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INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880 - 12865] *(Division 2 enacted by Stats. 1935, Ch. 145.)*

PART 2. LIFE AND DISABILITY INSURANCE [10110 - 11549] *(Part 2 enacted by Stats. 1935, Ch. 145.)*

CHAPTER 2.6. Long-Term Care Insurance [10231 - 10237.6] *(Chapter 2.6 added by Stats. 1988, Ch. 1342, Sec. 1.)*

ARTICLE 1. Definitions [10231 - 10231.8] *(Heading of Article 1 renumbered from Article 2 by Stats. 1992, Ch. 1132, Sec. 2.)*

10231. Unless the context requires otherwise, the definitions in this article shall govern the construction of this chapter.

(Added by Stats. 1988, Ch. 1342, Sec. 1.)

10231.2. "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 shall be regulated under this chapter. The commissioner shall review and approve individual and group policies, certificates, riders, and outlines of coverage. Other applicable laws and regulations shall also apply to long-term care insurance insofar as they do not conflict with the provisions in this chapter. Long-term care benefits designed to provide coverage of 12 months or more that are contained in or amended to Medicare supplement or other disability policies and certificates shall be regulated under this chapter.

(Amended by Stats. 2001, Ch. 159, Sec. 147. Effective January 1, 2002.)

10231.4. "Applicant" means either of the following:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

(b) In the case of a group long-term care insurance policy, the proposed certificate holder.

(Added by Stats. 1988, Ch. 1342, Sec. 1.)

10231.5. "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.

(Added by Stats. 1988, Ch. 1342, Sec. 1.)

10231.6. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to any of the following:

(a) One or more employers or labor organizations, or a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organization.

(b) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if that association meets both of the following:

(1) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation.

(2) Has been maintained in good faith for purposes other than obtaining insurance.

(c) An association or a trust or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering that policy or a certificate within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner

that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for a primary purpose other than that of obtaining insurance, have been in active existence for at least one year, have a constitution and bylaws which provide all of the following, and provide evidence that the following have been consistently implemented:

(1) The association or associations hold regular meetings, not less than annually, to further purposes of the members.

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members.

(3) The members have voting privileges and representation on the governing board and committees.

Thirty days after that filing the association or associations shall be deemed to satisfy these organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(d) A group other than as described in subdivisions (a), (b), and (c), subject to all of the following findings by the commissioner:

(1) The issuance of the group policy or certificate is not contrary to the best interest of the public.

(2) The issuance of the group policy will result in economies of acquisition or administration.

(3) The benefits are reasonable in relation to the premiums charged.

(4) The use of the true or fictitious name of the group, group master policyholder, group policy, certificate, or any trust or other entity created or used for the marketing of the group policy or certificates is not deceptive or misleading with regard to the status, character, or proprietary or representative capacity of the insurer, group, trust, or other entity.

(5) The group's main revenue source is not related to the marketing of insurance.

(6) The group's outreach method to obtain new members is not related to the solicitation of insurance.

(7) The group provides benefits or services, other than insurance, of significant value to its members. The commissioner shall investigate the percentage of members using the other services and the monetary value of those services.

(e) A life care contract provider which has received a certificate of authority in accordance with Chapter 10 (commencing with Section 1770) of Division 2 of the Health and Safety Code. Any life care contract provider which has not received the certificate of authority from the State Department of Social Services shall be subject to this chapter.

(Amended by Stats. 1992, Ch. 1132, Sec. 5. Effective January 1, 1993.)

10231.8. "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.

(Added by Stats. 1988, Ch. 1342, Sec. 1.)

ARTICLE 3. General Provisions [10232 - 10233.9] *(Article 3 added by Stats. 1988, Ch. 1342, Sec. 1.)*

10232. (a) 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 described in subdivision (d) of Section 10231.6, unless the commissioner has determined that the requirements imposed by subdivision (d) of Section 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 subdivision (d) of Section 10231.6 shall accomplish an informational filing with the commissioner which consists of the following materials:

(1) A specimen master policy and certificate.

(2) The corresponding outline of coverage.

(3) Representative advertising materials to be used in this state.

(4) At the option of the insurer, any other documentation which the insurer believes will provide information sufficient to allow the commissioner to determine that the requirements of subdivision (d) of Section 10231.6 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.

(b) 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 described in subdivision (c) of Section 10231.6, unless, prior to advertising, marketing, or offering that coverage within this state, the association or associations, or the insurer of the association or associations, files evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons, have been organized and maintained in good faith for a primary purpose other than that of obtaining insurance, have been in active existence for at least one year, have a constitution and bylaws which provide all of the

following, and provide evidence that the following have been consistently implemented:

(1) The association or associations hold regular meetings, not less than annually, to further purposes of the members.

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members.

(3) The members have voting privileges and representation on the governing board and committees.

Thirty days after that filing, the association or associations shall be deemed to satisfy those organizational requirements, unless the commissioner makes the finding that the association or associations do not satisfy those organizational requirements.

The association or associations, or the insurer of the association or associations, shall accompany this organizational filing with an informational filing which consists of the following materials:

(1) A specimen master policy and certificate.

(2) The corresponding outline of coverage.

(3) Representative advertising materials to be used in this state.

(c) Compliance with the informational filings required to be made by this section shall also constitute compliance with the filing requirements of Section 10233.9.

(d) The materials required to be filed with the commissioner by this section shall be filed with the commissioner for informational purposes only, and not for approval purposes.

(Amended by Stats. 1992, Ch. 1132, Sec. 6. Effective January 1, 1993.)

10232.1. (a) Every policy that is intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall 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 as provided by Public Law 104-191 shall 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 not intended to be a federally qualified long-term care insurance contract.”

(b) 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” shall 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.

(c) 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. The commissioner may approve alternative wording if it is more descriptive of the benefits.

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

(Amended by Stats. 1999, Ch. 947, Sec. 1. Effective January 1, 2000.)

10232.2. (a) 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 and affirmatively concurrently file, offer, and market long-term care insurance policies or certificates not intended to be federally qualified, as described in subdivision (a) of Section 10232.1.

(b) 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 of this chapter.

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

(d) Group policies issued prior to January 1, 1997, shall be allowed to remain in force and not be required to meet the requirements of this chapter, as amended during the 1997 portion of the 1997–98 Regular Session, 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 pursuant to Section 7702B(f) 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.

(e) It is the intent of the Legislature that the commissioner approve by July 1, 2001, all accurate and complete contracts

submitted for approval pursuant to subdivision (b). It is the further intent of the Legislature that insurers submit contracts for approval and resolve further outstanding issues pursuant to subdivision (b) in a timely manner in order for the commissioner to approve the contracts by July 1, 2001.

(Amended (as amended by Stats. 1999, Ch. 947) by Stats. 2001, Ch. 51, Sec. 3. Effective July 9, 2001.)

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

(b) 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.”

(c) Every application for long-term care insurance shall include a checklist that enumerates each of the specific documents that this chapter requires 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:

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

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

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

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

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

(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 or Section 10235.18 if replacement is made by direct response solicitation. Unless the solicitation was made by a direct response method, the agent and applicant shall both sign at the bottom of the checklist to indicate the required documents were delivered and received.

(d) If 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 certificate, 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. The evidence shall:

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

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

(3) Be material to the acceptance for coverage.

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

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

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

(h) Every insurer shall maintain a record, in accordance with Section 10508, of all policy or certificate rescissions, both state and countrywide, and shall annually furnish this information to the commissioner, which shall include the reason for rescission, the length of time the policy or certificate was in force, and the age and gender of the insured person, in a format prescribed by the commissioner.

(i) The commissioner may, in his or her discretion, make public the aggregate data collected under subdivision (h), upon request.

(Amended by Stats. 2008, Ch. 227, Sec. 1. Effective January 1, 2009.)

10232.4. (a) 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.

(b) 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.

(c) 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 described in subdivision (b) 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 described in subdivision (b).

(Amended by Stats. 1999, Ch. 947, Sec. 4. Effective January 1, 2000.)

10232.5. 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:

(a) Preconditions the availability of benefits on prior hospitalization.

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

(c) Preconditions the availability of benefits for community-based care, home health care, or home care on prior institutionalization.

(d) Conditions eligibility for noninstitutional benefits, other than those in subdivision (c), on a prior institutional stay of more than 30 days.

(Repealed and added by Stats. 1989, Ch. 1273, Sec. 4.2.)

10232.6. The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation. Any regulations adopted by the commissioner shall substantially reflect the loss ratio standards contained in Section 10 of the National Association of Insurance Commissioners Long-Term Care Insurance Model Regulations, as most recently revised.

(Added by Stats. 1988, Ch. 1342, Sec. 1.)

10232.65. In addition to any other requirements of law, the following shall apply to a long-term care insurance policy:

(a) The insurer shall not require an amount greater than one month's premium to be submitted with an application for the policy of insurance if interim coverage is not provided. If interim coverage is provided, the insurer shall not require an amount greater than two months' premium for that purpose. No further premiums may be collected until the policy is delivered to the applicant.

(b) The insurer shall notify the applicant within 60 days from the date the insurer or insurer's authorized representative or producer receives the application and the amount as to whether or not the applicant will be issued a policy of insurance. If the applicant is not so notified, the insurer or insurer's authorized representative or producer shall pay interest to the applicant on the funds that the applicant submitted with the application, at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure, from the date the insurer or insurer's authorized representative or producer received those funds until they are refunded to the applicant or are applied toward the premium.

(Added by Stats. 2001, Ch. 328, Sec. 5. Effective January 1, 2002.)

10232.7. (a) 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 as described in subdivisions (a) and (b) of Section 10231.6, shall 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 if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(b) The return of a policy or certificate shall void the policy or certificate from the beginning and the parties shall 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 shall be fully refunded directly to the applicant by the insurer within 30 days after the policy or certificate is returned.

(c) Notwithstanding Section 10276 or any other law, long-term care insurance policies or certificates to which this section applies shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating in substance the conditions described in subdivisions (a) and (b).

(Amended by Stats. 1989, Ch. 1273, Sec. 5.)

10232.8. (a) 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:

(1) Impairment in two out of seven activities of daily living.

(2) 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.

(b) In every long-term care policy approved or certificate issued after the effective date of the act adding this section, that is intended to be a federally qualified long-term care insurance contract as described in subdivision (a) of Section 10232.1, the threshold establishing eligibility for home care benefits shall provide that a chronically ill insured will qualify if either one of two criteria are met or if a third criterion, as provided by this subdivision, is met:

(1) Impairment in two out of six activities of daily living.

(2) Impairment of cognitive ability.

Other criteria shall be 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 shall promulgate 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 shall include the third criterion. No policy shall 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 shall be eligible for benefits regardless of whether the individual meets the impairment requirements in paragraph (1) or (2) regarding activities of daily living and cognitive ability.

(c) 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. For the purposes of long-term care insurance as defined in Section 10231.2, an insurer shall not impose a certification requirement of longer than 90 days. If a health care practitioner makes a determination, pursuant to this section, that an insured does not meet the definition of “chronically ill individual,” the insurer shall notify the insured that the insured shall be entitled to a second assessment by a licensed health care practitioner, upon request, who shall personally examine the insured. The requirement for a second assessment shall not apply if the initial assessment was performed by a practitioner who otherwise meets the requirements of this section and who personally examined the insured. The assessments conducted pursuant to this section shall be performed promptly with the certification completed as quickly as possible to ensure that an insured’s benefits are not delayed. The written certification shall be renewed every 12 months. A licensed health care practitioner shall 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 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. It is the intent of this subdivision that the practitioner’s assessments be unhindered by financial considerations. This subdivision shall apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract.

(d) “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 shall 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; “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.

(e) 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.

(f) 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:

(1) 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.

(2) 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.

(3) 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).

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

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

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

The commissioner may approve the use of definitions of “activities of daily living” that differ from the verbatim definitions of this subdivision if these definitions would result in more policy or certificate holders qualifying for long-term care benefits than would occur by the use of the verbatim definitions of this subdivision. In addition, the following definitions may be used without the approval of the commissioner: (1) the verbatim definitions of eating, bathing, dressing, toileting, transferring, and continence in subdivision (g); or (2) the verbatim definitions of eating, bathing, dressing, toileting, and continence in this subdivision and a substitute, verbatim definition of “transferring” as follows: “transferring,” which shall mean 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. In addition to the verbatim definitions, the commissioner may approve additional descriptive language to be added to the definitions, if the additional language is (1) warranted based on federal or state laws, federal or state regulations, or other relevant federal decision, and (2) strictly limited to that language that is necessary to ensure that the definitions required by this section are not misleading to the insured.

(g) The definitions of “activities of daily living” to be used verbatim in policies and certificates that are not intended to qualify for favorable tax treatment under Public Law 104-191 shall be the following:

(1) 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.

(2) 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.

(3) 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.

(4) 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.

(5) 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.

(6) 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.

(7) Ambulating, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

(Amended by Stats. 2013, Ch. 345, Sec. 2. Effective January 1, 2014.)

10232.9.

(a) 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:

(1) Home health care.

(2) Adult day care.

(3) Personal care.

(4) Homemaker services.

(5) Hospice services.

(6) Respite care.

(b) For purposes of this section, policy definitions of these benefits may be no more restrictive than the following:

(1) “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.

(2) “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.

(3) “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.

(4) “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.

(5) “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.

(6) “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.

(c) Home care benefits shall not be limited or excluded by any of the following:

(1) Requiring a need for care in a nursing home if home care services are not provided.

(2) Requiring that skilled nursing or therapeutic services be used before or with unskilled services.

(3) Requiring the existence of an acute condition.

(4) Limiting benefits to services provided by Medicare-certified providers or agencies.

(5) 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.

(6) 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.

(7) Requiring “medical necessity” or similar standard as a criteria for benefits.

(d) 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, shall pay a maximum benefit payment for home care that is at least 50 percent 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, shall allow a similar durational maximum for home care that is at least one-half of the length of time allowed for institutional care.

(Added by renumbering Section 10232.8 by Stats. 1997, Ch. 699, Sec. 4. Effective October 6, 1997.)

10232.92. Every long-term care policy or certificate covering confinement in a nursing facility shall also include a provision with the following features:

(a) 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. 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.

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

(c) 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 as authorized by Public Law 104-191 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. There shall be 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 provided by Public Law 104-191.

(d) In policies or certificates that are not intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility shall be no more restrictive than that for home care benefits, as defined in subdivision (a) of Section 10232.8, and the definitions of impairment in activities of daily living and impairment of cognitive ability shall be the same as for home care benefits, as defined in subdivisions (a) and (g) of Section 10232.8. In policies or certificates that are intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility shall be no more restrictive than that for home care benefits, as defined in subdivision (b) of Section 10232.8, and the definitions of impairment in activities of daily living and impairment in cognitive ability shall be the same as those for home care benefits as defined in subdivisions (b), (c), (d), (e), and (f) of Section 10232.8.

(Repealed and added by Stats. 1999, Ch. 947, Sec. 6. Effective January 1, 2000.)

10232.93. Every long-term care policy or certificate shall define the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any home- and community-based services defined in Section 10232.9, assisted living benefit defined in Section 10232.92, 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.

(Added by Stats. 1997, Ch. 699, Sec. 6. Effective October 6, 1997.)

10232.95. 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.

(Added by Stats. 1997, Ch. 699, Sec. 6.3. Effective October 6, 1997.)

10232.96. 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.

(Added by Stats. 1997, Ch. 699, Sec. 6.5. Effective October 6, 1997.)

10232.97. 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:

(a) Impairment in two activities of daily living.

(b) Impairment in cognitive ability.

(Added by Stats. 1999, Ch. 947, Sec. 7. Effective January 1, 2000.)

10233. Precedent to the payment of benefits for any care covered by the terms of the policy, any insurer offering long-term care insurance as described in Section 10231.2 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.

(Added by Stats. 1989, Ch. 1273, Sec. 7.)

10233.2. Long-term care insurance may not:

(a) 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.

(b) 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.

(c) 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.

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

(e) 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.

(f) Include an additional benefit for a service with a known market value other than the statutorily required home- and community-based service benefits in Section 10232.9, the assisted living benefit in Section 10232.92, 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.

(Amended by Stats. 1999, Ch. 947, Sec. 8. Effective January 1, 2000.)

10233.25. No long-term care policy or certificate that is issued, amended, renewed, or delivered on and after January 1, 2002, shall contain a provision that prohibits or restricts any health facilities' compliance with the requirements of Section 1262.5 of the Health and Safety Code.

(Added by Stats. 2001, Ch. 691, Sec. 7. Effective January 1, 2002.)

10233.3. If a policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall 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.

(Added by Stats. 1992, Ch. 1132, Sec. 14. Effective January 1, 1993.)

10233.4. 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.

(Added by Stats. 1989, Ch. 1273, Sec. 9.)

10233.5. (a) 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.

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

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

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

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

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

(g) 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.

(h) 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)

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

2.PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

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

(a) Provide a brief description of the right to return—"free look" provision of the policy.

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

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

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

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

5.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.)

6.BENEFITS PROVIDED BY THIS POLICY.

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

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

(c) (Noninstitutional 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.)

7.LIMITATIONS AND 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 section 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 described in (6) above.)

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

8.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:

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

(b) Any automatic benefit adjustment provisions.

(c) 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.

(d) 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.

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

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

(a) Describe the policy renewability provisions.

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

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

(d) 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.

10.ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND RELATED MENTAL DISEASES.

(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's Disease, organic disorders, or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for that insured.)

11.PREMIUM.

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

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

12.ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.

13.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."

(Amended by Stats. 1999, Ch. 947, Sec. 9. Effective January 1, 2000.)

10233.6. A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include all of the following:

(a) A description of the principal benefits and coverage provided in the policy.

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy.

(c) 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.

(d) A statement that the group master policy determines governing contractual provisions.

(e) An explanation of the insured's rights regarding continuation, conversion, and replacement.

(Amended by Stats. 1992, Ch. 1132, Sec. 16. Effective January 1, 1993.)

10233.7. No policy may be advertised, marketed, or offered as long-term care or nursing home insurance unless it complies with this chapter.

(Added by Stats. 1989, Ch. 1273, Sec. 12.)

10233.9. 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:

(a) Specimen individual policy form or group master policy and certificate forms.

(b) Corresponding outline of coverage.

(c) Representative advertising materials to be used in this state.

(Added by Stats. 1989, Ch. 1273, Sec. 14.)

ARTICLE 3. Administration and Enforcement [10234 - 10234.7] *(Article 3 added by Stats. 1989, Ch. 1273, Sec. 15.)*

10234. The commissioner shall, as required by this chapter, or from time to time as conditions warrant, pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, adopt reasonable regulations, and amendments and additions thereto, as are necessary to administer this chapter.

(Added by Stats. 1989, Ch. 1273, Sec. 15.)

10234.2. (a) 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.

(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.

(c) 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 shall award reasonable attorney's fees and costs to a prevailing plaintiff who establishes a violation of this chapter.

(Added by Stats. 1992, Ch. 1132, Sec. 18. Effective January 1, 1993.)

10234.3. (a) 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 two hundred fifty dollars ($250) for each first violation. The penalty for committing a subsequent or a knowing violation of this chapter shall be not less than one thousand dollars ($1,000) and not more than twenty-five thousand dollars ($25,000) for each violation. The penalty for inappropriate replacement of long-term care coverage shall be not more than five thousand dollars ($5,000) for each violation.

(b) Any insurer that violates this chapter is liable for an administrative penalty of not less than five thousand dollars ($5,000) for each first violation. The penalty for committing a subsequent or knowing violation shall be not less than ten thousand dollars ($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 ten thousand dollars ($10,000) and not more than five hundred thousand dollars ($500,000).

(c) Penalties shall be paid to the Insurance Fund.

(Added by Stats. 1992, Ch. 1132, Sec. 19. Effective January 1, 1993.)

10234.4. 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:

(a) Suspend or revoke the license of any broker, agent, or other producer licensed by the department.

(b) Suspend an insurer's certificate of authority to transact disability insurance.

(c) 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 this chapter.

(Repealed and added by Stats. 1992, Ch. 1132, Sec. 21. Effective January 1, 1993.)

10234.5. (a) 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:

(1) A summary of the facts establishing reasonable cause that a violation has occurred.

(2) Citation of the code section or other standard allegedly violated.

(3) A statement of the commissioner's intent to assess a penalty including the amount of the penalty, or to seek another remedy.

(4) A statement of the respondent's right to elect any of the following:

(A) To accept assessment of the penalty or other remedy as stated in the notice.

(B) To respond to the charge in writing, after which the commissioner may issue a final order or set a hearing.

(C) To request, within 10 days of receipt of the notice, a public hearing.

(c) 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.

(d) 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.

(e) 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.

(Repealed and added by Stats. 1992, Ch. 1132, Sec. 23. Effective January 1, 1993.)

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:

(1) A comparison of the different types of long-term care insurance and coverages available to California consumers and a specimen outline of coverage for each product currently marketed by each insurer listed in the rate guide.

(2) 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.

(b) The consumer rate guide to be prepared by the commissioner shall consist of two parts: a history of the rates for all policies issued in California for the current year and for four preceding years, and a comparison of the policies, benefits, and sample premiums for all policies currently being issued for delivery in California.

(1) 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 California for the current year and for four preceding years:

(A) Company name.

(B) Policy type.

(C) Policy form identification.

(D) Dates sold.

(E) Date acquired (if applicable).

(F) Premium rate increases requested.

(G) Premium rate increases approved.

(H) Dates of premium rate increase approvals.

(I) Any other information requested by the department.

(2) For the policy comparison portion of the rate guide required by this section, the department shall collect, and each insurer shall 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:

* *

NOTICE OF INCOMPLETE TEXT: The Policy Comparison Information
form appears in the hard-copy publication of the chaptered bill.
See Sec. 1 of Chapter 627, Statutes of 2012.

* *

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 shall use 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.

(c) 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 the nine preceding years.

(d) Insurers shall provide the information required pursuant to subdivisions (b) and (c) no later than July 31 of each year, commencing in 2000.

(e) The consumer rate guide shall be published no later than December 1 of each year commencing in 2000, and shall be distributed using all of the following methods:

(1) Through Health Insurance Counseling and Advocacy Program (HICAP) offices.

(2) By telephone using the department's consumer toll-free telephone number.

(3) On the department's Internet Web site.

(4) A notice in the Long-Term Care Insurance Personal Worksheet required by Section 10234.95.

(f) 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.

(Amended by Stats. 2012, Ch. 627, Sec. 1. Effective January 1, 2013. Note: See published chaptered bill for complete section text; the Policy Comparison Information form appears on page 4 of Ch. 627.)

10234.7. 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:

(a) The Health Insurance Counseling and Advocacy Program.

(b) 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.

(Added by Stats. 1989, Ch. 1273, Sec. 15.)

ARTICLE 3.7. Consumer Protection [10234.8 - 10234.97] *(Article 3.7 added by Stats. 1989, Ch. 631, Sec. 1.)*

10234.8. (a) 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.

(b) 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.

(Amended by Stats. 2000, Ch. 442, Sec. 4. Effective January 1, 2001.)

10234.85. No insurer, broker, agent, or other person shall cause a policyholder to replace a long term care insurance policy unnecessarily. Nothing in this section shall 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 within the meaning of this section. This section shall not apply to those instances in which a policy is replaced solely for the purpose of consolidating policies with a single insurer.

(Added by Stats. 1989, Ch. 631, Sec. 1.)

10234.86. (a) 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.

(b) Every insurer shall report annually by June 30, the 10 percent of its agents in the state with the greatest percentage of lapses and replacements as measured by subdivision (a).

(c) 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.

(d) 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.

(e) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(Amended by Stats. 2011, Ch. 426, Sec. 7. Effective January 1, 2012.)

10234.87. (a) 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 percent. No credit need be provided if a claim has been filed under the original policy or certificate.

(b) 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.

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

(Amended by Stats. 1998, Ch. 1067, Sec. 5. Effective January 1, 1999.)

10234.9. (a) 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 shall be retained by the insurer in accordance with Section 10508 for at least three years.

(b) An advertisement designed to produce leads must prominently disclose that "an insurance agent will contact you" if that is the case.

(c) 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.

(Repealed and added by Stats. 1992, Ch. 1132, Sec. 25. Effective January 1, 1993.)

10234.93. (a) Every insurer of long-term care in California shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) 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.

(4) 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 count toward the licensee's continuing education requirement, but may still result in completing more than the minimum number of continuing education hours set forth in this section:

(A) 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 eight hours of training prior to each license renewal.

(B) For licensees issued a license before January 1, 1992, eight hours of training prior to each license renewal.

(C) 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.

(5) 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."

(6) 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.

(7) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subdivision.

(8) 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.

(9) 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.

(10) Clearly post on its Internet Web site and provide written notice at the time of solicitation that a specimen individual policy form or group master policy and certificate form for each policy form offered in this state is available to a prospective applicant upon request. The individual specimen policy form or group master policy and certificate form shall be provided to a requesting party within 15 calendar days of receipt of a request.

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

(1) Twisting. Knowingly making any misleading representation, 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.

(2) 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.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing that 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.

(Amended by Stats. 2013, Ch. 321, Sec. 23. Effective January 1, 2014.)

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

(1) 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.

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

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

(b) 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:

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

(2) 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.

(3) 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.

(c) (1) The issuer, and where an agent is involved, the agent, shall make reasonable efforts to obtain the information set out in subdivision (b). 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.

(2) In the premium section of the personal worksheet, the insurer shall 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.

(3) 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.

(4) 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.

(d) 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.

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

(f) 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.

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

(h) 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.

(i) 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.

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

(Amended by Stats. 2000, Ch. 560, Sec. 2. Effective September 20, 2000.)

10234.97. (a) 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 shall be limited to the percentage of sale normally paid for renewal of long-term care policies or certificates. Replacement shall be contingent upon the insurer's declaration that the replacement policy materially improves the position of the insured, pursuant to Section 10235.16. This provision does not apply to replacement coverage which is group insurance as described in subdivision (a) of Section 10231.6.

(b) For purposes of this section, "commission or other compensation" includes pecuniary or nonpecuniary 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.

(c) 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.

(Amended by Stats. 1993, Ch. 316, Sec. 1. Effective August 30, 1993.)

ARTICLE 4. Implementation [10235 - 10236.15] *(Article 4 added by Stats. 1989, Ch. 767, Sec. 2.)*

10235. Except as provided in Section 10235.95, this article applies to all long-term care insurance policies delivered or issued for delivery in this state on or after January 1, 1990.

(Amended by Stats. 2008, Ch. 171, Sec. 1. Effective January 1, 2009.)

10235.2. 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:

(a) "Medicare" shall be 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, as then constituted and any later amendments or substitutes thereof, or words of similar import.

(b) "Skilled nursing care," "intermediate care," "home health care," and other services shall be 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.

(c) All providers of services, including, but not limited to, skilled nursing facilities, intermediate care facilities, and home health agencies shall be 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.

(Amended by Stats. 1999, Ch. 947, Sec. 9.5. Effective January 1, 2000.)

10235.8. 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:

(a) Preexisting conditions or diseases.

(b) Alcoholism and drug addiction.

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

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

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

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

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

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

(d) 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 section does not prohibit exclusions and limitations by type of provider or territorial limitations.

(Amended by Stats. 1999, Ch. 947, Sec. 10. Effective January 1, 2000.)

10235.9. (a) Every insurer shall 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.

(b) The insurer shall provide 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 shall annually report to the department the number of denied claims.

(c) The department shall make available to the public, upon request, the denial rate of claims by insurer.

(Added by Stats. 1997, Ch. 699, Sec. 12. Effective October 6, 1997.)

10235.10. 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.

(Added by Stats. 1989, Ch. 767, Sec. 2.)

10235.14. (a) Individual long-term care insurance policies shall contain a renewability provision. This provision shall be appropriately captioned, shall appear on the first page of the policy, and shall 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 shall clearly and concisely describe each circumstance under which the premium may change.

(b) 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 shall require 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 shall 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 shall be set forth in the policy, rider, or endorsement.

(c) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, those limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "preexisting condition limitations."

(d) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility shall set forth 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 shall label that paragraph "Limitations or Conditions on Eligibility for Benefits."

(Amended by Stats. 1992, Ch. 1132, Sec. 31. Effective January 1, 1993.)

10235.16. (a) Long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance is intended to replace any other accident and sickness or long-term care insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(b) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent shall furnish the applicant, prior to issuance or delivery of a policy or certificate, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of this notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. 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 long-term care insurance coverage to be 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 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.

(1) 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.

(2) 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.

(3) 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. 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.

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

(Date)
(Applicant's Signature)"

(c) 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.

(d) The replacement notice shall include the following statement except when the replacement coverage is group insurance as described in subdivision (a) of 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)

(Amended by Stats. 1992, Ch. 1132, Sec. 32. Effective January 1, 1993.)

10235.17. For purposes of this chapter, the commissioner shall define inappropriate replacement of long-term care insurance in consultation with other interested parties.

(Added by Stats. 1992, Ch. 1132, Sec. 33. Effective January 1, 1993.)

10235.18. (a) 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.

(1) 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.

(2) 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.

(3) (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. 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.

	(Company Name)"

(b) 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.

(Added by Stats. 1989, Ch. 767, Sec. 2.)

10235.20. 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 specified in subdivisions (a), (b), and (c), as follows:

(a) The waiver would be in the best interest of the insureds.

(b) The underlying purposes of this article could not be effectively or efficiently achieved without the waiver.

(c) Any of the following:

(1) The waiver is necessary to the development of an innovative and reasonable approach for insuring long-term care.

(2) 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.

(3) 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 the purposes of this article.

(Added by Stats. 1989, Ch. 767, Sec. 2.)

10235.30. (a) 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 nonforfeiture benefit with the following features:

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

(2) 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.

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

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

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

(6) The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.

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

(Amended by Stats. 1999, Ch. 947, Sec. 11. Effective January 1, 2000.)

10235.35. (a) Notwithstanding any other provision of law, the commissioner may require the administration by an insurer of the contingent benefit upon lapse, as described in Section 26 (A), (D) (3), (E), (F), (G), and (J) of the

Long-Term Care Insurance Model Regulation promulgated 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.

(b) The insurer shall 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 pursuant to Section 10235.50 to avoid an increase in the policy's premium amount.

(c) The commissioner may also approve any other alternative mechanism filed by the insurer in lieu of the contingent benefit upon lapse.

(Added by Stats. 2006, Ch. 312, Sec. 1. Effective January 1, 2007.)

10235.40. (a) No individual long-term care policy or certificate shall 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 shall receive from each applicant one of the following:

(1) 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.

(2) A waiver signed and dated by the applicant electing not to designate additional persons to receive notice. The required waiver shall read 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"

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

(c) 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 contained in subdivision (a) 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 shall clearly indicate the deduction payment plan selected by the applicant.

(d) 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 pursuant to subdivision (a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, not less than 30 days after a premium is due and unpaid.

(e) Each long-term care insurance policy or certificate shall 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 shall be available to the insured if requested within five months after termination and shall allow for the collection of a past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy certificate.

(Amended by Stats. 1999, Ch. 947, Sec. 12. Effective January 1, 2000.)

10235.50. Every policy or certificate shall include a provision that gives the policyholder or certificate holder the following rights to reduce coverage and lower premiums:

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

(1) Reducing the lifetime maximum benefit.

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

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

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

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

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

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

(Amended by Stats. 1999, Ch. 947, Sec. 13. Effective January 1, 2000.)

10235.51. (a) 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:

(1) Increase the amount of the per diem benefits.

(2) Increase the lifetime maximum benefit.

(3) 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.

(b) 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.

(c) 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.

(Added by Stats. 1997, Ch. 699, Sec. 16. Effective October 6, 1997.)

10235.52. (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:

(1) 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.

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

(A) 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.

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

(C) 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.

(b) 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.

(c) The insurer of a group policy as defined under subdivisions (a) to (c), inclusive, of Section 10231.6 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.

(d) This section shall become operative on June 30, 2003.

(Amended by Stats. 2003, Ch. 62, Sec. 201. Effective January 1, 2004.)

10235.91. 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 shall be filed and approved by the department.

(Added by Stats. 1997, Ch. 699, Sec. 18. Effective October 6, 1997.)

10235.94. 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.

(Added by Stats. 1999, Ch. 947, Sec. 15. Effective January 1, 2000.)

10235.95. (a) Notwithstanding Section 10235, this section applies to all long-term care policies in force, regardless of their dates of issuance.

(b) Interest shall accrue and shall be payable to the claimant at the rate of 10 percent per annum on the amount of any accepted claim beginning on the first calendar day after the day that the payment of the accepted claim is due pursuant to Section 2695.7 of Title 10 of the California Code of Regulations or any successor to that provision, provided that the claim is accepted on or after December 1, 2008.

(Added by Stats. 2008, Ch. 171, Sec. 2. Effective January 1, 2009.)

10236. Every individual and group long-term care policy and certificate under a group long-term care policy shall be either guaranteed renewable or noncancelable.

(a) "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.

(b) "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.

(c) 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.

(Amended by Stats. 2001, Ch. 159, Sec. 148. Effective January 1, 2002.)

10236.1. (a) Benefits under individual long-term care insurance policies issued before new premium rate schedules are approved under Section 10236.11 shall be deemed reasonable in relation to premiums if the expected loss ratio is at least 60 percent, calculated in a manner that provides for adequate reserving of the long-term care insurance risk.

(b) (1) For individual long-term care insurance policies issued before new premium rate schedules are approved under Section 10236.11, and for which rate revisions are filed on or after January 1, 2010, benefits shall be deemed reasonable in relation to the premium if the premium rate schedules have a lifetime expected loss ratio of at least 60 percent of the premium scale in effect on December 31, 2009, plus 70 percent of premium increases filed on or after January 1, 2010, calculated in a manner that provides for adequate reserving of the long-term care insurance risk.

(2) However, if the premiums in any rate revision filing calculated in the manner provided in paragraph (1) produce a lifetime expected loss ratio that is less than the highest lifetime expected loss ratio for this policy form in the initial filing or that for requested premium rates in any filing made after January 1, 2013, the insurer shall reduce the premiums in the filing so that the current lifetime expected loss ratio is equal to or greater than the highest initially filed loss ratio or that for requested premium rates filed after January 1, 2013. In the determination of a lifetime expected loss ratio, a margin may reflect changes in the manner in which risks are shared between the insurer and a block of policies due to changes in this law effective January 1, 2013, and that margin shall not be increased unless the manner in which risks are shared between the insurer and the block of policies is changed further by law or regulation. The determination of the lifetime expected loss ratio shall be based on the actual distribution of policies in force at the time of the first filing after January 1, 2013, and not any prior assumed distribution.

(c) In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:

(1) Statistical credibility of incurred claims experience and earned premiums.

(2) The period for which rates are computed to provide coverage.

(3) Experienced and projected trends.

(4) Concentration of experience within early policy duration.

(5) Expected claim fluctuation.

(6) Experience refunds, adjustments, or dividends.

(7) Renewability features.

(8) All appropriate expense factors.

(9) The discount rate used in the calculation of lifetime expected loss ratios.

(10) Experimental nature of the coverage.

(11) Policy reserves.

(12) Mix of business by risk classification.

(13) Product features, such as long elimination periods, high deductibles, and high maximum limits.

(d) Asset investment yield rate changes may not be used to justify a rate increase unless the insurer can demonstrate that its return on investments is lower than the maximum valuation interest rate for contract reserves for those policies or the commissioner determines that a change in interest rates is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state.

(e) The experience on all similar long-term care policy forms issued in this state by an insurer and its affiliates and retained within the affiliated group shall be pooled together and the combined experience shall be used as the basis for assumptions that satisfy the requirements in subdivisions (a) and (b). Those assumptions and requested rate increases may vary by policy form if actuarially appropriate. Similar long-term care policy forms shall be classified into one of the following benefit classifications: nursing facility and residential care facility only, home care only, or comprehensive long-term care benefits.

(f) Notwithstanding any other provision of this section, for rate revisions filed on or after January 1, 2010, the commissioner may approve an application for a rate revision based on less than a 70 percent loss ratio, but not less than a 60 percent loss ratio, for the portion attributable to the rate increase if an insurer can demonstrate that the rates are necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

(g) This section applies only to long-term care insurance policies issued before the approval of rate schedules under Section 10236.11.

(Amended by Stats. 2012, Ch. 627, Sec. 3. Effective January 1, 2013.)

10236.2. Except where the provisions of a group contract provide otherwise, the provisions of subdivisions (d) and (e) of Section 10236.1 shall apply to all group long-term care insurance policies issued before the approval of premium rate schedules under Section 10236.11.

(Added by Stats. 2012, Ch. 627, Sec. 4. Effective January 1, 2013.)

10236.5. (a) 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:

(1) The termination of group coverage resulted from the insured's failure to make any required payment of premium or contribution when due.

(2) 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:

(A) 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.

(B) 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.

(b) "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.

(c) "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:

(1) 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.

(2) 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.

(3) 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 percent 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.

(4) 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.

(Added by Stats. 1992, Ch. 1132, Sec. 35. Effective January 1, 1993.)

10236.8. If a group long-term care policy is replaced by another policy to the same master policyholder issued, the replacing insurer shall do all of the following:

(a) 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.

(b) 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.

(c) Offer coverage to all persons covered under the replaced group policy on its date of termination.

(d) Not exclude coverage for preexisting conditions if the terminating group coverage would provide benefits for those preexisting conditions.

(e) Not require new waiting periods, elimination periods, probationary periods, or similar preconditions related to preexisting conditions. The insurer shall waive any such time periods applicable to preexisting conditions to the extent that similar preconditions have been satisfied under the terminating group coverage.

(f) Not vary the benefits or the premium based on the insured's health, disability status, claims experience, or use of long-term care services.

(Added by Stats. 1992, Ch. 1132, Sec. 36. Effective January 1, 1993.)

10236.11. 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:

(a) 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.

(b) 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:

(1) 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.

(2) An actuarial certification consisting of at least all of the following:

(A) 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.

(B) A statement that the policy design and coverage provided have been reviewed and taken into consideration.

(C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.

(D) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include all of the following:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held.

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience.

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted).

(iv) 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.

(E) 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.

(c) 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. Insurers that have filed premium rate schedules and new policy forms by March 1, 2002, 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) June 30, 2003.

(d) Nothing in this section shall be construed as prohibiting an insurer from filing new group and individual policy forms, or from relieving an insurer of the obligation to file these forms, with the commissioner after January 1, 2003, if the policy form meets all the requirements of this chapter.

(Amended by Stats. 2002, Ch. 675, Sec. 4. Effective January 1, 2003.)

10236.12. All actuaries used by the commissioner to review rate applications submitted by insurers pursuant to this chapter who are employees of the department shall be members of the American Academy of Actuaries, with at least five years' relevant experience in long-term care insurance industry pricing or alternatively shall meet the professional requirements to issue a "statement of actuarial opinion" as required by subdivision (a) of Section 10236.13.

If the department does not have sufficient employees who are actuaries meeting the requirements of this section to perform the volume of work required by this chapter, the commissioner may contract, as necessary, with independent actuaries who 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 has employees who are actuaries, and independent actuaries under contract to the department, both meeting the requirements of this section to review rate applications, an insurer may generally choose between having the rate application reviewed by either employees or independent actuaries under contract to the department. The costs and expenses of reviews by independent actuaries under contract to the department shall be charged to the insurer. However, the department shall have the discretion to require a review by independent actuaries.

Employees of the department who are actuaries and who are otherwise qualified to review rate applications but who do not meet the requirements of this section may assist an independent actuary under contract to the department.

If the commissioner contracts with independent actuaries for purposes of this section, the commissioner shall promulgate regulations to maintain the confidentiality of rate filings and proprietary insurer information and to avoid conflicts of interest.

(Repealed and added by Stats. 2009, Ch. 101, Sec. 3. Effective January 1, 2010.)

10236.13. 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:

(a) Certification by an actuary, who is a member of the American Academy of Actuaries and who meets the qualification standards of that organization, that:

(1) 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.

(2) The premium rate filing is in compliance with the provisions of this section.

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

(1) 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.

(A) Annual values for the five years preceding and the three years following the valuation date shall be provided separately.

(B) The projections shall include the development of the lifetime loss ratio.

(C) 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.

(D) If 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:

(i) The projected experience should be limited to the increases in claims expenses attributable to the changes in law or regulations.

(ii) If the commissioner determines that potential offsets to higher claims costs may exist, the insurer shall be required to use appropriate net projected experience.

(2) Disclosure of how reserves have been incorporated in this rate increase.

(3) 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.

(4) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration.

(5) A statement that asset investment yield rate changes have not been used to justify the rate increase unless the insurer can demonstrate that its return on investments is lower than the maximum valuation interest rate for contract reserves for those policies or the commissioner determines that a change in interest rates is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state.

(6) If 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.

(c) 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.

(d) Sufficient information for approval of the premium rate schedule increase by the commissioner.

(e) (1) The insurer, at its discretion, may request a premium rate schedule increase that is lower than the rate increase necessary to provide the certification required by subdivision (a) or a series of premium rate schedule increases with a present value of not more than the rate increase necessary to provide the certification required by subdivision (a). The commissioner may accept the premium rate schedule increase or series of increases without submission of the certification required by subdivision (a) if all of the following apply:

(A) In the opinion of the commissioner, accepting the lower premium rate schedule increase or increases is in the best interest of California policyholders.

(B) The actuarial memorandum discloses to the commissioner the rate increase necessary to provide the certification required by subdivision (a).

(C) The rate increase filing satisfies all other requirements of this section.

(D) The insurer discloses to policyholders affected by the approved increases the filed increase, the approved premium rate schedule increase or increases, and the amount and timing of any subsequent rate schedule increases included in the rate increase filing whether those subsequent rate schedule increases are approved or not approved by the commissioner.

(2) The commissioner may approve a lower requested premium rate schedule increase and may approve the initial increase or more than just the initial increase requested pursuant to paragraph (1).

(3) If the amount of increase after all increases disclosed pursuant to subparagraph (D) of paragraph (1), whether the increase or increases are approved or not approved by the commissioner, triggers the contingent benefit upon lapse, the commissioner shall require the administration by an insurer of the contingent benefit upon lapse as a condition of approval of a premium rate schedule increase that is lower than the amount necessary to provide the certification required by paragraph (1) of subdivision (a) or with the initial increase and each subsequent increase in a series of premium rate schedule increases. The commissioner may waive this condition of approval if an insurer demonstrates that the waiver is necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

(4) For purposes of paragraph (2) of subdivision (a) of Section 10236.14, the loss ratio calculation shall assume future premiums are based on the total filed rate schedule increase or series of increases disclosed pursuant to subparagraph (D) of paragraph (1), whether the increase or increases are approved or not approved by the commissioner.

(5) Premium rate schedule increases requested pursuant to paragraph (1) or approved as described in paragraph (2) shall comply with the provisions of Sections 10234.6 and 10234.95.

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

(Amended by Stats. 2012, Ch. 627, Sec. 5. Effective January 1, 2013.)

10236.14. Approval of all premium rate schedule increases shall be subject to the following requirements:

(a) (1) 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:

(A) The accumulated value of the initial earned premium times 58 percent.

(B) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis.

(C) The present value of future projected initial earned premiums times 58 percent.

(D) Eighty-five percent of the present value of future projected premiums not in subparagraph (C) on an earned basis.

(2) However, if the premiums in any rate revision filing calculated in this manner produce a lifetime expected loss ratio that is less than the highest lifetime expected loss ratio for this policy form in the initial filing or that for requested premium rates in any filing made after January 1, 2013, the insurer shall reduce the premiums in the filing so that the current lifetime expected loss ratio is equal to or greater than the highest initially filed loss ratio or that for requested premium rates filed after January 1, 2013. In the determination of a lifetime expected loss ratio, the margin for moderately adverse experience shall be reflected and shall not be increased unless the manner in which risks are shared between the insurer and block of policies has been changed by this law or any future law or regulation. The determination of the lifetime expected loss ratio shall be based on the actual distribution of policies issued and not any assumed distribution prior to actual sales.

(b) 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 percent 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.

(c) 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.

(d) No request for a rate increase on any policy form approved under Section 10236.11 shall be approved by the commissioner except as follows: the experience on all similar long-term care policy forms issued in this state by the insurer and its affiliates and retained by the affiliated group that have been approved either prior to approval under, or pursuant to, Section 10236.11 shall be pooled together and the combined experience shall be used as the basis for assumptions that satisfy the requirements in subdivision (a). Those assumptions and requested rate increases may vary by policy form if actuarially appropriate. Similar long-term care policy forms shall be classified into one of the following benefit classifications: nursing facility and residential care facility only, home care only, or comprehensive long-term care benefits. An insurer is not precluded from filing requests for premium rate schedule increases on all of its policy forms if the combined experiences after pooling all applicable policy forms satisfies the requirements of subdivision (a).

(e) Notwithstanding any other provision of this section, for applications for rate revisions filed on or after January 1, 2013, the commissioner may approve the application if an insurer demonstrates that the rates are necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

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

(Amended by Stats. 2012, Ch. 627, Sec. 6. Effective January 1, 2013.)

10236.15. Premium rate schedule increases that have been approved shall be subject to the following:

(a) For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in paragraph (1) of subdivision (b) of Section 10236.13, 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.

(b) (1) 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 specified in subdivision (a), the commissioner may require the insurer to implement any of the following:

(A) Premium rate schedule adjustments.

(B) Other measures to reduce the difference between the projected and actual experience.

(2) 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.

(c) 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.

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

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

(Added by Stats. 2000, Ch. 812, Sec. 11. Effective January 1, 2001.)

ARTICLE 5. Inflation Escalator and Benefit Increases [10237 - 10237.6] *(Article 5 added by Stats. 1990, Ch. 530, Sec. 3.)*

10237. This article applies to all long-term care insurance policies delivered or issued for delivery in this state on or after January 1, 1991.

(Added by Stats. 1990, Ch. 530, Sec. 3.)

10237.1. No insurer may 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 shall 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:

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

(b) 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 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

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

(d) The insurer of a group long-term care insurance policy as defined in subdivision (a), (b), or (c) of Section 10231.6, shall offer the holder of the group policy the opportunity to have the inflation protection pursuant to this section 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 insurer's offer.

(Amended by Stats. 1999, Ch. 947, Sec. 16. Effective January 1, 2000.)

10237.2. If the policy is issued to a group, the required offering in Section 10237.1 shall be made to the group policyholder; except that if the policy is issued to a group as defined in subdivision (d) of Section 10231.6, other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(Added by Stats. 1990, Ch. 530, Sec. 3.)

10237.3. The offer in Section 10237.1 shall not be required of any of the following:

(a) Life insurance policies or riders containing accelerated long-term care benefits.

(b) 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.

(Added by Stats. 1990, Ch. 530, Sec. 3.)

10237.4. (a) Inflation protection benefit increases under a policy that contains these benefits shall continue 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.

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

(c) 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.

(Amended by Stats. 1999, Ch. 947, Sec. 17. Effective January 1, 2000.)

10237.5. (a) 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 percent shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

(b) 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 percent annual compound inflation protection.

Signature of Applicant	Date”

(Amended by Stats. 1999, Ch. 947, Sec. 18. Effective January 1, 2000.)

10237.6. (a) An insurer shall include the following information in or with the outline of coverage:

(1) A graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5 percent 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.

(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

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

(Added by Stats. 1997, Ch. 699, Sec. 22. Effective October 6, 1997.)