WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 12. CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE [22000 - 22010] *(Division 12 added by Stats. 1990, Ch. 1290, Sec. 2.)*

22000. The California Partnership for Long-Term Care Program is hereby established.

(Amended by Stats. 1999, Ch. 802, Sec. 1. Effective January 1, 2000.)

22001. The purpose of the program is to link private long-term care insurance and health care service plan contracts that cover long-term care with the In-Home Supportive Services program (Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9) and Medi-Cal, and to provide specified in-home supportive services benefits and specified Medi-Cal benefits to the purchasers of approved and certified insurance policies and health care service plan contracts who qualify under the special provisions of this division.

(Amended by Stats. 1999, Ch. 802, Sec. 2. Effective January 1, 2000.)

22002. The State Department of Health Care Services shall seek any federal waivers and approvals necessary to accomplish the purposes of this division.

(Amended by Stats. 2016, Ch. 487, Sec. 3. (SB 1384) Effective January 1, 2017.)

22003. (a) Individuals who participate in the program and have resources above the eligibility levels for receipt of medical assistance under Title XIX of the Social Security Act (Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code) shall be eligible to receive those in-home supportive services benefits specified by the State Department of Social Services, and those Medi-Cal benefits specified by the State Department of Health Care Services, for which they would otherwise be eligible, if, prior to becoming eligible for benefits, they have purchased a long-term care insurance policy or a health care service plan contract covering long-term care that has been certified by the State Department of Health Care Services pursuant to this division.

(b) Individuals may purchase approved and certified long-term care insurance policies or health care service plan contracts which cover long-term care services in amounts equal to the resources they wish to protect, so long as the amount of insurance purchased exceeds the minimum level set by the State Department of Health Care Services pursuant to Section 22009.

(c) The resource protection provided by this division shall be effective only for long-term care policies, and health care service plan contracts that cover long-term care services, when the policy or contract is delivered, issued for delivery, or renewed on July 1, 1993, and thereafter.

(Amended by Stats. 2016, Ch. 487, Sec. 4. (SB 1384) Effective January 1, 2017.)

22004. Notwithstanding other provisions of law, the resources, to the extent described in subdivision (c), of an individual who purchases an approved and certified long-term care insurance policy or health care service plan contract which covers long-term care services shall not be considered by:

(a) The State Department of Health Care Services in determining:

(1) Medi-Cal eligibility.

(2) The amount of any Medi-Cal payment.

(3) The amount of any subsequent recovery by the state of payments made for medical services.

(b) The State Department of Social Services in determining:

(1) Eligibility for in-home supportive services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Division 9.

(2) The amount of any payment for in-home supportive services.

(c) The resources not to be considered as provided by this section shall be equal to, or in some proportion set by the State Department of Health Care Services or State Department of Social Services that is less than equal to, the amount of long-term care insurance payments or benefits made as described in Section 22006.

(Amended by Stats. 2016, Ch. 487, Sec. 5. (SB 1384) Effective January 1, 2017.)

22005. The State Department of Health Care Services shall only certify a long-term care insurance policy or a health care service plan contract that meets the Medi-Cal asset protection requirements.

(Amended by Stats. 2016, Ch. 487, Sec. 6. (SB 1384) Effective January 1, 2017.)

22005.1. (a) The State Department of Health Care Services shall only certify a long-term care insurance policy that substantially meets the requirements of Chapter 2.6 (commencing with Section 10231) of Part 2 of Division 2 of the Insurance Code, except the requirements of Sections 10232.1, 10232.2, 10232.8, 10232.9, and 10232.92 of the Insurance Code, and that provides all of the items specified in subdivision (b). The State Department of Health Care Services shall only certify a health care service plan contract that has been approved by the Department of Managed Health Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code as providing substantially equivalent coverage to that required by Chapter 2.6 (commencing with Section 10231) of Part 2 of Division 2 of the Insurance Code, and that provides all of the items specified in subdivision (b). Policies issued by organizations subject to the Insurance Code and regulated by the Department of Insurance shall also be approved by the Department of Insurance.

(b) Only policies and contracts that provide all of the following items shall be certified by the department:

(1) Individual assessment and case management by a coordinating entity designated and approved by the department.

(2) Levels and durations of benefits that meet minimum standards set by the department pursuant to Section 22009.

(3) Protection against loss of benefits due to inflation. An applicant shall be offered, at the time of purchase, the following options:

(A) One option that provides, at a minimum, protection against inflation that automatically increases benefit levels by 5 percent each year over the previous year, up to an age specified by the program.

(B) At least one lower-cost option that provides protection against inflation that automatically increases benefit levels by, at a minimum, either 3 percent each year over the previous year or a fixed amount each year equal to 5 percent of the original benefit levels.

(4) A periodic record issued to the insured including an explanation of insurance payments or benefits paid that count toward Medi-Cal asset protection under this division.

(5) Compliance with any other requirements imposed by regulations adopted by the State Department of Health Care Services or the State Department of Social Services and consistent with the purposes of this division.

(c) (1) The State Department of Health Care Services may also certify a new policy or certificate, or maintain certification of a previously issued policy or certificate when the policyholder or certificate holder elects to reduce benefit levels, with a per diem benefit of at least one hundred dollars ($100) per day for a nursing facility, residential care facility, and home care and community-based services, if the policy or certificate provides a lifetime maximum benefit of not less than seventy-three thousand dollars ($73,000). A policy or certificate certified pursuant to this subdivision shall provide protection against inflation that automatically increases benefit levels by, at a minimum, either 3 percent each year over the previous year or a fixed amount each year equal to 5 percent of the original benefit levels, or, for a policyholder or certificate holder who elects to reduce benefit levels and is 70 years of age or older, 1 percent each year over the previous year.

(2) An insurer may offer a policy or certificate with the benefits described in paragraph (1) only if the insurer also offers the applicant policy benefits that provide at least a lifetime maximum benefit that, at the time of purchase, is equivalent in dollars to at least 365 times 70 percent of the average daily private pay rate for a nursing facility and a nursing facility per diem benefit of no less than 70 percent of the average daily private pay rate for a nursing facility.

(3) Except for the lifetime maximum benefit, per diem benefit, and inflation protection levels permitted by paragraphs (1) and (2), policies and certificates authorized by this subdivision shall comply with the standards described in paragraph (2) of subdivision

(b).

(d) A premium rate schedule increase shall not exceed a cumulative total of 40 percent over any three-year period, and the amount of the increase shall be spread equally over each of the three years. The insurer shall send a premium increase notification each of the three years and include options, if available to the policyholder, to reduce coverage and lower the premium that would maintain partnership certification. If the Department of Insurance approves a premium rate schedule increase on or after January 1, 2023, the premium increase notification shall include the options described in paragraphs (1) to (7), inclusive, as applicable, and disclose that the policyholder or certificate holder may have additional options to lower the premium, including additional options to increase the elimination period or to reduce the daily benefit, benefit duration, and protection against inflation. Paragraphs (1) to (6), inclusive, do not require an insurer to create new benefit levels or amend its approved rate schedule. Each of the options set forth in paragraphs (1) to (7), inclusive, shall maintain partnership certification as long as the policy or certificate maintains at least the minimum benefit levels permitted by paragraph (1) of subdivision (c). Notwithstanding subdivision (b), a policy or certificate shall also maintain partnership certification if the policy or certificate is converted to a nonforfeiture benefit or a contingent benefit upon lapse. Even if a policyholder or certificate holder is not subject to a premium increase, the election of one of the available options set forth in paragraphs (1) to (7), inclusive, shall not result in a loss of partnership certification as long as the policy or certificate maintains at least the minimum benefit levels permitted by paragraph (1) of subdivision (c).

(1) Reduce the daily benefit by 50 percent, rounded up or down to the closest daily benefit level on the insurer's approved rate schedule.

(2) Reduce the daily benefit by 25 percent, rounded up or down to the closest daily benefit level on the insurer's approved rate schedule.

(3) Reduce the benefit duration to the lowest duration on the insurer's approved rate schedule, but not below 12 months.

(4) Reduce the benefit duration to the next highest duration on the insurer's approved rate schedule, relative to the current duration, but not below 12 months.

(5) Increase the elimination period to 90 days for a policy or certificate with an elimination period of less than 90 days, if the insurer's approved rate schedule includes a 90-day elimination period.

(6) Convert a policy or certificate to a minimum coverage policy or certificate as described in paragraph (1) of subdivision (c), if the insurer offers such a policy for sale in California.

(7) Reduce the protection against inflation to a lower-cost option that automatically increases benefit levels by either 3 percent each year over the previous year or a fixed amount each year equal to 5 percent of the original benefit levels. If the policyholder or certificate holder is 70 years of age or older and experiences a 50-percent or greater increase in premium over the life of the policy or certificate, the insurer shall also offer protection against inflation that automatically increases benefit levels by 1 percent each year over the previous year. An offer made pursuant to this paragraph to reduce protection against inflation shall allow a policyholder or certificate holder, regardless of the issue date, issue age, or present age, to retain the accrued daily, weekly, monthly, and lifetime benefit amounts in effect at the time of the reduction.

(Amended by Stats. 2023, Ch. 204, Sec. 22. (AB 1140) Effective January 1, 2024.)

22005.2. (a) Each organization issuing policies certified by the State Department of Health Care Services under this division shall each year contribute to a fund to be used for common educational and marketing expenses for reaching the target population designated by the California Partnership for Long-Term Care Program. The amount of each participating issuer's required annual contribution shall be determined by the department and shall not be less than twenty thousand dollars ($20,000).

(b) This section shall become operative on January 1, 2019.

(Repealed (in Sec. 8) and added by Stats. 2016, Ch. 487, Sec. 9. (SB 1384) Effective January 1, 2017. Section operative January 1, 2019, by its own provisions.)

22005.3. (a) The insurer or producer shall, at the time of application, provide all of the following to the applicant:

(1) A graph that illustrates the difference in premium rates and policy benefits payable in accordance with the inflation protection provisions described in Section 22005.1.

(2) An illustration of the differences in benefits between the policies described in paragraphs (1) and (2) of subdivision (c) of Section 22005.1.

(3) A description of the available lower-cost options and the advantages and disadvantages of each option, including the differences between lower and higher minimum benefits, lower and higher inflation protection options, the types of services covered, and how these options compare to the anticipated costs of home, community-based, and institutional care.

(b) The State Department of Health Care Services shall prepare the materials described in subdivision (a) on behalf of issuers as provided in Section 22005.2 and shall require that the materials be incorporated into producer training curriculum.

(Amended by Stats. 2018, Ch. 565, Sec. 4. (SB 1248) Effective January 1, 2019.)

22006. The State Department of Health Care Services, in determining eligibility for Medi-Cal, and the State Department of Social Services, in determining eligibility for in-home supportive services, shall exclude resources up to, or equal to, the amount of insurance payments or benefits paid by approved and certified long-term care insurance policies or health care service plan contracts which cover long-term care services to the extent that the benefits paid are for all of the following:

(a) In-home supportive services benefits specified in regulations adopted by the State Department of Social Services pursuant to Section 22009, or those services that Medi-Cal approves or benefits that Medi-Cal provides as specified in regulations adopted by the State Department of Health Care Services pursuant to Section 22009.

(b) Services delivered to insured individuals at home or in a community setting as part of an individual assessment and case management program provided by coordinating entities designated and approved by the State Department of Health Care Services.

(c) Services the insured individual receives after meeting the disability criteria for eligibility for long-term care benefits established by the State Department of Health Care Services.

(Amended by Stats. 2016, Ch. 487, Sec. 11. (SB 1384) Effective January 1, 2017.)

22007. The program shall be designed so that the estimated aggregate state expenditures for long-term care services for individuals participating in the program do not exceed the aggregate expenditures that would be made for these services under the Medi-Cal program in effect prior to the implementation of this program.

(Amended by Stats. 1999, Ch. 802, Sec. 10. Effective January 1, 2000.)

22008. Advice and counseling may be provided by the Health Insurance Counseling and Advocacy program within the California Department of Aging to individuals interested in purchasing long-term care insurance or health care service plan contracts that cover long-term care services approved and certified pursuant to this division.

(Amended by Stats. 1999, Ch. 802, Sec. 11. Effective January 1, 2000.)

22008.5. Individuals who participate in the program shall remain eligible for those in-home supportive services benefits and those Medi-Cal benefits for which they are eligible under the program for the life of the purchaser of the policy or contract, as long as the purchaser maintains his or her insurance policy or health care service plan contract in force, or otherwise qualifies for continued benefits in accordance with regulations promulgated by the departments.

(Amended by Stats. 1999, Ch. 802, Sec. 12. Effective January 1, 2000.)

22009. (a) The State Department of Health Care Services shall adopt regulations to implement this division, including, but not limited to, regulations that establish:

(1) The population and age groups that are eligible to participate in the program.

(2) The minimum level of long-term care insurance or long-term care coverage included in health care service plan contracts that must be purchased to meet the requirement of subdivision (b) of Section 22003.

(3) (A) The amount and types of services that a long-term care insurance policy or health care service plan contract that includes long-term care services must cover to meet the requirements of this division. The types of policies or plans shall include nursing and residential care facility coverage only, home care, community-based services, and residential care facility coverage only, and comprehensive coverage.

(B) Policies that provide only home care benefits shall include coverage for electronic or other devices intended to assist in monitoring the health and safety of an insured.

(4) Which coordinating entities are designated and approved to deliver individual assessment and case management services to individuals at home or in a community setting, as required by subdivision (b) of Section 22006.

(b) The State Department of Health Care Services shall also adopt regulations to implement this division, including, but not limited to, regulations that establish:

(1) The disability criteria for eligibility for long-term care benefits as required by subdivision (c) of Section 22006.

(2) The specific eligibility requirements for receipt of the Medi-Cal benefits provided for by the program, and those Medi-Cal benefits for which participants in the program shall be eligible.

(c) The State Department of Social Services shall also adopt regulations to implement this division, including, but not limited to, regulations that establish:

(1) The specific eligibility requirements for in-home supportive services benefits.

(2) Those in-home supportive services benefits for which participants in the program shall be eligible.

(d) The State Department of Health Care Services and the State Department of Social Services shall also jointly adopt regulations that provide for the following:

(1) Continuation of benefits pursuant to Section 22008.5.

(2) The protection of a participant's resources pursuant to Section 22004, and the ratio of resources to long-term care benefit payments as described in subdivision (c) of Section 22004.

(e) (1) The departments shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement this division. The adoption of regulations pursuant to this section in order to implement this division shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted pursuant to this section shall not be subject to the review and approval of the Office of Administrative Law. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 120 days unless the adopting agency complies with all of the provisions of Chapter 3.5 (commencing with Section 11340) as required by subdivision (c) of Section 11346.1 of the Government Code.

(Amended by Stats. 2018, Ch. 565, Sec. 5. (SB 1248) Effective January 1, 2019.)

22010. (a) In implementing this division, the State Department of Health Care Services may contract, on a bid or nonbid basis, with any qualified individual, organization, or entity for services needed to implement the project, and may negotiate contracts, on a nonbid basis, with long-term care insurers, health care service plans, or both, for the provision of coverage for long-term care services that will meet the certification requirements set forth in Section 22005.1 and the other requirements of this division.

(b) In order to achieve maximum cost savings, the Legislature declares that an expedited process for issuing contracts pursuant to this division is necessary. Therefore, contracts entered into on a nonbid basis pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(Amended by Stats. 2016, Ch. 487, Sec. 13. (SB 1384) Effective January 1, 2017.)