WAC 284-54-150 Minimum standards—General. No contract may be advertised, solicited, or issued for delivery in this state as a long-term care contract which does not meet the following standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) No contract shall limit benefits to an unreasonable period of time or an unreasonable dollar amount. For example, a provision that a particular condition will be covered only for one year without regard to the actual amount of the benefits paid or provided, is not acceptable. Policies or contracts may, however, limit in-patient institutional care benefits to a reasonable period of time. Benefits may also be limited to a reasonable maximum dollar amount, and, as for example in the case of home health care visits, to a reasonable number of visits over a stated period of time.

(2) If a fixed-dollar indemnity, fee for services rendered or similar long-term care contract contains a maximum benefit period stated in terms of days for which benefits are paid or services are received by the insured, the days which are counted toward the benefit period must be days for which the insured has actually received one or more contract benefits or services. If benefits or services are not received on a given day, that day may not be counted. Waiver of premium shall not be considered a contract benefit for purposes of accrual of days under this section, and long-term care total disability shall not operate to reduce the benefit.

(3) If a contract of a managed health care plan contains a maximum benefit period it must be stated in terms of the days the insured is in the managed care delivery system. The days which are counted toward the benefit period may include days that the insured is under a care plan established by the case manager, or days in which the insured actually receives one or more benefits or services.

(4) A long-term care contract must cover skilled, intermediate, and custodial or personal care, whether benefits are for institutional or community based care.

(5) No contract may restrict or deny benefits because the insured has failed to meet medicare beneficiary eligibility criteria.

(6) No insurer may offer a contract form which requires prior skilled or intermediate care as a condition of coverage for institutional or community based care.

(7) No insurer may offer a contract form which requires prior hospitalization as a condition of covering institutional or community based care.

(8) No long-term care contract may restrict benefit payments to a requirement that the patient is making a "steady improvement" or limit benefits to "recuperation" of health.

(9) All long-term care contracts shall be issued as individual or family contracts only, unless coverage is provided pursuant to a group contract, issued to a bona fide group, which contract provides continuity of coverage equivalent to that which would be provided under a guaranteed renewable individual contract, and otherwise satisfies the commissioner that it is not contrary to the best interests of the public.

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. WSR 94-14-100 (Order R 94-10), § 284-54-150, filed 7/6/94, effective 8/6/94. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-150, filed 7/9/87.]