living comes increased scrutiny from policymakers, consumer advocacy groups, the media and organizations representing the elderly. The National Center for Assisted Living (NCAL) represents the assisted living profession's perspective to the many groups throughout society and government that shape laws, regulations, policies and opinions that will affect the future of assisted living.

Life Care Communities

Life Care Communities (LCCs) represent the ultimate of the one-stop shopping concept to retirement living. These are usually large campuses where all three levels of care (minimal services, custodial care and skilled nursing) are provided. These communities are attractive to residents who do not want to move as increased care needs develop. Some of these settings require a large entry fee for admittance. Others charge for services on a month-to-month basis. Continuing Care Communities require big campuses and there are generally very few of them in the city. Typically LCCs are 200-250 unit housing complexes combined with a package of social and medical services, including emergency medical care, long-term nursing care, meals, recreational programs, transportation services, housekeeping services, and other services. Residents may be required to be of a minimum age; 60 is common. In many LCCs the entry fee is non-refundable after a limited period, though recently the trend has been towards guaranteeing a substantial, if not complete, refund upon death, departure, or nursing home confinement. In exchange for these fees and charges, the LCC provides the resident with a contract guaranteeing shelter and an array of services for life of the individual.

In 1991 the state of California passed legislation, which defined what a retirement community had to provide in order to advertise themselves as a 'life care' community. In that legislation it said that a "life care" community had to provide:

- Guaranteed health care coverage for life - no exceptions;
- A guarantee that if the resident's resources were exhausted that they could not lose their residence or their benefits;
- The retirement community had to have a nursing facility within the community itself .
- The residence (apartment) that they occupied when they entered the community could not be taken from the resident for any reason.

Very few continuing care retirement communities meet these stringent requirements, although they may provide many of the services and benefits of a true 'lifecare' community. Strictly speaking a 'lifecare' community is always a "continuing care" community, but most CCRC's are not 'lifecare' communities and thus, do not advertise themselves as such under California law.

Continuing Care Retirement Communities

According to the California Registry website “Continuing Care Retirement Communities, sometimes called Life Care Communities, combine all three levels of care - independent living, assisted living and nursing home care in a single setting. Continuing care retirement communities (CCRC) offer an innovative and independent lifestyle for single and married older adults. Today, CCRCs are the fastest growing segment of the housing market for older Americans. In return for substantial entrance fees, these communities promise a place to live for the rest of your life, some, if not all, of your meals, and most important, nursing care, should the need for it arise. This type of community is different from other housing and care options for older people because it offers a long term contract that provides for housing, services and nursing care, usually all in one location. The CCRC continues to meet residents needs in a familiar setting as they grow older, also known as, “aging in place.” Increasing levels of care are provided for from within the community. CCRC residents can take advantage of a wide variety of activities and services conveniently offered within the community. The CCRCs emphasis on the individual, coupled with a supportive environment, allows people to continue to pursue your lifelong interests.

CCRCs work like any insurance policy. Premiums paid by all policyholders are pooled to pay benefits to those who suffer some misfortune. Not all residents will need nursing care, but for those who do, their care is funded with the fees paid by all the residents. Entrance fees are high, and most people entering a facility use the equity in their homes to pay for them. Entrance fees average from about \$50,000 to \$75,000 for one-bedroom apartments to about \$76,000 to \$96,000 for two bedrooms. In 1991 the state of California passed legislation which defined what a retirement community had to provide in order to advertise themselves as a ‘life care’ community. In that legislation it said that a "life care" community had to provide:

- Guaranteed health care coverage for life - no exceptions;
- A guarantee that if the resident's resources were exhausted that they could not lose their residence or their benefits(i.e. they had to be financially subsidized by the retirement community) ;
- The retirement community had to have a nursing facility within the community itself .
- The residence (apartment) that they occupied when they entered the community could not be taken from the resident for any reason.

Very few continuing care retirement communities meet these stringent requirements, although they may provide many if not all of the services and benefits of a true ‘lifecare’ community.

Family Care

A variety of changes in the demographic profile of the future elderly population will affect their need for formal, long-term care services in nursing homes. Prior to World War II, women as the primary care providers for the family, had neither the time nor energy to work outside the home for wages. As a result of World War II, when many men were overseas serving in the armed forces, almost 20 million women entered the work place. Today, most households require two incomes in order to pay the bills, leaving no one at home during the day to provide care for aging relatives. What often begins as a labor of love becomes an overwhelming burden on adult children and grandchildren starting with a few visits a week to their homes.

Obviously, the life span of the elderly and the proportion who have health limitations will be important because the need for long-term care, in general, increases with age and disabling health conditions. If more elderly persons live alone in the future, the demand for formal in-home and nursing home services will increase because fewer elderly persons will be living with family caregivers who would normally provide significant levels of informal long-term care services. Households where a non-working spouse or child is available may not be able to adequately handle the physical and mental demands of caring for someone who is seriously ill or disabled.

Adult Day Care centers provide different levels of medical care and therapy, along with meals, companionship, activities and social services. They offer family caregivers who work an alternative to using full-time providers at home. Participants in adult day care may stay for a half or full day, one to five days a week. In addition to medical services, adult day care centers provide meals and snacks, personal care assistance, exercise, recreation and outings and educational programs.

Fraternal, Religious, Union Organizations

There are various Fraternal, Religious or Union Organizations that offer long-term care coverage which may be issued for individual applicants or in the form of group certificates. Eligible groups include employer sponsored plans, trade groups (credit unions, labor organizations), association groups and/or special discretionary groups as permitted by the commissioner.

CHAPTER EIGHT

Advertising Guidelines and Marketing Practices

Advertisements Must Be Filed

10234.9 of the California Insurance Code was amended by the SB1943 and states that because the prospect of needing long term care is so unpleasant and many people don't want to face the issue, there is a temptation to establish the lead for a sale by discussing an opportunity other than that to purchase insurance. Once the agent is in the door, the truth comes out and the prospect may find it difficult to get him or her to leave. Thus, restrictions are placed on "cold lead" advertising. In particular, a disclosure must be made that "an agent will contact you." Additional restrictions are placed on advertising that promote fear or promise peach of mind, for much the same reason. 10234.9 (a) of the California Insurance Code states that every insurer providing long-term care coverage in California shall provide a copy of any advertisement intended for use in California to the commissioner for review at least 30 days before dissemination. The advertisement shall comply with all laws in California. In addition, the advertisement must be retained by the insurer for at least three years. 10234.9 (b) of the California Insurance Code states that an advertisement designed to produce leads must prominently disclose that "an insurance agent will contact you" if that is the case. 10234.9 (c) of the California Insurance Code states that an agent, broker, or other person who contacts a consumer as a result of receiving information generated by a cold lead device, shall immediately disclose the fact to the consumer.

No insurance policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a long-term care policy unless the policy or subscriber contract contains definitions or terms that cannot be less favorable for the insured as defined here. 10233.7 of the California Insurance Code states that no policies may be advertised, marketed, or offered as long-term care or nursing home insurance unless it complies with this rule. Any insurer offering long-term care insurance under this chapter shall provide to the Department of Insurance, for the commissioner's conveyance to the Department of Aging, a copy of the following materials for all long-term care insurance coverage advertised, marketed, or offered by that insurer in this state:

- Specimen individual policy form or group master policy and certificate forms;
- Corresponding outlines of coverage;
- Representative advertising materials to be used in this state.

The traditional long-term care policy is defined as any accident and health insurance policy or rider advertised, marketed offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than acute care unit of a hospital.

Use of Foreign Language Material

Chapter 358, Statutes of 2002; SB 1974, Polanco authorizes the Commissioner to approve insurance policies and associated materials in languages other than English if certain conditions are satisfied. Existing law requires an insurance policy to meet certain requirements, including specifying the parties to an insurance contract and the risks insured against.

Marketing Guidelines

There is a prohibition against any advertising vehicle implying any connection between the insurer and any government agency or program, such as the Social Security Administration, or implying any endorsement by governmental agencies, charitable institutions, or senior organizations. SB 1943 directives include the requirement that an agent, broker, or other person who contacts a consumer as the result of having received information from a cold lead device must disclose that fact to the consumer. The thrust of all marketing efforts by agents and their companies in California are to adopt standards that provide for fair and accurate comparisons of policies, tax benefits (if any) and avoid the selling of excessive coverage. Any licensee that markets long-term care insurance/or California partnership contracts is still required to meet the specific requirements for marketing such contracts.

Agent Responsibilities

Fair and Accurate Comparisons

10234.93. (a) of the California Insurance Code has been amended by SB1052-1997 to state that every insurer of long-term care in California shall:

- Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;
- Establish marketing procedures to assure excessive insurance is not sold or issued;
- Try to determine applicant's existing coverage;
- Submit to the commissioner within six months of the effective date of this act, a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semiannually.
- Provide the following training and require that each agent or other insurer representative authorized to solicit individual consumers for the sale of long-term care insurance shall satisfactorily complete the following training requirements that, for a resident licensees shall be part of, and not in addition to, the continuing education requirements in Section 1749.3:
 - For licensees issued a license after January 1, 1992, eight hours of training in each of the first four 12-month periods beginning from the date of original license issuance and thereafter and eight hours of training prior to each license renewal.
 - For licensees issued a license before January 1, 1992, eight hours of training prior to each license renewal.

For nonresident licensees that are not otherwise subject to the continuing education, the evidence of training required here is to be filed with and approved by the commissioner as provided in subdivision (g) of Section 1749.4. Licensees shall complete the initial training requirements of this section prior to being authorized to solicit individual consumers for the sale of long-term care insurance. The training required by this section shall consist of topics related to long-term care services and long-term care insurance, including, but no limited to, California regulations and requirements, available long-term care services and facilities, changes or improvements in services or facilities, and alternatives to the purchase of private long-term care insurance. On or before July 1, 1998, the following additional training topics shall be required: differences in federally qualified and those not intended to be federally qualified, the effect of inflation in eroding the value of benefits and the importance of inflation protection, and NAIC consumer suitability standards and guidelines.

Display prominently on page one of the policy or certificate and the outline of coverage: "Notice to buyer: *"This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."* Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

Insurer Responsibilities

Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subdivision. **Applicants must receive notice that this policy may not cover all costs.** Every insurer shall provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222. Provide a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each prospective applicant prior to the presentation of an application or enrollment form for insurance.

In addition to other unfair trade practices, including those identified in this code, the following acts and practices are prohibited:

- *Twisting* -- Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
- *High pressure tactics* -- Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
- *Cold lead advertising* -- Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contract will be made by an insurance agent or insurance company. The issue of greatest concern to regulators throughout the history of long term care insurance has been that of rate stability.

Some of the most egregious abuses in this market have come from insurers who have kept rates steady on existing customers for five to ten years and then raised them up to %100 and more. The effect can be devastating, as individuals are left with few choices, all of them bad. Those, not in good health must either accept the premium increase, reduce their coverage or drop it entirely. Those in good health have options that are only slightly more palatable, due to rapidly increasing issue age premiums at later ages.

Agent Reporting

Insurance companies in California must submit to the Insurance Commissioner a list of all agents or other insurance representatives authorized to sell individual long term care insurance policies updated every six months. SB 1052 adds further reporting that could impact agents. Every insurer must now maintain records of every agent's replacement sales and lapses as a percentage of sales. On June 30 every insurer shall report to the Department of Insurance the 10% of its agents in the state with the greatest percentage of lapses and replacements. Insurers must also list company-wide lapses and replacements as a percentage of sales. Of course, replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing.

General Disclosure Requirements

Every piece of advertising, each statement, all representations and sales presentations must be free from any form of information that can be construed as being misleading or untruthful in any way. Some the examples include;

- All conversations regarding insurance must be identified by the agent as being "insurance" and cannot disguise the product;
- Sales promotions cannot be misleading in any way;
- The agent must fully disclose the name of the insurance company represented at all times;
- Agents must insure that when making presentations the materials being used is truthful and all reacquired information is being disclosed

Additional Agent Responsibilities could include

- Agent must turn all monies over to the insurance company within the required time period (usually 15 days);
- Agent owes a fiduciary duty to the insured;
- An agent is an agent of the insurance company and must act appropriately within the scope of the agency relationship;
- Making sure all required signatures are provided on the application, fair credit act forms and any other form required by the insurance company;
- Providing the client with a "Buyers Guide";
- Providing the client with a policy summary sheet;
- Reviewing the application for all necessary signatures;
- Reviewing the Fair Credit Reporting Act and Forms with the client.

Regulations for Agent Training to Market California Partnership Products

The Department of Health Services DHS requires agents to take specific continuing education (CE) training to be authorized to market Partnership policies. The training consists of an initial 8 hours of classroom CE on the Partnership, and thereafter an additional 8 hours of classroom CE on the Partnership every two-year license approval period. Regulations provide that agents who fail to comply with this CE requirement shall not sell Partnership policies, and companies are required to enforce this requirement or jeopardize their relationship with the CPLTC. Also, Partnership course instructors must pass an exam before they are allowed to teach. 2) The DHS provides services to help agents expand their understanding of the Partnership product, the importance of these quality consumer protections, and ways they can better serve their clients. Any licensee that markets long-term care insurance/or California partnership contracts is still required to meet the specific requirements for marketing such contracts.

REQUIREMENTS	Agents Licensed after 1/1/92 (Junior Agents)			
License Year	1	2	3	4
Partnership	8 hrs	8 hrs	8 hrs	8 hrs
Long-Term Care	8 hrs	8 hrs	8 hrs	8 hrs
TOTAL	28 hrs		24 hrs	

REQUIREMENTS	Agents Licensed Before 1/1/92 (Senior Agents)
License Year	Every 2 years
Partnership	8 hrs
Long-Term Care	8 hrs
TOTAL	16 hrs

Appendix 1 Provider Legislative Reference

The selling of long term care in California has changed dramatically in the past few years. Some of the Nation's most aggressive long term care consumer protection regulations and agent due care rules are now law in our State. Understanding the following Long-Term Care legislation is significant. Compliance with these rules is mandatory and the sanctions for violating them severe. They provide the evolutionary changes for each law throughout each legislative year.

Year 1993

SB 1943

The provisions for SB 1943 went into effect on January 1, 1993. This law made major changes in both the definition of long-term care insurance and in the design and sale of those products. Specifically, it added a number of consumer provisions, did away with many of the gatekeepers that had plagued older policies, and liberalized the triggers for benefits. Below are the specific points that SB 1943 changed or affected in some way:

- Provides that long-term care insurance include insurance designed to provide that coverage, without restriction as to length of coverage, and also includes disability based long-term care policies, and specifies that long-term care benefits designed to provide coverage of 12 months or more that are contained in Medicare supplement or other policies is regulated;
- Requires associations to be organized and maintained in good faith for a primary purpose other than obtaining insurance;
- Requires associations to provide evidence that the required provisions of the constitution bylaws have been consistently implemented;
- Requires certain groups to have a main resource source not related to the marketing of insurance, to have outreach methods to obtain new members not related to the solicitation of insurance and to provide benefits or services other than insurance, of significant value to its members;
- Requires any policy or certificate limited to institutional care to be called a nursing facility only policy or certificate, one limited to home care to be called a home care only policy or certificate, and would permit only those that provide both institutional and home care to be called comprehensive long-term care insurance;
- Requires specific notice regarding untrue statements on an application;
- Provides that where an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy or certification, then the insurer may only rescind the policy or certificate or deny an otherwise valid claim, upon clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant;
- Provides that the contestability period is 2 years and that no long term care policy or certificate may be field issued;
- Requires long-term care insurance that provides home health care benefits or home care or community-based services to provide specific benefits;
- Provides that in every long-term care policy or certificate that provide home care benefits, the threshold establishing eligibility for home care benefits shall be at least as permissive as a provision that the insured will qualify if either one of two specific criteria or combination of criteria to be substituted, if the insurer demonstrates that the interest of the insurer is better served;
- Provides that long-term care insurance may not provide for benefits based on standards described as "usual and customary" or similar words;
- Provides that if a policy replaces another long-term care policy the replacing insurer shall waive any time periods applicable to preexisting conditions and prohibitory periods to the extent that similar exclusions have been satisfied.
- Imposes requirements relating to marketing practices;

- Prohibits certain fair trade practices including cold lead advertising without disclosing that an insurance agent or company will make contact;
- Requires prior approval of certain advertisements;
- Requires agents to make reasonable efforts to determine the appropriateness of a recommended purchase or replacements;
- Requires every long-term care insurer to file its commission structure or an explanation of the insurer's compensation plan with the Commissioner;
- Provides for hearings before an Administrative Law Bureau and the Department of Insurance, except where a fine is over \$100,000 in which case the Administrative Procedures Act would be applicable;
- Requires every insurer providing long-term care coverage in California to provide a copy of any advertisement to the Commissioner for review at least 30 days before dissemination;
- Requires long-term care insurers to establish marketing procedures, submit to the Commissioner a list of all agents and other insurer representatives authorized to solicit long-term care insurance sales, and provide continuing education to those agents or representatives;
- Requires notice to applicant containing specific information for replacement is to be signed by the agent;
- Requires long-term care policies issued to individuals to be either guaranteed renewable or noncancelable;
- Requires group insurance to provide for continuation coverage for the certificate holder;
- Makes changes to the long-term insurance act inapplicable to the California Partnership for Long-Term Care Pilot Program.

SB 1943 directly outlawed policies with such a high disability levels letting the existing California law prevail.

Year 1997

SB 527

- Provides that if an insurer provides long-term care insurance intended to qualify for favorable tax treatment under federal law, the insurer shall also offer coverage that conforms to the current state eligibility requirements, as specified;
- Requires insurers to provide a specified notice at the time of solicitation, and a specified notice in the application form.

SB 1052 – Chapter 699, Statutes of 1997, Division 2., Part 2., Chapter 2.6 of CIC: This bill was passed with SB 527 and AB 1483.

- Requires every policy that is intended to be a qualified long-term care insurance contract as provided by federal law to be identified as such with a specified disclosure statement, and, similarly would require every policy that is not intended to be a qualified long-term care insurance contract as provided by federal law to be identified as such;
- Requires insurers that offer policies or certificates that are intended to be federally qualified

The SB 1052 rules are broad and complex leading to new mandatory California Continuing Ed requirements that must be met by all long term care agents on or before July 1, 1998. Again, due to the perceived need to preserve protections for the long-term care insurance purchasers as soon as possible, this bill was passed on October 5, 1997 and is effective immediately.

AB 1483

Introduced by Assembly member Gallegos on February 28, 1997 and passed *effective immediately* on October 5, 1997 requiring that every policy that is intended to be a qualified long term care insurance contract as provided by federal law or a “tax qualified policy”, to be identified as such with a specific disclosure statement, including riders to life insurance policies.

- Requires insurers that offer policies or certificates that are intended to be federally qualified long-term care insurance policies to also fairly and affirmatively offer and market policies that are not intended to be federally qualified long-term care contracts;
- Sets forth eligibility criteria for policies and certificates intended to be qualified long-term care insurance contracts as provided by federal law as well as for policies and certificates that are not intended to be federally qualified;
- Revises various definitions.

Year 1998

SB 1537 – 1998; Long-term care insurance: This legislation concerns IRS decisions on the taxability of long-term care policies.

- Requires the Department of Insurance to adopt emergency regulations to require insurers offering both forms of policies to offer a holder of either form of policy a one-time opportunity to exchange the policy from one form into the other form, if a federal law is enacted, or the United States Department of the Treasury issues a decision, declaring that the benefits paid under long-term care insurance policies or certificates, that are not intended to be federally qualified, are either taxable or nontaxable as income.
- Provides for the emergency regulations to require insurers to allow exchanges to be made on a guaranteed issuance basis, but to allow insurers to lower or increase the premium, with the new premium based on the age of the policyholder at the time the holder was issued the previous policy, as specified.
- Provides for the exchanges to be made by rider to a policy at the discretion of the department, and would also provide that policies may not be exchanged if the holder is receiving benefits under the policy or would immediately be eligible for benefits as a result of an exchange.
- Requires insurers to take certain actions to notify holders of these policies and certificates of the availability of the exchange option;
- Provides that those provisions apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract;
- Requires that outline to include information regarding the toll-free telephone number of the Health Insurance Counseling and Advocacy Program.
- Provides that the cumulative premium credits allowed need not reduce the premium for the replacement policy or certificate to less than the premium of the original policy or certificate;

SB 870

Signed September 7, 1999, this bill was designed to “clean-up” certain disclosure issues and reflect the market’s interest in residential care and home health care coverage.

- Makes 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;
- Changes relating to coverage for preexisting conditions; changes regarding prohibited policy provisions and prohibited insurer actions in connection with policies;
- Changes regarding the right of a policy or certificate holder to appeal decisions regarding benefit eligibility care plans, services and providers, and reimbursements.

SB 475

- Requires the Insurance Commissioner to annually prepare a consumer rate guide for consumers for long-term care insurance, as specified;
- Specifies the dates and methods for distributing the consumer rate guide;

- Requires each insurer to provide, and the Department of Insurance to collect, specified data on long-term care policies and certificates, including all policies, whether issued by the insurer or purchased or acquired from another insurer, in the United States, on or after January 1, 1990;
- Provides that the data collected are public records open to members of the public for inspection, unless they are a trade secret as defined.

Year 2000

SB 898

- Authorize the Insurance Commissioner to require insurers to make benefit modification, premium rate schedule adjustments, or other modification where actual claims experience does not track with projected experience.
- Authorize the Insurance Commissioner to sanction insurers that persistently file inadequate initial premium schedules;
- Incorporate provisions relating to non-forfeiture benefits.
- Limits premium increases for these policies, as specified;
- Provide for the insurance Commissioner's prior approval of long-term care insurance individual and group policy forms and certificates, outlines of coverage, advertising materials used in this state, and rates and premium...
- *** Require insurers to offer at least one plan of long-term care insurance that is non-cancelable.** (This was deleted.)
- Requires premium rate schedules and new policy forms to be filed with the commissioner by January 1, 2002, for all group long-term care policies to be sold on or after January 1, 2003, and for all previously approved individual long-term care policies to be sold on or after January 1, 2003, unless the deadline is extended by the commissioner.

Year 2001

SB 455 – [Effective January 1, 2002, Chapter 328, Statutes 2001, makes the following changes – *SB 455* restores Section 10232.65 to the Insurance Code, that imposes limitations of one month (two months if interim coverage is provided) on the amount of premium that may be collected by a long-term care policy issuer with the application prior to the time the policy is delivered. This requires a 60-day notification regarding issuance or non-issuance of a policy and interest payment made to applicant for failure to notify.

Year 2002

SB 1613 – Chapter 675, Statutes of 2002. Long-term care insurance – This bill requires the evidence of the continuing education to be filed with and approved by the insurance Commissioner for specified nonresident licensees. It also requires that until June 30, 2003, the notification to be provided within 18 months if certain conditions are met. It specifies that an insurer is not prohibited from filing new group and individual policy forms with the commissioner after January 1, 2003. This bill authorizes an insurer that has filed premium rate schedules and new policy forms by March 1, 2002, to continue to offer and market long-term care policies approved prior to January 1, 2002, until 90 days after approval of the premium rate schedules and new policies forms or June 30, 2003.

SB 1974 -- Insurance Policies, Chapter 358, Statutes of 2002. This bill authorizes the Commissioner to approve insurance policies and associated materials in languages other than English if certain conditions are satisfied.

Attachments

- Attachment I -- Tax Treatment of Long-Term Care Expenses & Long-Term Care Insurance – HIPAA (Public Law 104-191, 110 Statutes 1936, 2054, 2063)
- Attachment II -- California Partnership For Long-Term Care (Title 22, Division 3, Subdivision 1, Chapter 8 of the California Code of Regulations)
- Tax Form 8853
- HICAP Contacts
- LTC Personal Work Sheet
- NAIC Suitability Letter
- Form LTC 1099
- Provider Enrollment Regulations California Code of Regulations, Title 22, Division 3
- Notice Regarding Standards for Medi-Cal Eligibility
- LTC Tax Comparison

Attachment I

Tax Treatment of Long-Term Care Expenses & Long-Term Care Insurance

Health Insurance Portability & Accountability Act of 1996
(Public Law 104-191, 110 Statutes 1936, 2054 & 2063)

Federal & state tax codes have a purpose beyond raising revenue. Public policy is often served by providing economic relief to taxpayers or motivation for particular behavior. The 1996 Health Insurance Portability & Accountability Act (HIPAA – Public Law 104-191, 110 Stat. 1936, 2054 & 2063) is one of the most far-reaching laws passed by Congress in the latter part of the 20th century. The effects of HIPAA are so complex that federal and state governments continue to grapple with its legislative intent.

HIPAA's impact on the treatment of long-term care expenses and long-term care insurance is the focus of this section. Congress attempted to fulfill a number of different public policy objectives in taking on long-term care as a topic: (1) classifying long-term care costs as a medical expense thus providing taxpayers with some economic relief; (2) categorizing long-term care insurance as accident & health insurance thereby providing clarity as to the tax treatment of premiums and benefits; and (3) providing the general public an incentive to purchase long-term care insurance.

The general categories in this section include:

- *Tax treatment of long-term care expenses*
- *Definition of a “chronically ill” individual*
- *General tax treatment of TQ & NTQ long-term care insurance*
- *Tax qualified long-term care insurance deductibility*
- *Current efforts to expand tax incentives for long-term care expenses and long-term care insurance*

Tax Treatment of Long-Term Care Expenses

The Internal Revenue Code allows deductions for medical and dental expenses under certain circumstances (IRC Sec. 213d). Prior to the passage of HIPAA, a broad range of long-term care expenses were generally not deductible. Part of Congress' intent in enacting HIPAA was to provide tax relief to individuals and families that were incurring long-term care costs. However, part of the challenge facing legislators was determining which expenses would qualify.

The broad and expanding nature of long-term care expenses made it difficult to stipulate a “laundry list” of qualified services. The IRS defines “qualified long-term care services” as:

Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner

This overly broad universe of services could potentially be used by anyone at any time for services normally covered under healthcare insurance. To control when the cost of long-term care services could receive favorable tax treatment, Congress established a trigger basis for initiating benefits by tying services to a state of disability defined as a *chronically ill individual*.

- A chronically ill individual must be certified by a licensed health care practitioner within the previous 12 months as one of the following:
 1. *The insured is unable, for at least 90 days, to perform at least two activities of daily living (ADL's) without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence. (See IRS Notice 97-31, issued May 6, 1997 or CIC 10232.8(e1 – 6) for the definitions of the ADL's.)*
 2. *The insured requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.*

This standardized definition of a chronically ill person cannot be altered in any way by state law, and it is the only definition allowed to receive the favorable tax treatment for the cost of long-term care services.

Licensed Health Care Practitioner

The Internal Revenue Service defines the licensed health care practitioner (LHP) in very general terms. They can include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists. IRS Publication 502 includes an extensive list of licensed health care practitioners. California Insurance Code Section 10232.8(c) narrows the list by specifying the role of the LHP in the certification, assessment, and plan of care of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and “shall not be compensated in any manner that is linked to the outcome of the certification” (CIC 10232.8(c)). Federal and State law requires the certification of the insured’s assessment be renewed annually.

90-Day Certification for Activities of Daily Living

This component of the long-term care qualification may be the most misunderstood. A review of its impact as it applies to long-term care insurance is addressed later in this section. Its relevance to the deductibility of long-term care expenses is clear. Congress intended to limit long-term care costs to those associated with chronic illness. A clinical definition of chronic illness is one that is expected to last 90 days or more. Some expenses for acute or short term illnesses were already deductible as a medical expense. If policy makers had ignored the distinction between acute and chronic, it would have had the unintended consequence of allowing taxpayers to deduct all their expenses associated with short-term disabilities, due to the vague nature of the definition of a qualified *long-term care service*.

Therefore, a taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition, must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days. Keep in mind, the requirement concerns the likelihood of needing care, not the actual receipt of care. In fact, there is no requirement that the person actually receives the full 90 days of care. The insured must be recertified at least annually.

Note: IRS Publication 502 stipulates that the 90 day certification period is not a deductible period for people who have long-term care insurance. Long-term care insurance can still pay benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is likely to need qualified long-term care services for at least 90 days. The certification may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

Substantial Assistance

For the purposes of the activities of daily living, IRS Notice 97-31 (1997) allows substantial assistance to be defined to mean both *hands-on assistance* and *standby assistance*.

- **Hands-On Assistance:** means the physical assistance of another person without which the individual would be unable to perform the ADL.

- **Stand-By 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 ADL.

Severe Cognitive Impairment & Substantial Supervision

Notice 97-31 defines a *severe cognitive impairment* “as a loss or deterioration in intellectual capacity that is similar to Alzheimer’s disease and like forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short-term and long-term memory, orientation to people, places or time and deductive or abstract reasoning.” The 90-day certification by a LHP is not a requirement for qualification under the cognitive impairment trigger. Similar to the ADL qualification however, the insured must be recertified every 12 months to ensure that they still qualify for benefits.

Note: Taxpayers and tax preparers must document an ADL or cognitive impairment consistent with HIPAA rules in order to deduct long-term care expenses as a medical expense. Many tax preparers miss this point and it could be a critical matter during a tax audit.

Tax Qualified Long-Term Care Insurance

The Federal and state governments have recognized the impact of long-term care expenses on their state Medicaid budgets. Over the last 40 years the Medicaid (called Medi-Cal in California) program has become the primary source for long-term care expenses in the United States for the middle class population. Congress is attempting to shift the Medicaid burden to the private sector by providing general tax incentives to purchase long-term care insurance in anticipation of the huge number of baby boomers who may need care in the future.

Prior to HIPAA, neither long-term care insurance premiums or benefits were addressed in the Federal tax code. There was uncertainty as to whether LTC insurance would be classified as (accident & health or disability) for the purposes of both the deductibility of premiums and the taxation of the benefits. However, the common belief was that as long as premiums were paid with after-tax dollars, benefits would be tax free. This was pre-HIPAA a rule of thumb for all insurance.

HIPAA stipulates that generally, long-term care insurance policies that use the definition of a chronically ill individual will be “qualified long-term care insurance” and that long-term care expenses incurred by a taxpayer who qualifies as a chronically ill individual will be

deductible as a medical expense (HIPAA also requires certain consumer protection provisions that will be discussed later).

- *Tax qualified long-term care insurance is treated the same as an accident & health insurance policy*
- *Benefits pass tax-free*
 1. *Per diem and cash method policy benefits received are subject to an annually adjusted amount -- \$220/day in 2003 (indexed upwards annually by approximately 5%.*
- *Premiums are generally deductible*
 1. *Limits apply to individuals, sole proprietors, owners of S-corporations, & LLP's*
 2. *Premiums paid by an employer for an employee are 100% deductible*
 3. *Not counted as income to an employee*
 4. *Cannot currently include qualified long-term care insurance in a Section 125 Cafeteria plan or flexible spending arrangement*

Various deductibility scenarios will be explored later in this section.

Congress created a generalized structure to which qualified products must adhere. For purposes of HIPAA, a qualified long-term care insurance product must pay benefits using no less than 5 or no more than 6 of the following activities of daily living:

- *Eating*
- *Toileting*
- *Transferring*
- *Bathing*
- *Dressing*
- *Continence*

Note: Qualified long-term care insurance policies may not use “medical necessity” as a benefit trigger and must coordinate benefit payment with Medicare.

This 5 – 6 ADL structure created concern in California because policies issued in California after January 1, 1993, that provided benefits for home care services, were required to use a benefit trigger of 7 ADL's; the six listed above plus ambulating. Generally, all qualified long-term care insurance policies issued nationwide utilize a 6 ADL structure requiring a loss of 2 or 3 ADL's to qualify for benefits (subject to certification by a LHP that the impairment is likely to last for at least 90 days).

Qualified long-term care insurance policies are required to meet specific consumer protection guidelines of the 1993 National Association of Insurance Commissioners Model Act and Regulations for Long-term Care Insurance. Many of the consumer protections in the NAIC Models had already been adopted in California with the passage of State Senate Bill 1943, including:

- *Guaranteed renewability or non-cancellability*
- *Prohibitions on exclusions and limitations*
- *Provisions relating to extension of benefits & conversions*
- *Replacement*
- *Unintentional lapse*
- *Post-claim underwriting*
- *Requirement to offer inflation protection & rejection by consumer*
- *Restrictions on preexisting conditions and probationary periods*
- *Disclosure*
- *Non-forfeiture provisions*

HIPAA requires that long-term care insurance policies comply with its guidelines to be considered “qualified” long-term care insurance. Policies that do not meet these requirements are considered to be non-qualified long-term care insurance policies. Premiums paid for a non-qualified policy are not presumed to be deductible as accident and health insurance. However, HIPAA was silent as to the tax treatment of benefits received from non-qualified policies issued after January 1, 1997 causing confusion. To date, the Department of the Treasury has not issued an opinion on this conflict and Congress has not taken the matter up again leading to continued speculation about the tax implications of these benefits.

HIPAA also establishes a reporting mechanism for benefits received under all long-term care insurance policies. Similar to disability insurance, if a policyholder receives benefits from a long-term care insurance policy, they will receive an IRS 1099 LTC Form issued by the carrier. Benefits reported on the 1099 must also be reported on IRS Form 8853. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does not need to determine the tax qualified status of the actual long-term care insurance policy from which the benefits were paid. Form 8853, which contains the medical savings and the IRS 1099 information, adds additional mystery to the taxation of non-qualified benefits conundrum because it provides a vehicle for these benefits to be taxed. Despite continuing confusion neither the Department of the Treasury nor Congress seems anxious to clarify this matter.

Long-term care insurance benefits that are part of a life insurance or annuity contract may not receive the same tax favored status as benefits received from a tax qualified long-term care insurance policy. If the benefits constitute an advance payment of death benefit, then it is likely that they will not be taxed as income. If, however, the benefits received are part of the accumulation value of the contract, taxes may be payable. In no case are the premiums paid for life insurance or annuity contracts, which include long-term care insurance benefits, deductible as tax qualified long-term care insurance premiums.

Grandfathered Long-Term Care Insurance Policies

Congress realized that there were many long-term care insurance policies issued prior to January 1, 1997, that would not comply with HIPAA. Either their benefit structures or payment mechanisms were inferior to its guidelines or, in the case of California, the benefit triggers were considered too generous. Legislators left it to the Department of the Treasury to establish guidelines for “grandfathered” policies. In its interim directive on tax qualified long-term care insurance (Notice 97-31, May 1997), the Department of the Treasury indicated that long-term care insurance policies issued prior to January 1, 1997, meeting “long-term care insurance requirements of the State in which the contract was . . . issued” would be grandfathered for the purposes of tax qualification unless the policyholder made a “material change” to the policy. However, they did not define material change.

Final regulations issued in December 1998 identified criteria for which a material modification that would result in a policy losing its tax qualified status. Action that could be taken by the policyholder that is not material and would not jeopardize the policy's grandfathered status includes the following:

- *A change in the mode of premium payment*
- *A classwide increase or decrease in premiums for contracts that have been issued on a guaranteed renewable basis*
- *A reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder's family*
- *A reduction in coverage (with correspondingly lower premium) made at the request of a policyholder*
- *A reduction in premiums that occurs because the policyholder becomes entitled to a discount under the issuer's pre-1997 premium rate structure (such as a group or association discount or change from smoker to non-smoker status)*
- *The addition without an increase in premiums of alternative forms of benefits that may be selected by the policyholder*
- *The addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were a separate contract*
- *The deletion of a rider or provision of a contract (called an HHS – Health & Human Services – rider) that prohibited coordination of benefits with Medicare*
- *The effectuation of a continuation or conversion of coverage right under a group contract following an individual's ineligibility for continued coverage under the group contract*
- *The substitution of one insurer for another in an assumption reinsurance transaction*
- *Expansion of coverage under a group contract caused by corporate merger or acquisition*
- *Extension of coverage to collectively bargained employees*
- *The addition of former employees*

The Final Regulations suggest that the following practices will be treated as issuance of a new contract:

- *A change in terms of a contract that alters the amount or timing of an item payable by either the policyholder, the insured or insurance company*
- *A substitution of the insured under an individual contract*
- *A change (other than an immaterial change) in the contractual terms or in the plan under which the contract was issued relating to eligibility for membership in the group covered under a group contract*

Note: The important message that should be grasped from this review is that anytime a consumer considers replacing a policy issued prior to January 1, 1997, great caution must be exercised. A pre-HIPAA policy may contain provisions that might make it easier to qualify for benefits: for example, 2 out of 7 activities of daily living instead of the 2 out of 6 required by HIPAA; a medical necessity benefit trigger that is prohibited in HIPAA; no HIPAA 90 day certification requirement; the benefits of a pre-HIPAA policy do not require coordination with Medicare, which increases the amount available to pay for care.

Tax Qualified Long-Term Care Insurance Premium Deductibility

The Health Insurance Portability & Accountability Act of 1996 and subsequent Department of the Treasury rulings have created a number of different premium deduction scenarios that benefit consumers. The tax incentives that allow for premium deductibility help the self-employed and employees of companies that provide employer-paid long-term care insurance. To a lesser extent, some individual taxpayers, who are not self-employed, will benefit from the premium deductibility allowed by HIPAA.

There are four primary deductibility scenarios for tax qualified long-term care insurance. They are:

- *Medical Savings Accounts*
- *Individual deductibility*
- *Deductibility for the self-employed, owners of S-corporations, limited liability partnerships (LLP) & limited liability corporations (LLC)*
- *Deductibility for employee/owners of C-corporations*

The intent of this next section is to provide students with broad-brush guidance pertaining to the tax deductibility of TQ long-term care insurance premiums. Most agents are not Certified Public Accountants (CPA's) or tax preparers. They should always refer clients to insured's tax advisor for the final analysis as to whether premium deductibility makes sense for them.

Medical Savings Accounts

Medical Savings Accounts (MSA) were established under HIPAA. Their primary appeal is to consumers under age 65, who are willing to take on the responsibility of a relatively large medical insurance deductible in favor of lower premiums. Simply stated, the consumer purchases a medical insurance plan with a high deductible that generally exceeds \$4,000. They are then allowed to take an above-the-line deduction on their taxes equal to a percentage of the deductible (65% for an individual, 75% for a couple or family). The amount of money deducted must be placed in an MSA account. The money placed in the MSA grows tax deferred, similar to an IRA or other qualified retirement plan. The funds accumulated can be used to pay for unreimbursed medical expense (allowed by IRC Sec. 213(d)) deductibles and co-insurance. *The money in the MSA can also be used to pay the premiums on a tax qualified long-term care insurance policy.* From a practical standpoint, this is the only way an individual, self-employed or otherwise, can garner the equivalent of an above-the-line deduction for a qualified long-term care insurance policy.

MSAs have achieved inconsistent acceptance since their introduction in 1997. Their applicability depends on the regional make-up of the medical care delivery system, the availability of medical insurance plans in an area, and the pricing disparity between conventional "low-deductible" plans and the "high-deductible" plans that qualify for the MSA program. MSAs represent an opportunity for some consumers to tailor their medical insurance and long-term care insurance priorities in a cost and tax-efficient manner.

Individual Deductibility

This deductibility scenario for tax-qualified long-term care insurance is one of the most misunderstood applications. It is true that only taxpayers who itemize their deductions can benefit from the deductibility of qualified long-term care insurance premiums. It is also a fact that, based on the taxpayer's age, only a portion of the long-term care insurance premium may be deducted. With this in mind, taxpayers and their advisors may be wise to step back and take a broader view of the opportunities.

Taxpayers over age 60 with above average income and assets are typically interested in long-term care insurance. Often these individuals do itemize their deductions because they own property and the standard deduction is not in their best interest. In this situation, expenses for medical care and insurance premiums are deductible to the extent that they exceed 7.5% of adjusted gross income. Prior to HIPAA, most taxpayers in this circumstance would not exceed 7.5% of their adjusted gross income in unreimbursed medical expenses. However, with the inclusion of qualified long-term care insurance as an accident and health insurance policy, some taxpayers may benefit.

HIPAA states that premiums for tax qualified long-term care insurance are deductible as an accident and health insurance policy. *However, unlike other accident and health insurance*

premiums, the amount of qualified long-term care insurance premiums is limited by a stipulated age to the amount that can be deducted. In 2003, the age that "banded" amounts that may be applied towards the taxpayer's un-reimbursed medical expenses are:

- **Under Age 40** **\$250**
- **Ages 41 – 50** **\$470**
- **Ages 51 – 60** **\$940**
- **Ages 61 – 70** **\$2510**
- **Ages 71 +** **\$3130**

Note: These amounts allowable towards deductions are indexed upward annually by a factor of approximately 5%.

Individual taxpayers under age 61 who itemize their deductions, may not get much of a tax relief by including the allowable long-term care insurance premium amount in their unreimbursed medical expenses. However, someone age 61+ may do better. To reiterate, individual taxpayers who itemize their deductions, may include the cost of tax qualified long-term care insurance as an accident and health insurance premium. The amount allowed is limited by the above-referenced, age-related amounts. The following is a *thumbnail* example of how this may work for a hypothetical husband and wife, both age 65, who are considering purchasing a qualified long-term care insurance policy with a joint annual premium of \$7,000. Assume, for the purposes of this example, that this couple has an adjusted gross income of \$100,000 therefore they must exceed \$7,500 of un-reimbursed medical expenses before they receive any type of tax relief from these types of deductions.

- Amount Allowed For TQ-LTCI: \$5020
- Medicare Supplement Premiums \$3600
- Medicare Part B Premiums \$1400
- Other Allowable Medical Expenses \$2,000
 (Rx, eyeglasses, dental)
- Total** **\$12,020**

In this example, the taxpayers would be allowed to deduct \$4,520 (\$12,020 minus their \$7,500 threshold) of un-reimbursed medical expenses. If they are in a combined federal *and* state income tax bracket of 35%, their tax savings would equal \$1,582 ($\$4,520 \times 35\%$). This would amount to a 22% premiums savings ($\$1,520 \mid \$7,000$). *Clearly, anyone can create an example that works!* But consider the facts in this case. The deductible amount allowed for long-term care insurance premiums in and of itself is not enough to trigger a deduction for

these taxpayers, nor are the stand-alone deductions for the other unreimbursed medical expenses. *However, the combination of all of them does provide this hypothetical couple with a meaningful savings.* Most agents are not qualified tax advisors and as such need to be cautious and circumspect in their recommendations. However, an agent may spot an opportunity for a taxpayer that might go unnoticed by the client's tax preparer. Clearly, if the agent inquires as to the unreimbursed expenses illustrated above they can spot a potential tax savings for the consumer and refer them to their tax advisor.

Deductibility for the Self-Employed

For the purposes of this discussion, self-employed individuals include sole proprietors, partners and owners of S-corporations, limited liability partnerships ("LLP") and limited liability corporations ("LLC"). An owner is defined as any individual who owns 2% or more of the business entity. While these types of business entities can have a separate tax identification number for the reporting of income, the tax return that is filed is informational in nature only. The profit or loss from the business entity is passed through to the owners pursuant to their share of ownership. Typically, in sole proprietorships and partnerships, spouses are not considered owners. If they are on the payroll, they would be considered employees. Spouses of owners of S-corporations, LLP's and LLC's are considered owners regardless of their direct or indirect participation in the business' activities. *With respect to accident and health insurance coverage purchased by one of these entities for a non-owner-employee, premiums are fully deductible, there is no imputed income to employee of premiums and the benefits pass tax free at time of claim.*

The good news for owners of these entities is that beginning in 2003 premiums for accident and health insurance are 100% deductible. It is not necessary for these taxpayers to exceed 7.5% of adjusted gross income to benefit from the tax code for these expenses. Tax qualified long-term care insurance, being accident and health insurance, falls into this general rule. The bad news is that the amount allowable for deduction is limited by the previously discussed age-related schedule.

While this is not optimal, it can lead to savings. Consider a self-employed husband and wife, both age 55 who are considering purchasing a tax qualified long-term care insurance policy with a joint annual premium of \$3,600 per year. They would be allowed to deduct \$1,880 ($\940×2). If they are in the combined Federal & State tax bracket of 35% their tax savings would be \$658 or approximately 18% of premium. Additionally, they may save on their self-employment taxes because the premium amount paid by the business entity would be received not as income, but as an employee benefit. This may save this self-employed couple an additional 16% of the premium paid. Individually or combined, these tax savings provides incentives to owners of these entities to purchase qualified long-term care insurance through their businesses. *Agents should be very cautious and understand their limitations of advising consumers about their insured's specific tax situation and circumstances.*

Deductibility in Closely-Held C-Corporations

The fine difference between owners of business entities discussed in the previous section and employee owners of closely-held C-corporations is that for the purposes of paying taxes they are considered employees, not owners. Therefore, premiums paid by the C-corporation for tax qualified long-term care insurance (a.k.a. accident and health insurance) for stockholder employees is deductible to the corporation: there is no imputed income to the employee stockholder for premiums paid; and the benefits will pass tax-free at time of claim. Some believe that this tax treatment of accident and health insurance premiums and benefits means that every employee in the company must receive “like” benefits. Others go to the other extreme and tell consumers that they can discriminate as to who receives such benefits. Both are incorrect.

The Internal Revenue Code Sec. 105 clearly indicates that accident and health insurance specifically provided to stockholder employees on a selective basis, without creating a distinguishable *class of employees* who are eligible for the benefit, is not allowed. The class must be based on employment status. It cannot be based on stock ownership. A class of employees such as “officer employees” can be created for the corporation who are eligible for a specific accident and health insurance benefit. However, they must be employees, not just officers or stockholders.

Court decisions on this matter go back to 1968. If the closely-held corporation cannot validate a clear class of employees who are eligible for the benefit then the premiums could be treated as dividends to the stockholder-employee and the premiums are not deductible to the corporation. It is therefore incumbent upon agents and their tax advisors to be judicious in establishing classes eligible for coverage. It is also important for the corporation to establish the plan in their minutes and to clearly identify the classes of employees that are eligible for benefits.

Again, once a bona fide class of employees is established, tax qualified long-term care insurance premiums are deductible to the corporation; there is no income imputed to the employee and the benefits pass tax free at time of claim. This tax scenario is the best of all worlds for employees of any corporation and owner-employees of closely-held C-corporations.

Final Items On Tax Deductibility

Currently long-term care insurance *may not* be included in Section 125 Cafeteria Plans or Flexible Spending arrangements. However, for the past several sessions of Congress, legislation has been introduced to allow for this. Additionally, this legislation has attempted to expand individual deductibility and create tax credits for taxpayers who incur long-term care expenses. Over the years there has also been legislation in California designed to expand premium deductibility for State income tax purposes and to provide credits for long-term care expenses. While this paper will not speculate on the outcome of these efforts to provide additional incentives to purchase qualified long-term care insurance, legislators appear to see private insurance as an important tool of public policy.

Attachment II

CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE A PROGRAM OF THE STATE DEPARTMENT OF HEALTH SERVICES

Lifetime Asset Protection Becomes Affordable for Consumers with Moderate Incomes

Introduction

In September 1994, California implemented a major new program to help people with moderate incomes and assets purchase high quality long-term care (LTC) insurance.

This program, known as the California Partnership for Long-Term Care (CPLTC), is a partnership between the State of California and select insurance companies that offer policies containing special consumer protections.

This program also provides education to consumers and special support to insurance agents in an effort to help individuals realize their potential risk of needing LTC, and how high quality LTC insurance provides a viable option for funding these costs.

How Does This Partnership Work?

While the Partnership policy is attractive to wealthier purchasers who tend to buy lifetime coverage, its special asset protection feature is important to people who can only afford policies of shorter duration. The asset protection feature of this program is its guarantee that the State and Federal Government will provide a financial back stop should the LTC benefits provided by a Partnership policy be insufficient to meet the needs of the purchaser. Individuals who buy Partnership policies are entitled to keep additional assets equal to the amount their policy pays out, should they ever need to apply for Medi-Cal for health or LTC benefits. In the absence of such protection, single individuals can only retain \$2,000 in non-exempt assets in order to qualify for Medi-Cal benefits. This special asset protection helps assure consumers who can only afford premiums for a one or two-year policy, that should they exhaust their policy benefits they won't have to become impoverished before they can receive Medi-Cal benefits.

Individuals who purchase Non-Partnership policies and use up their policy benefits must "spend down" their assets to poverty level in order to receive Medi-Cal assistance.

This special asset protection provision, only available in Partnership policies, provides one dollar of asset protection for each dollar paid out in Partnership policy benefits. This \$-for-\$ protection allows for a variety of product designs ranging from one year to lifetime coverage. The Partnership policies offer everyone high quality benefits and \$-for-\$ asset protection against the costs of LTC, including

consumers who can afford lifetime coverage. Most important, however, Partnership policies provide people with moderate incomes the option of choosing a shorter duration policy with the “high quality protection” they need and can afford, and eliminate the fear they might end up in poverty because their LTC costs used up their policy benefits.

The purchase of “high quality protection,” which includes such provisions as automatic built-in inflation protection, adequate daily per diem, a “monthly” rather than a “daily” cap on home and community-based benefits, care management, etc., is a major objective in the design of the Partnership product. Middle-income individuals with LTC insurance policies without these protections are at serious risk of depleting their policy benefits, becoming impoverished, and having to turn to Medi-Cal to pay their ongoing LTC costs, in spite of having purchased LTC insurance.

The impoverishment protection offered by Partnership policies provides an especially good option for the elderly, who are often less able to afford longer duration high quality policies of four years or more. Here are a few examples on how the Partnership’s special asset protection feature works:

	Assets	LTC Insurance Payouts	Medi-Cal Spend Down Requirement
Person A	\$50,000	\$50,000	\$0
Person B	\$200,000	\$500,000	\$0
Person C	\$1,000,000	\$500,000	\$500,000
Person D	\$200,000	\$0	\$200,000

In Table 1 Person A is an unmarried man with \$50,000 of savings that would have to be “spent down” to \$2,000 to qualify for Medi-Cal. Without LTC insurance, this person could quickly wipe out his savings should LTC be required. Person A, however, purchased a Partnership plan that would pay out \$50,000 of benefits, the average costs of a nursing home in his community for a year. Person A uses up all \$50,000 of insurance benefits and still needs nursing home care. In applying for Medi-Cal, Person A shows the eligibility worker a form issued by his insurance company indicating a total of \$50,000 of Partnership insurance benefits were paid

out. Medi-Cal will allow Person A to keep \$50,000 in additional savings and still qualify for Medi-Cal. Person A is in a nursing home for a year and a half after applying for Medi-Cal, during which time Medi-Cal paid out \$40,000 worth of claims for LTC and other medical costs. At the time of Person A's death, Medi-Cal begins action to collect from his estate. However, once again, Medi-Cal recognizes that Person A received \$50,000 of Partnership insurance benefits, which protected an equal amount of his estate against Medi-Cal estate collection. Person A is able to pass on \$50,000 in inheritance to his heirs.

Person B in Table 1 has \$200,000 of savings and chose to purchase a Partnership policy that would pay out \$200,000 worth of benefits, about four years of today's nursing home costs in Person B's community. Unfortunately, Person B ended up receiving services in her home for a year before spending the last 7 years of her life in a nursing home. The policy benefits of \$200,000 were used up after about 6 years. When she applied for Medi-Cal she was able to keep an additional \$200,000 of savings, and this amount was protected from Medi-Cal recovery in her estate at the time of her death. The money was used to provide for her granddaughter's college education.

Person C anticipated having assets of \$1,000,000 by the time she might need LTC, but chose to protect only a portion of her assets by purchasing a Partnership policy that would pay out \$200,000 in benefits. Person C did not need her policy benefits for about 20 years after she purchased the policy. *Because of the automatic inflation protection built into the Partnership policy, both the value of the Partnership benefits and the amount of asset protection had grown to \$500,000 by the time she went into a nursing home, where she remained for four years before her policy was exhausted.* Person C was allowed to keep \$500,000 of additional assets at the time she qualified for Medi-Cal. In addition, at the time she passed away Medi-Cal exempted from recovery \$500,000 of her estate.

Person D in the chart represents an individual who either did not purchase LTC insurance *or bought a non-Partnership policy.* Person D ended up needing to apply for Medi-Cal to pay his ongoing nursing home costs. However, he was required to "spend down" his non-exempt assets to only \$2,000 before becoming eligible for Medi-Cal. His home was considered "exempt" property and was disregarded for the purpose of qualifying for Medi-Cal. When he died Medi-Cal placed a lien against his home, in order to recover the value of the Medi-Cal claims paid during the time he was in the nursing home.

To really appreciate the above examples, it is important to understand the basics of how Medi-Cal eligibility and estate recovery works. Under current law, \$2,000 of assets is disregarded as "exempt property" in determining a single person's eligibility for Medi-Cal. The Medi-Cal applicant's residence can also be disregarded, as well as one car and a limited number of other assets. Additional assets can be retained if an individual is in a nursing home and his or her spouse is living in the community. (It is important to understand, however, that less than 11% of persons on Medi-Cal in nursing homes are married). The asset protection provided by the Partnership is in addition to any other assets Medi-Cal allows a person to keep and still qualify for Medi-Cal.

What Other Policy Provisions are Unique to Partnership products?

While the Partnership policy offers excellent protection for everyone, it is specifically designed for individuals with moderate incomes who are unlikely to be able to afford significant rate increases, or out-of-pocket expenses at the time they need LTC benefits. The following provisions are, therefore, included in all Partnership policies:

- 1) Required inflation protection is set at 5% compounded annually. Persons 70 years of age or older have a choice between a 5% compound or a 5% simple annual inflation adjustment. This inflation protection not only helps minimize out of pocket expenses due to inflation, but also proportionately increases the level of asset protection.
- 2) Policies can not be sold that provide less than 70% of the average daily nursing home costs in the State. The minimum nursing home daily amount for Calendar Year 2003 was \$110 a day.
- 3) The home and community-based care benefit in the Partnership Comprehensive policy is capped as a “monthly” rather than a “daily” benefit. As an example, a policyholder buys a Comprehensive Policy with a home and community-based care benefit of \$55 a day. A person needing home care seldom uses a fixed amount per day. With a “monthly” cap, the policyholder has a \$1,650 bucket of money to be used for home care (\$55 X 30 days in the month). This provides a flexible way for the policyholder to combine the availability of informal care with formal care, and reduce or avoid out of pocket expenses while maximizing the policy benefits.
- 4) Care Management/Care Coordination provides all policyholders with the benefit of having a qualified licensed health care professional evaluate their need for care, and, with the policy holders input, develop a plan of care which lists informal and formal services necessary to help them maintain as much independence in the most efficient way possible. All treatment plans must include a non-inclusive list of providers in the community appropriate to provide the necessary care.

Policyholders can also choose to have the care manager/care coordinator help them access the care and monitor the appropriateness of that care. This benefit helps maximize the value of the policy benefits, as well as provide assistance to an individual and most often a family during a time of crisis. Care Management Provider Agencies providing services to Partnership policyholders must be approved by the Partnership to assure they have staff with the appropriate experience and credentials, as well as methods to assure the quality of their services. The State of California has no regulatory oversight of care management organizations other than those that provide services to Partnership policyholders.

- 5) Prior to 2002 the Department of Insurance (DOI) policy approval process only included the review of policy premiums and actuarial memorandums for Partnership policies. Subsequently, the DOI reviews all policies' premiums and actuarial memorandums. There are requirements that any request for Partnership rate increases be based on the entire pool of Partnership purchasers, and be subject to a rate cap. Partnership regulations provide for the DOI to disapprove a Partnership policy filing by a company with a history of rate increases.
- 6) Provisions related to protecting the policyholder against possible lapse were championed by the Partnership, and are now required in all policies being marketed in California.
- 7) All Partnership policies have the benefit of a stringent review by expert staff at the Department of Health Services (DHS). In addition, a review is completed on all policies by the DOI to help assure provisions are accurately described in a way that is most understandable by the consumer.

What Else is Unique?

- 1) The DHS requires agents to take specific continuing education (CE) training to be authorized to market Partnership policies. The training consists of an initial 8 hours of classroom CE on the Partnership, and thereafter an additional 8 hours of classroom CE on the Partnership every two-year license approval period. Regulations provide that agents who fail to comply with this CE requirement shall not sell Partnership policies, and companies are required to enforce this requirement or jeopardize their relationship with the CPLTC. Also, Partnership course instructors must pass an exam before they are allowed to teach.
- 2) The DHS provides services to help agents expand their understanding of the Partnership product, the importance of these quality consumer protections, and ways they can better serve their clients. These services include agent seminars, educational material, agent flyers and newsletters, and a comprehensive Website (www.dhs.ca.gov/cpltc).
- 3) DHS collaborates with its issuer partners in finding ways to reach out to Californians with information that will help them become aware of the risks of needing LTC, the benefits of LTC insurance, and the availability of the Partnership policy. Some of the current consumer education and outreach efforts include a consumer Website, consumer education videos, educational pamphlets, Public Service Announcements on radio and television, participation on radio and television talk shows and other media events, print advertising, publication of articles in magazines and newspapers, participation in health forums, and presentations to consumer groups.

What Types of Coverage is Offered:

Two types of Partnership policies are available: a “Nursing Facility and Residential Care Facility Only” Policy and a “Comprehensive” Policy. The comprehensive policy covers care in a nursing home and residential care facility, as well as the full range of home and community care services. All Partnership Policies are Tax Qualified.

Benefits and Limitations:

While Partnership policies, like all private LTC insurance policies, are transportable throughout the United States, if a policyholder exhausts the policy benefits or otherwise needs to apply for Medicaid benefits for LTC, he or she will have to return to California in order to take advantage of the special Medi-Cal asset protection. Partnership policies are only available to California residents.