SITS - CALIFORNIA
LONG-TERM CARE INSURANCE 8-HR.

Course #320510
2020 Edition

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SECTION 1 – INTRODUCTION TO LONG-TERM CARE INSURANCE

A. LTC Insurance Legislative Timeline

- 1988 - MCCA
  - Medi-Cal Eligibility Look Back- 30 months
  - MMMNA (Minimum Monthly Maintenance Needs Allowance)
  - CSRA (Community Spouse Resource Allowance)
- 1993 - OBRA
  - Look back 36 months for transfers, 60 months for irrevocable trusts
  - Estate recovery
  - Partnership expansion ends
- 1997 - HIPAA
  - Medi-Cal planning a crime
  - Tax qualified long-term care insurance (TQ vs. NTQ)
- 2000 - Rate Stability (CA/Nationwide)
- 2005 - DRA (Deficit Reduction Act) and LTC
  - Changes to Medicaid Eligibility Rules
    - ✓ Look back, home equity, annuities, life estates, income first rule, CCRC's Penalties
  - Expansion of Partnership programs
- 2010 - Pension Protection Act/Obama Care/CLASS Act
- 2011 - First wave of Baby Boomers turns 65 (10,000 everyday for the next 20 consecutive years)
- 2013 - CLASS Act "officially repealed"
- **2015 - Baby Boomers turn 65 in mass (The Silver Tsunami)**
  - **78-80 million**
- 2040
  - 2 workers for every 8 retirees
  - One 16-year old for every six 65-year olds

B. Introduction to California Long-Term Care

- California has more people 65 and older than any other State
- On January 1, 2011, as the baby boomers begin to celebrate their 65th birthdays, 10,000 people will turn 65 every day. This will continue for 20 years.
- Between now and 2030 there will be a doubling in the number of Californian's living with Alzheimer's disease from 590,208 to over 1.1 million

C. Defining Long-Term Care

Generally, long-term care refers to a wide range of personal care and other related services provided on an extended basis (i.e. 90 or more days) to people who need help with certain Activities of Daily Living (ADLs) or who need supervision due to severe cognitive impairment such as Alzheimer's disease or by simply growing old and becoming frail.

- Long-Term Care can occur due to:
  1. Aging (Frailty) – inevitable (not if, but when and how long)
  2. Disease - statistical probability
  3. Accident – statistical probability

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D. Determining the Need for Care

Acute (Health Care)	Chronic Care (LTC)
Medically based injury or sickness	Physical-based (ADLS) or Mental-based (cognitive impairment)
Short Term	Long-Term (90 plus days)
Restorative in nature	Maintenance and/or supportive in nature
Cured in a short period of time	Usually cannot be cured
Individual can usually return to previous lifestyle (becomes independent)	Likely to affect individual until death (becomes dependent)
Paid for by public and private insurance	Not reimbursed by private insurance or Medicare

E. Demonstrating the Need for Care – "The key to long-term care is functioning"

THE 4 MODELS OF DISABILITIES:

1. SOCIAL MODEL (IADLs) **Instrumental Activities for Daily Living**	**2. PHYSICAL MODEL (ADLs)** **Activities of Daily Living** ***(listed in order as one loses them as they age)***
• Shopping for personal items/Driving • Managing Money • Using the telephone • Meal Preparation/Cooking • Medication Management • Doing heavy/light housework	• Bathing • Dressing • Toileting • Continence • Transferring • Eating
3. Mental Model (Cognitive Impairment)	**4. Medical Model (injury or Sickness)**
• Senior Moments • Senile • Dementia • Alzheimer's	• Acute • Short-term • Restorative • Covered by Medicare, med supps, primary insurance (SNF, HHC, Hospice)

F. Translating Needs into Services

1. Understanding the continuum of LTC

- It traditionally begins at home with the support of family and/or friends via:
  - ✓ Homemaker Services (IADL Assistance)
  - ✓ Personal Care (ADL Assistance)
  - ✓ Respite Care (provided in the House)
  - ✓ Adult Day Care (provided in the community)
  - ✓ Home Health Care (medical based)
  - ✓ Hospice Care (Terminally ill/6 months or less)

2. Due to the progression of the disability, care at home may no longer be viable. So, one may then transition into facility based care.

- CCRC's/LCC's/Independent Care Facilities
- Board & Care/Residential Care (stand-by assistance)
- Assisted Living (Stand-by and Hands on assistance)
- Skilled Nursing Facilities (SNF's) primarily medical based, short term, restorative type of care or short term pre-death care

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G. Types of Care (Informal vs. Formal)

1. Informal (means care in which no fee is charged)

- Family friends, neighbors, volunteers, Homemaker, Personal Care, Respite care Home Delivered Meals, Telephone Reassurance

2. Formal (means care in which a fee is charged)

- Homemaker, personal care, respite care, home health care, hospice care, physical therapy and all facility based care

3. Care in facilities has been often referred to as:

- Skilled Care: continuously, medical based care (.5%)
- Intermediate Care: Intermittent, medical based care (4.5%)
- Custodial Care: Intermittent, non medical based care (95%)

H. The Need for Long-Term Care

The Progress of Aging

- Beginning in 2011, 1 in 5 Californian's will be 60 years of age or older
- Between 2030 and 2040, when the first of the Baby boom generation reaches age 85, the percent of elderly who are in the oldest age group in California will reach 15%

Care needs of the under-age 65 population

- About 15% of nursing home residents are under 65
- The number of under-65 nursing home residents has risen about 23 percent in the past 8 years to about 203,000 according to CMS
- Still, the overall percentage of nursing home residents 30 and younger is less than 1% nationally

I. Cost of Care in California 2019 [1]

1. Homecare/Homemaker Services: State Average Hourly Rate $25.00

- 4 hour day: $100.00
- 6 hour day $150.00
- 8 hour day $200.00

2. Home Health Care/Aide: State Average Hourly Rate $30.00 (covered by Private Insurance/Medicare)

- 4 hour day: $120.00
- 6 hour day $180.00
- 8 hour day $240.00

3. Adult Day Health Care: State Average Daily Rate $80.00

4. Assisted Living/Residential Care: State Average Monthly Rate $3,700

- $115 to $150 average daily cost

5. Nursing Home Semi-Private $300 vs. Private $320 per day

- $109,500 per year vs. $116,800 per year

[1] Genworth 2018 Cost of Care Summary

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J. Who Pays for Long-Term Care?

1. Family and Friends

- Informal LTC represents 85% of LTC today
  - **a. Family Structure**
    - Family Members more widely dispersed
    - Traditional Caregivers are working more
    - Higher Divorce rates
    - Unable or unwilling to provide care
  - **b. Sandwich Generation**
    - Care giving takes physical/financial/emotional toll

2. Medicare 2020 (as it relates to LTC)

- Medicare is a federal "health" insurance program.
- Medicare principally finances acute medical care for the elderly and the disabled
- Emphasis on Acute
- The level and scope of nursing home coverage focuses in post-acute care and thus does not fully address extended care or custodial needs.
  - **a. Part A (Hospital Services)**
    Post Hospital Skilled Nursing Facility Care
    - Must have a 3 day prior hospital stay
    - Must enter facility within 30 days of leaving hospital
    - Will pay 100% of all skilled services for the 1st 20 days
    - **Day 21 thru day 100 (80 days) you must pay $176.00 per day and** Medicare will cover the difference
    - Beyond 100 days you pay 100%
  - b. **Medicare - Home Health Care**
    Medicare Part A covers home health care Physician must certify that medically necessary or skilled care is needed on an intermittent basis.
    - Intermittent care means that it is less than 8 hours per day of care, or fewer than seven days a week over a period of 21 days
    - Example: Physical, speech or occupational therapy
    - Hospice care for 6 months or less

3. Medicare Supplements

- Also known as Medigap insurance
- Covers some of Medicare's deductibles, co-payments and coinsurance
- Premiums vary dramatically
- **Most cover daily co-payment of $176.00 (2020) for the 21st through the 100th day for skilled nursing home stays**
- Some supplement plans pay for skilled nursing facility stays beyond the 100th day maximum (skilled care only)
- If Medicare does not pay, neither does the Medicare Supplement

4. Medi-Cal 2020 (as it relates to LTC)

- Jointly funded and administered by federal government through Centers for Medicare and Medi-Cal Services (CMS) and the states
- Unlike Medicare, Medi-Cal provides extensive benefits for long-term care

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- Medi-Cal is primary public financing source for long-term care
- Medi-cal does not require that all care be skilled
- Medi-Cal is designed to pay for long-term care, while Medicare pays for short term care

a. Deficit Reduction Act Changes(will not be inforced in CA)

- Significant changes in Medi-Cal rules
- DRA cuts nearly $40 billion over five years from Medicare, Medi-Cal, and other programs
- Significant changes (eligibility):
  - ✓ Look-back period **(60 months will not be enforced in CA)**
  - ✓ Transfer for penalty start date (will begin at date of application)
  - ✓ Undue hardship exception (more difficult to justify)
  - ✓ Treatment of annuities (will be considered a Look Back event)
  - ✓ Community spouse income rules (Income first rule)
  - ✓ Home equity limits **($893,000**+, Exempts Partnership Insured's)
  - ✓ Treatment of investments for CCRCS (now counted)
  - ✓ Promissory Notes and life estates (now counted)
  - ✓ **State long-term care partnership programs expanded**

b. Medi-Cal Eligibility Guidelines Long-Term Care

- Each state follows federal guidelines to determine eligibility as to what services they will pay
- A person eligible in one state may not be eligible in another.
- If they are eligible in another state, they may not get the same benefits
- Three types of eligibility requirements that must be met:
  1. General Eligibility
  2. Functional Eligibility
  3. Financial Eligibility

c. General Eligibility Requirements

- Must be 65 or older
- If under 65, must be eligible for disability benefits
- Must meet U.S. Citizenship or immigration rules
- Must be a resident of the state when they apply
- If an individual meets the above general eligibility requirements they must still meet the Functional Eligibility Requirements and Financial Eligibility Requirements

d. Functional Eligibility Requirements

- Individual states define functional eligibility for Medicaid programs
- States have a medical specialist evaluate the individual's care needs
- They typically consider the need for assistance with ADLS and/or skilled care needs
- Part of the assessment determines if the individual would be a candidate for home and community based services
- If an individual meets the state's Functional Eligibility Criteria, they must also meet its General and Financial eligibility requirements

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e. Financial Eligibility Requirements

- Unlike Medicare which is an entitlement program, Medi-Cal is a "means tested program"
- The federal government establishes broad guidelines for income and assets to determine Medi-Cal financial eligibility.
- Each state then determines their own rules within the federal guidelines

f. Financial Eligibility: Income Guidelines

- If an individual has enough income to pay for their care, they will not be eligible for Medi-Cal
- Income is considered anything the applicant receives
  - ✓ Income from investments
  - ✓ Social Security benefits
  - ✓ Private or government pensions
  - ✓ Worker's compensation
  - ✓ Income from annuities
  - ✓ VA Benefits
  - ✓ Payments an applicant is entitled to whether or not they actually receive them
- When applying for Medi-Cal, only the applicant's income is counted

g. Income Allowance (2020)

Medi-Cal beneficiaries are allowed to keep enough of their own income for the following:

- Medicare Part B
- Medicare Supplement Insurance premiums
- Personal monthly needs allowance which varies by state
- If living in the community (home) and individual may keep $600 per month (for a single elder over 65 or disabled)
- Living in a nursing home and **personal needs allowance (PNA) of $35** per month (CA)

h. Asset Allowance

- Medi-Cal beneficiaries are able to keep assets that are considered "non-countable" or exempt
- Assets that are considered "countable" or non-exempt must be spent on care before the applicant can qualify for Medi-Cal
- Assets are also considered "inaccessible" which means they were given away, are in an irrevocable trust, or were transferred.
  - ✓ There are both permissible and non-permissible asset transfers

i. Non-Countable Assets

- Personal Items Plus Cash less than $2000/CA
- Primary Home
- Household Items
- Primary Vehicle
- Life Insurance with a cash value of less than $1,500
- Property Essential to Self Support
- Burial Arrangements
- Trusts

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- ✓ Special Needs Trusts
- ✓ Trusts created with "Exempt" Assets
- ✓ Miller Trusts (cap states only)

j. Primary Residence

- ➢ The home is considered the principal place of residence as long as
  - ✓ the Medi-Cal beneficiary lives in it
  - ✓ If the Medi-Cal beneficiary goes to a nursing facility, and still expresses an intent to return to the home
  - ✓ If the individual's spouse or other dependent relative is living in the home
- ➢ If none of the exceptions apply at a later date then the value of the home becomes a countable resource
- ➢ Prior to the enactment of the Deficit Reduction Act of 2005 (DRA) on February 8, 2006, a single or married individual applying for Medi-Cal nursing home coverage could exclude a house of <u>unlimited value</u>
- ➢ The DRA eliminates the ability of states to exempt more than $500,000 of a home's equity. If an individual's equity interest in the home exceeds $500,000 Medi-Cal cannot pay for long-term care services
- ➢ The DRA permitted the states to increase that $500,000 limit to as much as $750,000, if they passed a state law that did so (CA SB 483)
  - ✓ CA has elected $750,000 and waived Partnership Insured's (currently $893,000)
- ➢ For an individual there is still no limitation on value of home
- ➢ The rule capping home equity may be waived if the individual is able to prove hardship as defined by each individual state

k. Countable Assets (Non-Exempt)

- ➢ Countable assets are any assets that the applicant has access to regardless of any penalties or surrender charges
- ➢ If the total value of a person's countable assets exceeds the state's eligibility limit, they are not eligible for Medi-Cal
- ➢ All assets between a husband and wife are added together (regardless of a pre-nuptial agreement)
- ➢ An individual must spend all countable assets above the eligibility limit on care (referred to as "spend down")

l. Countable Assets

- ➢ Bank Accounts
- ➢ Cash greater than $2,000
- ➢ Retirement Funds (401Ks, IRAs) only for the individual applying for Medi-Cal
- ➢ Securities (Stocks/Bonds, Mutual Funds)
- ➢ Annuities (Deferred)
- ➢ Life Insurance with a cash value of more than $1,500
- ➢ Entrance fees for Continuing Care Retirement Communities
  - ✓ DRA expressly allows CCRCS to require residents to spend down their declared resources before applying for Medi-Cal

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m. **Spousal Impoverishment Provision**
- The Medicare Catastrophic Coverage Act of 1988 created the spousal impoverishment rule which allows the spouse who remains home to keep a certain amount of assets and income
- Beyond this allowance, all of the couple's assets are considered "countable" and available to pay for the institutionalized spouse's care (spend down)
- This includes assets earned by and held in the name of either partner (even those that are jointly held)

n. **Community Resource Allowance**
- Assets of community spouse and the institutionalized spouse are totaled as of the date of "institutionalization", the day on which the ill spouse enters either a hospital or a long-term care facility in which he or she then stays for at least 30 days
- Federal law dictates the maximum and minimum amounts that the community spouse can keep
- Called the CSRA- "community spouse resource allowance"
- The CSRA federal maximum is **$128,640** and the minimum is **$25,728 (2020)**
- States may adopt these or other standards as long as they do not go above the maximum or below the minimum
- The community spouse may keep one half of the couple's assets, not to exceed the federal maximum and not to go below the federal minimum
- Some states are more generous and allow the community spouse to keep up to the **$128,640** regardless of whether or not this represents half the couple's assets (CA)
- A single individual may only keep **$2,000.00** per month (CA)

o. **Community Spouse Income**
- The community spouse does not have to use their income to support the nursing home spouse
- The community spouse is entitled to some or all of the institutionalized spouses income up to the "minimum monthly maintenance needs allowance" or MMMNA
- The MMMNA may range from a low of **$2,113.75 to a high of $3,216 a month**
- The community spouse can petition the Medi-Cal agency for an increase

p. **Transfer of Assets**
- Congress implemented penalty periods to prevent Medi-Cal applicants for giving assets away and then qualifying for Medi-Cal right away
- The restrictions have been made harsher by the DRA
- In evaluating an asset transfer, states consider whose assets were transferred, to whom they were transferred, when the asset was transferred, and the purpose of the transfer

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q. Non-Permissible Transfer of Assets

- Assets given away without receiving something of essentially equal value in return
- If an applicant took action to avoid receipt of an asset to which they are entitled
- Elimination of joint ownership share
- Trusts
- Annuities
- Promissory Notes
- Life Estates

r. Look Back and Penalty Period

- The DRA gave states the authority to "look back" at an applicant's finances for 5 years from the date they apply for Medicaid **(the 60 month look back will not be enforced in CA)**
- **Current look back period in CA is 30 months**
- Any transfers that were made during that period for less than fair market value create a penalty period
- The penalty is a period of time during which the person transferring the assets will be ineligible for Medi-Cal

s. Penalty Period Calculation

- The penalty period is determined by dividing the amount transferred by the average Medi-Cal monthly nursing home rate
- The penalty period is the period of time in which the applicant would have been able to pay for their own long-term care had they not transferred their assets

t. Your Home

- Your Home is Exempt
- You can transfer Interest in Your Home
- To Your Spouse, or
  - ✓ Child under the age of 21
  - ✓ Blind or Disabled Child
  - ✓ Brother or Sister with an equity interest in the home living there at least 1 year
  - ✓ Child "Caregiver"

u. Annuities

Changes the DRA made regarding annuities(not enforced in CA)

- Annuities are treated as prohibited asset transfers subject to the penalty period unless:
  - ✓ Applicants disclose interest they or community spouse have in an annuity, regardless if its irrevocable or is treated as an asset
  - ✓ The state must be named as the remainder beneficiary
  - ✓ States can require the issuer to notify them when changes are made to the withdrawal amounts
- Even if annuity is not subject to penalty under provisions of DRA, this does not mean that it is excluded as income or resources

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v. **Estate Recovery and Liens**
- States must attempt to recover from a Medi-Cal beneficiary's estate whatever benefits it paid for the recipient's care.
- No recovery can take place until the death of the recipient's spouse, or as long as there is a child of the deceased who is under 21, blind or disabled
- States can recover from probate estate or property that passes outside of probate (jointly held assets, living trust, or life estates)

w. **Penalty Period Example Prior Law(Currently in CA)**
- Wally applies for Medi-Cal coverage on February 1, 2006
- Wally discloses a $22,000 gift made to a grandchild on July 1, 2005
- The average monthly cost of nursing home care is $4,000
- Since the transfer was uncompensated and occurred during his 30-month look-back period a penalty period calculation must be applied
  - ✓ $22,000/$4,000 = 5 month Penalty Period
- Wally's penalty period begins July 1, 2005 (the date of the transfer) and runs for 5 months to mid-November.
- Wally's penalty period had already expired by the time he applied for Medi-Cal on February 1, 2006.

x. **Penalty Period Example New Law-Different Result(Outside of CA)**
- Wally applies for Medi-Cal coverage on March 1, 2011,
- Wally discloses a $22,000 gift made to a grandchild on July 1, 2010
- The calculation of the penalty period remains the same, 5 months
- The penalty period does not begin until March 1, 2011 (the date he applied for Medi-Cal)
  - ✓ Under the old law the penalty period would have started on the date he transferred the money on July 1, 2010
- Wally will be denied Medi-Cal coverage for 5 months until mid August of 2011

MEDI-CAL SERVICES

Required	Optional
Hospitalization	Home Care
Physician Services	Personal Care
Laboratory and X-Ray	Homemaker Services
Nursing Home Care	Assisted Living Facilities[1]
	Rehabilitation
	Physical, Speech & Occupational Therapy
	Respite Care
	Adult Day Care
	Hospice Care

[1] Varies by State

y. **What Services are covered by Medicaid in the State of California?**
- Overview of Facility and Home-Based Services
- Nursing Facility
- Assisted Living Services (limited services trial in 3 counties)
- Pre-Admission Screening for Nursing Facility and Assisted Living Services

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- Intermediate Care Facilities for the Mentally Retarded
- Program for All-Inclusive Care of the Elderly (PACE)
- Long-Stay Hospitals
- Specialized Care
- Hospice Care/Adult Day Health Care Services
- Home Health Services
- Durable Medical Equipment and Supplies
- Rehabilitation Services (Inpatient, Outpatient, and School)
- Home Care (Personal care/Homemaker services) IHSS

z. Medi-Cal Recovery - Liens and Estate Claims

- Department of Health Services (DHS), implemented an ER Program in June 1981
- Estate Recovery is different from Estate Taxation

z1. Estate Recovery

Estate Recovery is barred from claiming

- during the lifetime of a surviving spouse; or,
- when there is a surviving child who is under the age of 21; or,
- when there is a surviving child who is blind or disabled

K. Alternative to Funding Long-Term Care

- Life Insurance with accelerated death benefits /LTC riders
- Annuities/LTC Riders
- Home Equity Conversions/Reverse Mortgages
- CCRC's
- Self Insuring/Personal Assets
- Viaticle Settlements

SECTION 2 – LONG-TERM CARE INSURANCE

A. Long-Term Care Insurance

- Is the business of insuring against loss
- Essentially, long-term care insurance is the business of insuring against the loss of one's ability to function independently in society whether it is due to any injury or sickness or through the natural progression of growing old and/or becoming frail.

B. Appropriateness of Long-term Care Insurance

There are six issues, traditionally, that one should address before considering long-term care insurance:

1. Age
2. Health
3. Income
4. Assets
5. Gender
6. Marital Status

1. Age:

- The younger you are the lower the premiums
- The greater chance of being able to qualify

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2. **Health:**
   a. **LTC Underwriting**
      - LTCI premiums are based on insuring individuals that are currently healthy and likely to remain that way
      - Agent's are responsible for field underwriting all applications
      - The NAIC/CA prohibits post-claims underwriting
      - Chronic conditions like Parkinson's disease, multiple sclerosis and dementia are uninsurable
      - Common conditions like hypertension, arthritis, diabetes, cancer, or heart attacks may be insurable

   b. **Underwriting Tools**
      Carriers make underwriting decisions using a number of tools:
      - Application
      - Paramedical Examination
      - M.D. Examination
      - Telephone Interview (Personal History Interview) PHI
      - Medical Records
      - Face to face interview (based on age)
      - Medical Information Bureau (MIB) (optional)
      - Prescription Profiles (required)
      - Carriers offer Pre-qualification Hotlines

   c. **Pre-Existing Conditions**
      LTCi policies and certificates shall NOT use a definition of "preexisting condition" that is stricter than the following:
      - Condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.
      - Not LTCi policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person
      - Commissioner may extend the limitation periods as to specific age group category

   d. **Prohibitions against Post-Claims Underwriting**
      - LTCi applications must include clear and unambiguous questions designed to ascertain the health condition of the applicant
        - ✓ Exception is guaranteed issue policies
      - If application asks whether applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed
      - Policies should state: Caution: If your answers on this application are incorrect or untrue, the company has the right to deny benefits or rescind your policy
      - Copy of completed application shall be delivered to insured no later than at the time of delivery of policy
      - Every insurer shall maintain a record of all policy or certificate rescissions

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e. incontestability clause

Policy in Force	Incontestability Requirements
Less than six months	The carrier must show that the misrepresentations was material to the acceptance for coverage
6 months to 2 years	The carrier must show that the policy holder made a misrepresentation that was both material to the approval for coverage and that it pertains to the condition for with the claim has been made
2 years or longer	The carrier must show that the policyholder intentionally misrepresented their health when they applied for coverage.

1. **Income**
   - Equivalent to the one year of a Californian's nursing Home Stay: **2020/$120,000 per year**
   - As long as the LTCI premium does not exceed **7%** of one's income: $7,000 range/Income to premium rule **3% - 7%** max ($3,600-$8,400)
2. **Assets (net of home)**
   - Equivalent to two years of a California nursing home stay: **2020/$120,000 x 2 years = $240,000**
3. **Gender**
   - Women are more likely to need LTC because of longer life expectancies (greater risk)
   - Women often outlive husbands/no caregiver
4. **Marital Status**
   - Discounts
   - More feature options: share care, spousal paid up
   - Underwriting considerations
   - Income/Asset protection

C. NAIC/CA Suitability Requirements

- NAIC/CA provides consumers with valuable information so they can make informed decisions regarding LTCI insurance
- NAIC/CA requires carriers to develop and use suitability standards
- Appropriateness of the sale of long-term care insurance is based on
- Individual's financial situation
- Goals and needs with respect to long-term care
- In replacement situations an analysis of the benefits and costs of existing coverage needs to be compared to the proposed coverage

a. Personal Worksheet

- All applicants must complete the "Long-Term Care Personal Worksheet"
- Producer must go over the applicant's income, assets, goals and needs information
- Applicant must fill out personal worksheet OR
- Sign personal worksheet indicating that the individual chooses not to provide the information

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- If not signed, carrier can suspend the application until oral or written verification is obtained that the individual still chooses to purchase long-term care insurance

b. **Required Disclosure of Rating Practices**
   Insurers shall provide the following information to the applicant at the time of application
   - Statement that policy may be subject to a rate increase in the future
   - An explanation of potential future premium rate revisions, and the policyholder's option in the event of a premium rate revision
   - The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase
   - A general explanation for applying premium rate or rate schedule adjustments
   - Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years

c. **Things You Should Know Before You Buy**
   - When a clients information provided in the "LTC Personal worksheet" does not satisfy the company's market and suitably standards, the company will send the LTC Insurance suitability letter **(>7% of income rule or less than $30,000 in net of home assets)** that must be completed and returned to the company before any further action is taken

d. **Long-Term Care Insurance Suitability Letter**
   - For your protection, state law requires us to consider this information when we review your application to avoid selling a policy to those who may not need coverage.

SECTION 3 – LONG-TERM CARE INSURANCE: DEFINITIONS; REGULATIONS;

"Long-term care insurance" includes any insurance policy, certificate or rider advertised, marketed, offered, solicited, or designed to provide coverage for diagnostic, preventative, 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 benefits types: Coverage for institutional care including care in a nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing home, <u>or personal care home; home care coverage including home health care, personal care, homemaker services</u>, 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.

A. <u>Essentially, long-term care insurance can be offered under 3 types of contracts in California as previously stated in Section 10232.2:</u>

- Nursing Facility and Residential Care facility only
- Home Care Only
- Comprehensive Long-Term Care Insurance; Institutional Care and Home Care
- Home, Community, RCF Only/No NH! (SB1483/2017)

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B. **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 - ADL Assistance
4. Homemaker Services – IADL Assistance
5. Hospice Services
6. Respite Care

C. **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 aide 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 non-medical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, 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 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.

D. **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.

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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.

* In many cases where homemaker and personal care services are being provided, the person providing these services is traditionally defined as "unskilled". Having a licensed or skilled requirement would not be practical in this scenario.

E. Nursing Facility/Residential Care Facility

1. Nursing Facility

- Provides 24 hour a day nursing service under a planned program of policies and procedures
- Has a Duly Licensed Physician available
- Has At Least One Nurse Employed Full Time
- Nurse on Duty or On Call
- Maintains Clinical Records

2. RCF

- A Facility Licensed as a RCF for the Elderly or RCD as defined in the CA Health and Safety Code
- Provide care on a 24 hour basis
- Have a Trained Employee at all times
- Three Meals a Day
- Have arrangements for an MD or RN in case of emergency
- Provide assistance with Meds
- The benefit amount payable for care shall be no less than 70 % of the benefit amount payable for intuitional confinement
- All expense incurred must include maintenance and personal care services

F. Plan Design

- Type of Coverage: Facility, Homecare, Comprehensive, Home/Community/RFC Only, (Hybrid, Traditional, Partnership)
- Dollar Amount ($100 - $500/month $10 increments)
- Duration/Length of Coverage (1 - 5 years, 6years) or pools of Money
- Elimination Period (0,30,90,180,365)
- Inflation (5% simple or 5% compounded, PBIO, GPO, FPO, CPIU, 2% or 3% simple or compounded)
- Non-forfeiture (yes/no) must offer

G. Designing a California Long-Term Care Policy

California allows a daily, weekly or Monthly Home Care Reimbursement Benefit – Whatever the NH Benefit is: $180 x 30 days = $5,400 (The HC Benefit must be at least 50% of the NH Benefit with the option of increasing it to 100%.) Remember, the residential care facility benefit must be at least 70% of the NH daily benefit.

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H. Daily Benefit Amount

- This is the maximum amount your insurance will pay in any single day. Carriers offer DBAs from $100 to $500 in $10 increments.
- What DBA is right for you? If you want your DBA to approximately match the 2016 California average daily cost of nursing home care, you may want to choose a $270 DBA (remember, the NH amount will always pay 100% of the DBA, RCF must be at least 70% of that amount and home care must be at least 50%).
- If you are able to pay a portion of the cost of care out of your own pocket, (for example, from your savings) or if you live in an area where the cost of care is lower than the national average, you may want to choose a lower DBA.
- On the other hand, you may want to choose a higher DBA if you live in an area where the cost of care is higher than the national average. It is important to keep in mind that services can be more costly in metropolitan areas

NH Daily $ Benefit Options	*RCF $Benefit*	*HC Daily Benefit Options*
$100 - $500 per day 100% (in $10 increments)	(70% of NH as a minimum) $70 – ($2,100 - $15,000)	$1,500 - $15,000 per month (50% of NH as a minimum)

- ✓ Reimbursement
  - ✓ Indemnity
  - ✓ Cash

I. Benefit Period (Lifetime Maximum)

- ✓ Your benefit period represents the minimum period of time (years/days) that you can expect your coverage to last. You can choose one of the following options:

  1 Yr (365 days) | 4 Yr (1460 days) | Lifetime/Unlimited
  2 Yr (730 days) | 5 Yr (1825 days) | (no longer available)
  3 Yr (1095 days)

Daily Benefit	3 yr Benefit Period (1,095 days) Pool of Money - 80% - $150 x 1,095 =	5 yr Benefit Period (1,825 days) Pool of Money - 90% - $150 x 1,825 =
$180	**$197,100**	**$328,500**
$200	**$219,000**	**$365,000**
$250	**$273,750**	**$456,250**
$300	**$328,500**	**$547,500**

J. Calendar Day Elimination Period

This is the initial amount of time during which covered services are received, but for which the policy will not pay benefits. Insured's select a 0-, 30-, 90- or 180-day elimination period. It starts on the first day of disability for which a covered service is used and continues until the selected number of calendar days have passed during which the insured continues to meet the benefit eligibility requirements. The insured does not have to incur covered expenses during the elimination period, except for the initial day which starts the elimination period. This elimination period only needs to be satisfied once in the life of the policy. Some benefits (Respite Care. Hospice Care, Supportive Equipment and Care Advisory Services) don't require that the Elimination Period be met. However, days on which you receive only these services don't qualify as a covered expense for the start date of the elimination period.

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Zero 0	30 days	60 days	100 days	365 days
20 days	50 days	90 days	180 days	

K. <u>Inflation Protection/Benefit Increase Option (BIO)* /Mandate to Offer (CA)</u>

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:

- Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5 percent.
- 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.
- Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount limit.
- The insurer of a group long-term care insurance 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.

L. <u>Mandatory Offering of Non-Forfeiture</u>

- No insurer may deliver or issue for delivery a long-term care policy in this state unless the insurer offers at the time of application an option to purchase a shortened benefit period non-forfeiture benefit with the following features:
  - Eligibility begins no later than after 10 years of premium payments.
  - The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater.
  - The same benefits covered in the policy and any riders at the time eligibility begins are payable for a qualifying claim.
  - The lifetime maximum benefit may be reduced by the amount of any claims already paid.
  - Cash back, extended term, and reduced paid-up forms of non-forfeiture benefits shall not be allowed.
  - The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.
- This section shall not apply to life insurance policies that accelerate benefits for ltci.

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M. Additional Features and Benefits (optional, at carrier's discretion)

- Equipment/Home Modification
  - Ramps
  - Grab Bars
  - Special Bed
- Informal Caregiver Training
- Transportation/Ambulance Benefit
- Restoration of Benefits
- Return of Premium
  - Return of Premium on Death
- Alternate Plan of Care/Emerging Trends
- Spouse/Companion Discounts
- Bed Reservation
- Care Coordinator/Care Management Feature
- Shared Care
- International Coverage

N. Premium Options/Waivers (optional, varies by carrier)

- Rate Guarantee
- 5 pay or 10 pay options
- Paid up at age 65
- Level Premium
- Rate Classes
- Waiver of Premium
  - Spouse Premium Waiver
  - Surviving Spouse Premium Waiver

O. Third Party Lapse Notification

Unintentional Lapse - The largest single source of claim expense in long-term care insurance is Alzheimer's disease and related dementia (ADRD). Tragically, this same condition could cause an individual to forget to keep his or her premiums current, thus allowing the policy to lapse right before he she became eligible for benefits. Thus, regulation requires that insurers reinstate lapsed policies where the insured can demonstrate that the lapse was due to a cognitive loss. The insured has the right to reinstate coverage for up to five months following the date of lapse.

SECTION 4 – HOW BENEFITS ARE TRIGGERED

A. Benefit Triggers

- HIPAA standardized benefit triggers in 1997
- Policyholder must be "chronically ill" for at least 90 days for ADL only
- Licensed health care practitioner certifies policyholder needs substantial assistance
- Two benefit triggers are:
  - Unable to perform two of six ADL's
  - Severe cognitive impairment that requires substantial supervision to protect policyholder or others

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1. **ADL Trigger -** For purposes of the ADL Trigger, taxpayers may rely on all or any of the following safe-harbor definitions:
   - ✓ Substantial assistance means hands-on assistance and standby assistance.
   - ✓ Hands-on assistance means the physical assistance of another person without which the individual would be unable to perform the ADL.
   - ✓ Standby assistance means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL (such as being ready to catch the individual if the individual falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the individual's throat if the individual chokes while eating.
2. **Cognitive Impairment Trigger** - For purposes of Cognitive Impairment Trigger, taxpayers may rely on either or both of the following safe-harbor definitions
   - ✓ Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to and includes Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment I the individual's (I) short-term or long-term memory, orientation as to people, places or time and deductive or abstract reasoning.
   - ✓ Substantial Supervision means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her health or safety (such may result from wandering)
   - ✓ Under the cognitive impairment trigger, unlike the ADL trigger, a qualified LTCI contract is not required to take any ADL into account for purposes of determining whether an individual is a chronically ill individual

B. <u>Face to Face Assessment/At Time of Claim</u>

- ➢ How claimant performs ADLs
- ➢ Is there cognitive impairment
- ➢ How claimant performs IADLs
- ➢ What was original injury (if any)
- ➢ Talk to physicians and care givers
- ➢ Assess informal care available and whether relief to care giver is required (respite)
- ➢ List of medications
- ➢ What psycho-social issues may be impacting ADL's
- ➢ What are the family relationships
- ➢ Any safety issues in house
- ➢ Explain the coordination and monitoring and determine need and claimants desire

C. <u>Reassessments</u>

- ➢ Ongoing face to face reassessment at least every six months
- ➢ Periodic telephone contact in interim
- ➢ Assess change in needs and adjusts Plan of Care

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D. **Coordination and Monitoring**

- How Claimant performs ADLs
- If desired by client, and deemed necessary by Care Manager, services also include:
  - Coordination (Implementation)
  - Ongoing monitoring

E. **Verification of Necessity**

- Documentation that services are necessary
- Precedent to the payment of benefits for any care covered by the terms of the policy, any insurer offering long-term care insurance may obtain a written declaration by a physician or independent needs assessment agency, or any other source of independent judgment suitable to the insurer that services are necessary.
- It's important for the agent to understand that regardless of what a client's doctor may say in terms of benefit triggering thresholds, the company has the right to verify the necessity of services.

F. **Denied claims; notice of reasons and information related to denial; reporting requirements**

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

G. **Right to Appeal**

- 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.

H. **Prohibited Provisions**

Long-term care insurance may not:

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

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customary," "reasonable and customary," or words of similar import.

- Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.
- Include an additional benefit for a service with a known market value other than the statutorily required home-and community-based service benefits in (which shall be at least 50% of the nursing home benefit), the assisted living benefit (which shall never be less than 70% nursing home benefit), or a nursing facility benefit itself (which is 100% payout), unless the additional benefit is disclosed in the schedule page of the policy.

SECTION 5 – ADDITIONAL LTCI REQUIREMENTS

A. <u>Outline of Coverage</u>

- Shall be a free-standing document
- Shall be delivered prior to soliciting and LTCI application
- Shall contain no material of an advertising nature

B. <u>Exclusions and limitations</u>

No policy may be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as to the following;

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

C. <u>Step-Down Provisions</u>

D. <u>Step-up Coverage</u>

E. <u>Updating Existing Coverage</u>

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F. Premium Collections

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

- 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.
- The insurer shall notify the applicant for the insurance policy 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 fund 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.

G. Right to Return

- LTCI applicants can return the policy or certificate within 30 days of the delivery and receive full refund of premiums
- They can do this for any reason

SECTION 6 – REPLACEMENT OF LONG-TERM CARE INSURANCE

A. Replacement of long-term care insurance unnecessarily application modification

- No insurance, 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 policy holder 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.
- In recommending the purchase or replacement of any long-term care insurance, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase of replacement.

B. Reporting of Replacement/Lapsed Policies

- Replacement Sales – Due to the sales abuses that arose in the Medicare Supplement market in the 70's and 80's, regulators have taken care to limit replacement sales by requiring extensive reporting, by agent, of such sales. The purpose of this is surface any individual who generates business largely through this avenue.
- 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

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lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

- Every insurer shall report annually by June 30, the 10 percent of its agents in the state with the greatest percentage of lapses and replacements as measured by subdivision (a).
- 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.
- 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 as a percent of its total number of policies in force in the state as of the end of the preceding calendar year.
- Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

SECTION 7 - CONSUMER PROTECT/AGENT RESPONSIBILITIES

A. <u>All Agents, Brokers and Insurers:</u>

- Duty of Honesty
- Duty of good faith
- Duty of fair dealing

B. <u>Every insurer shall:</u>

- Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
- Establish marketing procedures to assure excessive insurance is not sold or issued.
- Submit to the commissioner within six months of the effective date of this act, a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semiannually.
- Every insurer shall provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222.
- Provide a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each prospective applicant prior to the presentation of an application or enrollment form for insurance.
- In addition to other unfair trade practices, including those identified in this code, the following acts and practices are prohibited:
- Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
- High pressure tactics. Employing any method of marketing having the effect of or

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tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure top purchase or recommend the purchase of insurance.
- Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contract will be made by an insurance agent or insurance company.

SECTION 8 – RATE STABILITY

A. Benefits

- Benefits under individual long-term care insurance policies issued before new premium rate schedules are approved under Senate Bill 898 (Rate Stability Bill) 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. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:
  - Statistical credibility of incurred claims experience and earned premiums.
  - The period for which rates are computed to provide coverage.
  - Experienced and projected trends.
  - Concentration of experience within early policy duration.
  - Expected claim fluctuation.
  - Experience refunds, adjustments, or dividends.
  - Renewability features.
  - All appropriate expense factors.
  - Interest.
  - Experimental nature of the coverage.
  - Policy reserves.
  - Mix of business by risk classification.
  - Product features, such as long elimination periods, high deductibles, and high maximum limits.

B. Contingent Non-forfeiture

Contingent non-forfeiture requires a carrier that has raised rates above a specified cumulative percentage based on the issue age of the policyholder to:

- Offer the policyholder a reduced benefit that would eliminate future rate increases; and
- Make available non-forfeiture benefit that the policyholder could accept in place of the rate increase. The non-forfeiture benefit made available would conform to the tax-qualified definition under HIPAA; the policy would be deemed paid up and the carrier would pay future benefits equal to the amount of premium paid.
- Contingent non-forfeiture deters carriers from rate increases that would trigger it, and from policy under pricing that would entail rate increases. The carriers also know that their failure to ensure rate stability may lead to pressure on state governments to enact mandatory non-forfeiture.

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- Contingent non-forfeiture was made part of the NAIC Model Act in June, 1998. The majority of states have now adopted it, and every carrier now builds this feature into its policies. California required it in 2004.

SECTION 9 – CALIFORNIA PARTNERSHIP FOR LTC(New Changes occurred in 2019)

A. What is the California Partnership?

- Simply put, it's a joint venture between the State of California and Private (Participating) Long-term Care Insurance carriers.
- Current Participating Carriers are:
  - Bankers Life and Casualty *(suspended sales)*
  - CalPERS Long-term Care Program *(re-launched December 2013)*
  - Genworth
  - John Hancock Life Insurance Company (*withdrew Nationwide)*
  - New York Life Insurance Company(pending 2020)
  - Metropolitan Life Insurance Company (*withdrew Nationwide*)
  - Transamerica (pending 2020)

B. How did it start and where is it now?

Robert Wood Johnson Foundation Planning Grant

- Formed in 1972 to provide funds for health care research and demonstration projects.
- Included a program to promote LTCI in 1987
- These programs were designed to encourage public/private partnerships linking insurance carriers with States Medicaid Programs and allowing purchasers to protect some or a majority of their assets from Medicaid "spend-down" rules
- The intent was and is to encourage the purchase of private insurance for LTC and reduce the dependence on Medicaid
- Governor makes it a permanent program on August 16, 2004

C. The Objectives of the California Partnership

- Increasing the Percentage of "At-Risk" Californian's with Insurance that will protect against impoverishment for Long-term Care expenses.
- Constrain the growth of Public Expenditure for Long-term Care.
- Improve the Quality and Availability of Long-term Care Insurance Available to Consumers.

D. Concept of the California Partnership

- Relieve physical, financial and emotional burden on one's family and friends
- Maintain financial independence
- Protect one's assets from exorbitant expenses
- Ensure one's ability to secure quality care
- Ensure peace of mind for one's self and family ➡ ***Why the buyer buys***

E. Unique Aspects of the CA Partnership

How the Partnership works

- Private Insurers Develop Policies
- Individuals Purchase Policies

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- Private Policies are Back-Stopped by Public Benefits
- If the Insurance Runs Out, the Policyholder can apply for Public Benefits
- Each $1 of Insurance Payout protects an Equal Amount of the Insured's Assets
- Result: The Policyholder gets
  - Needed LTC care and lifetime protection of assets
  - Peace of Mind

F. Important Notice

- State Endorsed (Good housekeeping Seal of Approval)
- Provide Asset Protection
- Has a rate cap feature currently not required under traditional policies
- A Unique Care Management Feature

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

SECTION 10 – CALPERS/STRS LTCI PROGRAM (as of launch December 2013)

A. CalPERS Long-Term Care Program Overview

- CalPERS Long-Term Care Program was established in 1995
- 150,330 current policyholders (as of June 30, 2012)
- Long-Term Care Fund value $3.6 billion (as of June 30, 2012)
- Long-Term Care Policy Categories:
  - LTC1 - Long-Term Care policies issued 1995-2002 (125,257 policyholders as of June 30, 2012)
  - LTC2 - Long-Term Care policies issued 2003-2004
  - LTC3 - Long-Term Care policies issued 2005-2008 (16,190 policyholders as of June 30, 2012)
- Current policies include comprehensive and facility-only (e.g., nursing home or assisted living facility) coverage with lifetime benefits, 6-year and 3-year benefit policies with and without inflation protection, and 2-year and 1-year benefit Partnership policies with inflation protection.

B. What types of long-term care policies will CalPERS offer in December 2013.

- CalPERS' fourth generation of long-term care insurance will be LTC4 Non-Partnership and LTC4 California Partnership plans. The new product offering is competitive in the long-term care insurance market place. CalPERS designed the new long-term care product to ensure the program remains financially prudent and will serve LTC for many years to come. The new product will include many improved benefits and optional riders.

C. Who is eligible to apply?

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- Any California public employee is eligible to apply, as well as immediate family members of a California public employee. Even if you do not apply, your eligible family members can still apply. Eligible family members include spouses, parents, parents-in-law and adult siblings. California public employees include, but are not limited to, State of California and all State Departments, State Assembly and Senate, school districts, cities, counties, special districts and water districts.

D. What is the benefit design of LTC4 plans?

- The focus of the LTC4 is to promote independence and a greater ability for our policyholders to remain safely at home as long as possible, and provide more optional benefits. CalPERS will accept applications on a continuous basis and be available to our eligible population when it becomes important to them. Table 1 below reflects the benefit design of LTC4 Non-Partnership Plan.

Table 1: CalPERS LTC4 Non-Partnership Plan Benefit Design

Features	Design
Nursing Home	Covers up to 100% of Daily Benefit Amount (DBA)
Assisted Living/Residential Care Facility	Covers up to 100% of DBA
Home and Community Care	Covers up to 100%of Monthly Benefit Amount
Daily Benefit Amounts*	$150 to 400 in $10 increments
Benefit Period*	Choice of 3, 6 or 10 years
Elimination Period*	90 calendar days with a single service day to start
Monthly Home Care	100% of Facility Care Benefit Amount, paid as prorated monthly benefit
Bed Reservation	Covers up to 100% of DBA for up to 14 days per hospitalization
Hospice	Covers up to 100% of DBA
Respite care	Covers up to 100% of the Home and Community Care Monthly Maximum
Alternate Plan of Care	Covers up to 100% of DBA
Care Advisory Service	Pays 100% of covered expenses and expenses will not reduce the total coverage amount
Stay at Home Benefit	Pays up to 30 times DBA
International Benefits	Pays the coverage on an indemnity basis at 50% for up to 365 days of care
Contingent Non-Forfeiture Benefit	Offers to convert coverage to a paid-up reduced benefit policy if there is a substantial premium increase
Spousal Discount	25% if both approved; 10% if one approved
Waiver of Premium	The premium will be waived when receiving benefits, except for Stay-at-Home, Respite Care or Care Advisory Services Benefit
Optional Inflation Protection Benefit (Rider)*	3%, 5% simple inflation, or 3%, 5% compound inflation
Optional Future Purchase Option (Rider)*	Offers every 3 years and only end if on claim
Optional Non-Forfeiture Benefit (Rider)	Pays the greater of: (a) 90 times the daily nursing home benefit at time of lapse; or (b) the sum of premiums paid less claims paid at time of lapse excluding waived premium if the policy lapses after the 10th policy year
Optional Return of Premium Death Benefit (Rider)	Returns full of partial premiums paid less claims if death occurs prior to age 75
Optional Restoration of Benefits (Rider)	The insured's benefit period will be totally restored if the insured recovers and is not eligible for benefits for at least 180 consecutive

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	days. The maximum amount that can be restored over the life of the policy is equal to the original Total Benefit Amount.
Optional Paid-up Survivor Benefit (Rider)	They policy is paid up if one of the couple dies after the end of the 10th policy year

Benefit differs from the California Partnership plan. See Table 2 for benefit design of the California Partnership plan.

E. California Partnership Benefit Changes

- California Partnership policies allow the policyholder to keep an amount of assets equal to that paid in long-term care insurance benefits and still qualify for Medi-Cal, rather than having to spend-down savings to meet Medi-Cal requirements. California Partnership policies also require the compound 5% built-in inflation protection, which policyholders are not allowed to change to simple inflation protection until age 70, and a 30-day deductible period on 1 and 2 year policies. Table 2 below reflects the benefit design of LTC4 California Partnership plan.

Table 2: CalPERS LTC4 California Partnership Plan Benefit Design

Features	Design
Nursing Home	Covers up to 100% of DBA
Assisted Living/Residential Care Facility	Covers up to 100% of DBA
Home and Community Care	Covers up to 100% of Monthly Benefit Amount
Daily Benefit Amounts*	$190 to $400 in $10 increments (minimum set annually by MediCal)
Benefit Period*	Choice of 1 or 2 years
Elimination Period*	30 calendar days with a single service day start
Monthly Home Care	100% of Facility Care Benefit Amount, paid as prorated monthly benefit
Bed Reservation	Covers up to 100% of DBA for up to 14 days per hospitalization
Hospice	Covers up to 100% of DBA
Respite Care	Covers up to 100% of the Home and Community Care Monthly Maximum
Alternate Plan of Care	Covers up to 100% of DBA
Care Advisory Service	Pays 100% of covered expenses and expenses will not reduce the total coverage amount
Stay at Home Benefit	Pays up to 30 times DBA
International Benefits	Pays the coverage on an indemnity basis at 50% for up to 365 days of care
Contingent Non-Forfeiture Benefit	Offers to convert coverage to a paid-up reduced benefit policy if there is a substantial premium increase
Spousal Discount	25% if both approved; 10% if one approved
Waiver of Premium	The premium will be waived when receiving benefits, except for Stay-at-Home, Respite Care or Care Advisory Services Benefit
Inflation Protection Benefit	5% compound inflation, member can change to 5% simple inflation at age 70
Optional Non-Forfeiture Benefit	Pays the greater of : (a) 90 times the daily nursing home benefit at time of lapse; or (b) the sum of premiums paid less claims paid at time of lapse excluding waived premium if the policy lapses after the 10th policy year
Optional Return of Premium Death Benefit (Rider)	Returns full of partial premiums paid less claims if death occurs prior to age 75
Optional Restoration of Benefits (Rider)	The insured's benefit period will be totally restored if the insured recovers and is not eligible for benefits for at least 180 consecutive days. The maximum amount that can be restored over the life of the

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	policy is equal to the original Total Benefit Amount
Optional Paid-up Survivor Benefit (Rider)	The policy is paid up if one of the couple dies after the end of the 10th policy year

Benefit differs from the Non-Partnership plan. See Table 1 for benefit design of the Non-Partnership plan.

F. What are the new or improved features and optional riders of LTC4 plans and what do they mean?

- **Daily Benefit Amounts (DBA)**

  DBA is the maximum amount the insurance will pay for a single day of long-term care services. Under LTC4, the DBA is expanded and ranged from $150 ($170 for Partnership but changes annually) to $400, in $10 increments.

  Assisted Living/Residential Care Facility Benefit - Covers up to 100% of DBA

LTC4	Prior Offerings
	LTC1 (plans sold 1995-2002) 50% of DBA
Covers up to 100% of DBA	LTC2 (plans sold 2003-2004) 70% of DBA
	LTC3 (plans sold 2005-2008) 70% of DBA

Assisted Living Facility/Residential Care Facility means a licensed facility engaged primarily in providing ongoing care and related services that meets all of the following criteria:

- Provides 24-hour a day care and services sufficient to support needs resulting from inability to perform Activities of Daily Living (ADL) or Severe Cognitive Impairment
- Has an awake, trained and ready-to-respond employee on duty in the facility at all times to provide care
- Provides 3 meals a day and accommodates special dietary needs
- Has written contractual arrangements or otherwise ensures that residence receive the medial care services of a Physician or nurse in case of emergency
- Has appropriate methods and procedures to assist residents in self-administration of prescribed medications

Home and Community Care Benefit - Covers up to 100% of DBA

LTC4	Prior Offerings
	LTC1 (plans sold 1995-2002) 50% of DBA
Covers up to 100% of DBA	LTC2 (plans sold 2003-2004) 70% of DBA
	LTC3 (plans sold 2005-2008) 70% of DBA

Home and Community Care Benefit include the following benefits:

- Home Health Care Services
- Personal Care Services: Covers assistance for ADL including bathing, dressing, eating, toileting, transferring and continence
- Homemaker Services Incidental to Personal Care: The insured would be eligible to receive homemaker services if personal services are being received by the insured on a regular basis

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- Adult Day Health/Social Care: Pays benefits for a structured, comprehensive program which provides a variety of community-based services including health, social and related supportive services in a protective setting on a less than 24-hour basis

SECTION 11 - HICAP/DEPARTMENT OF AGING REVIEW

A. What is HICAP?

- The Health Insurance Counseling and Advocacy Program (HICAP) is a not-for-profit, volunteered-based program that assists seniors with Medicare, Medicare supplement insurance, long-term care insurance, and other health insurance needs.
- HICAP, the Health Insurance Counseling and Advocacy Program, offers consumers a resource, funded by the Department of Aging, to help them better understand their options with regard to the purchase of long-term care insurance. Some agents, typically those without sufficient training or understanding of the product, may tend to misrepresent it in order to make a sale. HICAP is a counterbalance to this practice. The practice of misrepresentation was more pervasive in the past when there were few distributors and insurers in the market. Today, it is more difficult to get away with this practice, as increased competition for sales has made more resources available to consumers.
- HICAP's ability to monitor inappropriate sales and stay current is bolstered through notification requirements and the requirement that the DOI send copies of all approved marketing materials to the organization.

SECTION 14 – TAX TREATMENT OF LONG-TERM CARE EXPENSES AND LONG-TERM CARE INSURANCE

Tax Qualified LTC Insurance 2020 Tax Information

<table>
<tr><th>Type of Taxpayer</th><th>Deduction for LTCi Premium</th><th>Taxation of Benefits</th></tr>
<tr><td>Individual Taxpayer who does not itemize</td><td>No Deduction</td><td></td></tr>
<tr><td>Individual Taxpayer who does itemize deductions</td><td>Treated as a medical expense.

Limited to the lesser of the actual premium paid of the maximum allowable premium per person from the age based table below.
<table>
<tr><th>Attained age at close of tax year</th><th>2020 Eligible Premium Limit</th></tr>
<tr><td>40 or younger</td><td>$430</td></tr>
<tr><td>41 through 50</td><td>$810</td></tr>
<tr><td>51 through 60</td><td>$1,630</td></tr>
<tr><td>61 through 70</td><td>$4,350</td></tr>
<tr><td>71 and older</td><td>$5,430</td></tr>
</table>
The eligible premium paid for the individual taxpayer and his/her spouse may be deducted to the extent that total medical expenses for such persons exceed 10% of adjusted gross income (AGI).</td><td><u>Reimbursement benefits</u> for qualified long-term care services are not taxed, regardless of whether premium was deducted or not.</td></tr>
<tr><td>401K Plans</td><td>May <u>not</u> be paid through 401K retirement accounts.[11]</td><td></td></tr>
<tr><td>IRA Owners</td><td>Individual Retirement Accounts may <u>not</u> be used to pay LTCI Premiums</td><td></td></tr>
</table>

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MSA / HSA Owner	Taxpayer may pay for LTCI premiums from a Medical Savings Account (MSA)1 or beginning 2004, from a Health Savings Account (HSA) up to the allowable premium per chart above.	Benefits received from an Indemnity, Per Diem or Cash Benefit policy are not taxed, regardless of whether premium was deducted or not. Except those benefits that exceed the greater of: • The actual LTC expense incurred or, • **$380 per day in 2020 and adjusted each year for inflation.**
Section 125 Plans	LTCI premiums become taxable to employee if paid through Section 125 plan. [11]	
Employees	• Premium paid by employer • Deductible 100% as business expense by employer [2,9] • Not taxable income to employee [8,9] • Premium not limited to age based maximum deduction • Applies to individual and group LTC insurance	
C Corporation Owner	If owner is a corporate employee, then treated as employee. [4]	
Other Business Owners • Sole Proprietors • S Corporation 2% or more owner • Partnerships and Limited Liability Partnerships • Limited Liability Corporation Owners	Treated as a business expense for medical insurance premiums.[12] Limited to the lesser of the actual premium paid or the maximum allowable premium per person from the age based table below.	

Attained age at close of tax year	2020Eligible Premium Limit
40 or younger	$430
41 through 50	$810
51 through 60	$1,630
61 through 70	$4,350
71 and older	$5,430

This information is not intended as tax or legal advice. Consult an accountant, tax advisor or attorney regarding the tax implications of buying Tax-Qualified LTC Insurance. This information refers to only Tax Qualified Long-Term Care Insurance. The tax treatment of Non-Qualified Long Term Care Insurance is unknown.

1 HIPAA 1996, P.L.4-49L	4 IRC Sec. 106(a)	7 IRC Sec. 104(a)	**10 IRC Sec.7702B(b)(2)(C)**	13 IRC Sec. 213(d)(10)(B)
2 IRC SEC. 7702B(a)(3)	5 IRC SEC. 7702B(a)(2)	8 IRC SEC. 213(d)(1)	11 IRC SEC. 125(f)	
3 IRC SEC. 105(b)	6 IRC SEC. 7702B(d)	9 IRC SEC. 702B(a)(1)	12 IRC SEC. 162(l)	

SECTION 15 – ASSET BASED LONG-TERM CARE INSURANCE

A. What is Asset Based Long-term Care insurance?

We already know that conventional long-term care insurance is the TQ, NTQ, and Partnership long-term care insurance contracts that require either ongoing premiums, a shortened premium schedule such as a ten year premium schedule or even a single pay. Conventional LTC contracts provide coverage when and if you have a claim that is considered eligible.

- What are some of the primary objections to conventional long-term care insurance from the consumer? It's too expensive, I may not use it, thus will possibly waste my premium dollars. With asset base products the scenario changes to a guaranteed claim or at the very least a return of the premium dollars paid plus interest. Just like conventional long-term care insurance you may pay premium over your lifetime, over a short number of years or in a single payment. Asset based long-term care insurance is not for everyone. As its name implies it has something to do with

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assets. The prospect for asset based long-term care insurance will be middle to upper income with some level of assets that are not needed for retirement income or the ability to pay premiums for a period of time.

- The basis of asset based long-term care insurance is the combination of either permanent life insurance or a deferred annuity with a long-term care insurance contract as a rider or integrated into one contract. The concept behind asset base long-term care insurance contract is to reposition existing assets to provide the long-term care insurance benefit package with either the life insurance death benefit or the annuity cash value. Both the life insurance cash values and the annuity cash values will earn a current rate of interest that is accumulated on a tax-deferred basis. Examples of appropriate assets that could be "repositioned" would be a CD earning a relatively low rate of interest. Why not have it earn a like rate of interest while providing significant leverage by providing the long-term care insurance benefits. While a CD is probably the easiest asset to picture being "repositioned" there really is no limit to what asset could be converted to this use. This would include tax-qualified dollars from IRA or 401k accounts. There are plan designs that address the details regarding the use of qualified monies for an asset based long-term care insurance program.

- By combining the permanent life insurance contract or the annuity contract with long-term care insurance the consumer is provided access to two contracts married into one allowing for the use of the same premium dollars to fund two contracts. If we combine the permanent life insurance with the long-term care insurance we end up with a contract that will pay *either* for long-term care costs or if there is never a long-term care claim the death benefit would be payable to the named beneficiary of the estate of the insured if there is no named beneficiary. The additional scenario would be if the long-term care claim did not use all of the base long-term care insurance benefits before the insured died, there would be a partial death benefit payable at the time of death. These products may provide a more flexible solution to the most common objections that were mentioned earlier. The premium dollars become double duty dollars providing long-term care insurance benefits and/or life insurance death benefit depending on use of other benefits or cash values for which ever need is deemed appropriate. *The typical design reduces the death benefit dollar for each dollar paid out for long-term care expenses from the base long-term care insurance contract.*

- Some of the product designs available today are noted below:
  - Tax Qualified Long-term Care insurance benefits integrated with individual annual premium whole life or annual flexible premium universal life.
  - Tax Qualified Long-term Care benefits integrated with Second to die single premium whole life or second to die universal life.
  - Tax Qualified Long-term Care benefits integrated with Single premium deferred annuity
  - Tax Qualified Long-term Care benefits integrated with Single premium variable universal life
  - Tax Qualified Long-term Care benefits integrated with a whole life or universal

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life policy funded with a qualified immediate annuity.
- Extended Long-term care benefits provided via optional rider.

- The extended long-term care insurance rider would provide additional long-term care insurance benefits beyond those benefits provided from the base long-term insurance contract. When benefits are available from the rider the prior payment of the base long-term insurance benefit would have also eliminated the payment of either most or all the death benefit.

B. <u>How are benefit levels determined?</u>

The death benefit is determined based on the premium or deposit the client agrees is affordable and the IRS formula that determines the guideline premium via the corridor test. This test is complex and this course is not intended to provide a complete explanation of this calculation.

LTC daily benefits are determined as a percentage or fractional portion of the death benefit with the total benefits available possibly as a multiple of the death benefit. Additional long-term care insurance benefits are typically available via optional riders.

C. <u>What are some of the advantages from using an asset based long-term care insurance product?</u>

- The asset linked products make a long-term care insurance policy into a guaranteed claim scenario instead of use it or lose it.
- Uses the premiums for life insurance and long-term care insurance as double duty dollars.
- Provides tax favored cash values as emergency fund or any other use if the insurance protection becomes less important during the insured's lifetime.
- Even with long-term care insurance the surviving spouse or children could be left with unpaid expenses from a long-term care or last illness scenario that the life insurance proceeds, if any, could be used to pay.
- A parent that was taken care in part by an adult child or children may want that child or children compensated for loss of earnings while taking care of the parent. The life insurance benefit or the residual value of the annuity, if any could be used for this purpose.
- The asset linked products may provide a more stable premium environment for long-term care premiums. This is currently an area of focus by the National Association Insurance Commissioner, NAIC, at their annual meeting. There is significant concern regarding the potential for premium increases on conventional long-term care insurance contracts that are guaranteed renewable. Many of the asset based plan designs illustrate the premium or deposit required at guaranteed interest rates and with guaranteed costs to show how much premium would be required for a policy to survive to age 100 under the worst case scenario. This allows the insured to know the maximum amount of assets they would transfer in order to provide coverage over their lifetime. There are also long-term care insurance riders provided from some carriers with non-cancelable contract terms.

D. <u>Tax treatment of Asset Linked contract benefits:</u>

- Death benefit is treated like any life insurance death benefit. The death benefit is

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typically received income tax free. The death benefit would normally not be subject to probate if payable to a named beneficiary versus the estate of the insured. Death benefit proceeds from the life insurance would generally be includable in the insured's estate assuming that the insured retained any incidents of ownership thus potentially subjecting the value of the death benefits to estate tax. This may be avoided with the use of an irrevocable trust which would then own the insurance contract. The death benefit from a deferred annuity may have income tax due on the deferred earnings of the contract when received by the beneficiary. The actual tax liability will be dependent on the relationship of the beneficiary to the owner of the annuity contract.

- Cash values would accumulate on an income tax deferred basis so long as the contract is not a life insurance contract that has been determined to be a modified endowment contract, MEC. With the exception of MEC contracts, cash values would be available via loans with no income tax liability assuming the policy does not lapse. Withdrawals against a universal life contract may or may not be considered taxable. There is an IRS rule referred to as the "Force Out Rule" that is part of code 7702. The effect is that withdrawals made during the first 15 years of a universal life contract may have income tax consequences. During the first five years the formula is more
- likely to cause an income tax. This consequence is lessened somewhat during years 6 through 15.
-
- What is a MEC contract? Think of a policy designed as a seven pay life. This contract would be designed to require seven years of premium payments before being paid up. If a contract has cash value greater than what a seven pay life contract would require, it is effectively an MEC.

Senate Bill 281 Section 10295.12.

(a) Insurers shall ensure that agents offering, marketing, or selling accelerated death benefits on their behalf are able to describe the differences between benefits provided under an accelerated death benefit and benefits provided under long-term care insurance, as follows:

(1) The difference between the benefits afforded to an insured through an accelerated death benefit and a long-term care insurance policy or rider.
(2) The differences between benefit eligibility criteria.
(3) Whether an elimination period applies to either an accelerated death benefit or long-term care insurance and a description of the elimination period.
(4) The benefits under the accelerated death benefit or long-term care insurance if benefits are never needed.
(5) The benefits under the accelerated death benefit or long-term insurance if benefits are needed.
(6) Restrictions on benefit amounts.
(7) Tax treatment of benefits.
(8) Income and death benefit considerations.
(b) Completion of California agent education or continuing education for long-term care insurance shall meet the requirements of this section.

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SECTION 16 – ADMINISTRATIVE AND MONETARY PENALTIES FOR VOLATIONS OF CHAPTER 2.6, PART 2, DIVISION 2 OF THE CIC (SB 1943)

A. Violations; penalties; attorney fees; injunctions; damages; restitution

In additional 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.

- 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.
- 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.

B. Violations; penalty fees; subsequent violations; Insurance Fund

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.

- 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).

SECTION 17 – CHOOSING AN INSURANCE COMPANY

An insurance company's financial standing and track record are important in choosing a long-term care insurance policy. Consumers should consider the rate increase data included in the rate guide along with several other important factors.

A. Financial Standing

- A company's size and ratings are important factors to take into consideration when making your long-term care insurance choice. While an A+ rating is no guarantee the

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company will remain in business or not increase their premiums, companies with superior ratings are more likely to have the ability to pay future claims. The rating services you should look to include:

A.M. Best	(908) 439-2200
Standard & Poors	(212) 438-2000
Moody's	(212) 553-0377
Fitch Financial	(800) 753-4824
Weiss Ratings, Inc.	(800) 289-9222

- A.M. Best rates all long-term care insurance companies. Most carriers have ratings from one or more of the other services listed. These ratings will reflect the company's size (amount of assets and surplus). Agents should provide the client with the most recent rating statistics.

SECTION 18 – CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

The California Life & Health Insurance Guarantee Association is a statutory entity created in 1991 when the California legislature enacted the California Life and Health Insurance Guarantee Association Act. The guarantee association is composed of all insurers licensed to sell life insurance, health insurance, and annuities in the state of California. In the event that a member insurer is found to be insolvent and is ordered to be liquidated by a court, the Guarantee Association Act enables the guarantee association to provide protection (up to the limits spelled out in the Act) to California residents who are holders of life and health insurance policies, and annuity contracts, with the insolvent insurer.

A. What happens when my insurance company goes out of business?

Insurance companies that experience severe financial difficulties are taken over by the insurance department of the state in which they are based. You should be notified by the insurance department if this occurs. Even if the company is placed under the control of the insurance department, claims will continue to be honored as long as the premiums are paid or cash value exists. The claims will be covered by stated guaranty associations, which will either pay them directly or transfer the policies to a financially stable insurance company.

B. What is a life and health guaranty association?

Life & Health insurance guaranty associations were created to protect state residents who are policyholders and beneficiaries of policies issued by a life or health insurance company that has gone out of business. All 50 states, the District of Columbia and Puerto Rico have life and health insurance guaranty associations.

All insurance companies (with limited exceptions) licensed to write life and health insurance or annuities in a state are required to be members of the state's life and health insurance guaranty association. If a member company becomes insolvent (goes out of business) the state guaranty association obtains money to continue coverage and pay claims from member insurance companies writing the same line or lines of insurance as the insolvent company.

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C. **If my company is out of business, why should I keep paying premiums?**

If you are paying premiums to your company, you must continue to do so even after your company has been taken over. Those premiums go to the guaranty association providing you continuing coverage, and if you stop paying premiums, your insurance benefits may be terminated.

D. **Is Long-Term care insurance covered by the guaranty associations?**

Yes, long-term care insurance is typically considered health insurance for guaranty coverage purposes.

E. **Are all policies fully protected?**

Not always. Like the FDIC, state guaranty associations have maximum benefit limits. These limits are established by state law and can vary from state to state, but most states provide at least;

- $300,000 in life insurance death benefits
- $100,000 in cash surrender or withdrawal values for life insurance
- $100,000 in withdrawal and cash values for annuities
- $550,000 in health insurance policy benefits(CA)

The overall benefit "cap" in most states for an individual life policy is $300,000 although some states have maximums that are much higher.

Websites of Interest: www.dhs.ca.gov/cpltc - California Partnership for Long-Term Care, www.insurance.ca.gov - California Department of Insurance, www.KFF.org - The Henry J. Kaiser Family Foundation, www.RWJF.org - The Robert Wood Johnson Foundation, www.CANHR.org - California advocates for Nursing Home Reform, www.NASMD.org - National Association of State Medicaid Directors, www.cahealthadvocates.org - California Health Advocates

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