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## California Statutory Provisions, Requirements, and Terminology

### A. Company Responsibilities and Prohibitions

#### 1. Application and Underwriting

##### Applications Must Ask "Yes" or "No" Health Questions

In California, "all applications for long-term care insurance except for guaranteed issue, must contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the **applicant**."

Each question must contain only one health status inquiry and can require only a "yes" or "no" answer, except that the application may include a request for the name of any prescribed medication and the name of a prescribing physician." *CIC §10232.3(a)*

##### Warning on Application That Misstatements May Result in Rescission

"If the **application** requests the name of any prescribed medications or prescribing physicians, then any mistake or omission shall not be used as a basis for the denial of a **claim** or the **rescission** of a policy or certificate."

The following warning must be printed conspicuously and in close conjunction with the applicant's signature block:

**"Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."**

*CIC §10232.3 (a)(b)(c)*

##### Insurer Must Have, Use and Apply Suitability Standards

Every insurer or other entity marketing long-term care insurance must:

- "Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the **applicant**."
- Train its agents in the use of its suitability standards.
- Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner. (b) The agent and insurer shall develop procedures that take into **consideration**, when determining whether the applicant meets the standards developed by the insurer, the following: (1) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage. (2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.
- (3) The value, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement. (C) (1) The issuer, and where an agent is involved, the agent, shall

make reasonable efforts to obtain the information set out in subdivision (b). The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet," contained in the Long-Term Care Insurance Model Regulations of the National Association of Insurance Commissioners. The personal worksheet used by the insurer shall contain, at a minimum, the information in the NAIC worksheet in not less than 12-point type. The insurer may request the applicant to provide additional information to comply with its suitability standards. (2) In the premium section of the personal worksheet, the insurer shall disclose all rate increases and rate increase requests for all policies, whether issued by the insurer or purchased or acquired from another insurer, in the United States on or after January 1, 1990.

- The premium section shall include a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov)." If the personal worksheet is approved prior to the availability of the rate guide, the worksheet shall indicate that the rate guide will be available beginning December 1, 2000.
- A copy of the issuer's personal worksheet shall be filed and approved by the commissioner. A new personal worksheet shall be filed and approved by the commissioner each time a rate is increased in California and each time a new policy is filed for approval by the commissioner. The new personal worksheet shall disclose the amount of the rate increase in California and all prior rate increases in California as well as all prior rate increases and rate increase requests or filings in any other state. The new personal worksheet shall be used by the insurer within 60 days of approval by the commissioner in place of the previously approved personal worksheet. (d) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sale of employer group long-term care insurance to employees and their spouses and dependents. (e) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet is prohibited. (f) The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate. (g) Agents shall use the suitability standards developed by the insurer in marketing long-term care insurance. (h) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. Alternatively, the issuers shall send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the National Association of Insurance Commissioners. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file. (i) The insurer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter. (j) This section shall not apply to life insurance policies that accelerate benefits for long-term care." CIC §10234.95(f) and (h)

### **Company Must Resolve All Underwriting Issues Submitted on Application - No Post Claims Underwriting**

This practice by insurers is strictly prohibited by California Regulations. This refers to the practice where an insurer gathers information about the health, mental, and capacity for an individual policyholder to function after a [claim](#) for benefit payments is filed. An insurer would do this, if they could, to attempt to find reasons to cancel a policy or be in a position to deny a claim based on this information derived after the fact. *CIC 10232.3(d)*

### Every Application Must Include a Checklist

Every [application](#) for long-term care insurance must “include a checklist that enumerates each of the specific documents which are required be given to the [applicant](#) at the time of solicitation. The documents and notices to be listed in the checklist include, but are not limited to, the following:

- The "Important Notice Regarding Policies Available" pursuant to Section 10232.25.
- The Outline of Coverage pursuant to Section 10233.5.
- The HICAP Notice pursuant to paragraph of subdivision (a) of Section 10234.93.
- The long-term care insurance CA Consumer shoppers Guide pursuant to paragraph (9) of subdivision (a) of Section 10234.93.
- The "Long-Term Care Insurance Personal Worksheet" pursuant to subdivision (c) of Section 10234.95.
- Notice to applicant regarding replacement of [accident](#) and sickness for long-term care insurance (*Sections 10235.16 and 10235.18 of the CIC*)

*CIC §10232.3(c)*

## 2. Definition of Pre-Existing Condition

- “No long-term care [insurance policy](#) or certificate other than a group policy or certificate, as described in subdivision (a) of Section 10231.6, shall use a definition of preexisting condition which is more restrictive than a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the [effective date](#) of coverage of an insured person.
- Every long-term care insurance policy or certificate shall cover preexisting [conditions](#) that are disclosed on the [application](#) no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.
- The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an [applicant](#), and on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision expires.
- Unless a waiver or [rider](#) has been specifically approved by the commissioner, no long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subdivision (b).”

*CIC §10232.4*

### No New Pre-Existing Conditions on Replacement Policies

Insurers using direct response solicitation methods must deliver a notice regarding replacement of [accident](#) and sickness or long-term care coverage to the [applicant](#) upon issuance of the policy or certificate. The required notice must be provided in the following form:

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

According to (your application) (information you have furnished), you intend to **lapse** or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance coverage delivered herewith issued by (company name) Insurance Company. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy or certificate. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage.

(1) Health **conditions** which you may presently have (preexisting conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar **claim** might have been payable under your present coverage. *CIC 10235.18(a)(1)*

### Permitted Exclusions and Limitations

"Policies in California for long-term care insurance cannot limit or exclude coverage by type of illness, treatment, medical condition, or **accident**." (*CIC §10235.8 as amended by SB 870, Oct. 1999*)

### Permitted Pre-Existing Conditions

"Policies can limit and exclude the following:

- Pre-existing **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." *CIC §10235.8 as amended by SB 870, Oct. 1999*)

### 3. Contestability Period Is Two Years

*CIC 10232.3(f)* See below.

### 4. Completed Application Must Be Delivered With Policy

*CIC 10232.3(g)* See below.

### Notice to Applicant Regarding Replacement

The "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance" pursuant to Section 10235.16 "if replacement is not made by direct response solicitation or Section 10235.18 if replacement is made by direct

response solicitation. Unless the solicitation was made by a direct response method, the agent and **applicant** must both sign at the bottom of the checklist to indicate the required documents were delivered and received.”

### If Medical Underwriting Not Complete

“If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an **application** before issuing the policy or certificate, then the insurer may only rescind the policy or certificate or deny an otherwise valid **claim**, upon clear and convincing evidence of **fraud** or material **misrepresentation** of the risk by the **applicant**. The evidence shall:

- Pertain to the condition for which benefits are sought.
- Involve a chronic condition or involve dates of treatment before the date of application.
- Be material to the acceptance for coverage.
- No long-term care policy or certificate may be field issued.
- The contestability period as defined in Section 10350.2 for long-term care insurance shall be 2 years.
- A copy of the completed application shall be delivered to the insured at the time of delivery of the policy or certificate.
- Every insurer shall maintain a record, in accordance with Section 10508, of all policy or certificate rescissions, both state and countrywide, except those voluntarily initiated by the insured, and shall annually furnish this information to the commissioner in a format prescribed by the commissioner.” *CIC §10232.3 (a)-(g)*

## 5. Protection Against Unintentional Lapse

The older we get, the more we forget. So, in order to recognize this and to provide a measure of protection against **lapse** for aging adults, the law prescribes a number of requirements for insurers.

### Forgetfulness

The key protections required of insurers against forgetfulness and **lapse** are as follows:

- Applicant May Designate Another to Receive Notice of Lapse
  - In this case, the insurer must receive either:
    - Information on designee, or
    - Verbatim waiver (see below) signed and dated.
- Insurer Must Offer the Right to Change the Designee Every Two Years
- Insurer Must Mail a Notice 30 Days Before Termination
- Policy and Certificate Must Include Five-month Reinstatement

“The insurer must receive either:

- Information on designee, or
- Verbatim waiver signed and dated.

*CIC §10235.40*

### Information on Designee

A written designation listing the name, address, and telephone number of at least one individual, in addition to the **applicant**, who is to receive notice of **lapse** or termination of the policy or certificate for nonpayment of premium.”

### Verbatim Waiver Signed and Dated

“A waiver signed and dated by the **applicant** electing not to designate additional persons to receive notice. The required waiver shall read as follows:

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

----- Signature of Applicant Date”

### Insurer Must Offer Right to Change Designee, Every Two Years

In addition, the insurer must notify the insured of the right to change the written designation, no less often than once every two years.

“No individual long-term care policy or certificate will be issued in California until the **applicant** has been given the right to designate at least one individual, in addition to the applicant, to receive notice of **lapse** or termination of a policy or certificate for nonpayment of premium. “

### Insurer Must Mail a Notice 30 Days Before Termination

No individual long-term care policy or certificate will **lapse** or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the **effective date** of the lapse or termination, gives notice to the insured and to the individual or individuals designated pursuant to subdivision at the address provided by the insured for purposes of receiving notice of lapse or termination.

Notice must be given by first-class United States mail, postage prepaid, not less than 30 days after a premium is due and unpaid.

### Policy and Certificate Must Include Five-Month Reinstatement

Each long-term care **insurance policy** or certificate must include a provision which, in the event of **lapse**, provides for **reinstatement** of coverage, if the insurer is provided with proof of the insured's cognitive impairment or the loss of functional capacity. This option must be available to the insured if requested within five months after termination and has to allow for the collection of a past due premium, where appropriate.

The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy certificate.” *CIC §10235.40*

## 6. Inflation Protection

When people buy long-term care insurance today, they generally have a lot of time and years to live before they die. What things cost to live today will assuredly continue to cost more and more in the future. And, the longer we live, the more likely that we will have increased need for and larger costs associated with medical and care over the rest of our lives.

Long-term care insurance was created for and is in existence to financially protection against and the dollars for the costs associated with the needs to have long term care and help pay for the long term care needs resulting from an illness.

The issue that we all have dealt with over the years is how to keep our incomes growing at a rate that will at least keep up with the effects of inflation on costs of things we want and need. With long term care insurance and long-term care costs now and in the future, the issue here is how the long-term benefit amounts purchased today will be able to keep up with the rise in costs over the years, both near and longer term.

### Requirement for Illustration

In California, “an insurer shall include the following information in or with the outline of coverage:

- A graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5 percent over the **policy period** with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
- Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. *CIC §10237.6*

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

Also in California, “no insurer may deliver or issue for delivery a long-term care **insurance policy** or certificate 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.” *CIC §10237.6*

### Requirement for Waiver

Applicant Must Sign statement Refusing 5% Annual Compounded Adjustments.

They have the right to either accept the benefit or to sign a statement refusing it. The benefit does add to the cost of the coverage, so it is allowed to be optional. *CIC 10237.5*

## B. Reporting Requirements

### 1. Insurers Must File Rescission Annually

Insurers must file all rescissions annually.

“Every insurer must maintain a record, in accordance with Section 10508, of all policy or certificate rescissions, both state and countrywide, except those voluntarily initiated by the insured, and shall annually furnish this information to the commissioner in a format prescribed by the commissioner.” *CIC §10232.3 (h)*

### 2. Insurers Must Report the Number of Replacement Sales and Lapses

- “Every insurer must maintain records for each agent of that agent's amount of replacement sales as a percent of the agent' s total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.
- Every insurer must 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 must 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 must report annually by June 30, the number of replacement policies sold as a percent of its total annual sales in the state and as a percent of its total number of policies in force in the state as of the end of the preceding calendar year.
- Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance." *CIC §10234.86*

### Reporting Number of Applicants Who Refused to Complete the Personal Worksheet

Insurers must annually report the number of applicants who refused to complete the personal worksheet and the number that did not meet the suitability requirements.

"The insurer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter.

(j) This section shall not apply to life insurance policies that accelerate benefits for long-term care." *CIC §10234.95(i)*

### Insurers Must File Personal Worksheet Upon Each Rate Increase - Suitability Standards

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

*CIC §10234.95(c)(4)*

### Insurers Must File Commission Structure for Replacement Coverage

RE: Sales commission; basis on improvement of insured's position; applicability; definition; filing of commission structure

"Every long-term care insurer shall file with the commissioner within six months of the **effective date** of this section, its commission structure or an explanation of the insurer's compensation plan. Any amendments to the commission structure shall be filed with the commissioner before implementation." *CIC §10234.97(c)*

### Commission Structure Filed With Commissioner Within Six Months

"Every long-term care insurer shall file with the commissioner within six months of the **effective date** of this section, its commission structure or an explanation of the insurer's compensation plan. Any amendments to the commission structure shall be filed with the commissioner before implementation."

## 3. Insurers Semi-Annual Filing All Agents Authorized to Sell Long-Term Care Insurance

"Responsibilities of long-term care insurers with respect to marketing procedures, supplying list of agents, continuing education, buyer notification, inquiring about applicant's existing insurance, auditable procedures, insurance counseling, and insurance shoppers guide; unfair trade practices." *CIC §10234.93*

Every insurer of long-term care in California shall:

- “Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
- Establish marketing procedures to assure excessive insurance is not sold or issued.
- Submit to the commissioner within six months of the [effective date](#) of this act, a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semiannually.
- Every long-term care insurer shall file with the commissioner within six months of the effective date of this section, its commission structure or an explanation of the insurer's compensation plan. Any amendments to the commission structure shall be filed with the commissioner before implementation.” *CIC §10234.93*

## 4. Insurers Must File Initial Premium Rates

### Submission of New Business Premiums

“The premium rate schedules for all individual and group long-term care insurance policies issued in this state must be filed with and receive the prior approval of the commissioner before the policy may be offered, sold, issued, or delivered to a resident of California.” (*Section 10236.11 of the CIC*)

“No insurer may increase the premium for an individual or group long-term care [insurance policy](#) or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner.” *CIC §10236.11*

### Insurers Must File All Rate Increase Requests for Approval Rate Increase Subject to CDI Approval

“No insurer may increase the premium for an individual or group long-term care [insurance policy](#) or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner.”

“All rate increases are subject to CDI approval.” *CIC §10236.13*

## C. Required Policy Definitions

**Terms and Conditions *CIC §10235 – CIC §10236.15***  
**Policy Terms *CIC §10235.2***

“No long-term care [insurance policy](#) delivered or issued for delivery in California can use the things we talk about below unless the terms are defined in the policy and the definitions satisfy the following requirements:

- **“Medicare”** is defined as the “Health Insurance for the Aged Act,” Title XVIII of the Social Security Amendments of 1965 or Title I, Part I of Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act.” *CIC §10235.2*
- **“Skilled nursing care,” “intermediate care,” “home health care,”** and other services are defined in relation to the level of skill required, the nature of the care, and the setting in which the care is required to be delivered.” *CIC §10235.2(b)*
- **“All providers of services, including skilled nursing facilities, intermediate care facilities, and home health agencies** must be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.”

In addition, according to the statutes, the policy definitions of these benefits may be no more restrictive than the following:

- **“Home health care”** is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.
- **“Adult day care”** is medical or non-medical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.
- **“Personal care”** is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. “Instrumental activities of daily living” include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.
- **“Homemaker services”** is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- **“Hospice services”** are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.
- **“Respite care”** is short-term care provided in an institution such as a nursing home, 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. *CIC §10232.9(b)(1-6)*

## D. Consumer Protection

### 1. Shortened Benefit Period

Insurers must offer a shortened benefit period as a nonforfeiture option. In California, there are certain requirements that insurers have to include in their policies and that agents must make their clients aware of. The following summarized the regulations (*CIC §10235.30*) on this as it relates to “nonforfeiture” benefits and provisions:

“No insurer may deliver or issue for delivery a long-term care policy in this state unless the insurer offers at the time of [application](#) an option to purchase a shortened benefit period nonforfeiture benefit with the following features:

#### Begins After 10 Years

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

#### Minimum Policy Benefits = Three Months Nonforfeiture Benefit

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.

#### Amount and Frequency Same as Original Policy Terms

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

## Policy Benefit May Be Reduced by Claims Paid

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

## Prohibited: Return of Premium, Reduced Paid-Up and Extended Term

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

## Lifetime Maximum Amount Increases Proportionally to Number of Years of Premium Payment

The lifetime maximum benefit amount increases proportionally with the number of years of premium payment. (b) This section shall not apply to life insurance policies that accelerate benefits for long-term care.”

## Life Riders Accelerating Benefits Are Exempt

“Life policies with accelerated benefits or long term care are exempt from this requirement.

*CIC §10235.30*

## 2. Other Type Nonforfeiture Benefits

An additional note here on another separate issue in the “Changing Your Benefits” category: If you find that you cannot afford to continue paying the same amount of premiums for the coverage you bought, you have the right to reduce your benefits in return for a lower premium. Companies must, at a minimum, let you reduce the daily benefit or change the number of years the company will pay benefits so the lower premium is an amount that is more affordable.

*CA Long-term care Rate Guide-A Guide to Long-Term Care*

## 3. Distinguish Between Groups and Individual Disclosure in Certificates

“A certificate issued pursuant to a group long-term care [insurance policy](#), which policy is delivered or issued for delivery in this state, shall include all of the following:

- A description of the principal benefits and coverage provided in the policy.
- A statement of the principal [exclusions](#), reductions, and limitations contained in the policy.
- A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums.
- A statement that the group master policy determines governing contractual provisions.

*CIC §10233.6*

## 4. Explanation of Insured’s Rights Regarding Continuation, Conversion Replacement

An explanation of the insured's rights regarding continuation, conversion, and replacement.”

## 5. 30-Day Free Look

“Purchasers of individual long-term care insurance (except purchasers through employer groups or trade associations) have the right to review the policy or certificate for 30 days after they receive it. If they decide not to buy the insurance, for any reason, they may return the policy to the insurer or the agent without explanation,

and all the money they paid will be refunded to them. (Policyholders should always keep a record of the date when received the policy and the date they returned it, or return it by certified mail.) “

California regulations speak to this issue as follows. “It says that the return of a policy or certificate will void the policy or certificate from the beginning and the parties will be in the same position as if no policy, certificate, or **contract** had been issued. All premiums paid and any policy fee paid for the policy must be fully refunded directly to the **applicant** by the insurer within 30 days after the policy or certificate is returned.

Long-term care insurance policies or certificates must have a notice prominently printed on the first page of the policy or certificate, or attached to it, stating clearly the 30 day look provision.” *CIC §10232.7*

## 6. Right to Reduce Coverage and Lower Premiums

In the event of a premium increase, the insured must be offered the option to lower premiums and reduce coverage.

### Downgrading

*CIC §10235.50*

### Every Policy or Certificate Must Allow Lowering Premium

In California, “every policy or certificate must include a provision that gives the policyholder or certificate holder the following rights to reduce coverage and lower their premiums:

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

#### Reducing Policy Maximum

“Reducing the lifetime maximum benefit.”

#### Reducing Daily, Weekly, Monthly Benefit

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

#### Converting to Nursing Facility Only or Home Care Only

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

#### Premium Based on Issue Age and Issue Date

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

#### Inflation Protection Will Continue

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

## Insurer Must Notify of Option to Downgrade if Lapse Is Imminent

“In the event a policy or certificate is about to [lapse](#), the insurer shall provide written notice to the insured of the options to lower the premium by reducing coverage and of the premiums applicable to the reduced coverage options.”

## Insurer Must Notify of Option to Downgrade if Premium Increased

“The insurer may include in the notice additional options. The notice must provide the insured at least 30 days in which to elect to reduce coverage and the policy must be reinstated without underwriting if the insured elects the reduced coverage.

In the event of a premium increase, the insured must be offered the option to lower premiums and reduce coverage.” *CIC §10235.50*

## 7. Right to Increase Coverage

### Upgrading

*CIC §10235.51*

### Every Policy or Certificate Must Allow Increase in Coverage

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

- **Increase daily, weekly, monthly benefits** (the amount of the per diem benefits)
- **Increase in policy maximum** (the lifetime maximum benefit)
- **Increase all benefits in comprehensive LTC product** (the amount of both the nursing facility per diem benefit and the home and community-based care benefits of a comprehensive long-term care [insurance policy](#) or certificate)”

### Premium Priced at Attained Age

“The premiums for the riders to increase coverage may be based on the attained age of the insured. The premium for the original policy or certificate will not be changed and will continue to be based on the insured's age when the original policy or certificate was issued.”

## 8. Insurer May Require Insured to Undergo New Underwriting

New coverage may be underwritten.

“The insurer may require the insured to undergo new underwriting, in addition to the payment of an additional premium, to qualify for the [additional coverage](#). The insurer may restrict the age for issuance of additional coverage and restrict the aggregate amount of additional coverage an insured may acquire to the maximum age and coverage the insurer allows when issuing a new policy or certificate.” *CIC §10235.51(c)*

## E. Policy Replacement

**Premium Credits for Replacement Policies**  
**Premium Credits Towards Replacement Policies or Certificates**  
*CIC §10234.87*

### 1. Premium Credits for Replacement Policies

5% of Prior Annual Premium (Life Riders Exempt) (Amended 1999)

“If an insurer replaces a policy or certificate that it has previously issued, the insurer shall recognize past insured status by granting premium credits toward the premiums for the replacement policy or certificate. The premium credits shall equal 5% of the annual premium of the prior policy or certificate for each full year the prior policy or certificate was in force. The premium credit shall be applied toward all future premium payments for the replacement policy or certificate, but the cumulative credit allowed need not exceed 50%. No credit need be provided if a [claim](#) has been filed under the original policy or certificate.

The cumulative credits allowed need not reduce the premium for the replacement policy or certificate to less than the premium of the original policy or certificate.

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

## 2. Premium Credits Examples

When an agent of and an insurer for long term care policies engages in the replacement of a policy or group certificate that they originally issued, the insurer must provide premium credits that take into account the insured’s previous premiums paid on the original [contract](#). They must apply premium credits toward the new premium amount for the newer policy. The following examples show how this would work in two situations:

### Credit Less Than Maximum of 50%

Chuck has had and paid for a long-term policy for 5 years with a premium of \$2,000 per year. He wants to replace his policy with a new one with the same company which has a premium of \$3,000 per year. In this case, Chuck is allowed a premium credit on his newer policy for a portion of the premiums he had paid on his original policy. Since California regulations requires a credit that must equal 5% of the original premium of \$2,000 for the number of 5 years that he paid on it, his credit toward the new \$3,000 premium each year will be as follows:  $5\% \text{ times } 5 \text{ years} = 25\% \text{ times } \$2,000 = \$500$  Credit; which when subtracted from the new premium of \$3,000 = \$2,500. This \$2,500 amount would be Chuck's new premium on his newer policy.

### Credit More Than Maximum of 50%

Nancy has had and paid for a long-term policy for 15 years with a premium of \$2,000 per year. She wants to replace her policy with a new one with the same company which has a premium of \$3,000 per year. In this case, Nancy is allowed a premium credit on her newer policy for a portion of the premiums she had paid on her original policy. Since California regulations requires a credit that must equal 5% of the original premium of \$2,000 for the number of 15 years that she paid on it up to 50%, her credit toward the new \$3,000 premium each year will be as follows:  $5\% \text{ times } 15 \text{ years} = 75\%$ (limited to 50% maximum)so,  $50\% \text{ times } \$2,000 = \$1000$  Credit; which when subtracted from the new premium of \$3,000 = \$2,000. This \$2,000 amount would be Nancy's new premium on her newer policy.

## 3. Replacement Policy Conversions

### Continuation or Conversion of Group Coverage *CIC §10236.5*

Every Certificate Must Provide for Continuation or Conversion

Group Coverage Renewability: "If one purchases a long-term care certificate through a group, they have the right to either continuation or conversion if their coverage terminates."

### Definition of "Continuation"

The definition of "continuation" means "one maintains the same coverage if they continue to pay the premium on time."

### Definition of "Conversion"

The definition of "conversion" means "one will be issued an individual policy containing identical or equivalent coverage regardless of their health or their age."

### Authorized Limitations Under Conversion

"The premium will be calculated on their age at the time the group certificate was issued."

*CIC §10236.5*

## 4. Exchange From Group Non-Tax Qualified to Tax Qualified

In California - Pre-1997 Policy (Issued Before Dec 31, 1997)

### Tax Treatment: Policies Are "Grandfathered"

They receive the same tax benefits as the new policies that comply with the new law

"LTC policies or certificates in California issued before December 31, 1997 that were "federally non-tax qualified" and had some home care benefits received special [consideration](#) that would allow them to retain their tax-qualified status in the future."

*CIC §10232.2(d)*

## F. Long-Term Care Personal Worksheet With Company-Specific Premium Increase Information

### 1. In California

"A copy of the issuer's personal worksheet must be filed and approved by the commissioner. A new personal worksheet must be filed and approved by the commissioner each time a rate is increased in California and each time a new policy is filed for approval by the commissioner.

The new personal worksheet must disclose the amount of the rate increase in California and all prior rate increases in California, as well as all prior rate increases and rate increase requests or filings in any other state. The new personal worksheet must be used by the insurer within 60 days of approval by the commissioner in place of the previously approved personal worksheet." *CIC 10234.95(c)(4)*

### 2. Filed In Any Other State

#### Disclosure of Rate Increase in Any State

"In the premium section of the personal worksheet, the insurer must disclose all rate increases and rate increase requests for all policies, whether issued by the insurer or purchased or acquired from another insurer, in the United States on or after January 1, 1990.

The premium section must include a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate

increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800- 434-0222), or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov)." *CIC §10234.95*

## G. Option to Increase Coverage

### 1. What About Clients on Fixed Incomes?

The increases in benefits created by the options to increase also increases the cost of the benefits and the policies, as well. Seniors on fixed incomes may not have the capacity in their incomes to keep up with the increases. This should be considered when looking at the short-term and longer-term suitability of a LTC policy purchase.

### 2. Insurer Must Offer Inflation Protection

In California, "no insurer may deliver or issue for delivery a long-term care **insurance policy** or certificate 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." *CIC §10237.1*

The California Insurance Code says that "the inflation option will increase the benefit levels annually. It would guarantee the individual the right to increase benefit levels without the person having to provide evidence of **insurability** or health status as long as the option for the previous period has not been declined. It would cover specified percentage of actual or reasonable charges."

### 3. Rejection Statement Must Be Verbatim

They have the right to either accept the benefit or to sign a statement refusing it. The benefit does add to the cost of the coverage, so it is allowed to be optional. *CIC §10237.5(b)*

Requirement for Waiver - Applicant Must Sign statement Refusing 5% Annual Compounded Adjustments

The rejection, to be included in the **application** or on a separate form, must state:

**"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject 5 percent annual compound inflation protection.**

----- Signature of Applicant Date"

### 4. Mandated Offer Goes to Group Policyholder

"If the policy is issued to a group, the required offering must be made to the group policyholder; except that if the policy is issued to a group other than to a continuing care retirement community, the offering must be made to each proposed certificate holder." *CIC §10237.1*

Insurers must 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:

### Group Policy Offering

“The insurer of a group long-term care [insurance policy](#) must offer the holder of the group policy the opportunity to have the inflation protection extended to existing certificate holders, but the insurer is relieved if the holder of the group policy declines the insurer's offer.” *CIC §10237.2*

### Life Insurance With Accelerated Benefits and Expense Incurred Plans Are Exempt

“The previous requirements are not required of any of the following:

- Life insurance policies or riders containing accelerated long-term care benefits.
- Expense incurred long-term care insurance policies. For purposes of this subdivision, "expense incurred" does not include policies paying a certain percentage of reasonable and customary charges up to a specified, indemnity-type maximum amount.” *CIC §10237.3*

HIPAA also allows Life Insurance Contracts to Pay an Accelerated Benefit in the event the insured suffers a chronic illness as defined in IRC Sections 7702(B) and 101(g)(1). The IRS is silent on chronic illness riders in annuity contracts.

## 5. No Limits on Inflation Protection

“Inflation protection benefit increases under a policy that contains these benefits must continue without regard to an insured's age, [claim](#) status or claim history, or policy term, the length of time the person has been insured under the policy.” *CIC §10237.4(a)*

## 6. No Reduction of Inflation Benefit Increase Due to Payment of Claims

“The inflation protection benefit increases under a policy or certificate that contains an inflation protection feature must not be reduced due to the payment of claims.” *CIC §10237.4(c)*

## 7. Insurer Must Offer Level Premiums If Offering Automatic Increases

“An offer of inflation protection that provides for automatic benefit increases must include an offer of a premium which the insurer expects to remain constant. The offer must disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.” *CIC §10237.4(b)*

## 8. Outline of Coverage (OOC) Must Include:

An insurer must include the following information in or with the outline of coverage (*CIC §10237.6*):

### A 20-Year Graph Contrasting IP With No IP

“A graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of not less than 5 percent over the [policy period](#) with a policy that does not increase benefits. The graphic comparison must show benefit levels over at least a 20-year period.”

## 9. Projected Out-of-Pocket Costs Without Inflation Protection

This following graph illustrates daily and annual out-of-pocket expenditures between policies with a daily benefit equal to the median CA cost but without inflation protection and 5% compounded annual increases over 20 and 30 years.

## Compound Interest Model

Year	5% Compound Interest	\$272/Day Policy	\$ Out of Pocket
2015	\$99,646	\$99,646	\$0
2020	\$125,176	\$99,646	\$27,530
2025	\$162,312	\$99,646	\$62,666
2030	\$207,156	\$99,646	\$107,510
2035	\$247,156	\$99,646	\$164,744
2040	\$337,436	\$99,646	\$237,790
2045	\$430,664	\$99,646	\$331,018

### Expected Premium Increases to Pay for IP

“Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.” *CIC § 10237.6(a)(2)*

### 10. Illustration Must Be Reasonable

“An insurer may use a reasonable hypothetical or graphic demonstration for purposes of this [disclosure](#).” *CIC § 10237.6(b)*

### 11. Other Optional Forms of Inflation Protection

Other optional forms of Inflation protection include methods and calculations that can be based on various approaches including:

- **Automatic, simple and compound (USC)** which are systematic and mathematical approaches to specific benefit increases.
- **Consumer price index (CPI)** which looks at the CPI increase in any year and calculates that effect on an commensurate increase in benefits.
- **Future purchase option (FPO)** which generally guarantees the opportunity to increase benefits at certain intervals and up to specific maximums based on the original benefit level.

### 12. Requirement to Make Specimen Policy Available on Website and By Request

All insurers of long-term care in California must:

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

**Insurer Must Maintain Records for Each Agent for Amount of Replacement Sales and Lapses**  
*CIC 10234.93. (a)(10)*

### 13. Lapse and Replacement Data

**CIC § 10234.86**

#### Insurers Must Calculate Data for Each Agent and Maintain Records

“Every insurer must maintain records for each agent of that agent's amount of replacement sales and lapses.”

#### Replacement Sales Relative to Annual Total Sales

“Every insurer must maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales.”

### Lapses Relative to Total Annual Sales

“Every insurer must maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.”

### June 30th Report: Agents With Greatest Lapse and Replacement Rate

“Every insurer must report annually by June 30, the 10 percent of its agents in the state with the greatest percentage of lapses and replacements.”

### June 30th Report: Percentage of Lapsed Policies

“Every insurer must 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.”

### June 30th Report: Percentage of Replacement Policies

“Every insurer must report annually by June 30, the number of replacement policies sold as a percent of its total annual sales in the state and as a percent of its total number of policies in force in the state as of the end of the preceding calendar year.”

### Purpose of Reporting Is Close Review of Agent Activities

“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.” *CIC §10234.86*

## 14. Insurer Must Retain Auditable Procedures for Compliance

There are responsibilities of Long-Term Care insurers regarding procedures.

“Responsibilities of long-term care insurers with respect to marketing procedures, supplying list of agents, continuing education, buyer notification, inquiring about applicant's existing insurance, auditable procedures, insurance counseling, and insurance shoppers guide; unfair trade practices.”

“Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subdivision.” *CIC §10234.93*

## 15. Additional Insurer Obligations

In addition to any other requirements of law, the following applies 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 must notify the applicant within 60 days from the date the insurer or insurer's authorized representative or producer receives the application and the amount as to whether or not the applicant will be issued a policy of insurance. If the

applicant is not so notified, the insurer or insurer's authorized representative or producer shall pay interest to the applicant on the funds that the applicant submitted with the application, at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure, from the date the insurer or insurer's authorized representative or producer received those funds until they are refunded to the applicant or are applied toward the premium." *CIC §10234.65*

## 16. California Life and Health Insurance Guarantee Association (CLHIGA)

A danger with long-term-care policies is that if an insurer goes under, it's difficult to predict what will happen to LTC policies with that insurer. People often buy LTC policies many years before they may be used.

Long-term care policies have been only been around the early 80s. Many of the policies are just starting to become exposed to claims as insureds age to their senior years. Little history is known about how a company failure might affect LTC policyholders.

California LTC consumers have the backstop in the California State Guarantee Association. It covers long-term care insurance benefits up to \$200,000, increased by the change in health care cost component of the consumer price index from January 1, 1991, to the date the insurer becomes insolvent.

According to *CIC §1067.02 (a)(1)*:

This article provides coverage for the policies and contracts specified in of the following:

"To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees, or payees of the persons covered under paragraph (2)."

According to *CIC §1067.02(b)(1)*:

"This article shall provide coverage to the persons specified in subdivision (a) for direct, non-group life, health, or annuity policies or contracts, and supplemental contracts to any of these, and for certificates under direct group policies and contracts, except as limited by this article. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts. The health policies and contracts covered under this article include, but are not limited to, basic hospital, medical, and surgical insurance, major medical insurance, disability income insurance, disability insurance, including insurance appertaining to injury, disablement, or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness, and long-term care insurance, including any net cash surrender and net cash withdrawal values."

## H. Agent Responsibilities and Prohibitions

### 1. Duty of Honesty, Good Faith, Fair Dealing

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

"With regard to long-term care insurance, all insurers, brokers, agents, and others engaged in the business of insurance owe a policyholder or a prospective policyholder a duty of honesty, and a duty of good faith and fair dealing."

Every long-term care insurer and insurance agent owes every **applicant** and policyholder a duty of honesty, good faith and fair dealing. Among other things, this duty means that advertisements and other marketing materials may not be misleading. Applicants must be given fair and accurate comparisons of policies. No excessive insurance or inappropriate replacement policies may be sold. High pressure tactics are expressly forbidden, and insurance agents must receive special training in order to sell long-term care insurance. *CA Long-term care Rate Guide-A Guide to Long-Term Care*

“The conduct of an insurer, broker, or agent during the offer and sale of a policy previous to the purchase is relevant to any action alleging a breach of the duty of honesty, and a duty of good faith and fair dealing.” *CIC §10234.8*

## 2. Long-Term Care Training

### Licensees Must Meet 8-Hour Mandatory Long-Term Care Training Requirement

“Every insurer of long-term care in California must:

- Provide the following training and require that each agent or other insurer representative authorized to solicit individual consumers for the sale of long-term care insurance shall satisfactorily complete the following training requirements that, for resident licensees, shall be part of, and not in addition to, the continuing education requirements in Section 1749.3:
  - For licensees issued a license after January 1, 1992, eight hours of training in each of the first four 12-month periods beginning from the date of original license issuance and thereafter and eight hours of training prior to each license renewal.
  - For licensees issued a license before January 1, 1992, eight hours of training prior to each license renewal. *CIC §10234.93(a)(A)(B)*

### Nonresident Licensees Must Meet 8-Hour Mandatory Long-Term Care Training Requirement

For nonresident licensees that are not otherwise subject to the continuing education requirements set forth in Section 1749.3, the evidence of training required by this section shall be filed with and approved by the commissioner as provided in subdivision (g) of Section 1749.4. *CIC §10234.93(a)(C)*

## 3. Suitability

### Agents must use company suitability standards.

In California, “agents and insurers must develop procedures that take into **consideration**, when determining whether the **applicant** meets the standards developed by the insurer, the following:

- **Affordability of coverage:** In California, “agents and insurers must develop procedures that take into consideration the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.”
- **Applicant's LTC Goals and Needs:** In California, “agents and insurers must develop procedures that take into consideration the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.”
- **Value, Benefits and Cost of Value, Benefits and Costs of the Applicant's Existing Insurance:** In California, “agents and insurers must develop procedures that take into consideration the value, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.” *CIC §10234.95*

## 4. Personal Worksheet

### NAIC Personal Worksheet in 12 Point Type at Time of Application

“The issuer, and where an agent is involved, the agent, must make reasonable efforts to obtain the information on ability to pay, client’s goal, and benefits vs. cost, etc. The efforts must include presentation to the **applicant**, at or prior to **application**, of the "Long-Term Care Insurance Personal Worksheet," contained in the Long-Term Care Insurance Model Regulations of the National Association of Insurance Commissioners.

The personal worksheet used by the insurer must contain, at a minimum, the information in the NAIC worksheet in not less than 12-point type. The insurer may request the applicant to provide additional information to comply with its own suitability standards.” *CIC §10234.95(h)*

### Consumer May Decline to Provide Information

If the issuer determines that the **applicant** does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the **application**. Alternatively, the issuers shall send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the National Association of Insurance Commissioners. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file. *CIC §10234.95 (h)*

Even though it is the carrier responsibility to develop and use suitability standards and train its agents on its use, agents should have a solid understanding of the basic NAIC model requirements and the reasoning behind them.

## I. Replacement

### 1. Replacement Coverage

Any time long-term care coverage is replaced, the sales commission that is paid by the insurer and that represents the percentage of the sale normally paid for first year sales of long-term care policies or certificates must be calculated based on the difference between the annual premium of the replacement coverage and that of the original coverage.

#### Definition

“If the premium on the replacement product is less than or equal to the premium for the product being replaced, the sales commission must be limited to the percentage of the sale normally paid for renewal of long-term care policies or certificates.”

“ **'Commission or other compensation'** includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards, and finder's fees.” *CIC §10234.97*

#### Basis on Improvement of Insured’s Position

Replacement must be contingent upon the insurer's declaration that the replacement policy materially improves the position of the insured.

#### Applicability

This does not apply to replacement coverage that is group insurance.

### Restriction on Replacement Sales Commission

“Every long-term care insurer must file with the commissioner within six months of the **effective date** of regulations, its commission structure or an explanation of the insurer’s compensation plan. Any amendments to the commission structure must be filed with the commissioner before implementation.” *CIC §10234.97*

## 2. Replacement of Existing Insurance Notice

Replacement of policies is serious business and great care and caution must be taken whenever this is done. Agents must take special care and be well versed in both the policy being replaced as well as the new one they are recommending to be purchased.

Clients who replace their own policies or agents who recommend replacing policies owe it to their clients to make every effort to compare policies to make sure that the client ends up in a better position with the new policy than they had with their original one.

While most agents are professional and have the client’s best interest at heart, there are some who would want to replace policies for the sake of making a commission. In order to make it difficult for some to do this in a way that the client may not know about the replacement and/or may not be made aware of the differences between the two, California introduced statutes to make its residents and agents do replacement of policies in an organized, documented way with a process to follow for the benefit of all concerned; company, client, and agent. *CIC §10235.16*

### Application Must Contain Questions

It is required that Long-term care insurance **application** forms “must include a question designed to elicit information as to whether the proposed insurance is intended to replace any other **accident** and sickness or long-term care insurance presently in force. They provided for a supplementary application or other form to be required to be signed by the **applicant** with a question of whether this application was for replacement or not.” *CIC §10235.16*

### Notice Must Be Delivered Before Delivery of Policy

“An insurer, upon determining that a sale will involve replacement (other than an insurer using direct response solicitation methods) or its agent must furnish the **applicant** a notice regarding replacement of **accident** and sickness or long-term care coverage prior to issuance or delivery of a policy or certificate.

One signed copy of this notice has to be retained by the applicant and an additional copy, signed by the applicant, must be retained by the insurer.”

### Mandated Form of Notice Before Delivery of the Policy

The California-required notice shall be provided in the following form:

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

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

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

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

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage. (Contact your present insurer)

If, after due **consideration**, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded. (Warning: misstatement may = rescission)

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

\_\_\_\_\_ (Date)

\_\_\_\_\_ (Applicant's Signature)"

For group coverage not subject to the 30-day return provision of Section 10232.7, the notice shall be modified to reflect the appropriate time period in which the policy may be returned and premium refunded. (Modify Notice if 30-day free look does not apply)

The replacement notice shall include the following statement except when the replacement coverage is group insurance as described in subdivision (a) of Section 10231.6:

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

Additional or different benefits (please specify) \_\_\_\_\_

No change in benefits, but lower premiums \_\_\_\_\_

Fewer benefits and lower premiums \_\_\_\_\_

Other (please specify) \_\_\_\_\_

(Disclaimer by agent and insurer: **COMPARISON TO YOUR CURRENT COVERAGE:** Replacement materially improves your position – reasons must be listed)

(Signature of Agent and Name of Insurer)

\_\_\_\_\_ (Signature of Applicant)

\_\_\_\_\_ (Date)

As a further note in this regard, insurers using direct response solicitation methods must deliver a notice regarding replacement of accident and sickness or long-term care coverage to the **applicant** upon issuance of the policy or certificate. The required notice must be provided to the applicant in the following form: **CIC § 10235.18**

The "Mandated" form of Notice reads as follows:

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

According to (your application) (information you have furnished), you intend to **lapse** or otherwise terminate existing **accident** and sickness or long-term care insurance and replace it with long-term care insurance coverage to be issued by (company name) Insurance Company. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new coverage.

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

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due **consideration**, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded. The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_ (Date)

\_\_\_\_\_ (Applicant's Signature)

## **J. Consumer Protection**

Agents must provide information and the places and people that are available to them within California. They deserve to have the best protections and information available relative to their issues surrounding Long Term Care.

Here are those required items:

“Every insurer of long-term care in California must 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.” *CIC §10234.93*

Insurers/agents must provide “Taking Care of Tomorrow” to applicant – which can be accessed on the Department of Aging’s website at [www.aging.ca.gov](http://www.aging.ca.gov) (CIC §10234.93(a)(9))

California Department of Insurance’s (CDI) toll-free consumer services 1-800-927-HELP

Agents are required to provide their applicants the local HICAP program name, location and telephone number and statewide HICAP telephone number [1-800-434-0222](tel:1-800-434-0222) (CIC §1 0234.93(a)(8))

HICAP notice on outline of coverage (*Section 10232.3(c)(3) of the CIC*)

(8) Every insurer shall provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222.

**“INFORMATION AND COUNSELING.** The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number [1-800-434-0222](tel:1-800-434-0222) for a referral to your local HICAP office.” *CIC §10233.5 (Information and counseling 1-800-927-HELP (Department’s LTC Guide and HICAP))*

**Rights to Reduce, Add or Purchase New Coverage**  
*Section 10235.50 of the CIC*

## 1. Downgrading

- **Every Policy or Certificate Must Allow Lowering Premium:** In California, “every policy or certificate must include a provision that gives the policyholder or certificate holder the following rights to reduce coverage and lower their premiums: A right, exercisable any time after the first year, to retain a policy or certificate while lowering the premium in no fewer than the following three ways:”
  - **Reducing Policy Maximum:** “Reducing the lifetime maximum benefit.”
  - **Reducing Daily, Weekly, Monthly Benefit:** “Reducing the nursing facility per diem and reducing the home- and community-based service benefits of a home care only policy and of a comprehensive long-term care policy.”
  - **Converting to Nursing Facility Only or Home Care Only:** “Converting a “comprehensive long-term care” policy or certificate to a “Nursing Facility Only” or a “Home Care Only” policy or certificate, if the insurer issues those policies or certificates for sale in the state.”
- **Premium Based on Issue Age and Issue Date:** “The premium for the policy or certificate that is reduced in coverage will be based on the age of the insured at issue age and the premium rate applicable to the amount of reduced coverage at the original issue date.”
- **Inflation Protection Will Continue:** “If the [contract](#) in force at the time a reduction in coverage is made provides for benefit adjustments for anticipated increases in the costs of long-term care services, then the reduced nursing facility per diem, lifetime maximum benefit, and daily, weekly, or monthly home care benefits will be adjusted in the same manner and in the same amount as the contract in force prior to the reduction in coverage.”
- **Insurer Must Notify of Option to Downgrade If Lapse Is Imminent:** “In the event a policy or certificate is about to [lapse](#), the insurer shall provide written notice to

the insured of the options to lower the premium by reducing coverage and of the premiums applicable to the reduced coverage options.”

- **Insurer Must Notify of Option to Downgrade If Premium Increased:** “The insurer may include in the notice additional options. The notice must provide the insured at least 30 days in which to elect to reduce coverage and the policy must be reinstated without underwriting if the insured elects the reduced coverage.
- In the event of a premium increase, the insured must be offered the option to lower premiums and reduce coverage.” *CIC §10235.50*
- **New Coverage May Be Underwritten:** “The insurer may require the insured to undergo new underwriting, in addition to the payment of an additional premium, to qualify for the [additional coverage](#). The insurer may restrict the age for issuance of additional coverage and restrict the aggregate amount of additional coverage an insured may acquire to the maximum age and coverage the insurer allows when issuing a new policy or certificate.” *CIC §10235.51*
- **Replacement Policy:** “By replacing the existing policy or certificate in accordance with Section 10234.87.”
- **Replacement at Issue Age Premium:** “By replacing the existing policy or certificate with a new policy or certificate in which case [consideration](#) for past insured status shall be recognized by setting the premium for the replacement policy or certificate at the issue age of the policy or certificate being replaced.”
- **Update May Be Underwritten:** “The insured may be required to undergo new underwriting, but the underwriting can be no more restrictive than if the policyholder or certificate holder were applying for a new policy or certificate.” *CIC §10235.52*

*(Amended 1999 SB 870) CIC §10235.50*

## 2. Updating

- **Policy Provision Must Allow Insureds to Update:** “Every policy must contain a provision that, in the event the insurer develops new benefits or benefit eligibility or new policies with new benefits or benefit eligibility not included in the previously issued policy, the insurer will grant current holders of its policies who are not in benefit or within the elimination period the following rights:”
- **Insurer Must Notify Within 12 Months:** “The policyholder will be notified of the availability of the new benefits or benefit eligibility or new policy within 12 months. The insurer's notice shall be filed with the department at the same time as the new policy or [rider](#).”
- **Rider, Separate Attained Age Premium:** “The insurer shall offer the policyholder new benefits or benefit eligibility in one of the following ways:
  - By adding a rider to the existing policy and paying a separate premium for the new benefits or benefit eligibility based on the insured's attained age. The premium for the existing policy will remain unchanged based on the insured's age at issuance.”

*(Amended 1999 SB 870) CIC §10235.52*

## 3. Right to Choose a Paid-Up Benefit Following a Rate Increase

### Contingent (Benefit Upon Lapse) Nonforfeiture

In California, if you were to receive a substantial premium increase, you have the right to stop paying premiums and have your policy converted to paid-up status. Your paid-up policy would have a maximum benefit at least equal to the amount of premiums you had paid over your lifetime.

- “Notwithstanding any other provision of law, the commissioner may require the administration by an insurer of the contingent benefit upon [lapse](#), as described in Section 26 (A), (D) (3), (E), (F), (G), and (J) of the Long-Term Care Insurance Model Regulation promulgated by the National Association of Insurance Commissioners, as adopted in October 2000, as a condition of approval or

acknowledgment of a rate adjustment for a block of business for which the contingent benefit upon lapse is not otherwise available.

- The insurer shall notify policyholders and certificate holders of the contingent benefit upon lapse when required by the commissioner in conjunction with the implementation of a rate adjustment. The commissioner may require an insurer who files for such a rate adjustment to allow policyholders and certificate holders to reduce coverage pursuant to Section 10235.50 to avoid an increase in the policy's premium amount. *CIC §10236.13(e)(3)*
- If the amount of increase after all increases disclosed pursuant to subparagraph (D) of paragraph (1), whether the increase or increases are approved or not approved by the commissioner, triggers the contingent benefit upon lapse, the commissioner shall require the administration by an insurer of the contingent benefit upon lapse as a condition of approval of a premium rate schedule increase that is lower than the amount necessary to provide the certification required by paragraph (1) of subdivision (a) or with the initial increase and each subsequent increase in a series of premium rate schedule increases. The commissioner may waive this condition of approval if an insurer demonstrates that the waiver is necessary to protect the financial condition of the insurer, including [avoidance](#) of further reductions in capital and surplus." *CIC §10235.35*

*(Sections 10235.35 and 10236.13(e)(3) of the CIC)*

## 4. Right to Request and Receive Sample Policy

### Consumer's Right to Request and Receive a Sample Policy

All consumers of long-term care in California are entitled to request and receive a Sample LTC policy.

"... The individual specimen policy form or group master policy and certificate form shall be provided to a requesting party within 15 calendar days of receipt of a request." *CIC §10234.93(a)(10)*

### Right to Appeal Contract Language

#### Section 10235.94 of the CIC

## 5. Consumer/Policy Holder Right to Appeal

### Benefit Eligibility, Care Plan, Services and Providers, Reimbursement Amount

"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." *CIC §10235.94*

## K. Replacement of Long-Term Care Insurance Unnecessarily

"No insurer, [broker](#), agent, or other person shall cause a policyholder to replace a long term care [insurance policy](#) unnecessarily. Nothing in this section shall be construed to allow an insurer, broker, agent, or other person to cause a policyholder to replace a long term care insurance policy that will result in a decrease in benefits and an increase in premium. It shall be presumed that any third or greater policy sold to a policyholder in any 12-month period is unnecessary within the meaning of this section. This section shall not apply to those instances in which a policy is replaced solely for the purpose of consolidating policies with a single insurer." *CIC §10234.85*

### 1. Should I Replace My Existing Policy With a Newer One?

The advantage of replacing an older policy is that newer policies may offer more desirable benefits and features and fewer restrictions. Assisted living in a Residential Care Facility for the Elderly (RCFE), Home Care benefits, Inflation Protection, and no

requirements for a prior hospital stay are some of the benefits and features being offered in current long-term care products. However, just because a policy is newer does not necessarily mean it is better than the one you have. In some instances, your insurer may be required to offer you its newer policy, but you may have to undergo new underwriting to obtain the new coverage.

One disadvantage to replacement is that the insurance company will charge higher premiums because you are older than you were when you bought your original policy. In addition, if you have any preexisting **conditions** or you are 80 years old or older, companies may refuse to issue new coverage. If you are still insurable you might consider adding new coverage to the benefits you already have, or buying an additional policy to supplement your existing benefits. Before you add benefits to an existing older policy you should check with your agent, company, or tax advisor to see if you will lose the grandfathered tax status granted policies purchased prior to January 1, 1997. Whenever you are considering replacing a policy, consulting a HICAP counselor is recommended. *CA Long-term care Rate Guide-A Guide to Long-Term Care*

## L. Agent Retention of Records for Five Years

### 1. Long-Term Care Personal Worksheet

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

## M. Long-Term Care Rate and History Guide

### 1. CDI/HICAP Shall Annually Prepare a Consumer Rate Guide for LTC Insurance

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

#### Explain Different Kinds of LTC Insurance and Coverages Available to Consumers

“A comparison of the different types of long-term care insurance and coverages available to California consumers.”

#### Premium History of Such Insurer

“A premium history of each insurer that writes long-term care policies for all the types of long-term care insurance and coverages issued by the insurer in each state.

The consumer rate guide to be prepared by the commissioner consists of two parts: a history of the rates for all policies issued in the United States on or after January 1, 1990, and a comparison of the policies, benefits, and sample premiums for all policies currently being issued for delivery in California.

For the rate history portion of the rate guide required by this section, the department collects, and each insurer provides to the department, all of the following information for each long-term care policy, including all policies, whether issued by the insurer or purchased or acquired from another insurer, issued in the United States on or after January 1, 1990:

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

For the policy comparison portion of the rate guide required by this section, the department collects, and each insurer provides to the department, the information needed to complete the following form, along with any other information requested by the department, for each long-term care policy currently issued for delivery in California, including all policies, whether issued by the insurer or purchased or acquired from another insurer:

If an insurer does not offer a policy for sale that fits the criteria set forth in the sample premium portion of the policy comparison section of the rate guide, the department will include in that section of the form for that policy a statement explaining that a policy fitting that criteria is not offered by the insurer and that the consumer may seek, from an agent, sample premium information for the insurer's policy that most closely resembles the policy in the sample.

The department uses the format set forth in this section for the policy comparison portion of the rate guide, unless the working group convened pursuant to subdivision (a) designs an alternative format and agrees that it should be used instead.

In compiling the policy comparison portion of the rate guide, the department separates the group policies from the individual policies available for sale so that group policies for all insurers appear together in the guide and individual policies for all insurers appear together in the guide.

The policy comparison portion of the rate guide contains a cross-reference for each policy form listed indicating the page in the rate guide where rate information on the policy form can be found.

Insurers provide the information required no later than July 31 of each year, commencing in 2000."

### **Published Each Year Effective 12/1/2000**

"The consumer rate guide is published no later than December 1st of each year commencing in 2000."

## **2. Modes of Distributions for Rate Guide**

"The consumer rate guide is distributed using all of the following methods:

- **HICAP:** Through Health Insurance Counseling and Advocacy Program (HICAP) offices. (1/800-434-0222)
- **CDI Toll-Free Number:** By telephone using the department's consumer toll-free telephone number. (1/800-927-HELP (4357) )

- **CDI Internet Web Site:** On the department's Internet web site ([www.insurance.ca.gov](http://www.insurance.ca.gov))
- **Long-Term Care Insurance Personal Worksheet:** A notice in the Long-Term Care Insurance Personal Worksheet required by Section 10234.95. Notwithstanding any other provision of law, the data submitted by insurers to the department pursuant to this section are public records, and is open to inspection by members of the public. However, a trade secret, is not subject to this subdivision." CIC §10234.6

Companies and agents are required to give a copy of the long-term care insurance guide, "Taking Care of Tomorrow," developed by the California Department of Aging to each person who applies for a long-term care [insurance policy](#). This guide covers many issues related to long-term care, as well as long-term care insurance.

### 3. Long-Term Care Rate and History Guide

To get a more specific look at the rate histories of companies and long-term rates, the links on the web site shown below will show which companies have had rate increases and those that had no rate increase on long-term care insurance policies in California and other states since January 1, 1990.

For convenience, the rate increase history is divided into two sections:

- Rate History for Companies That Are Actively Writing New Business in California and;
- Rate History for Companies That Are Not Actively Writing New Business in California.

The information is sorted by company name, policy category and policy form. If the company, or its policies, were sold to another company, the new company's name is shown as well. Go to [http://www.insurance.ca.gov/SAB/Premium\\_Surveys/LTC-Rate\\_Guide/rate\\_history.html](http://www.insurance.ca.gov/SAB/Premium_Surveys/LTC-Rate_Guide/rate_history.html)

The **unique aspects** of LTC that give rise to rate inadequacy and how the failure to price properly can hurt consumers.

Remember that rate increases are not a sign of a "bad" policy, and the absence of a rate increase is not a sign of a "good" policy. Conversely, just because a company has not had any rate increases does not mean that it never will raise its rates.

Rate increases are a function of a very complicated process companies use to try to limit risk of paying out more benefits than the premiums they collect. Some companies screen people very carefully rejecting anyone who might have a pre-existing health condition. This "screening process" is called medical underwriting. Companies may also price their policies very conservatively to avoid any future increases, and their premiums may be higher as a result. Other companies may do neither of these things.

Consumers may want to consider how carefully a company "underwrites" applicants. While it may be harder to get coverage from a company that uses strict underwriting, the risk of later rate increases may be less.

If they have a health condition and a company agrees to issue them a policy anyway, they may want to plan for later increases if they buy from one of these companies. Their agent should know about and can tell them all about medical underwriting by the companies they are considering.

Remember, when they buy long-term care insurance they should expect to keep it for the rest of their life. They need to choose a premium they will be able to afford to pay each year, far into the future.

When they decide how much premium they can afford to pay, it's a good rule of thumb to build into their calculation and plan an extra amount of 10 to 20 percent as a cushion against the shock of future increases. If there is no increase later they won't have lost anything.

You, as their agent, should be able to answer their questions about rate increases before they complete an [application](#). They can also write a letter to the company and ask them the same questions, then keep the company's letter with their policy if they decide to buy it.

If you or any consumers have any questions about the data shown in the rate increase history section, they can call the California Department of Insurance's Consumer Hotline at 1-800-927-HELP (1-800-927-4357). *2015 Long-Term Care Rate Guide Taking Care of Tomorrow. Go to [www.insurance.ca.gov](http://www.insurance.ca.gov). CIC §10234.6*

## N. Statutory Rate Stabilization Requirements

### 1. Importance of Rate Stability In Long-Term Care Insurance

This is not only a concern for the agent to deal responsibility with it, but it is also a responsibility for the company to operate within sound financial and business parameters when approaching rates and the many factors that affect rates for the future.

It is also of primary concern of the state of California that they provide regulations that monitor, measure, record, and provides guidelines to protect consumers from unfair increases from company potentially if they did not have to operate within guidelines designed to minimize long term problems for consumers in having benefits when the time comes many years into the future.

This is an important issue for agents because of the frequent and common concerns voiced by purchasers of long-term care insurance. How they will be able to afford their coverage when they get older, when they stop working and when they have limited income for the rest of their lives. This is combined with the eventuality that rates will go up for the same coverage, as well as the reality that they will have to increase their benefit coverage levels and premium over the years to offset the inflationary costs of care and coverages.

The rate guide provides current and historical knowledge to the consumer so that they can make an informed choice now. It allows them to have a grasp on the future so that the mystery can be cleared up so they have a better handle on the future relative to their potential future costs and how they might deal with that eventuality.

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

Because of this extreme importance, we review the process and regulations here to give you some insight into the regulations that companies face in being in sync with

the parameters set forth by the California DOI.

### Why Are Long-Term Care Insurance Rates Regulated?

Policies currently available in California from insurers regulated by the California Department of Insurance are subject to the "rate stabilization" law. This means that premium rates are subject to actuarial review by the Department and rate increases on these policies are subject to additional review and justification requirements. If one purchased a policy before rate stabilization came into effect, they may be able to purchase a "rate stabilization" policy within 12 months of the availability of their insurer's new policy. If one is eligible for a new policy, they may have to go through the underwriting process again. It is a good idea not to cancel any existing policy prior to being approved for a new policy.

### O. Company Responsibilities

For companies, like for agents, rate stability is also one of the most important regulatory issues in long term care insurance. As mentioned previously, unlike regular health insurance, LTCi prefunds an event that, for the most part, occurs once and later in a person's life. Companies must perform and have a rate structure that assures the future rates to be fair for both consumer and company alike. Policyholders pay premiums for many years, 15 years or more, before they access benefits and have claims that require benefit payments. With many people on fixed incomes in their later years when they need care, large rate increases can often prevent them from keeping their coverage, laying waste to years of premium payments made in the past without the value of benefits paid when they need them the most.

Though the NAIC has promulgated model regulations for rate stability, no state has enlarged on the NAIC rate provisions like California. While the NAIC Model places certain restrictions on rate increases, the provisions of SB 898 have extended these to include additional requirements and sanctions when insurers exceed specific benchmark amounts.

These and other requirements to certify the adequacy of initial rate filings and requests for rate increases makes California unique and at the forefront of consumer protection in rate stability.

### P. Submission of New Business Premiums

"The premium rate schedules for all individual and group long-term care insurance policies issued in this state must be filed with and receive the prior approval of the commissioner before the policy may be offered, sold, issued, or delivered to a resident of California." *CIC § 10236.11*

"No insurer may increase the premium for an individual or group long-term care [insurance policy](#) or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner." *CIC § 10236.11*

### Q. Rate Revisions Filed on or After January 1, 2010

"CA regulations limit premium increases for these policies. All rate revisions must be filed on or after January 1, 2010. Required premium rate schedules and new policy forms to be filed with the commissioner by January 1, of each year, for all group long-term care policies to be sold on or after January 1, 2010, and for all previously approved individual long-term care policies to be sold on or after January 1, 2011, unless the deadline is extended by the commissioner." (Section 10236.1 of the CIC)

## 1. Rate Increase Subject to CDI Approval

“No insurer may increase the premium for an individual or group long-term care [insurance policy](#) or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner.”

“All rate increases are subject to CDI approval.” (*Sections 10236.13 through 10236.15 of the CIC*)

## 2. What Rates Are Stabilized - Explained

Every individual long-term care [insurance policy](#) must contain a provision that it is either guaranteed renewable or noncancelable. Group long-term policies and certificates are also to be guaranteed renewable or noncancelable, as well. Noncancelable means that the insurer cannot cancel one’s coverage or increase their premiums.

## 3. Contingent Nonforfeiture

In California, if you were to receive a substantial premium increase, you have the right to stop paying premiums and have your policy converted to paid-up status. Your paid-up policy would have a maximum benefit at least equal to the amount of premiums you had paid over your lifetime. (*Covered also previously in the “Consumer Protection” Section*)

## Chapter Complete

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