Chapter 284-54 WAC
LONG-TERM CARE INSURANCE RULES

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WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-54-750 Standards for education of licensees soliciting long-term care contracts. [Statutory Authority: RCW 48.02.060, 48.17.150, and 48.85.030. WSR 05-09-022 (Matter No. R 2005-01), § 284-54-750, filed 4/12/05, effective 5/13/05; WSR 97-19-007, § 284-54-750, filed 9/4/97, effective 10/5/97.] Repealed by WSR 10-02-087 (Matter No. R 2009-18), filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 48.83.170. Later promulgation, see WAC 284-17-262.

WAC 284-54-010 Purpose and authority. The purpose of this chapter, is to effectuate chapter 48.84 RCW, the Long-Term Care Insurance Act, by establishing minimum standards and disclosure requirements to be met by insurers, health care service contractors, health maintenance organizations, and fraternal benefit societies with respect to long-term care insurance and long-term care benefit policies and contracts issued for delivery in this state before January 1, 2009.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-54-010, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-010, filed 7/9/87.]

WAC 284-54-015 Applicability and scope. (1) Except as otherwise specifically provided, this chapter shall apply to every policy, contract, or certificate, and riders pertaining thereto, of an insurer, fraternal benefit society, health care service contractor, or health maintenance organization, if such contract is primarily advertised, marketed, or designed to provide long-term care services over a prolonged period of time, which services may range from direct skilled

medical care performed by trained medical professionals as prescribed by a physician or qualified case manager in consultation with the patient's attending physician to rehabilitative services and assistance with the basic necessary functions of daily living for people who have lost some or complete capacity to function on their own. Such contract is "long-term care insurance" or a "long-term care contract," and is subject to this chapter.

(2) Pursuant to RCW 48.84.020, this chapter shall not apply to medicare supplement insurance; nor shall it apply to a contract between a continuing care retirement community and its residents.

(3) Long-term care contracts not meeting the requirements of this chapter, may not be issued or delivered in this state after December 31, 1987.

(4) This chapter is applicable only to long-term care policies, contracts, or certificates issued prior to January 1, 2009. Long-term care policies, contracts, or certificates delivered under policies issued on or after January 1, 2009, are governed by chapters 48.83 RCW and 284-83 WAC.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). WSR 08-24-019 (Matter No. R 2008-09), § 284-54-015, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-015, filed 7/9/87.]

WAC 284-54-020 Definitions of terms used in this chapter and chapter 48.84 RCW. For purposes of the administration of chapter 48.84 RCW and this chapter:

(1) "Community based care" means services including, but not limited to: (a) Home delivered nursing services or therapy; (b) custodial or personal care; (c) day care; (d) home and chore aid services; (e) nutritional services, both in-home and in a communal dining setting; (f) respite care; (g) adult day health care services; or (h) other similar services furnished in a home-like or residential setting that does not provide overnight care. Such services shall be provided at all levels of care, from skilled care to custodial or personal care.

(2) "Contract" means a long-term care insurance policy or contract, regardless of the kind of insurer issuing it, unless the context clearly indicates otherwise.

(3) "Direct response insurer" means an insurer who, as to a particular contract, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent.

(4) A "gatekeeper provision" is any provision in a contract establishing a threshold requirement which must be satisfied before a covered person is eligible to receive benefits promised by the contract. Examples of such provisions include, but are not limited to the following: A three-day prior hospitalization requirement, recommendations of the attending physician, and recommendations of a case manager.

(5) "Institutional care" means care provided in a hospital, skilled or intermediate nursing home, or other facility certified or licensed by the state primarily affording diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services. Such a facility provides twenty-four-hour nursing services on its premises or

in facilities available to the institution on a formal prearranged basis.

(6) "Insured" shall mean any beneficiary or owner of a long-term care contract regardless of the type of insurer.

(7) "Insurer" includes insurance companies, fraternal benefit societies, health care service contractors and health maintenance organizations unless the context clearly indicates otherwise.

(8) "Premium" shall mean all sums charged, received or deposited as consideration for a contract and includes any assessment, membership, contract, survey, inspection, service, or similar fees or charges as paid.

(9) "Terminally ill care" means care for an illness, disease, or injury which has reached a point where recovery can no longer be expected and the attending physician has certified that the patient is facing imminent death; or has a life expectancy of six months or less.

(10) "Adult day health care" means a program of community based social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the individual's home.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-020, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060, 48.84.030 and 48.01.030. WSR 94-14-100 (Order R 94-10), § 284-54-020, 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), § 284-54-020, filed 7/9/87.]

WAC 284-54-030 Standards for definitions applicable to long-term care contracts. The following definitions are applicable to long-term care contracts and the implementation of chapter 48.84 RCW and this chapter, and no contract may be advertised, solicited, or issued for delivery in this state as a long-term care contract which uses definitions more restrictive or less favorable to an insured than the following:

(1) "Acute care" means care provided for patients who are not medically stable. These patients require frequent monitoring by health care professionals in order to maintain their health status.

(2) "Benefit period" means the period of time for which the insured is eligible to receive benefits or services under a contract. A benefit period begins on the first day that the insured is eligible for and begins to receive the benefits of the contract. The benefit period ends when the insured is no longer eligible to receive benefits or has received the lifetime maximum benefits available. Such benefit period must be stated in terms of days rather than in terms of months of benefit.

(3) "Case manager" or "case coordinator" means an individual qualified by training and/or experience to coordinate the overall medical, personal and social service needs of the long-term care patient. Such coordination activities shall include but are not limited to: Assessing the individual's condition to determine what services and resources are necessary and by whom they might most appropriately be delivered; coordination of elements of a treatment or care plan and referral to the appropriate medical or social services personnel or agency; control coordination of patient services and continued monitoring of the patient to assess progress and assure that services are

delivered. Such activities shall be conducted in consultation with the attending physician.

(4) "Chronic care" or "maintenance care" means care that is necessary to support an existing level of health and is intended to preserve that level from further failure or decline. The care provided is usually for a long, drawn out or lingering disease or infirmity showing little change or slowly progressing with little likelihood of complete recovery, whether such care is provided in an institution or is community-based and whether such care requires skilled, intermediate or custodial/personal care.

(5) "Convalescent care" or "rehabilitative care" is nonacute care which is prescribed by a physician and is received during the period of recovery from an illness or injury when improvement can be anticipated, whether such care requires skilled, intermediate or custodial/personal care, and whether such care is provided in an institutional care facility or is community-based.

(6) "Custodial care" or "personal care" means care which is mainly for the purpose of meeting daily living requirements. This level of care may be provided by persons without professional skills or training. Examples are: Help in walking, getting out of bed, bathing, dressing, eating, meal preparation, and taking medications. Such care is intended to maintain and support an existing level of health or to preserve the patient from further decline. Custodial or personal care services are those which may be recommended by the case manager in consultation with the patient's attending physician and are not primarily for the convenience of the insured or the insured's family.

(7) "Guaranteed renewable" means that renewal of a contract may not be declined by an insurer for any reason except for nonpayment of premium, but the insurer may revise rates on a class basis.

(8) A "home health aide" is a person who is providing care under the supervision of a physician, licensed professional nurse, physical therapist, occupational therapist, or speech therapist. Care provided may include ambulation and exercise, assistance with self-administered medications, reporting changes in a covered person's conditions and needs, completing appropriate records, and personal care or household services needed to achieve medically desired results.

(9) "Home care services" or "personal care services" are services of a personal nature including, but not limited to, homemaker services, assistance with the activities of daily living, respite care services, or any other nonmedical services provided to ill, disabled, or infirm persons which services enable those persons to remain in their own residences consistent with their desires, abilities and safety. An insurer may require that services are provided by or under the direction of a home health care agency or home care agency regulated by this state, or that services are administered in accordance with a plan of treatment developed by or with the assistance of health care professionals.

(10) "Home health care" shall mean, but is not limited to, any of the following health or medical services: Nursing services, home health aide services, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional services, medical or social services, and medical supplies or equipment services. An insurer may require that services are provided by or under the direction of a regulated home health care agency regulated by this state, or that services are administered in accordance with a plan of treatment developed by or with the assistance of health care professionals.

(11) "Intermediate care" means technical nursing care which requires selected nursing procedures for which the degree of care and evaluation is less than that provided for skilled care, but greater than that provided for custodial/personal care. This level of care provides a planned continuous program of nursing care that is preventive or rehabilitative in nature.

(12) "Long-term care total disability" means the functional inability due to illness, disease or infirmity to engage in the regular and customary activities of daily living which are usual for a person of the same age and sex.

(13) "Managed long-term care delivery system" means a system or network of providers arranged or controlled by a managed long-term care plan. Such systems provide a range of long-term care services with provisions for effective utilization controls and quality assurance. In the case of provision of long-term care in the managed care environment, a case manager or other qualified individual may be used to develop and coordinate a care plan of appropriate long-term care services.

(14) "Managed long-term care plan" means a plan which on a prepaid basis assumes the responsibility and the risk for delivery of the covered long-term care services set forth in the benefit agreement. Actual services are rendered by the plan through its own staff, through capitation, or other contractual arrangements with providers. Managed long-term care plans may include but are not limited to those offered by health maintenance organizations, and health care service contractors, if their services are provided through a managed long-term care delivery system.

(15) "Noncancellable" means that renewal of a contract may not be declined except for nonpayment of premium, nor may rates be revised by the insurer.

(16) "One period of confinement" means consecutive days of institutional care received as an inpatient in a health care institution, or successive confinements due to the same or related causes when discharge from and readmission to the institution occurs within a period of time not more than ninety days or three times the maximum number of days of institutional care provided by the policy to a maximum of one hundred eighty days, whichever provides the covered person with the greater benefit.

(17) "Preexisting condition," as defined by RCW 48.84.020(3), means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.

(18) "Respite care" is short-term care which is required in order to maintain the health or safety of the patient and to give temporary relief to the primary caretaker from his or her caretaking duties.

(19) "Skilled care" means care for an illness or injury which requires the training and skills of a licensed professional nurse, is prescribed by a physician, is medically necessary for the condition or illness of the patient, and is available on a twenty-four-hour basis.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-030, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-030, filed 7/9/87.]

WAC 284-54-040 Minimum standards for benefit triggers—Physician certification, activities of daily living, and cognitive impairments. (1)(a) Except as provided in (b) of this subsection, every long-term care insurance contract or certificate issued on or after January 1, 1996, which provides coverage to a resident of this state, shall require certification by the insured's attending physician that the services are appropriate due to illness or infirmity, or include provisions which condition the payment of benefits on an assessment of the insured's ability to perform specific activities of daily living or the insured's cognitive impairment.

(b) Certificates issued on or after January 1, 1996, under a group long-term care insurance contract that was in force on December 31, 1995, need not meet the standards of this section.

(2) Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the contract or certificate in a separate paragraph labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall be explained in that section. If a trigger differs for different benefits, an explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, the policy shall so specify.

(3) Eligibility for the payment of benefits based on the inability of the insured to perform certain activities shall not be more restrictive than requiring a deficiency in the ability to perform not more than three of the following activities of daily living.

(a) "Activities of daily living" on which an insurer intends to rely as a measure of functional incapacity shall be defined in the policy, and shall include at least all of the following:

(i) Bathing: The ability of the insured to wash himself or herself either in the tub or shower or by sponge bath, including the task of getting into or out of a tub or shower.

(ii) Continence: The ability of the insured to control bowel and bladder functions; or, in the event of incontinence, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(iii) Dressing: The ability of the insured to put on and take off all items of clothing, and necessary braces, fasteners, or artificial limbs.

(iv) Eating: The ability of the insured to feed himself or herself by getting food and drink from a receptacle (such as a plate, cup, or table) into the body including intravenously or by feeding tube.

(v) Toileting: The ability of the insured to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene.

(vi) Transferring: The ability of the insured to move in and out of a chair, bed, or wheelchair.

(b) For purposes of this section, the determination of a deficiency shall not be more restrictive than:

(i) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(ii) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

(c) Upon prior approval of the commissioner in writing, an insurer may use standards or definitions for activities of daily living in addition to the standards set forth in (a) of this subsection; however, in no case may an insurer require a deficiency in more than three activities of daily living as a barrier to benefits. Any additional activities of daily living approved by the commissioner, shall be used in addition to those set forth in (a) of this subsection, and not in lieu thereof. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers. No contract or certificate may combine more than one activity of daily living to create a compound impairment requirement.

(d) Each long-term care insurance contract or certificate shall include a clear description of the process for appealing and resolving benefit determinations.

(4) If an insurer proposes standards other than those described in this section, the insurer shall describe to the satisfaction of the commissioner how the proposed assessment will reasonably be expected to produce reliable, valid, and clinically appropriate results and shall demonstrate that the alternate assessment method is not less beneficial to the insured than the standards described in this section.

(5) For purposes of this section the following definitions apply:

(a) "Cognitive impairment" means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

(b) "Hands-on assistance" means any amount of physical assistance (whether minimal, moderate, or maximal) without which the insured would not be able to perform the activity.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-040, filed 9/11/95, effective 10/12/95.]

WAC 284-54-050 Exclusions. No contract shall limit or exclude coverage by type of illness, accident, treatment, or medical condition, except with respect to the following:

(1) Conditions arising out of war or act of war (whether declared or undeclared);

(2) Conditions arising out of participation in the commission of a felony, riot or insurrection;

(3) Conditions resulting from suicide, attempted suicide (while sane or insane) or intentionally self-inflicted injury;

(4) Benefits available under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;

(5) Services performed by a member of the covered person's immediate family;

(6) Services for which no charge is made in the absence of insurance;

(7) Dental care or treatment;

(8) Eye glasses, hearing aids and examination for the prescription or fitting thereof;

(9) Rest cures and routine physical examinations;

(10) Chemical dependency;

(11) Treatment in a government hospital or in a government facility unless required by law;

(12) Benefits provided under medicare or other governmental programs (except medicaid);

(13) Experimental treatments, supplies, or services;

(14) Other exclusions appropriate to the particular contract, justified to the satisfaction of the commissioner, in connection with the filing of the contract form, may be permitted by prior written agreement.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-050, filed 7/9/87.]

WAC 284-54-100 Renewability. No insurer shall refuse to renew any long-term care contract or coverage thereunder: Provided, That after written approval of the commissioner, an insurer may discharge its obligation to renew by obtaining for the insured coverage with another insurer which coverage provides equivalent benefits for value paid.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-100, filed 7/9/87.]

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.]

WAC 284-54-160 Minimum standards—Gatekeeping provisions. Any gatekeeper provisions must be reasonable in relation to the benefits promised in the contract. It must be demonstrated to the satisfaction of the commissioner that a reasonable number of insureds who can be expected to receive benefit or contract payments because of an illness, injury or condition, are not precluded by the gatekeeper from receiving said benefits. Policies or contracts providing long-term care benefits following institutionalization shall not condition such benefits upon admission to the long-term care facility within a period of fewer than thirty days after discharge from the institution.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-160, filed 7/9/87.]

WAC 284-54-180 Reduction of coverage. Effective January 1, 1996, every person purchasing a long-term care insurance contract in this state shall have the right to reduce the benefits of a long-term care contract without providing evidence of insurability. Such a reduction may include, for example, changes which result in a contract with a longer elimination period, a lower daily benefit, or a shorter benefit period: Provided, however, That an insurer shall not reduce benefits to a level below the minimum level which has been approved by the commissioner on the date the reduction of coverage is requested.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-180, filed 9/11/95, effective 10/12/95.]

WAC 284-54-190 Nonduplication with state or national health care benefits. In the event that a state or federal program is enacted which substantially duplicates all or part of the coverage of an in-force long-term care insurance contract or certificate, current benefits or features which are duplicated by a state or national program shall be revised or eliminated promptly and in an orderly manner, subject to prior approval by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-190, filed 9/11/95, effective 10/12/95.]

WAC 284-54-200 Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance contract or certificate replaces another long-term care insurance contract or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care insurance contract for similar benefits to the extent that similar exclusions have been satisfied under the original contract.

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. WSR 94-14-100 (Order R 94-10), § 284-54-200, filed 7/6/94, effective 8/6/94.]

WAC 284-54-210 Minimum standards for community based care benefits in long-term care insurance policies. (1) No long-term care insurance contract or certificate which provides benefits for community based care services may limit or exclude benefits:

(a) By requiring care in a skilled nursing facility before covering community based care services;

(b) By requiring that the insured first or simultaneously receive nursing or therapeutic services in a home, community or institutional setting before community based care services are covered;

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) By requiring that community based care services may be delivered only by licensed nurses or therapists when the type of services to be provided comes within the authorized scope of license of other regulated health care providers;

(e) By excluding coverage for personal care services provided by a home health aide;

(f) By requiring that the delivery of community based care services be at a level of certification or licensure greater than that required for the eligible service;

(g) By requiring that the insured have an acute condition before community based care services are covered;

(h) By limiting benefits to services provided by medicare-certified agencies or providers; or

(i) By excluding coverage for adult day care services.

(2) A long-term care insurance contract or certificate, if it provides for community based care services, shall provide coverage for total community based care services in a dollar amount equivalent to at least one-half of one year's coverage available for institutional benefits under the contract or certificate at the time covered commun-

ity based care services are received. This requirement does not apply to contracts or certificates issued to residents of continuing care retirement communities.

(3) Community based care coverage may be applied to the nonhome health care benefits provided in the contract or certificate when determining maximum coverage under the terms of the contract or certificate.

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. WSR 94-14-100 (Order R 94-10), § 284-54-210, filed 7/6/94, effective 8/6/94.]

WAC 284-54-250 Grace period. Every long-term care contract must contain a grace period of no fewer than thirty-one days following the due date for the payment of premiums.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-250, filed 7/9/87.]

WAC 284-54-253 Unintentional lapse. The purpose of this section is to protect insureds from unintentional lapse by establishing standards for notification of a designee to receive notice of lapse for nonpayment of premiums at least thirty days prior to the termination of coverage and to provide for a limited right to reinstatement of coverage unintentionally lapsed by a person with a cognitive impairment or loss of functional capacity. These are minimum standards and do not prevent an insurer from including benefits more favorable to the insured. This section applies to every insurer providing long-term care coverage to a resident of this state, which coverage is issued for delivery or renewed on or after January 1, 1996, through December 31, 2008.

(1) Every insurer shall permit an insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium, if the premium is not paid on or before its due date. The designation shall include the designee's full name and home address.

(a) The notice shall provide that the contract or certificate will not lapse until at least thirty days after the issuer sends the notice to the insured's designee.

(i) Issuers must be able to show:

(A) Proof that they produced the notice;

(B) Proof that they sent the notice;

(C) The name and address of the person or persons to whom they sent the notice. The address may consist of either:

(I) A physical mailing address; or

(II) An electronic mailing address for delivery by electronic means under the requirements of RCW 48.185.005.

(D) The date that they sent the notice.

(ii) Upon request of the commissioner, to verify that they sent the notice, issuers must be able to provide:

(A) An attestation from the person who sent the notice or supervised sending the notice; or

(B) Proof of sending the notice, which regardless of delivery method, may consist of, but is not limited to a confirmation document that shows the date the issuer mailed the item, the name and address

of the insured, and the lapse designee if the insured has named a lapse designee for the policy. Delivery of the notice may occur using one of these or similar methods:

(I) Certified mail, which may be proven by obtaining a certificate of mailing from the United States Postal Service;

(II) A commercial delivery service;

(III) First class United States mail, postage prepaid; or

(IV) Proof of delivery by electronic means under the requirements of RCW 48.185.005.

(iii) If the insured has an insurance producer of record, then the issuer must also provide notice to the insured's producer of record within seventy-two hours after the issuer sends the notice to the insured and to the lapse designee, if the insured has named a lapse designee for the policy. In sending this notice, issuers must comply with the mailing requirements in (a)(ii) of this subsection.

(iv) An issuer may not give notice until thirty days after a premium is due and unpaid. Notice is deemed to have been given as of five days after the date that the issuer sent the notice.

(v) Upon the request of the commissioner, issuers must be able to demonstrate that they use due diligence to attempt to locate policyholders or named lapse designees when they receive notification of nondelivery of lapse notices.

(b) Where a policyholder or certificate holder pays premium through a payroll or pension deduction plan, the insurer shall permit the insured to designate a person to receive notice of lapse or termination for nonpayment of premium within sixty days after the insured is no longer on such a premium payment plan. The application or enrollment form for contracts or certificates where premium will be paid through a payroll or pension deduction plan shall clearly indicate the payment plan selected by the applicant.

(c) The insurer shall offer in writing an opportunity to each insured to change the lapse designee, or update the information concerning the lapse designee, no less frequently than once a year.

(i) Issuers must print this notice in not less than twelve point type either:

(A) On the front side of the first page of the billing statement; or

(B) On a separate document that is not printed on the billing statement.

(ii) If the insured has named a lapse designee for the account, then the issuer must print on the notice the name and contact information that the issuer has on record for the lapse designee.

(2) Every insurer shall provide a limited right to reinstate coverage in the event of lapse or termination for nonpayment of premium, if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity and reinstatement is requested within the five months after the policy lapsed or terminated due to nonpayment of premium.

(a) The standard of proof of cognitive impairment or loss of functional capacity shall be no more restrictive than the benefit eligibility criteria for cognitive impairment or loss of functional capacity contained in the contract or certificate.

(b) Current good health of the insured shall not be required for reinstatement if the request otherwise meets the requirements of this section.

(3) An insurer shall permit an insured to waive the right to designate an additional person to receive notice of lapse or termination for nonpayment of premium.

(a) The waiver shall be in writing, and shall be dated and signed by the applicant or insured.

(b) No less frequently than once in every twenty-four months, the insured shall be permitted to revoke this waiver and to name a designee.

(4) Designation by the insured to receive notice of lapse or termination for nonpayment of premium does not constitute acceptance of any liability on the part of the designee for services provided to the insured or applicant.

[Statutory Authority: RCW 48.02.060, 48.83.170 and 48.84.030. WSR 17-03-089 (Matter No. R 2013-29), § 284-54-253, filed 1/13/17, effective 7/1/17. Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-253, filed 9/11/95, effective 10/12/95.]

WAC 284-54-260 Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any applicable waiting period, and all other applicable provisions of the contract or certificate.

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. WSR 94-14-100 (Order R 94-10), § 284-54-260, filed 7/6/94, effective 8/6/94.]

WAC 284-54-270 Requirement to offer inflation protection. (1) No insurer may offer a long-term care insurance contract unless, in addition to any other inflation protection option, the insurer offers to the policyholder the option to purchase a contract that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the contract. Insurers must offer to each applicant, at the time of purchase, the option to purchase a contract with an inflation protection feature no less favorable than one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the contract is issued to a group, the required offer in subsection (1) of this section shall be made to the group policyholder; except, if the policy is issued to an association group (defined in RCW 48.24.045) other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(3) The offer in subsection (1) of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(4)(a) Insurers shall include the following information in or with the disclosure form:

(i) A graphic comparison of the benefit levels of a contract that increases benefits over the contract period with a contract that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(c) It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations may, for example, include providing increases to attained age, or for a period such as at least twenty years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

(5) Inflation protection benefit increases under a contract which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the contract.

(6) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(7)(a) Inflation protection as provided in subsection (1)(a) of this section shall be included in a long-term care insurance contract unless an insurer obtains a written rejection of inflation protection signed by the applicant.

(b) The rejection shall be considered a part of the application and shall state:

> "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this contract with and without inflation protection. Specifically, I have reviewed Plans . . . . . , and I reject inflation protection."

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-270, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060, 48.84.030 and 48.01.030. WSR 94-14-100 (Order R 94-10), § 284-54-270, filed 7/6/94, effective 8/6/94.]

WAC 284-54-300 Information to be furnished, style. (1) Each insurance producer, or other representative of an insurer selling or offering benefits that are designed, or represented as being designed, to provide long-term care insurance benefits, shall deliver the disclosure form as set forth in WAC 284-54-350 not later than the time of

application for the contract. If an insurance producer has solicited the coverage, the disclosure form shall be signed by that insurance producer and a copy left with the applicant. The insurer shall maintain a copy in its files.

(2) The disclosure form required by this section shall identify the insurer issuing the contract and may contain additional appropriate information in the heading. The informational portion of the form shall be substantially as set forth in WAC 284-54-350 and words emphasized therein shall be underlined or otherwise emphasized in each form issued. The form shall be printed in a style and with a type character that is easily read by an average person eligible for long-term care insurance.

(3) Where inappropriate terms are used in the disclosure form, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor, or health maintenance organization shall substitute appropriate terminology.

(4) In completing the form, each subsection shall contain information which succinctly and fairly informs the purchaser as to the contents or coverage in the contract. If the contract provides no coverage with respect to the item, that shall be so stated. Address the form to the reasonable person likely to purchase long-term care insurance.

(5) A policy which provides for the payment of benefits based on standards described as "usual," "customary," or "reasonable" (or any combination thereof), or words of similar import, shall include an explanation of such terms in its disclosure form and in the definitions section of the contract.

(6) If the contract contains any gatekeeper provision which limits benefits or precludes the insured from receiving benefits, such gatekeeper provision shall be fully described.

(7) All insurers shall use the same disclosure form. It is intended that the information provided in the disclosure form will appear in substantially the same format provided to enable a purchaser to compare competing contracts easily.

(8) The information provided shall include the statement: "This is NOT a medicare supplement policy," and shall otherwise comply with WAC 284-66-120.

(9) The required disclosure form shall be filed by the insurer with the commissioner prior to use in this state.

(10) In any case where the prescribed disclosure form is inappropriate for the coverage provided by the contract, an alternate disclosure form shall be submitted to the commissioner for approval or acceptance prior to use in this state.

(11) Upon request of an applicant or insured, insurers shall make available a disclosure form in a format which meets the requirements of the Americans With Disabilities Act and which has been approved in advance by the commissioner.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-54-300, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-300, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-300, filed 7/9/87.]

WAC 284-54-350 Form to be used—Long-term care insurance disclosure form. No later than January 1, 1996, the disclosure form shall be substantially as follows:

(Company Name)
Disclosure Form
Long-term Care Insurance

The decision to buy a new long-term care policy is very important. It should be carefully considered.

The following data give you some general tips and furnish you with a summary of benefits available under our policy.

Your long-term care policy provides thirty days (sixty days for direct response insurers) within which you may decide without cost whether you wish to keep it. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available under your policy.

If you now have insurance which provides benefits for long-term care, read your policy carefully. Look for what is said about renewing it. See if it contains waiting periods before benefits are paid. Note how it covers preexisting conditions (health conditions you already have). Compare these features with similar ones in any new policy. Use this information to measure the value of any insurance or health care plans you now have.

DON'T BUY MORE INSURANCE THAN YOU REALLY NEED. One policy that meets your needs is usually less expensive than several limited policies.

If you are eligible for state medical assistance coupons (medicaid), you should not purchase a long-term care insurance policy.

After you receive your policy, make sure you have received the coverage you thought you bought. If you are not satisfied with the policy, you may return it within thirty days (sixty days for direct response insurer) for a full refund of premium.

LTC DISCLOSURE FORM

1. INSTITUTIONAL CARE

What levels of care are covered by the policy?	**YES**		**NO**
Does the policy provide benefits for these levels of care?			
Skilled Nursing Care?	_____		_____
Intermediate Nursing Care?	_____		_____
Custodial/Personal Care?	_____		_____
(By state law, all long-term care policies in Washington State must cover all three of the above levels of care.)	_____		_____
Where can care be received and be covered under the policy?			
Does the policy pay for care in any licensed facility?	_____		_____
If no, define the restrictions on where care can be obtained:	_____		_____
Is the alternative plan of care benefit available with institutional part of policy?	_____	If yes, see section 2	_____
Does the alternative plan of care benefit include home care?	_____	If yes, see section 2	_____
Does the alternative plan of care benefit include structural home improvements?	_____		_____

2. HOME/COMMUNITY BASED CARE

What types of care are covered by the policy?			
Does the policy provide home care benefit for:			
Check all that apply			
Adult day care	_____		_____
Adult day health care	_____		_____

Chore services
Home health aides
Homemaker services
Hospice
Hygiene/personal care
Laboratory services
Meals/nutrition services
Medical equipment/supplies
Prescription drugs
Physician/nursing services
Respite care
Social workers
Therapies (List)
Transportation
Other: _____

Are these separate or post-confinement benefits? **Separate** **Post - Confinement**

Where can home/community-based care be received?

Check all that apply

Adult day care centers
Alternative care facilities
Assisted living facilities
Boarding homes
Community centers
Congregate care facilities
Multiple family residences
Single family residences
Other: _____

Does the alternative plan of care benefit include home care?

Does the alternative plan of care benefit include structural improvements?

Must the alternative plan of care be pre-certified?
If yes, by whom? _____

3. BOTH INSTITUTIONAL AND COMMUNITY-BASED CARE

What is the maximum daily benefit amount for: **YES/NO/COMMENTS**

Institutional/nursing home care?
Home/Community Based Care?
Are there limits on the number of days (or visits) per year for which benefits will be paid for:
Institutional/nursing home care?
Home/Community based care?
What are the dollar limits the policy will pay during the policyholder's lifetime for:
Institutional/Nursing home care?
Home/Community based care?
Total lifetime limit?

What basic features and benefits does the policy offer?

Is the policy guaranteed renewable?
Can you purchase additional increments of coverage? If yes:
When can additional coverage be purchased?
How much can be purchased?
When is additional coverage no longer available for purchase?

Does the policy have inflation protection?

If yes, what is the % amount of the increase?
Is the rate of increase simple or compound?
When do increases stop?

If policy includes inflation coverage, what is the daily benefit for:

Institutional/nursing home care.

5 years from policy effective date? _____

10 years from policy effective date? _____

Home/Community based care.

5 years from policy effective date? _____

10 years from policy effective date? _____

After the limits have been reached for inflation adjustments, what is the maximum daily benefit for:

Institutional/nursing home care _____

Home/community based care _____

After the limits have been reached for inflation adjustments, what is the maximum lifetime benefit for:

Institutional/nursing home care _____

Home/community based care _____

Is there a waiver of premium provision for:

Institutional/nursing home care? _____ _____

Home/community based care? _____ _____

How many days of confinement in an institution are required before the waiver of premium benefit is available? _____

How many days of confinement at home are required before the waiver of premium benefit is available? _____

How many days of benefits must be paid before waiver is effective? _____

Does the policy have a nonforfeiture benefit? _____

If yes, how many years must policy be in effect before the insured benefits from nonforfeiture values?

What would the benefit value be in terms of dollars after 20 years? _____

What does the nonforfeiture benefit promise? (give an appropriate example showing dollars and time limits) _____

Does the policy have a death benefit? _____

If yes, specify value (in dollars of %) _____

What conditions or limitations apply, if any? _____

Does the policy have a restoration of benefits provision? _____ _____

If yes, give amount of benefit and minimum required # of days between benefits. _____

If disability recurs, is there a new elimination or waiting period before benefits begin again? _____ _____

If yes, after how long? _____

How long is the waiting period for preexisting conditions? _____

How is the preexisting condition defined? _____

When do benefits begin?

How long is the elimination or waiting period before benefits begin for:

Institutional/nursing home care? _____

Home/community based care? _____

What gatekeepers are required before benefits start? _____

Doctor certification _____ _____

Case management _____ _____

If yes, by whom? _____

Medical necessity _____ _____

Plan of treatment _____ _____

If yes, by whom? _____

Inability to perform activities of daily living (ADLs) _____ _____

If yes, how many ADLs must fail before benefits begin?

If the policy uses an ADL gatekeeper(s), define "inability to perform ADL."

Is there a separate benefit qualification requirement if there is a cognitive impairment? _____ _____

Who determines a qualifying event? _____

Define any separate benefit qualification requirement if there is a cognitive impairment: _____

What does the policy cost? _____

How often can the premium increase?

By how much annually can the premium increase?

Is there a discount if both spouses buy policies?

If so, how much?

Do you lose the discount if one spouse dies?

4. ADDITIONAL POLICY INFORMATION

Use this space to outline additional benefits, further explanations or clarifications

5. POLICY DEFINITIONS

(Include definitions of policy provisions)

WHAT DOES THE POLICY COST?

COMPANY NAME	**POLICY OPTION 1**	**POLICY OPTION 2**	**POLICY OPTION 3**	**POLICY OPTION 4**
ELIMINATION (DEDUCTIBLE) PERIOD				
BENEFIT PERIOD				
$ BENEFIT FOR DAY				
$ MAXIMUM BENEFIT				
Institutional/Nursing Home				
Home Health/Community Based				
PREMIUM SUBTOTAL $				
OPTIONAL BENEFITS				
Inflation				
Non Forfeiture				
Spousal Discount				
Death Benefit				
Other				
Other				
Other				
PREMIUM TOTAL $				
BENEFIT "TRIGGERS" (QUALIFICATION REQUIREMENTS)				
List				
List				
List				

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. WSR 95-19-028 (Order R 95-5), § 284-54-350, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-350, filed 7/9/87.]

WAC 284-54-500 Format of long-term care contracts. No long-term care contract shall be delivered or issued for delivery to any person in this state if it fails to comply with the following:

(1) The style, arrangement, and over-all appearance of the policy shall give no undue prominence to any portion of the text (except as required by this chapter). Every printed portion of the text of the contract and of any amendment or attached papers shall be plainly printed in easily read type.

(2) Limitations, exclusions, exceptions, and reductions of coverage or benefits shall be set forth in the policy and shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "LIMITATIONS and EXCEPTIONS," or "EXCLUSIONS and REDUCTIONS," except that if a limitation, exclusion, exception, or reduction specifically applies only to a particular benefit of the policy, a statement of such limitation, exclu-

sion, exception, or reduction shall be included with the benefit provision to which it applies.

(3) Each contract delivered or issued for delivery to any person in this state shall clearly indicate on its first page that it is a "LONG-TERM CARE INSURANCE" contract. In addition, the contract shall contain a table of contents which shall clearly identify the location within the contract of each of the provisions of the contract with particular attention to the location of contract provisions for (a) limitations, exclusions, exceptions or reductions of coverage, (b) renewability, (c) definitions, (d) gatekeeping provisions, and (e) any unique provisions or circumstances such as elimination periods, or minimum or maximum limits. The term "contract" or "certificate" may be substituted on the first page of the contract for the word "insurance" where appropriate.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-500, filed 7/9/87.]

WAC 284-54-600 Loss ratio requirements. (1) The provisions of chapter 284-60 WAC shall apply to every contract of long-term care issued by a disability insurer and fraternal benefit society. The provisions of WAC 284-54-610 through 284-54-680 shall apply to every long-term care contract issued by a health care service contractor or health maintenance organization.

(2) Benefits for all long-term care contracts shall be reasonable in relation to the premium or price charged.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-600, filed 7/9/87.]

WAC 284-54-610 Loss ratio definitions. The following definitions apply to WAC 284-54-610 through 284-54-680:

(1) "Loss ratio" means the claims incurred plus or minus the increase or decrease in reserves as a percentage of the earned premiums, or the projected incurred claims plus or minus the increase or decrease in projected reserves as a percentage of projected earned premiums, as defined by the commissioner.

(2) "Claims" shall mean the cost of health care services paid to or provided on behalf of covered individuals in accordance with the terms of contracts issued by health care service contractors or health maintenance organizations or capitation payments made to providers of long-term care.

(3) The "expected loss ratio" is a prospective calculation and shall be calculated as the projected "benefits incurred" divided by the projected "premiums earned" and shall be based on the pricing actuary's best projections of the future experience within the "calculating period."

(4) The "actual loss ratio" is a retrospective calculation and shall be calculated as the "benefits incurred" divided by the "premiums earned," both measured from the beginning of the "calculating period" to the date of the loss ratio calculations.

(5) The "overall loss ratio" shall be calculated as the "benefits incurred" divided by the "premiums earned" over the entire "calculating period" and may involve both retrospective and prospective data.

(6) The "calculating period" shall be the time span over which the pricing actuary expects the premium rates whether level or increasing, to remain adequate in accordance with his best estimate of future experience and during which the pricing actuary does not expect to request a rate increase.

(7) The "benefits incurred" shall be the "claims incurred" plus any increase (or less any decrease) in the "reserves."

(8) The "claims incurred" shall mean:

(a) Claims paid during the accounting period; plus

(b) The change in the liability for claims which have been reported but not paid; plus

(c) The change in the liability for claims which have not been reported but which may reasonably be expected.

The "claims incurred" shall not include expenses incurred in processing the claims, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, or profit.

(9) The "reserves," as referred to in this section, shall include:

(a) Active life disability reserves;

(b) Additional reserves whether for a specific liability purpose or not;

(c) Contingency reserves;

(d) Reserves for select morbidity experience; and

(e) Increased reserves which may be required by the commissioner.

(10) The "premiums earned" shall mean the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-610, filed 7/9/87.]

WAC 284-54-620 Loss ratio—Grouping of contract forms. For purposes of rate making and requests for rate increase.

(1) The actuary responsible for setting premium rates shall group similar contract forms, including forms no longer being marketed if issued on or after January 1, 1988, in the pricing calculations. Such grouping shall rely on the judgment of the pricing actuary and be satisfactory to the commissioner. Among the factors which shall be considered are similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between contract holders. Such grouping shall enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW 48.44.220 or 48.46.370.

(2) The insureds under similar contract forms are grouped at the time of rate making in accord with RCW 48.44.220 or 48.46.370 because they are expected to have substantially like insuring, risk and exposure factors and expense elements. The morbidity and mortality experience of these insureds will, as a group, deteriorate over time. It is hereby defined to be an unfair discriminatory practice and therefore prohibited pursuant to RCW 48.44.220 or 48.46.370 and 48.84.040(3) to withdraw a form from its assigned grouping by reason of the deteriorating health of the insureds covered thereunder.

(3) One or more of the contract forms grouped for rate making purposes may, by random chance, experience significantly higher or

more frequent claims than the other forms. It is hereby defined to be an unfair discriminatory practice and therefore prohibited pursuant to RCW 48.44.220 or 48.46.370, to deviate from the assigned grouping of contract forms for pricing purposes at the time of requesting a rate increase unless the pricing actuary can justify to the satisfaction of the commissioner that a different grouping is more equitable because of some previously unrecognized and nonrandom distinction between forms or between groups of insureds.

(4) Successive contract forms of similar benefits are sometimes introduced by health care service contractors and health maintenance organizations for the purpose of keeping up with trends in hospital costs, new developments in medical practice, additional supplemental benefits offered by competitors, and other reasons. While this is commendable, contract holders who can not qualify for the new improved contracts, or to whom the new benefits are not offered, are left isolated as a high risk group under the prior form and soon become subject to massive rate increases. It is hereby defined to be an unfair discriminatory practice and therefore prohibited pursuant to RCW 48.44.220 or 48.46.370 and 48.84.040(3), to fail to combine successive generic contract forms and to fail to combine contract forms of similar benefits covering generations of contract holders in the calculation of premium rate and loss ratios.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-620, filed 7/9/87.]

WAC 284-54-630 Loss ratio requirements—Individual contract forms. The following standards and requirements apply to individual contract forms:

(1) Benefits shall be deemed reasonable in relation to the premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the health care service contractor or health maintenance organization which calculating period is satisfactory to the commissioner.

(2) The calculating period may vary with the benefit and renewal provisions. The health care service contractor or health maintenance organization may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations. A brief explanation of the selected calculating period shall accompany the filing.

(3) Contract forms, the benefits of which are particularly exposed to the effects of inflation and whose premium income may be particularly vulnerable to an eroding persistency and other similar forces, shall use a relatively short calculating period reflecting the uncertainties of estimating the risks involved. Contract forms based on more dependable statistics may employ a longer calculating period. The calculating period may be the lifetime of the contract for guaranteed renewable and noncancellable contract forms if such forms provide benefits which are supported by reliable statistics and which are protected from inflationary or eroding forces by such factors as fixed dollar coverage, inside benefit limits, or the inherent nature of the benefits. The calculating period may be as short as one year for coverage which are based on statistics of minimal reliability or which are highly exposed to inflation.

(4) A request for a rate increase to be effective at the end of the calculating period shall include a comparison of the actual to the expected loss ratios, shall employ any accumulation of reserves in the determination of rates for the new calculating period, and shall account for the maintenance of such reserves for future needs. The request for the rate increase shall be further documented by the expected loss ratio for the new calculating period.

(5) A request for a rate increase submitted during the calculation period shall include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to and support from the reserves, and shall account for the maintenance of such reserves for future needs. If the experience justifies a premium increase it shall be deemed that the calculating period has prematurely been brought to an end. The rate increase shall further be documented by the expected loss ratio for the next calculating period.

(6) The commissioner may accept a series of two or three smaller rate increases in lieu of one large increase. These should be calculated to reduce lapses and antiselection that often result from large rate increases. A demonstration of such calculations, whether for a single rate increase or for a series of smaller rate increases, satisfactory to the commissioner, shall be attached to the filing.

(7) Health care service contractors and health maintenance organizations shall review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-630, filed 7/9/87.]

WAC 284-54-650 Loss ratio experience records. Health care service contractors and health maintenance organizations shall maintain records of earned premiums and incurred benefits for each contract year for each contract, rider, endorsement, amendment and similar form which were combined for purposes of premium calculations, including the reserves. Records shall also be maintained of the experience expected in the premium calculations. Notwithstanding the foregoing, with proper justification, the commissioner may accept approximation of contract year experience based on calendar year data.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-650, filed 7/9/87.]

WAC 284-54-660 Evaluating loss ratio experience data. In determining the credibility and appropriateness of experience data, due consideration shall be given to all relevant factors including:

(1) Statistical credibility of premiums and benefits such as low exposure or low loss frequency;

(2) Past and projected trends relative to the kind of coverage, such as inflation in medical expenses, inflation in expense charges and others;

(3) The concentration of experience at early contract durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially higher or lower than in later contract durations;

(4) The mix of business by risk classification;

(5) The expected lapses and antiselection at the time of rate increases.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-660, filed 7/9/87.]

WAC 284-54-680 Loss ratio—Special circumstances. Loss ratios other than those indicated in WAC 284-54-630 may be approved by the commissioner with satisfactory actuarial demonstrations. Examples of coverage where the commissioner may grant special considerations are:

(1) Contract forms exposed to high risk of claim fluctuation because of the low loss frequency, or the catastrophic or experimental nature of the coverage.

(2) Individual situations where higher than usual expenses are expected because of peculiar administrative or geographic circumstances.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-680, filed 7/9/87.]

WAC 284-54-700 Advertising. In addition to this chapter, specific applicable standards for the regulation of advertisements relating to individual, group, blanket, and franchise and individual and group health care service contractors' agreements, are included in WAC 284-50-010 through 284-50-230, and are applicable to the advertisement of all long-term care insurance contracts.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-700, filed 7/9/87.]

WAC 284-54-800 Unfair or deceptive acts. RCW 48.84.910 authorizes the commissioner to prohibit particular unfair or deceptive acts in the conduct of the advertising, sale, and marketing of long-term care policies and contracts. The purpose of this section is to define certain minimum standards which insurers should meet with respect to long-term care. If the following standards are violated with such frequency as to indicate a general business practice by an insurer, it will be deemed to constitute an unfair method of competition or a deceptive act by such insurer and a violation of this section.

(1) Misrepresenting pertinent facts or insurance contract provisions.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to communications arising under insurance policies or contracts.

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies or contracts.

(4) Refusing to pay claims or provide benefits without conducting a reasonable investigation.

(5) Failing to affirm or deny coverage of claims within a reasonable time.

(6) Compelling an insured to institute litigation to recover amounts due under an insurance contract by offering substantially less

than the amounts ultimately recovered in actions brought by such an insured.

(7) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Making claims payments to an insured or beneficiaries not accompanied by an explanation setting forth the coverage under which the payments are being made.

(9) Failing to promptly provide a reasonable explanation of the basis in the insurance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Asserting to an insured or claimant a policy of appealing from arbitration awards in favor of an insured or claimant for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by unreasonably requiring an insured, claimant, or the attending physician of the patient to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failure to expeditiously honor drafts given in settlement of claims within three working days of notice of receipt by the payor bank except for reasons acceptable to the commissioner.

(13) Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established.

(14) Issue checks or drafts in partial payment of a loss or claim under a specific coverage which contain language which appear to release the insurer from its total liability.

(15) Failure to reply to the insurance commissioner within fifteen working days of receipt of an inquiry, such reply to furnish the commissioner with an adequate response to the inquiry.

(16) Failure to settle a claim on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions as permitted by this chapter.

(17) Making statements which indicate the rights of persons may be impaired if a form or release is not completed within a given time unless the statement otherwise is provided by policy provisions or is for the purpose of notifying that person of the provisions of an applicable statute of limitations.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-800, filed 7/9/87.]

WAC 284-54-900 Chapter not exclusive. Nothing contained in this chapter shall be construed to limit the authority of the commissioner to regulate a long-term care contract under other sections of Title 48 RCW.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. WSR 87-15-027 (Order R 87-7), § 284-54-900, filed 7/9/87.]