SB-1384 California Partnership for Long-Term Care Program. (2015-2016)

Senate Bill No. 1384

CHAPTER 487

An act to amend Section 10232.1 of, and to add Section 10232.81 to, the Insurance Code, and to amend Sections 22002, 22003, 22004, 22005, 22005.1, 22006, 22009, and 22010 of, to amend, repeal, and add Section 22005.2 of, to add Section 22005.3 to, and to add and repeal Section 22011 of, the Welfare and Institutions Code, relating to long-term care.

[Approved by Governor September 22, 2016. Filed with Secretary of State September 22, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1384, Liu. California Partnership for Long-Term Care Program.

Existing law establishes the California Partnership for Long-Term Care Program administered by the State Department of Health Care Services. 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 and the Medi-Cal program and to provide Medi-Cal program benefits to certain individuals who have income and resources above the eligibility levels for receipt of medical assistance, but who have purchased certified private long-term care insurance policies. Existing law provides criteria for certification of a long-term care insurance policy, including a requirement that it provide protection against loss of benefits due to inflation. Existing law requires each organization issuing certified policies to contribute a specified amount to a fund to be used for common educational and marketing expenses, as specified.

This bill would require the department to adopt regulations requiring that a long-term care insurance policy or health care service plan contract that includes long-term care services include nursing and residential care facility coverage only, home care and community-based care coverage only, or comprehensive coverage. The bill would also require that a health care service plan contract or long-term care insurance policy, as a condition of certification, include specified protections against loss of benefits due to inflation. The bill would also, until January 1, 2019, require the formation of an executive and legislative task force to provide advice and assistance in implementing reforms to the California Partnership for Long-Term Care Program and to consider other means to assist consumers in paying for long-term care services and supports, as specified. The task force would be composed of representatives of various state agencies and departments, including the State Department of Health Care Services, the State Department of Social Services, and the California Department of Aging. The bill would, until January 1, 2019, authorize the department, under specified conditions, to use moneys in the fund described above to administer the task force, implement recommendations made by the task force, and facilitate review of policy forms for certification by the program and the Department of Insurance.

Existing law requires long-term care insurance policies or certificates to provide certain coverage and to make certain disclosures, as specified.

This bill would require an insurance policy, certificate, or rider that is offered under the California Partnership for Long-Term Care Program to be called a home and community-based services policy, certificate, or rider and for it to prominently display that it is for home and community-based services only, as specified. The bill would require those policies, certificates, or riders to provide specified coverage.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 10232.1 of the Insurance Code is amended to read:

10232.1. (a) Every policy that is intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: “This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for federal and state tax benefits.” Every policy that is not intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: “This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract.”

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

(c) Any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, shall be called a “home care only” policy or certificate and the words “Home Care Only” shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(d) Any policy, certificate, or rider in which benefits are limited to the provision of all care settings, except nursing facility care, and that is offered under the California Partnership for Long-Term Care Program established by Section 22000 of the Welfare and Institutions Code shall be called a home and community-based services policy, certificate, or rider and the words “Home and Community-Based Services Only” shall be prominently displayed on the first page of the form and the outline of coverage. The commissioner may approve an alternative version of those words if the alternative version is more descriptive of the benefits provided.

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

SEC. 2. Section 10232.81 is added to the Insurance Code, to read:

10232.81. (a) Every long-term care policy, certificate, or rider that purports to provide benefits of home and community-based services under the California Partnership for Long-Term Care Program established by Section 22000 of the Welfare and Institutions Code shall provide at least the following:

(1) Residential care facility.

(2) Assisted living facility.

(3) Home health care.

(4) Adult day care.

(5) Personal care.

(6) Homemaker services.

(7) Hospice services.

(8) Respite care.

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

(1) “Residential care facility” means a facility that is licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code. Outside California, an eligible provider is a facility that meets licensure standards applicable to the facility, if any, and is engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in activities of daily living or impairment in cognitive ability and which also provides care and services on a 24-hour basis, has a trained and ready-to-respond employee on duty in the facility at all times to provide care and services, provides three meals per day and accommodates special dietary needs, has agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency, and has appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

(2) “Assisted living facility” means a facility licensed as an assisted living facility as defined in the Health and Safety Code. Outside California, an eligible provider is a facility that meets licensure standards applicable to the facility, if any, and is engaged primarily in providing food and shelter and providing personal care services, or in administering medication by a person licensed or otherwise authorized to administer the medication.

SEC. 3. Section 22002 of the Welfare and Institutions Code is amended to read:

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

SEC. 4. Section 22003 of the Welfare and Institutions Code is amended to read:

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.

SEC. 5. Section 22004 of the Welfare and Institutions Code is amended to read:

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.

SEC. 6. Section 22005 of the Welfare and Institutions Code is amended to read:

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.

SEC. 7. Section 22005.1 of the Welfare and Institutions Code is amended to read:

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 10230) 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 10230) 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 State Department of Health Care Services 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.

(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.

SEC. 8. Section 22005.2 of the Welfare and Institutions Code is amended to read:

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) Only to the extent that all activities identified in subdivision (a) and additional activities identified in Section 58051 of Title 22 of the California Code of Regulations have been fully funded for the fiscal year in which contributions are received, the fund may also be used to administer the task force established by Section 22011, implement recommendations made by the task force, and facilitate review of policy forms for certification by the program and approval by the Department of Insurance. Use of these funds shall be consistent with the purpose of the program as established by Section 22001.

(c) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

SEC. 9. Section 22005.2 is added to the Welfare and Institutions Code, to read:

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.

SEC. 10. Section 22005.3 is added to the Welfare and Institutions Code, to read:

22005.3. The insurer or producer shall, at the time of application, provide to the individual 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.

SEC. 11. Section 22006 of the Welfare and Institutions Code is amended to read:

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.

SEC. 12. Section 22009 of the Welfare and Institutions Code is amended to read:

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 and community-based care 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.

SEC. 13. Section 22010 of the Welfare and Institutions Code is amended to read:

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.

SEC. 14. Section 22011 is added to the Welfare and Institutions Code, to read:

22011. (a) An executive and legislative task force shall be formed to provide advice and assistance in implementing reforms to the California Partnership for Long-Term Care Program and to consider other means to assist consumers in paying for long-term care services and supports.

(b) The task force formed pursuant to subdivision (a) shall be composed of representatives designated by each of the following:

(1) The State Department of Health Care Services.

(2) The State Department of Social Services.

(3) The California Department of Aging.

(4) The Department of Insurance.

(5) The Department of Managed Health Care.

(6) The Senate Committee on Rules.

(7) The Speaker of the Assembly.

(c) The task force shall consult with persons knowledgeable of and concerned with long-term care, including, but not limited to, the following:

(1) Consumer representatives.

(2) Long-term care providers.

(3) Representatives of long-term care insurance companies and administrators of health care service plans which cover long-term care.

(4) Private employers.

(5) Academic specialists in long-term care and aging.

(6) Representatives of the Public Employees' Retirement System and the State Teachers' Retirement System.

(d) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.