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Washington Long-Term Care

LTC Refresher 4-Hour Course

Course # 627236

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WA Long Term Care 4 Hour Refresher Course

The reason for having a long term care policy is to pay for assistance if you need help doing everyday tasks due to chronic illness, injury, even aging. It is an estate planning tool to help keep an estate intact because those costs can deplete an average estate. Long term care itself is simply that, care for a long time. You may be recovering from a broken hip and you will recover, but you are too healthy to be hospitalized yet you need help, or you may have dementia, or you may be able to do most things on your own as you age but you need help with others. Families can and do take on much of this but that is not always feasible. Long term care is not designed to treat or cure a medical issue, but to help a person cope with a reduced level of physical or cognitive functions over a period of time. Long term care insurance can help pay for the assistance, sometimes paying out to family members as well.

Medicare does not cover long term care except for a 20 day stay in a skilled nursing facility after having been admitted to a hospital for 3 consecutive days. Medicaid will cover this type of need, but you have to have nothing left to spend (you cannot have just given it away either, there is a look back period) and the next available spot is what you get, no choices, if we're talking about a facility.

A long term care insurance policy gives you choices on where to go or if you want to stay home, that care is covered as well.

Long term care terminology and settings for care

Skilled (primary) 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.

Home health care vs. home care

"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 non-medical 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 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.

"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 condition and needs, completing appropriate records, and personal care or household services needed to achieve medically desired results.

"**Home health care**" means any of the following health or medical services: Nursing services, home health aide, 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.

Community based care means services including, but not limited to: home delivered nursing services or therapy custodial or personal care day care home and chore aid services nutritional services, both in-home and in a communal dining setting respite care adult day health care services and other similar services furnished in a home-like or residential setting that does not provide overnight care.

Alternative care is care or services that are not specified in a policy, but that may be provided if it is appropriate and is agreed upon by the insurance company, the insured person and his or her physician. The alternative care benefits are provided in lieu of normal contract benefits. The care is usually more desirable to the individual and may be less costly to the insurance company. One example would be placing a person in an adult family home instead of a nursing home.

People's needs and desires for long-term care situations are changing, reflecting changes in the culture. Conventional nursing home situations are less appropriate and desirable for many people today—and are more expensive and provide a higher level of care than is necessary in many cases. However, some insurance—and some thinking in the insurance industry—still clings to the conventional model, as reflected in some policies' benefit structures. The Office of the Insurance Commissioner has worked at changing rules and regulations so that future policies will be required to allow more flexibility. Some long-term care policies require an "alternative plan of care"—a written designation of what care will be provided, who will provide it and for how long—in order for alternative care to be covered.

Policies may specify not only that a plan of care is required, but that it must be written or certified by a specific person, such as a physician or case manager.

Key Points of the Office of the Insurance Commissioner's (OIC's) definition of the alternative plan of care are:

- No requirement to be confined in a nursing home before alternative plan is allowable.
- The alternative plan of care must be agreed to the insured's caregiver, the issuer of the policy, and the insured.
- The alternative plan of care must be part of a plan of care developed by a designated health care professionals.
- It's important to note that state regulations allow for each operative day of a plan of care to be counted as one day of service, even if no benefits are given that day. For example, a claimant with a two-month plan of care might receive care only every other day. In this way, during a two-month period, the claimant would receive only 30 days of care, but would use up 60 days of policy benefits. For this reason, it is best to keep a plan of care short so it can be reevaluated.

Some examples of care which are still considered "alternative" care options:

- Nutritional counseling, speech therapy, physical therapy, occupational rehabilitation and/or laboratory services.
- Other services include structural changes to a home including ramps, guard rails, and others that might enable a person to remain independent in the home.
- Long Term Care services can be combined. For example, a family can provide basic and primary care with community support such as respite care (short-term care while the family caregiver takes time off) or part-time adult day care.

Case management services include, but are not limited to, a comprehensive individualized face-to-face assessment conducted in the insured's place of residence which takes an all-inclusive look at the patient's total needs and resources, and links the patient to a full range of appropriate services using all available funding sources. The assessment is reevaluated at least once every six months. When desired by the insured and when it is determined to be necessary by the case manager, case management services will include coordination of appropriate services and ongoing monitoring of the delivery of such services.

Activities of Daily Living (ADL's) and cognitive impairment

"Activities of daily living (ADL)" - Measure of a person's level of independence/dependence. Includes individual tasks such as bathing, transferring, dressing, toileting, eating, and maintaining continence. Long-term care classifies risks according to a persons' ability to perform these daily activities.

Cognitive impairment ranges from mild to severe. Mild case symptoms can be forgetfulness, inability to concentrate or make decisions, all of which can be from stress, so it is important for a medical professional to diagnose. Severe symptoms are the same but to a larger degree. E.g., forgetting things changes from 'where are my keys?' to forgetting how to speak, walk, or swallow.

Plan of care means a written, individualized plan of services approved by the case manager that specifies the type, frequency and providers of all formal and informal long-term care services required for the insured. Changes in the plan of care must be documented to show alterations which have been agreed to and are required by a change in the situation or condition of the insured.

Adult day care

"Adult day care" - Daytime, *community-based programs* for functioning impaired adults that provides a variety of health, nutrition, social, and related services in a protective setting to those who are otherwise being cared for by family members. Its purpose is to enable individuals to remain at home and in the community and to encourage family members to care for them by providing relief from the burden of constant care.

"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.

Types of Long Term Care Insurance

What Private Long-Term Care Insurance Covers… Like most insurance policies, the details of services covered, and benefits paid will vary from policy to policy. However, there are some minimum standards for what all LTC policies must cover if sold in Washington State, and rules and regulations written and enforced by the Office of the Insurance Commissioner to which all policies must conform. It is the differences between policies, and types of policies, that you will want to evaluate, as well as the financial stability of the insurance companies.

The services addressed by LTC insurance include nursing home care, home health care (medical care administered in the person's home by a qualified professional), home care and community-based care. Community-based care encompasses many of those alternative options listed under What is Long-Term Care and Types of Care and Providers of Care —such as assisted living, adult day care, adult family homes, continuing care retirement communities and hospice care.

All long-term care policies sold in Washington State must cover all levels of care in a nursing home, whether custodial (personal) or skilled. They also must cover care for mental and emotional illness—including Alzheimer's disease and senility—as well as for physical conditions.

Other long-term care benefits do vary widely by policy. For example, some policies may:

- pay a fixed benefit amount per day.
- have daily limits on payouts.
- have a ceiling on total benefits.
- require full payment for some services.
- impose elimination (deductible) periods, in which the policyholder must pay for care for an initial designated time period before benefits begin.
- cover alternatives such as assisted living, adult day care or home health care (or other alternatives agreed upon by patient, doctor, and insurer).
- allow you to stop paying premiums once you are receiving care paid by your policy benefits.
- offer an inflation option that ensures coverage will keep pace to some extent with the rate of inflation (a good idea for those with pensions that don't have cost-of-living increases).
- offer restoration of benefits when a certain amount of time passes with no care.
- impose conditions such as length of stay in a facility or length of time receiving care before the policy begins to pay.

Many policies also support other important nonmedical needs called Instrumental activities of daily living (IADs). These can include:

- housekeeping
- money management
- grocery shopping
- pet care

Individual Policies are purchased from an insurance producer or direct from a carrier, and are written as to a client's individual needs, resources, and budget. First, looking at any existing continuing income not needed by your spouse, how much of a benefit do you want? It can range from $1500 per month to $10,000 per month or more. How long benefits last are important. The benefit period is not for life, it can be 2-6 years. There is a period of time after a claim before benefits are paid known as the elimination period. This works like a deductible but is measured in days not dollars, so, the longer the elimination period the lower the premium. There are riders you may add on which will increase the cost but will expand coverage. An important rider is the cost of living or inflation rider since you may not use these benefits for years.

Employer/Worksite Plans (Advantages – relaxed underwriting, portability, premium discounts).

These are plans you can get at work as an employee. Just like any group plan there is limited underwriting when you first join the group or when the group starts the plan. Should you decline coverage until open enrollment, medical underwriting will occur. Open enrollment is once per year for employees to change their benefit plans, add, subtract, etc. There may appear to be a premium discount because of the large number of people signing up, but the fact is people who know they are likely to need the benefit will join the plan so there may not be any savings. The fact that you have a group plan does not mean that you must stay with the group, portability allows you to convert the group plan to an individual plan without needing to prove insurability.

As long as a person is healthy and qualifies for an individual plan, they need to compare carefully not only the premium but the benefits and choose which is best for their needs.

Federal Government: Coverage for federal employees is a group plan for federal employees. It was established in 2002 as a result of by an act of Congress, the Long Term Care Security Act in 2000. Known as the federal long term care insurance program (FLTCIP), it is not a one size fits all. An insured may choose the main items such as the daily benefit, the benefit period, and which inflation adjustment. The coverage will have a 90-day elimination or waiting period. There is an interactive page designed to help insureds with the planning of purchasing and filing claims.

Life Insurance Policies: Linked benefit/hybrid

A Long Term Care rider on a life insurance policy is an option with many companies. This rider can be written in 2 different ways, it all depends on what the company offers.

First, a Long Term Care rider that could be called hybrid is one where the death benefit of the policy is used towards Long Term Care costs if needed. A policy for $350,000 purchased with a rider for Long Term Care would pay a death benefit of $250,000 if $100,000 was paid towards the cost of Long Term Care. If the insured dies without using any long term care products, a death benefit of $350,000 would be paid. Pros and cons include the fact that although the price is lower than purchasing a separate policy if the benefit is used towards long term care costs, the death benefit paid out on the eventual passing of the insured may NOT be enough to meet the needs of the beneficiaries.

The other Long Term Care rider does not link the 2 dollar amounts together so if the same scenario existed: life insurance for $350,000, Long Term Care costs of $100,000, then the death benefit would still be $350,000. This policy will cost more than the other.

Another alternative that may help with some of the long term care or nursing home costs is an accelerated death benefit rider in a life insurance policy. No one needs to be terminally ill in order to need long term care, but 1) if you have a life policy with this rider and 2) you are terminal, the policy will pay out 80-90% of the death benefit to the insured while they are alive.

Long-Term Care Insurance Partnership Plans - Asset Protection

Partnership plans are a collaboration between private carriers and a state's Medicaid program. The intention is to take the burden of long term care expenses off the Medicaid system and have the consumer and insurance companies carry it. Since Long Term Care policies are not lifetime policies and may have a benefit period of 5 years, after 5 years how do you pay for the necessary care? Medicaid will pay but all of a person's assets need to be spent down so Medicaid is used as a last resort. A partnership plan will increase the amount of assets, dollar for dollar spent, that a person can keep or not spend down.

So, it is a long term care policy that an insured purchased through a producer that may allow the heirs to inherit and keep the house or other assets the insured still has. This policy is a part of the partnership program with Medicaid. Long term care can be expensive, and Medicaid has restrictions in order to use it. This partnership plan helps protect the insureds assets both at the qualifying and as asset protection for the family when the insured dies.

Alternatives to private Long-Term Care Insurance can be group plans, family taking care of you, and Medicaid. Another option is a long term care rider on a life insurance policy or utilizing the accelerated death benefit on a life insurance policy. This last option will only work if you are terminally ill, but insurance companies may pay 80% - 90 % of the death benefit to the insured while they are still alive.

Building a policy

When building a policy naturally you want to compare premiums, but the 4 most important items are those you need when the policy pays.

1. How much will it pay
2. how long will it pay for
3. how long until it pays out
4. and inflation protection

Daily or Monthly benefit amount are 2 different payment plans for the carrier. The end result may be the same. a client has care, but the out of pocket costs may be vastly different. Let's take a look at a client with a $4500 monthly benefit compared to a client with a benefit of $150 per day. Each policy will pay out a total of $4500 for the entire month. The difference between the two plans shows in the benefit paid.

If a client has an aide coming in twice a week at a cost of $300 per visit, over a month that is 8 visits for a total payout of $2400. Our client with the monthly benefit will have the full amount of $2400 paid.

If a client has an aide coming in twice a week at a cost $300 per visit, the daily benefit will only have ½ of the costs paid since the visit is $300 and the daily benefit is $150. The client will have to make up the difference out of pocket.

Benefit period is the period of time that benefits will be paid out. The benefit period can range from one year to 6 or 7 years or more. 92% of all Long Term Care claims are for 3 years or less. The longer the benefit period the higher the premium.

Lifetime maximum benefit is the amount a company will stop paying and all the costs at this point are passed to the consumer. This could be the amount the policy is for (i.e., monthly benefit x benefit period), but if there is a restoration of benefits provision this amount will be higher. A policy may pay $5000 per month for 5 years or until $150,000 has been paid out, whichever is first or whichever is last.

Elimination period is the period of time between the start of a claim and when benefits will be paid. It is a deductible measured in days, not dollars. The longer the elimination period, the lower the premium.

> A **Calendar Day** elimination period means once the benefits are triggered the clock starts. A person with a 90-day elimination who has a caregiver in house twice per week would have 30 days used towards the elimination period at the end of the first month.
>
> A **Service Day** elimination period means once the benefits are triggered the clock starts but only counts actual service days. A person with a 90-day elimination who has a caregiver in house twice per week would have 8 days used towards the elimination period at the end of the first month.

Inflation protection is very important to have on this policy. The benefit that looks good today may only be a fraction of what is needed in 10 or 20 years. There are a few ways to protect your coverage against inflation, these are shown here:

> *Automatic*: There is a cost of living adjustment available where the coverage increases with the consumer price index (CPI), or there are companies that will offer a flat percentage. Medical and Long Term Care costs have risen faster than inflation so a 5% increase may be better than an increase based on the CPI. Another note is that this continues as long as you pay premium and does not require any more medical underwriting for the additional coverage. Since your total coverage amount increases your premium will increase as well.

Guaranteed: Guaranteed insurability options or future increase options are available on some policies that allow an insured to purchase more coverage without providing proof of insurability. This rider has a fee, and it may be worth it to some, but not all insured. Generally, every 2 or 3 years the insured is offered the option to increase coverage with the premiums for the additional coverage based on the current or attained age. If turned down the company may choose to not offer it again.

Other optional features: all of these riders will add to the premium but may be a great benefit for some:

Nonforfeiture is available with some Group plans. If the policy lapses this rider will give you access to the premiums paid if you need care later.

Shared care is a rider that will add to the premium and allows you to use your spouse's benefits in the event you have used all your benefit and still need care.

Dual waiver of premium is when the waiver of premium will waive the premium if an insured has a claim, joint waiver of premium waives the premium for both spouses when one has a claim.

Survivor benefit goes into effect when both partners have their policy for a period of time claim free, and 1 partner dies, the surviving partners premium is waived for life, and they have full benefits.

Limited payment option is the ability to 'buy out' the contract or pay all the premiums in full over a shorter period of time than, say, the rest of your life. As we age the likelihood of using a benefit increases yet who wants to pay premiums when retired and on a fixed or limited income? A 10 pay policy covers you for life and is paid up in 10 years, a paid up at 65 (retirement age) is paid up at that specified age. Of course, the premiums are higher than a pay for life plan, but it is for a limited period of time.

Restoration of Benefits restores your policy to the full benefit if you close the claim and are claim free for 180 days. e.g., an insured breaks a hip and needs Long Term Care benefits for 6 months, this will restore the full benefit if, once they are healed, they are claim free for 180 days.

Waiver of Home health care elimination period is offered because home care is less costly than care in a facility and a person may want to remain home but needs some care a few times a week. Also called Zero day home care, there is no elimination period for benefits to be paid.

Return of Premium answers the question 'what if I never use the benefit?' The amount of premium paid is returned to a beneficiary on the death of the insured.

Long-Term Care Insurance Provisions

Once a benefit trigger has been triggered the policy will start to pay. There is an elimination or waiting period where there are no benefits and only then will the carrier pay out for covered care.

How Benefits Are Paid:

Benefits are paid either on a daily basis or a monthly basis. Additionally, they can be paid by reimbursement or indemnity basis. They can be paid to the provider or cash to the insured.

Reimbursement, Indemnity, Cash

A **reimbursement** policy reimburses you for the costs paid. This can also be known as the expense incurred method. You may pay the provider and submit the claims forms and receipts to the carrier as they are incurred, and the carrier pays you the amount covered in the policy (which may or may not be 100% of what was paid out). An easier option here is to assign the claims to the provider so they may bill the carrier directly.

If the daily benefit is $150 and the cost of care is $125, the policy pays $125. If the daily benefit is $150 and the cost of care is $250, the policy pays $150. So, the policy pays all approved costs up to the policy limit. If the cost of $250 was not an approved item, the policy pays $0. There may be limitations with non-qualifying benefits not covered and licensed providers being required.

Policies may also use an **indemnity** method where the insured is indemnified to a set amount in the policy regardless of the actual expenses incurred as soon as you qualify for benefits. If the daily benefit is $150, you will receive $150 whether the cost of care is $125 or $225. Some carriers do not require monthly proof of billed services, others will. A licensed provider must be used to meet the minimums required by the doctor. Excess benefits may be used for any purpose.

Cash or cash indemnity is very much like an indemnity policy where the full benefit is paid once you qualify for benefits, but there are no restrictions on how the benefits are used. Total care from a family member is allowed.

Daily and monthly benefits

The plan may be written with a daily benefit or a monthly benefit. The end result may be the same. a client has care. The out of pocket costs may be vastly different. Let's take a look at a client with a $4500 monthly benefit compared to a client with a benefit of $150 per day. Each policy will pay out a total of $4500 for the entire month. If a client has an aide coming in twice a week at a cost of $300 per visit, over a month that is 8 visits for a payout of $2400. Our client with the monthly benefit will have the full amount of $2400 paid. Our client with the daily benefit will only have ½ of the costs paid since the visit is $300 and the daily benefit is $150. The client will have to make up the difference out of pocket.

What Services Are Covered

Like most insurance policies, the details of services covered and benefits paid will vary from policy to policy. However, there are some minimum standards for what all Long Term Care policies must cover if sold in Washington State, and rules and regulations written and enforced by the Office of the Insurance Commissioner to which all policies must conform. It is the differences between policies, and types of policies, that you will want to evaluate, as well as the financial stability of the insurance companies.

The services addressed by Long Term Care insurance include nursing home care, assisted living care, home health care (medical care administered in the person's home by a qualified professional), home care and community-based care. Community-based care encompasses many of those alternative options listed under What is Long-Term Care and Types of Care and Providers of Care —such as assisted living, adult day care, adult family homes, continuing care retirement communities and hospice care.

All long-term care policies sold in Washington State must cover all levels of care in a nursing home, whether custodial (personal) or skilled. They also must cover care for mental and emotional illness—including Alzheimer's disease and senility—as well as for physical conditions.

Where Services Are Covered can vary from policy to policy. There are skilled nursing facilities, assisted living facilities, and care at home.

Types of LTC Services and Providers of Care

- assisted living facilities
- congregate care facilities
- home health agencies
- adult family homes
- hospice centers
- adult day care centers
- adult day health care
- respite centers
- continuing care retirement communities
- chore workers
- social workers
- family caregivers
- nursing homes
- life care communities
- Alzheimer's units
- hospital sub-acute units

If a long-term care insurance policy or contract is used to pay for costs, it will specify which kinds of services are covered, and by which type of provider, and under what circumstances.

Some of the community options listed above are still considered "alternative" options. Many in the field hope that alternative service settings and providers--as long as they are licensed, certified, and otherwise qualified--will become the standard as long-term care evolves. These options are better for many people, often more personalized and flexible, and often cost everyone less.

It is important to understand:

- the differences between types of long-term care services
- the types of providers that deliver them
- the types of care they are most likely to want, need, or use most effectively
- comparative costs of these services
- types of care and care providers that are available in the area in which they live
- where the services can be delivered to the patient (e.g., home, assisted living unit, nursing home)

What Services Are Not Covered (Exclusions and Limitations)

All Long Term Care policies contain certain limitations and exclusions because a policy that covers every conceivable condition and type of care would carry astronomical premiums. Although the specific limitations and exclusions in any given policy vary, the following items are excluded from coverage under Long Term Care policies:

- Alcoholism
- Drug abuse
- Care necessitated by an act of war
- Care necessitated by an intentionally self-inflicted injury
- Certain mental and nervous disorders
- Care provided outside the US and Canada

These policies are to take care of the needs of the insured. They do **not cover** medical costs, trips to the doctor, dentist, eyeglasses, hearing aids, cost of medication, clothing, etc.

How Much Coverage is available

You choose a daily limit and a benefit period and multiply it out. Amounts may range from $50-$500 depending on the company and the benefit period is from 2-6 years. These are not infinite benefit policies and they will end.

Benefits Triggers - Terms and conditions that must be met before the policyholder can receive policy benefits are called benefit triggers (sometimes they are also called **gatekeepers**). These define specific parameters for the individual's type and degree of impairment as the basis for when benefits will be paid.

Virtually all long-term care policies have these provisions. They help the company to limit the number of eligible claims, thus helping companies manage their risks, and control their losses. Therefore, the more restrictive the number and/or nature of a policy's gatekeepers, the cheaper the policy is to buy.

There are now only three benefit triggers that are currently allowed in Washington State (federally "qualified" plans that provide for special tax treatment under the new health insurance law may contain other triggers):

1. **ADLs Requirement**
   The number of ADLs (and sometimes the types) required to trigger benefits depends on the policy. However, OIC rules do not allow any policy to require more than three of six ADLs to have failed before benefits are triggered. Who must certify the need for care may be a part of the ADLs benefit trigger. In such a case, a physician may have to certify that the ADLs have failed before the policy will pay benefits.

2. **Physician Certification**
   If a policy has a physician's certification benefit trigger, a physician must certify that the level of care being received is necessary and appropriate. In the past, most insurance companies required that a doctor authorize or prescribe all long-term care services. However, it is now becoming common for insurers to specify that the long-term care plan of care must be approved by a "case manager." Case managers often are hired by the insurance company, though they may also be totally independent. They assess needs and coordinate services. They evaluate the claimant's medical, social, and family situation to determine the most appropriate level of and location for care.

3. **Cognitive Impairment**
   Cognitive impairment is commonly described as deterioration or loss of intellectual capacity as shown by measurable deficits in the areas of memory, orientation, and reasoning. Alzheimer's disease and similar forms of senility or dementia are conditions that can produce these deficits.

Contingent Nonforfeiture provision provides the insured will not lose their investment in the product if they stop paying and the policy lapses ***due to a price increase by the carrier***. This provision will allow a partial benefit to be paid. It is built into all tax-qualified long term care policies. Insurers may not raise rates on a policy except for on a classification basis or block of business. Not to be confused with...

A nonforfeiture rider on a long term care insurance policy which provides the insured will not lose their investment in the product if they stop paying and may receive a partial refund **or** a partial benefit. It is a rider and can be added to a policy for a fee.

Upgrades to add new benefits, If you are insurable, you may be able to purchase new benefits offered by the carrier. You could do this as a rider, or you may purchase another policy that has the new benefits already. You will need to compare the costs between the two options. If you are no longer insurable your existing policy will still cover claims as long as you continue to pay premium until a claim is filed.

Downgrades to make it more affordable, Rates for long term care may increase on a classification basis, i.e., all persons over 75 in this zip code, If the premiums become unaffordable a client may choose to downgrade the coverage benefit to one they can afford and still have some type of coverage.

Tax Qualified and Non Tax Qualified, The majority of retired persons will not be able to pay for long term care services out of pocket, whether it is in home or in a facility. Medicaid is here to pick up some of the costs but is overburdened and forces consumers to spend down all of their assets. In order to encourage people to take responsibility for the cost and keep their assets to pass down to the heirs, the government offers some tax incentives to purchase Long Term Care policies. Not all Long Term Care policies qualify for this treatment, there are standards set by the government. In the end though, premiums paid are tax deductible up to a specified dollar amount and the benefit will not be treated as taxable income.

Some of the standards set are:

1. benefit triggers:
    - the inability to perform 2 out of 6 activities of daily living
    - severe cognitive impairment
2. Consumer protections:
    - 30 day free look
    - contingent nonforfeiture option included
    - the ability to set up a third party to be notified in the event of unintended lapse
3. Policy features:
    - nonforfeiture benefit offered
    - inflation protection must be offered

Other policy provisions

Protection against lapse

"Reinstatement"-Long-term care insurance policyholders in Washington State have the right to reinstate coverage after a lapse or termination due to nonpayment of premiums, if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity, and if reinstatement is requested within five months after the policy lapsed. (The policy's requirement for proof of cognitive impairment or loss of functional capacity for reinstatement cannot be any more stringent than the proof requirement for benefit eligibility.)

"Third party notice of lapse"- All policies must permit the insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium, in case the premium is not paid by its due date, and the coverage cannot lapse until at least 30 days after the notice is mailed to the third-party designee (this is 60 days for insureds paying a premium through a payroll or pension deduction plan). This protects the policyholder from lapse or termination in case cognitive impairment or loss of functional capacity results in nonpayment of premiums.

Unintentional Lapse… The long-term care policyholder must receive notice of lapse for nonpayment of premiums at least ***thirty days prior to the termination*** of coverage and has a limited right to reinstate the coverage if the policy lapsed unintentionally by a person with a cognitive impairment or loss of functional capacity.
The following are minimum standards for "unintentional lapses."

a. Every insurer must 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 notice must provide that the contract or certificate will not lapse until at least **30 days** after the notice is mailed to the insured's designee.

- Where a policyholder or certificate holder pays premiums **through a payroll or pension deduction plan,** the insurer must permit the insured to designate a person to receive notice of lapse or termination for nonpayment of premium within **60 days** after the insured is no longer on such a premium payment plan.

b. Every insurer must 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.

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

- Current good health of the insured must not be required for reinstatement if the request otherwise meets the requirements of this section.

c. An insurer must permit an insured to waive his or her right to designate an additional person to receive notice of lapse or termination for nonpayment of premium.

- The waiver must be in writing, dated, and signed by the applicant or insured.

- No less frequently than once in every 24 months, the insured must be permitted to revoke this waiver and to name a designee.

d. **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.

Waiver of premium

"Waiver of premium"- A waiver of premium allows the policyholder to stop paying premiums after a designated time following the start of policy-covered care. Some policies will waive premiums after a certain number of "days in facility." Others will waive premiums after a certain number of "covered benefit days." If a policyholder has a 90-day waiver of premium, after 90 days of covered care, he will no longer have to pay policy premiums. (If the policy also had a 20-day elimination period, however, it would be 110 days before policy premiums no longer need to be paid.)

Guaranteed Renewable - All long term care policies are guaranteed renewable. The insurance company cannot nonrenew the policy and they only can cancel the policy for nonpayment of premium or fraud. This does not prevent them from raising rates.

Rate increases

An insurance company may raise rates on policies but only on a classification basis. i.e., age, gender, zip code, not on an individual basis.

Plan Replacement Considerations

Suitability Standards

An insurance company must have suitability standards in place. Long term care policies are a terrific product but if someone cannot afford the premiums, it is wrong for them. The reason for insurance is protection, long term care protects an insureds assets from being disbursed to cover costs of care. If there are no assets to protect this becomes an added expense for only the reason of choices in care. There may be better alternatives for this client. You will need to ask about a client's income and assets; too low and the policy is not suitable because it is unaffordable and Medicaid will cover the costs. What if a relative wants to pay for the coverage? This could keep the client off Medicaid, and they would have choices should they ever need assistance.

Substantial assets and income means your client may need an LTCI policy to protect those assets. There are cases where a person can pay out of pocket for the care needed, but that is very rare.

What about somewhere in the middle? Do they plan on spending down the assets in order to have Medicaid pay for care that may or may not be needed? Do they understand the drawbacks of Medicaid? It is not 'free', Medicaid can take assets in return for coverage, even after death. The choices are not there with Medicaid in reference to facilities, you get the next bed where it is available. Long term care insurance gives you these choices. Do they want to protect the assets to leave to family members?

Alternatives to replacing a policy

Instead of total replacement of a policy with another newer version, see if a rider with the new coverage can be added to the existing policy. A policy is charged at the rate of the age you were when first purchased it. Replacing a policy will increase your premium immediately and maybe not for a better benefit.

Replacement forms and documentation

Each state will have documentation for the replacement. Washington's is as follows and is not specific to long term care insurance but covers all forms of disability insurance in WA. The point of replacement paperwork is to make sure the client has access to information they can review later that shows them if, in fact, this new product is better than the old one and they should continue or stop and keep the old plan. Insureds don't always hear/understand/remember that a preexisting condition could be excluded and that if they keep the old policy that condition could be covered.

WAC 284-50-430 Requirements for replacement.

(1) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other disability insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(2) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection (3) of this section. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in subsection (4) of this section. In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

(3) The notice required by subsection (2) of this section for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

notice to applicant regarding replacement of accident and sickness insurance

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

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

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

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

. . . .

(Date)

. . . .

(Applicants' Signature)

Medicare

Skilled Care versus Custodial Care (not covered).

The type of long-term care required by the individual depends on his condition. Types of long-term care can be divided into two broad categories-- long-term health care (Skilled Nursing Care) and personal care (Custodial Care).

Skilled (Nursing) Care is required daily and must be performed by a skilled medical practitioner (i.e., nurse). A Registered Nurse must be on duty 24 hours a day.

Custodial Care (a.k.a. Personal Care) is for people who do not need ongoing medical services, but rather need help with what are known as "**Activities of Daily Living**" (ADLs)-- such as eating, dressing, bathing, toileting, transferring and continence. This is the type of care that is most needed by the elderly.

This type of care is not covered by Medicare

Rules governing hospital discharges to skilled nursing.

Medicare will cover a skilled nursing facility for 20 days at no charge ONLY after a beneficiary has been admitted to the hospital for 3 consecutive days. Keep in mind a person may be in the hospital under observation but not be admitted (under part A). If this is the case and they are sent to a skilled nursing facility, Medicare will not pay.

Medicare Part A (Hospital Insurance) (Part A covers inpatient hospital stays, care in a skilled nursing facility (SNF), hospice care, and some home health care.) covers skilled nursing care in certain conditions for a limited time (on a short-term basis) if all of these conditions are met:

- You have Part A and have days left in your benefit period to use.
- You have a qualifying hospital stay:
    - Time that you spend in a hospital as an outpatient before you're admitted doesn't count toward the 3 inpatient days you need to have a qualifying hospital stay for SNF benefit purposes.
    - Observation services aren't covered as part of the inpatient stay.
    - You must enter the SNF within a short time (generally 30 days) of leaving the hospital and require skilled services related to your hospital stay.
    - After you leave the SNF, if you re-enter the same or another SNF within 30 days, you don't need another 3-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days.
- Your doctor has decided that you need daily skilled care. It must be given by, or under the supervision of, skilled nursing or therapy staff.
- You get these skilled services in a SNF that's certified by Medicare.
- You need these skilled services for a medical condition that's either:
    - A hospital-related medical condition treated during your qualifying 3-day inpatient hospital stay (not including the day you leave the hospital), even if it wasn't the reason you were admitted to the hospital.
    - A condition that started while you were getting care in the SNF for a hospital-related medical condition (for example, if you develop an infection that requires IV antibiotics while you're getting SNF care)

Medicare restrictions (first 100 days).

- Days 1–20: $0 for each benefit period
- Days 21–100: $185.50 coinsurance per day of each benefit period.

What it is

Skilled care is nursing and therapy care that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel. It's health care given when you need skilled nursing or skilled therapy to treat, manage, and observe your condition, and evaluate your care.

Medicare-covered services include, but aren't limited to:

- Semi-private room (a room you share with other patients)
- Meals
- Skilled nursing care
- Physical therapy (if needed to meet your health goal)
- Occupational therapy (if needed to meet your health goal)
- Speech-language pathology services (if they're needed to meet your health goal)
- Medical social services
- Medications
- Medical supplies and equipment used in the facility
- Ambulance transportation (when other transportation endangers your health) to the nearest supplier of needed services that aren't available at the SNF
- Dietary counseling
- Swing bed services

Medicaid

Overview

Medicaid is a health insurance that is funded by state and federal moneys and is administered by each state. Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities.

Resources

> *WAC 388-513-1315... Eligibility for long-term care (facility, home, hospice) a.k.a. (institutional, waiver, hospice) services.*
>
> *WAC 182-513-1315 General eligibility requirements for long-term care (LTC) programs.*

This section lists the sections in this chapter that describe how the agency determines a person's eligibility for long-term care services. These sections are:

(1) WAC **182-513-1316** General eligibility requirements for long-term care (LTC) programs.

(2) WAC **182-513-1317** Income and resource criteria for an institutionalized person.

(3) WAC **182-513-1318** Income and resource criteria for home and community based (HCB) waiver programs and hospice.

(4) WAC **182-513-1319** State-funded programs for noncitizens who are not eligible for a federally funded program.

WAC 182-513-1316 General eligibility requirements for long-term care (LTC) programs.

(1) To be eligible for long-term care (LTC) services, a person must:

(a) Meet the general eligibility requirements for medical programs under WAC **182-503-0505**, except:

(i) An adult age nineteen or older must meet citizenship and immigration status requirements under WAC **182-503-0535** (2)(a) or (b);

(ii) A person under age nineteen must meet citizenship and immigration status requirements under WAC **182-503-0535** (2)(a), (b), (c), or (d); and

(iii) If a person does not meet the requirements in (a)(i) or (ii) of this subsection, the person is not eligible for medicaid and must have eligibility determined under WAC **182-513-1319**.

(b) Attain institutional status under WAC **182-513-1320**;

(c) Meet the functional eligibility under:

(i) Chapter **388-106** WAC for a home and community services (HCS) home and community based (HCB) waiver or nursing facility coverage; or

(ii) Chapter **388-828** WAC for developmental disabilities administration (DDA) HCB waiver or institutional services; and

(d) Meet either:

(i) SSI-related criteria under WAC **182-512-0050**; or

(ii) MAGI-based criteria under WAC **182-503-0510**(2), if residing in a medical institution. A person who is eligible for MAGI-based coverage is not subject to the provisions under subsection (2) of this section.

(2) A supplemental security income (SSI) recipient or a person meeting SSI-related criteria who needs LTC services must also:

(a) Not have a penalty period of ineligibility due to the transfer of assets under WAC **182-513-1363**;

(b) Not have equity interest in a primary residence greater than the home equity standard under WAC **182-513-1350**; and

(c) Disclose to the agency or its designee any interest the applicant or spouse has in an annuity, which must meet annuity requirements under chapter **182-516** WAC.

(3) A person who receives SSI must submit a signed health care coverage application form attesting to the provisions under subsection (2) of this section. A signed and completed eligibility review for LTC benefits can be accepted for people receiving SSI who are applying for long-term care services.

(4) To be eligible for HCB waiver services, a person must also meet the program requirements under:

(a) WAC **182-515-1505** through **182-515-1509** for HCS HCB waivers; or

(b) WAC 182-515-1510 through 182-515-1514 for DDA HCB waivers.

WAC 182-513-1317 Income and resource criteria for an institutionalized person.

(1) This section provides an overview of the income and resource eligibility rules for a person who lives in an institutional setting.

(2) To determine income eligibility for an SSI-related long-term care (LTC) applicant under the categorically needy (CN) program, the agency, or its designee:

(a) Determines available income under WAC **182-513-1325** and **182-513-1330**;

(b) Excludes income under WAC **182-513-1340**; and

(c) Compares remaining available income to the special income level (SIL) defined under WAC **182-513-1100**. A person's available income must be equal to or less than the SIL to be eligible for CN coverage.

(3) To determine income eligibility for an SSI-related LTC client under the medically needy (MN) program, the agency or its designee follows the income standards and eligibility rules under WAC **182-513-1395**.

(4) To be resource eligible under the SSI-related LTC CN or MN program, the person must:

(a) Meet the resource eligibility requirements under WAC **182-513-1350**;

(b) Not have a penalty period of ineligibility due to a transfer of assets under WAC **182-513-1363**;

(c) Disclose to the state any interest the person or the person's spouse has in an annuity, which must meet the annuity requirements under chapter **182-516** WAC.

(5) A resident of eastern or western state hospital is eligible for medicaid if the person:

(a) Has attained institutional status under WAC **182-513-1320**; and

(b) Is under age twenty-one; or

(c) Applies for or receives inpatient psychiatric treatment in the month of the person's twenty-first birthday that will likely continue through the person's twenty-first birthday, and can receive coverage until:

(i) The facility discharges the person; or

(ii) The end of the month in which the person turns age twenty-two, whichever occurs first; or

(d) Is at least age sixty-five.

(6) To determine long-term care CN or MN income eligibility for a person eligible under a MAGI-based program, the agency or its designee follows the rules under chapter **182-514** WAC.

(7) There is no asset test for MAGI-based LTC programs under WAC **182-514-0245**.

(8) The agency or its designee determines a person's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For an SSI-related person residing in a medical institution, see WAC **182-513-1380**;

(b) For an SSI-related person on a home and community based waiver, see chapter **182-515** WAC.

WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice.

(1) This section provides an overview of the income and resource eligibility rules for a person to be eligible for a categorically needy (CN) home and community based (HCB) waiver program under chapter **182-515** WAC or the hospice program under WAC **182-513-1240** and **182-513-1245**.

(2) To determine income eligibility for an SSI-related long-term care (LTC) HCB waiver, the agency, or its designee:

(a) Determines income available under WAC **182-513-1325** and **182-513-1330**;

(b) Excludes income under WAC **182-513-1340**;

(c) Compares remaining gross nonexcluded income to:

(i) The special income level (SIL) defined under WAC **182-513-1100**; or

(ii) For HCB service programs authorized by the aging and long-term supports administration (ALTSA), a higher standard is determined following the rules under WAC **182-515-1508** if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

(3) A person who receives MAGI-based coverage is not eligible for HCB waiver services unless found eligible based on program rules in chapter **182-515** WAC.

(4) To be resource eligible under the HCB waiver program, the person must:

(a) Meet the resource eligibility requirements and standards under WAC **182-513-1350**;

(b) Not be in a period of ineligibility due to a transfer of asset penalty under WAC **182-513-1363**;

(c) Disclose to the state any interest the person or that person's spouse has in an annuity and meet the annuity requirements under chapter **182-516** WAC.

(5) The agency or its designee determines a person's responsibility to pay toward the cost of care for LTC services as follows:

(a) For people receiving HCS HCB waiver services, see WAC **182-515-1509**;

(b) For people receiving DDA HCB waiver services, see WAC **182-515-1514**.

(6) To be eligible for the CN hospice program, see WAC **182-513-1240**.

(7) To be eligible for the MN hospice program in a medical institution, see WAC 182-513-1245.

WAC 182-513-1319 State-funded programs for noncitizens who are not eligible for a federally funded program.

(1) This section describes the state-funded programs available to a person who does not meet the citizenship and immigration status criteria under WAC **182-513-1316** for federally funded coverage.

(2) If a person meets the eligibility and incapacity criteria of the medical care services (MCS) program under WAC **182-508-0005**, the person may receive nursing facility care or state-funded residential services in an alternate living facility (ALF).

(3) Noncitizens age nineteen or older may be eligible for the state-funded long-term care services program under WAC **182-507-0125**. A person must be preapproved by the aging and long-term support administration (ALTSA) for this program due to enrollment limits.

(4) Noncitizens under age nineteen who meet citizenship and immigration status under WAC **182-503-0535** (2)(e) are eligible for:

(a) Nursing facility services if the person meets nursing facility level of care; or

(b) State-funded personal care services if functionally eligible based on a department assessment under chapter **388-106** or **388-845** WAC.

Transfer of Assets May 1, 2006, forward - WAC 388-513-1363 now WAC 182-513-1363

Evaluating an asset transfer for clients applying for or receiving long-term care (LTC) services.

(1) When determining a client's eligibility for long-term care (LTC) services, the medicaid agency or the agency's designee evaluates the effect of an asset transfer made within the sixty-month period before the month that the client:

(a) Attained institutional status, or would have attained institutional status but for a period of ineligibility; and

(b) Applied for LTC services.

(2) The agency or the agency's designee evaluates all transfers for recipients of LTC services made during or after the month the recipient attained institutional status.

(3) The agency or the agency's designee establishes a period of ineligibility during which the client is not eligible for LTC services if the client, the client's spouse, or someone acting on behalf of either:

(a) Transfers an asset within the time period under subsection (1) or (2) of this section; and

(b) There is uncompensated value because:

(i) Adequate consideration was not received for the asset, unless the transfer meets one of the conditions in subsection (4) of this section;

(ii) The transfer was compensated, but fails a requirement under subsection (4)(d)(iv) or (f) of this section; or

(iii) The transfer was determined to be an uncompensated asset transfer under chapter **182-516** WAC.

(4) The agency or the agency's designee does not apply a period of ineligibility for uncompensated value if:

(a) The total of all asset transfers in a month does not exceed the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later;

(b) The transferred asset was an excluded resource under WAC **182-513-1350** except a home, unless the transfer of the home meets the conditions under (d) of this subsection;

(c) The asset was transferred for less than fair market value (FMV), and the client can establish one of the following:

(i) An intent to transfer the asset at FMV. This intent is established by providing convincing evidence to the agency or the agency's designee;

(ii) The asset was transferred exclusively for a purpose other than to qualify for medicaid, continue to qualify for medicaid, or avoid estate recovery.

(A) An asset transfer is presumed to be for the purpose of establishing or continuing medicaid eligibility, avoiding estate recovery, or both;

(B) A client can rebut this presumption by providing convincing evidence that the transfer of an asset was exclusively for a purpose other than to qualify for medicaid, continue to qualify for medicaid, or avoid estate recovery.

(iii) All assets transferred for less than FMV have been returned to the client or the client's spouse; or

(iv) Denial of eligibility results in an undue hardship under WAC **182-513-1367**.

(d) The transferred asset was a home, if the home was transferred to the person's:

(i) Spouse;

(ii) Child who meets the disability criteria under WAC **182-512-0050** (1)(b) or (c);

(iii) Child who was under age twenty-one; or

(iv) Child who lived in the home and provided care, but only if:

(A) The child lived in the person's home for at least two years;

(B) The child provided verifiable care to that person during the time period in (d)(iv)(A) of this subsection for at least two years;

(C) The period of care under (d)(iv)(B) of this subsection was immediately before that person's current period of institutional status;

(D) The care was not paid for by medicaid;

(E) The care enabled that person to remain at home; and

(F) The physician's documentation verifies that the in-home care was necessary to prevent that person's current period of institutional status; or

(v) Sibling, who has lived in and has had an equity interest in the home for at least one year immediately before the date the person attained institutional status.

(e) The asset was transferred to the client's spouse; or to the client's or their spouse's child, if the child meets the disability criteria under WAC **182-512-0050** (1)(b) or (c);

(f) The transfer was to a family member before the current period of institutional status, and all the following conditions are met. If all the following conditions are not met, the transfer is an uncompensated transfer, regardless of consideration received:

(i) The transfer is in exchange for care services the family member provided to the client or their spouse;

(ii) The client or their spouse had a documented need for the care services provided by the family member;

(iii) The care services provided by the family member are allowed under the medicaid state plan or the department's home and community-based waiver services;

(iv) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(v) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(vi) The time for which care services are claimed is reasonable based on the kind of services provided; and

(vii) The assets were transferred as the care services were performed, with no more time delay than one calendar month between the provision of the service and the transfer.

(g) The transfer meets the conditions under subsection (5) of this section, and the asset is transferred:

(i) To another party for the sole benefit of the client's spouse;

(ii) From the client's spouse to another party for the sole benefit of the client's spouse;

(iii) To a trust established for the sole benefit of the client's or their spouse's child who meets the disability criteria under WAC **182-512-0050** (1)(b) or (c); or

(iv) To a trust established for the sole benefit of a person who is under age sixty-five who meets the disability criteria under WAC **182-512-0050** (1)(b) or (c).

(5) An asset transfer or establishment of a trust is for the sole benefit of a person under subsection (4)(g) of this section if the document transferring the asset:

(a) Was made in writing;

(b) Is irrevocable;

(c) States that the client's spouse, their blind or disabled child, or another disabled person can benefit from the transferred assets; and

(d) States that all assets involved must be spent for the sole benefit of the person over an actuarially sound period, based on the life expectancy of that person or the term of the document, whichever is less, unless the document is a trust that meets the conditions of a trust established under Section 42 U.S.C. 1396p (d)(4)(A) or Section 42 U.S.C. 1396 (d)(4)(C) as described under chapter **182-516** WAC.

(6) To calculate the period of ineligibility under subsection (3) of this section:

(a) Add together the total uncompensated value of all transfers under subsection (3) of this section; and

(b) Divide the total in (a) of this subsection by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility.

(7) The period of ineligibility under subsection (6) of this section begins:

(a) For an LTC services applicant: The date the client would be otherwise eligible for LTC services, but for the transfer, based on an approved application for LTC services or the first day after any previous period of ineligibility has ended; or

(b) For an LTC services recipient: The first of the month following ten-day advance notice of the period of ineligibility, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous period of ineligibility has ended.

(8) The period of ineligibility ends after the number of whole days, calculated in subsection (6) of this section, pass from the date the period of ineligibility began in subsection (7) of this section.

(9) If the transfer was to the client's spouse, from the client's spouse to the client, and it included the right to receive an income stream, the agency or the agency's designee determines availability of the income stream under WAC **182-513-1330**.

(10) If the transferred asset, for which adequate consideration was not received, included the right to receive a stream of income not generated by a transferred asset, the length of the period of ineligibility is calculated and applied in the following way:

(a) The amount of reasonably anticipated future monthly income, after the transfer, is multiplied by the actuarial life expectancy in months of the previous owner of the income. The actuarial life expectancy is based on age of the previous owner in the month the transfer occurs. If the client and their spouse co-owned the asset, the longer actuarial life expectancy is used. This product is the FMV of the asset;

(b) Any consideration received in return for the FMV of the asset under (a) of this subsection is subtracted to calculate the uncompensated value;

(c) The uncompensated value in (b) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility; and

(d) The period of ineligibility begins under subsection (7) of this section and ends under subsection (8) of this section.

(11) A period of ineligibility for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses have attained institutional status. When both spouses are institutionalized, the agency or the agency's designee divides the penalty equally between the two spouses. If one spouse is no longer subject to a period of ineligibility, the remaining period of ineligibility that applied to both spouses will be applied to the other spouse.

(12) Throughout this section, the date of an asset transfer is:

(a) For real property:

(i) The day the deed is signed by the grantor if the deed is recorded; or

(ii) The day the signed deed is delivered to the grantee.

(b) For all other assets, the day the intentional act or the failure to act resulted in the change of ownership or title.

(13) If a client or their spouse disagrees with the determination or application of a period of ineligibility, a hearing may be requested under chapter **182-526** WAC.

(14) Additional statutes that apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

(a) RCW **74.08.331** Unlawful practices—Obtaining assistance—Disposal of realty—Penalties;

(b) RCW **74.08.338** Real property transfers for inadequate consideration;

(c) RCW **74.08.335** Transfers of property to qualify for assistance; and

(d) RCW **74.39A.160** Transfer of assets—Penalties.

Resource (Asset) Eligibility Requirements - WAC 388-513-1350 now WAC 182-513-1350

Defining the resource standard and determining resource eligibility for SSI-related long-term care (LTC) services.

(1) General information.

(a) This section describes how the agency or its designee defines the resource standard and countable or excluded resources when determining a person's eligibility for SSI-related long-term care (LTC) services.

(b) "Resource standard" means the maximum amount of resources a person can have and still be resource eligible for program benefits.

(c) For a person not SSI-related, the agency applies program specific resource rules to determine eligibility.

(2) Resource standards.

(a) The resource standard for the following people is $2000:

(i) A single person; or

(ii) An institutionalized spouse.

(b) The resource standard for a legally married couple is $3000, unless subsection (3)(b)(ii) of this section applies.

(c) The resource standard for a person with a qualified long-term care partnership policy under WAC **182-513-1400** may be higher based on the dollar amount paid out by a partnership policy.

(d) Determining the amount of resources that can be allocated to the community spouse when determining resource eligibility is under WAC **182-513-1355**.

(3) Availability of resources.

(a) General. The agency or its designee applies the following rules when determining available resources for LTC services:

(i) WAC **182-512-0300** SSI-related medical—Resources eligibility;

(ii) WAC **182-512-0250** SSI-related medical—Ownership and availability of resources; and

(iii) WAC **182-512-0260** SSI-related medical—How to count a sponsor's resources.

(b) Married couples.

(i) When both spouses apply for LTC services, the resources of both spouses are available to each other through the month in which the spouses stopped living together.

(ii) When both spouses are institutionalized, the agency or its designee determines the eligibility of each spouse as a single person the month following the month of separation.

(iii) If the agency or its designee has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, but after eligibility has been established and services authorized for the institutionalized spouse, then the agency applies the standard under subsection (2)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the agency applies subsection (2)(b) of this section for the couple.

(iv) The resources of the community spouse are unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless (v) or (vi) of this subsection applies.

(v) When a single institutionalized individual marries, the agency or its designee redetermines eligibility applying the resource and income rules for a legally married couple.

(vi) A redetermination of the couple's resources under this section is required if:

(A) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;

(B) The institutionalized spouse's countable resources exceed the standard under subsection (2)(a) of this section, and WAC **182-513-1355** (2)(b) applies; or

(C) The institutionalized spouse does not transfer the amount, under WAC **182-513-1355** (3) or (5), to the community spouse by either:

(I) The end of the month of the first regularly scheduled eligibility review; or

(II) A reasonable amount of time necessary to obtain a court order for the support of the community spouse.

(4) Countable resources.

(a) The agency or its designee determines countable resources using the following sections:

(i) WAC **182-512-0200** SSI-related medical—Definition of resources.

(ii) WAC **182-512-0250** SSI-related medical—Ownership and availability of resources.

(iii) WAC **182-512-0260** SSI-related medical—How to count a sponsor's resources.

(iv) WAC **182-512-0300** SSI-related medical—Resources eligibility.

(v) WAC **182-512-0350** SSI-related medical—Property and contracts excluded as resources;

(vi) WAC **182-512-0400** SSI-related medical—Vehicles excluded as resources;

(vii) WAC **182-512-0450** SSI-related medical—Life insurance excluded as a resource; and

(viii) WAC **182-512-0500** SSI-related medical—Burial funds, contracts and spaces excluded as resources.

(ix) Chapter **182-516** WAC, Trusts, annuities, life estates, and promissory notes—Effect on medical programs.

(b) The agency or its designee determines excluded resources based on federal law and WAC **182-512-0550**, except:

(i) For institutional and HCB waiver programs, pension funds owned by a nonapplying spouse are counted toward the resource standard.

(ii) For long-term services and supports (LTSS), based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, one home is excluded only if it meets the home equity limits of subsection (8) of this section. See WAC **182-512-0350** (1)(b).

(c) The agency or its designee adds together the countable resources of both spouses if subsections (3)(b)(i) and (iv) apply, but not if subsection (3)(b)(ii) or (iii) apply. For a person with a community spouse, see WAC **182-513-1355**.

(5) Excess resources.

(a) For LTC programs, a person may reduce excess resources by deducting incurred medical expenses under subsection (6) of this section;

(b) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) In a medical institution, excess resources and available income must be under the state medicaid rate based on the number of days the person spent in the medical institution in the month.

(B) For HCB waiver eligibility, incurred medical expenses must reduce resources within allowable resource standards. The cost of care for the HCB waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program, see:

(A) WAC **182-513-1395** for LTC programs; and

(B) WAC **182-513-1245** for hospice.

(c) Excess resources not otherwise applied to medical expenses will be applied to the projected cost of care for services in a medical institution under WAC **182-513-1380**.

(6) Allowable medical expenses.

(a) The following incurred medical expenses may be used to reduce excess resources:

(i) Premiums, deductibles, coinsurance, or copayment charges for health insurance and medicare;

(ii) Medically necessary care defined under WAC **182-500-0070**, but not covered under the state's medicaid plan. Information regarding covered services is under chapter **182-501** WAC;

(iii) Medically necessary care defined under WAC **182-500-0070** incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the specific facility that provided the services.

(b) To be allowed, the medical expense must:

(i) Have been incurred no more than three months before the month of the medicaid application;

(ii) Not be subject to third-party payment or reimbursement;

(iii) Not have been used to satisfy a previous spenddown liability;

(iv) Not have been previously used to reduce excess resources;

(v) Not have been used to reduce participation;

(vi) Not have been incurred during a transfer of asset penalty under WAC **182-513-1363**; and

(vii) Be an amount for which the person remains liable.

(7) Nonallowable expenses. The following expenses are not allowed to reduce excess resources:

(a) Unpaid adult family home (AFH) or assisted living facility expenses incurred prior to medicaid eligibility;

(b) Personal care cost in excess of approved hours determined by the CARE assessment under chapter **388-106** WAC; and

(c) Expenses excluded by federal law.

(8) Excess home equity.

(a) A person with an equity interest in a primary residence in excess of the home equity limit is ineligible for long-term services and supports (LTSS) that are based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, unless one of the following persons lawfully resides in the home:

(i) That person's spouse; or

(ii) That person's dependent child under age twenty-one, blind child, or disabled child.

(b) The home equity provision applies to all applications for LTSS received on or after May 1, 2006.

(c) Effective January 1, 2016, the excess home equity limit is $552,000. On January 1, 2017, and on January 1st of each year thereafter, this standard may change by the percentage in the consumer price index - urban.

(d) A person who is denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver under WAC **182-513-1367**.

(9) Institutional resource standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

Treatment of Annuities April 1, 2009, forward - WAC 388-561-0201

WAC 388-561-0201 Annuities established on or after ((November)) April 1, ((2008)) 2009.

(1) The department determines how annuities affect eligibility for medical programs. Applicants and recipients of medicaid must disclose to the state any interest the applicant or spouse has in an annuity.

(2) A revocable annuity is considered an available resource.

(3) The following annuities are not considered ((available resources)) an available resource or a transfer of a resource as described in WAC 388-513-1363, if the annuity meets the requirements described in (4)(d), (e) and (f) of this subsection:

(a) An annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986;

(b) Purchased with proceeds from an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code of 1986;

(c) Purchased with proceeds from a simplified employee pension (within the meaning of section 408 of the Internal Revenue Code of 1986); or

(d) Purchased with proceeds from a Roth IRA described in section 408A of the Internal Revenue Code of 1986.

(4) The purchase of an annuity not described in subsection (3) established on or after ((November)) April 1, ((2008)) 2009, will be considered as an available resource unless it:

(a) Is immediate, irrevocable, nonassignable; and

(b) Is paid out in equal monthly amounts with no deferral and no balloon payments:

(i) Over a term equal to the actuarial life expectancy of the annuitant; or

(ii) Over a term that is not less than five years if the actuarial life expectancy of the annuitant is at least five years; or

(iii) Over a term not less than the actuarial life expectancy of the annuitant if the actuarial life expectancy of the annuitant is less than five years.

(iv) Actuarial life expectancy shall be determined by tables that are published by the office of the chief actuary of the social security administration (http://www.ssa.gov/OACT/STATS/table4c6.html).

(c) Is issued by an individual, insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established;

(d) Names the state as the remainder beneficiary when the ((applicant)) purchaser of the annuity is the annuitant and is an applicant for or recipient of medicaid, or a community spouse of an applicant for or recipient of long-term care or waiver services:

(i) In the first position for the total amount of medical assistance paid for the individual, including both long-term care services and waiver services; or

(ii) In the second position for the total amount of medical assistance paid for the individual, including both long-term care services and waiver services, if there is a community spouse, or a minor or disabled child as defined in WAC 388-475-0050 (b) and (c) who is named as the beneficiary in the first position.

(e) Names the state as the beneficiary upon the death of the community spouse for the total amount of medical assistance paid on behalf of the individual at any time of any payment from the annuity if a community spouse is the annuitant;

(f) Names the state as the beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual at the time of any payment from the annuity, including both long-term care

services and waiver services, unless the annuitant has a community spouse or minor or disabled child, as defined in WAC 388-475-0050 (b) and (c). If the annuitant has a community spouse or minor or disabled child, such spouse or child may be named as beneficiary in the first position, and the state shall be named as beneficiary in the second position:

(i) If the community spouse, minor or disabled child, or representative for a child named as beneficiary is in the first position as described in (f) and transfers his or her right to receive payments from the annuity for less than fair market value, then the state shall become the beneficiary in the first position.

(5) If the annuity is not considered a resource, the stream of income produced by the annuity is considered available income.

(6) An irrevocable annuity established on or after ((November)) April 1, ((2008)) 2009 that meets all of the requirements of subsection (4) except that it is not immediate or scheduled to be paid out in equal monthly amounts will not be treated as a resource if:

(a) The full pay out is within the actuarial life expectancy of the annuitant; and

(b) The annuitant:

(i) Changes the scheduled pay out into equal monthly payments within the actuarial life expectancy of the annuitant; or

(ii) Requests that the department calculate and budget the payments as equal monthly payments within the actuarial life expectancy of the annuitant beginning with the month of eligibility. The income from the annuity remains unearned income to the annuitant.

(7) An irrevocable annuity, established on or after ((November)) April 1, ((2008)) 2009 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource.

(8) An irrevocable annuity established on or after ((November)) April 1, ((2008)) 2009 that meets all of the requirements of subsection (4) or (5) is considered unearned income when the annuitant is:

(a) The client;

(b) The spouse of the client;

(c) The blind or disabled child, as defined in WAC 388-475-0050 (b) and (c), of the client; or

(d) A person designated to use the annuity for the sole benefit of the client, client's spouse, or a blind or disabled child of the client.

(9) An annuity is not considered an available resource when there is a joint owner, co-annuitant or an irrevocable beneficiary who will not agree to allow the annuity to be cashed, unless the joint owner or irrevocable beneficiary is the community spouse. In the case of a community spouse, the cash surrender value of the annuity is considered an available resource and counts toward the maximum community spouse resource allowance.

(10) Nothing in this section shall be construed as preventing the department from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity other than an annuity described in subsections (3), (4), and (5).

Long Term Care Partnership Asset Designation - DSHS 10 (12/2011)

This form is to assist in determining the amount of asset protection available under the partnership program

Medicaid Estate Recovery - WAC 182-527-2700 to 2740

182-527-2730 Definitions.

The following definitions apply to this chapter:

"Contract health service delivery area (CHSDA)" means the geographic area within which contract health services will be made available by the Indian health service to members of an identified Indian community who reside in the area as identified in 42 C.F.R. Secs. 136.21(d) and 136.22.

"Estate" means all property and any other assets that pass upon the client's death under the client's will or by intestate succession under chapter **11.04** or **11.62** RCW. The value of the estate will be reduced by any valid liability against the client's property when the client died. An estate also includes:

(1) For a client who died after June 30, 1995, and before July 27, 1997, nonprobate assets as defined by RCW **11.02.005**, except property passing through a community property agreement; or

(2) For a client who died after July 26, 1997, and before September 14, 2006, nonprobate assets as defined by RCW **11.02.005**.

(3) For a client who died on or after September 14, 2006, nonprobate assets as defined by RCW **11.02.005** and any life estate interest held by the client immediately before death.

"Heir" means a person entitled to inherit a deceased client's property under a valid will accepted by the court, or a person entitled to inherit under the Washington state intestacy statute, RCW **11.04.015**.

"Life estate" means an ownership interest in a property only during the lifetime of the person owning the life estate.

"Lis pendens" means a notice filed in public records warning that title to certain real property is in litigation and the outcome of the litigation may affect the title.

"Long-term care services (LTC)" means, for the purposes of this chapter only, the services administered directly or through contract by the department of social and health services (DSHS) for clients of the home and community services division of DSHS and the developmental disabilities administration of DSHS including, but not limited to, nursing facility care and home and community services.

"Property" means everything a person owns, whether in whole or in part.

(1) **"Personal property"** means any movable or intangible thing a person owns, whether in whole or in part;

(2) **"Real property"** means land, and anything growing on, attached to, or built on it, excluding anything that may be removed without injury to the land;

(3) **"Trust property"** means any type of property held in trust for the benefit of another.

"Qualified long-term care insurance partnership" means an agreement between the Centers for Medicare and Medicaid services (CMS) and the Washington state insurance commission which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of a person who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(C)(iii) of the act.

"Recover" or **"recovery"** means the agency or the agency's designee's receipt of funds to satisfy the client's debt.

182-527-2734 Liens during a client's lifetime.

For the purposes of this section, the term "agency" includes the agency's designee.

(1) **When the agency may file.**

(a) The agency may file a lien against the property of a Washington apple health client during the client's lifetime if:

(i) The client resides in a skilled nursing facility, intermediate care facility for individuals with an intellectual disability, or other medical institution under WAC **182-500-0050**;

(ii) The agency determines that a client cannot reasonably be expected to return home because:

(A) The agency receives a physician's verification that the client will not be able to return home; or

(B) The client has resided for six months or longer in an institution as defined in WAC **182-500-0050**; and

(iii) None of the following people lawfully reside in the client's home:

(A) The client's spouse or state-registered domestic partner;

(B) The client's child who is age twenty or younger, or is blind or permanently disabled as defined in WAC **182-512-0050**; or

(C) A client's sibling who has an equity interest in the home and who has been residing in the home for at least one year immediately before the client's admission to the medical institution.

(b) If the client returns home from the medical institution, the agency releases the lien.

(2) **Amount of the lien.**

(a) The agency may file a lien to recoup the cost of all non-MAGI-based and deemed eligible services under WAC **182-503-0510** it correctly purchased on the client's behalf, regardless of the client's age on the date of service.

(b) Services provided under the medicaid transformation project, defined in WAC **182-500-0070**, are excluded when determining the amount of the lien.

(3) **Notice requirement.**

(a) Before the agency may file a lien under this section, it sends notice via first class mail to:

(i) The client's last known address;

(ii) The client's authorized representative, if any;

(iii) The address of the property subject to the lien; and

(iv) Any other person known to hold title to the property.

(b) The notice states:

(i) The client's name;

(ii) The agency's intent to file a lien against the client's property;

(iii) The county in which the property is located; and

(iv) How to request an administrative hearing.

(4) **Interest assessed on past-due debt.**

(a) Interest on a past-due debt accrues at a rate of one percent per month under RCW **43.17.240**.

(b) A lien under this section becomes a past-due debt when the agency has recorded the lien in the county where the property is located and:

(i) Thirty days have passed since the property was transferred; or

(ii) Nine months have passed since the lien was filed.

(c) The agency may waive interest if reasonable efforts to sell the property have failed.

(5) **Administrative hearing.** An administrative hearing under this section is governed by WAC **182-527-2753**.

182-527-2738 Estate recovery—General right to recover.

For the purposes of this section, the term "agency" includes the agency's designee.

(1) **When the agency may file.** After a Washington apple health client has died, the medicaid agency may file liens to recover the cost of services subject to recovery that were correctly paid on the client's behalf.

(2) **Notice requirement.**

(a) Before the agency may file a lien under this section, it sends notice via first class mail as follows:

(i) If the estate has a personal representative, the agency sends notification to:

(A) The personal representative; and

(B) Any known title holder.

(ii) If the estate has known heirs but no personal representative, the agency sends notification to:

(A) Any known heir; and

(B) Any known title holder.

(iii) If the estate has no personal representative and no known heirs, the agency sends notification to:

(A) The address listed on the title; and

(B) Any known title holder.

(b) The notice states:

(i) The agency's intent to file a lien against the deceased client's property;

(ii) The amount the agency seeks to recover;

(iii) The deceased client's name, identification number, date of birth, and date of death;

(iv) The county in which the property is located; and

(v) How to request an administrative hearing.

(3) **The agency may not recover from the client's estate so long as there remains**:

(a) A surviving spouse; or

(b) A surviving child who:

(i) Is age twenty or younger; or

(ii) Is blind or disabled as defined in WAC **182-512-0050**.

(4) **Interest assessed on past-due debt**.

(a) Interest on a past-due debt accrues at a rate of one percent per month under RCW **43.17.240**.

(b) A lien under this section becomes a past-due debt when the agency has recorded the lien in the county where the property is located and nine months have passed since the lien was recorded or a creditor's claim was filed, whichever is sooner.

(c) The agency may waive interest if reasonable efforts to sell the property have failed.

(5) **Administrative hearing.** An administrative hearing under this section is governed by WAC **182-527-2753**.

182-527-2740 Estate recovery—Age-related limitations.

For the purposes of this section, the term "agency" includes the agency's designee.

(1) **Liability for medicaid services.**

(a) Beginning July 26, 1987, a client's estate is liable for medicaid services subject to recovery that were provided on or after the client's sixty-fifth birthday.

(b) Beginning July 1, 1994, a client's estate is liable for medicaid services subject to recovery that were provided on or after the client's fifty-fifth birthday.

(2) **Liability for state-only-funded long-term care services.**

(a) A client's estate is liable for all state-only-funded long-term care services provided by the home and community services division of the department of social and health services (DSHS) on or after July 1, 1995.

(b) A client's estate is liable for all state-only-funded long-term care services provided by the developmental disabilities administration of DSHS on or after June 1, 2004.

182-527-2742 Estate recovery—Service-related limitations.

For the purposes of this section, the term "agency" includes the agency's designee.

The agency's payment for the following services is subject to recovery:

(1**) State-only funded services, except**:

(a) Adult protective services;

(b) Offender reentry community safety program services;

(c) Supplemental security payments (SSP) authorized by the developmental disabilities administration (DDA); and

(d) Volunteer chore services.

(2) **For dates of service on and after January 1, 2014**:

(a) Basic plus waiver services;

(b) Community first choice (CFC) services;

(c) Community option program entry system (COPES) services;

(d) Community protection waiver services;

(e) Core waiver services;

(f) Hospice services;

(g) Intermediate care facility for individuals with intellectual disabilities services provided in either a private community setting or in a rural health clinic;

(h) Individual and family services;

(i) Medicaid personal care services;

(j) New Freedom consumer directed services;

(k) Nursing facility services;

(l) Personal care services funded under Title XIX or XXI;

(m) Private duty nursing administered by the aging and long-term support administration (ALTSA) or the DDA;

(n) Residential habilitation center services;

(o) Residential support waiver services;

(p) Roads to community living demonstration project services;

(q) The portion of the managed care premium used to pay for ALTSA-authorized long-term care services under the program of all-inclusive care for the elderly (PACE); and

(r) The hospital and prescription drug services provided to a client while the client was receiving services listed in this subsection.

(3) **For dates of service beginning January 1, 2010, through December 31, 2013:**

(a) Medicaid services;

(b) Premium payments to managed care organizations (MCOs); and

(c) The client's proportional share of the state's monthly contribution to the Centers for Medicare and Medicaid Services to defray the costs for outpatient prescription drug coverage provided to a person who is eligible for medicare Part D and medicaid.

(4) **For dates of service beginning June 1, 2004, through December 31, 2009:**

(a) Medicaid services;

(b) Medicare premiums for people also receiving medicaid;

(c) Medicare savings programs (MSPs) services for people also receiving medicaid; and

(d) Premium payments to MCOs.

(5) **For dates of service beginning July 1, 1995, through May 31, 2004:**

(a) Adult day health services;

(b) Home and community-based services;

(c) Medicaid personal care services;

(d) Nursing facility services;

(e) Private duty nursing services; and

(f) The hospital and prescription drug services provided to a client while the client was receiving services listed in this subsection.

(6) **For dates of service beginning July 1, 1994, through June 30, 1995:**

(a) Home and community-based services;

(b) Nursing facility services; and

(c) The hospital and prescription drug services provided to a client while the client was receiving services listed in this subsection.

(7**) For dates of service beginning July 26, 1987, through June 30, 1994: Medicaid services.**

(8**) For dates of service through December 31, 2009.** If a client was eligible for the MSP, but not otherwise medicaid eligible, the client's estate is liable only for any sum paid to cover medicare premiums and cost-sharing benefits.

(9) **For dates of service beginning January 1, 2010**. If a client was eligible for medicaid and the MSP, the client's estate is not liable for any sum paid to cover medical assistance cost-sharing benefits.

(10) **For dates of service beginning July 1, 2017, long-term services and supports authorized under the medicaid transformation project are exempt from estate recovery. Exempted services include those provided under:**

(a) Medicaid alternative care under WAC **182-513-1600**;

(b) Tailored supports for older adults under WAC **182-513-1610**;

(c) Supportive housing under WAC **388-106-1700** through **388-106-1765**; or

(d) Supported employment under WAC **388-106-1800** through **388-106-1865**.

182-527-2746 Estate recovery—Asset-related limitations.

For the purposes of this section, the term "agency" includes the agency's designee.

(1) **Before July 25, 1993.** For services received before July 25, 1993, that are subject to recovery, the agency may exempt:

(a) The first fifty thousand dollars of the estate's value at the time of the client's death; and

(b) Sixty-five percent of the remaining value of the estate.

(2) **July 24, 1993, through June 30, 1994.** For services that are subject to recovery that were received on or after July 25, 1993, through June 30, 1994, the agency exempts two thousand dollars' worth of personal property.

(3) **Life estate.**

(a) The agency may file a lien against a client's life estate interest in real property.

(b) The agency's lien against the property may not exceed the value of the client's life estate. Under this subsection, value means the fair market value of the property multiplied by the life estate factor that corresponds to the client's age on the client's last birthday. For a list of life estate factors, see the life estate and remainder interest tables maintained by the Social Security Administration.

(c) The agency may not enforce a lien under this subsection against any property right that vested before July 1, 2005.

(4) **Joint tenancy.**

(a) The agency may file a lien against property in which a client was a joint tenant when the client died.

(b) The agency's lien against the property may not exceed the value of the client's interest in the property. Under this subsection, value means the fair market value of the property divided by the number of joint tenants on the day the client died.

(c) The agency may not enforce a lien under this subsection against any property right that vested before July 1, 2005.

(5) **Qualified long-term care partnership.**

(a) Assets designated as protected by a qualified long-term care partnership (QLong Term CareP) policy issued after November 30, 2011, may be disregarded for estate recovery purposes if:

(i) The insured person's estate is the recipient of the estate recovery exemption; or

(ii) The insured person holds title to property which is potentially subject to a predeath lien and that person asserts the property is protected under the QLong Term CareP policy.

(b) A person must provide clear and convincing evidence to the office of financial recovery that the asset in question was designated as protected, including:

(i) Proof of a valid QLong Term CareP policy;

(ii) Verification from the Long Term Care insurance company of the dollar amount paid out by the policy; and

(iii) A current department of social and health services QLong Term CareP asset designation form when the QLong Term CareP policy paid out more than was previously designated.

(c) The insured person's estate must provide clear and convincing evidence proving an asset is protected before the final recovery settlement.

(6) **Rules specific to American Indians and Alaska natives.**

(a) Certain properties belonging to American Indians/Alaska natives (AI/AN) are exempt from estate recovery if at the time of death:

(i) The deceased client was enrolled in a federally recognized tribe; and

(ii) The estate or heir documents the deceased client's ownership interest in trust or nontrust real property and improvements located on a reservation, near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior, or located:

(A) Within the most recent boundaries of a prior federal reservation; or

(B) Within the contract health service delivery area boundary for social services provided by the deceased client's tribe to its enrolled members.

(b) Protection of trust and nontrust property under subsection (4) of this section is limited to circumstances when the real property and improvements pass from an Indian (as defined in 25 U.S.C. Chapter 17, Sec. 1452(b)) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses and stepchildren, that their tribe would nonetheless recognize as family members, to a tribe or tribal organization and/or to one or more Indians.

(c) Certain AI/AN income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) are exempt from estate recovery by other laws and regulations.

(d) Ownership interests in or usage rights to items that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

(e) Government reparation payments specifically excluded by federal law in determining eligibility are exempt from estate recovery as long as such funds have been kept segregated and not commingled with other countable resources and remain identifiable.

182-527-2750 Estate recovery—Delay of recovery for undue hardship.

For the purposes of this section, the term "agency" includes the agency's designee.

(1) If an undue hardship exists at the time of the client's death, an heir may ask the agency to delay recovery.

(a) Undue hardship exists only when:

(i) The property subject to recovery is the sole income-producing asset of an heir;

(ii) Recovery would deprive an heir of shelter and the heir cannot afford alternative shelter; or

(iii) The client is survived by a state-registered domestic partner.

(b) Undue hardship does not exist if the client or the heir created circumstances to avoid estate recovery.

(2) If the agency determines recovery would cause an undue hardship for an heir, the agency may delay recovery until the hardship no longer exists.

(3) If the agency denies an heir's request to delay recovery, the agency notifies the heir in writing. The notice includes instructions on how to request a hearing.

(4) If the agency grants a delay of recovery under this section, the heir must:

(a) Timely comply with any agency request for information or records;

(b) Not sell, transfer, or encumber the property;

(c) Reside on the property;

(d) Timely pay property taxes and utilities;

(e) Insure the property for its fair market value;

(f) Name the state of Washington as the primary payee on the property insurance policy;

(g) Provide the agency with a copy of the property insurance policy upon request;

(h) Continue to satisfy the requirements in subsection (1) of this section.

(5) If the heir dies, or violates any provision of subsection (4) of this section, the agency may begin recovery.

(6) If the agency denies the request, the heir may request an administrative hearing under WAC **182-527-2753**.

182-527-2753 Hearings.

For the purposes of this section, the term "agency" includes the agency's designee.

(1) An administrative hearing to contest action under this chapter determines only:

(a) In the case of a lien filed during the client's lifetime under WAC **182-527-2734**:

(i) Whether the client can reasonably be expected to return home from the medical institution;

(ii) Whether the client, or the client's estate, holds legal title to the identified property; and

(iii) Whether the client received services subject to recovery.

(b) In the case of a lien filed after the client's death:

(i) The cost the agency correctly paid for services subject to recovery;

(ii) Whether the client, or the client's estate, holds legal title to the identified property; and

(iii) Whether the agency's denial of an heir's request for a delay of recovery for undue hardship under WAC **182-527-2750** was correct.

(2) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the agency's proposed action;

(c) Be signed by the requestor and include the client's name, the requestor's address, and telephone number; and

(d) Within twenty-eight days of the date on the agency's notice, be filed with the office of financial recovery either:

(i) In person at the Office of Financial Recovery, 712 Pear St. S.E., Olympia, WA 98504-0001; or

(ii) By certified mail, return receipt requested, to Office of Financial Recovery, P.O. Box 9501, Olympia, WA 98507-9501.

(3) Upon receiving a request for an administrative hearing, the office of administrative hearings notifies any known titleholder of the time and place of the administrative hearing.

(4) An administrative hearing under this subsection is governed by chapters **34.05** RCW and **182-526** WAC and this section. If a provision in this section conflicts with a provision in chapter **182-526** WAC, the provision in this section governs.

(5) Disputed assets must not be distributed while in litigation.

(6) Absent an administrative or court order to the contrary, the agency may file a lien twenty-eight calendar days after the date the agency mailed notice of its intent to file a lien.

Web sources:

www.hca.wa.gov
www.dshs.wa.gov
www.washingtonlawhelp.org

Washington Long Term Care Laws and Regulations

Washington Long Term Care Partnership Rules:

Purpose and Authority WAC 284-83-400

WAC 284-83-400 through **284-83-420** is adopted pursuant to RCW **48.85.030** and **48.85.040**. The purpose of these sections is to effectuate chapter **48.85** RCW, the Washington Long-Term Care Partnership Act. Pursuant to RCW **48.85.030**, these sections establish 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 partnership insurance policies to include: Contracts, certificates, riders, and endorsements.

Applicability and Scope WAC 284-83-405

(1) WAC **284-83-400** through **284-83-420** applies to any qualified long-term care insurance partnership policy, as defined by federal law and this chapter.

(2) These sections do not apply to medicare supplement policies regulated under chapters **48.66** RCW and 284-55 or **284-66** WAC; policies or contracts between a continuing care retirement community and its residents; or to long-term care insurance policies that are not intended to provide asset protection under chapter **48.85** RCW.

(3) Policies that do not meet the requirements of the Washington Long-Term Care Partnership Act and the requirements of this chapter may not be advertised, issued, or delivered in this state as partnership policies.

Benefit Triggers WAC 284-83-140

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

> (a) "**Qualified long-term care services**" means services that meet the requirements of Section 7702B (c)(1) of the Internal Revenue Code of 1986, as amended, including: Necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b)(i) "**Chronically ill individual**" has the meaning of Section 7702B (c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(A) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or (B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. (ii) The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner certified that the individual meets these requirements.

(c) "**Licensed health care practitioner**" means a physician, as defined in Section 1861 (r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the federal Secretary of the Treasury.

(d) "**Maintenance or personal care services**" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(2) A qualified long-term care insurance policy must pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(3) A qualified long-term care insurance policy must condition the payment of benefits on a determination that the insured is a chronically ill individual as defined in subsection (1)(b)(i) of this section.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (3) of this section must be performed by a licensed or certified physician, registered professional nurse, licensed social worker, or other individual who meet requirements prescribed by the federal Secretary of the Treasury.

(5) Certifications required pursuant to subsection (3) of this section may be performed by a licensed health care professional at the direction of the issuer as is reasonably necessary with respect to a specific claim; except that when a licensed health care practitioner has certified that the insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period. Certified on 10/25/2019 WAC 284-83-140 Page 1 (6) Qualified long-term care insurance policies must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Minimum standards for Partnership policies-includes inflation requirements WAC 284-83-410

Every long-term care partnership policy must meet the standards for long-term care policies or contracts in chapters **48.83** and **48.85** RCW and this chapter, unless specifically provided otherwise.

(1) As used in WAC **284-83-400** through **284-83-420**, "qualified long-term care partnership policy" or "partnership policy" means a long-term care policy that meets all of the following additional requirements:

(a) The policy was issued on or after January 1, 2012, or exchanged as provided in WAC **284-83-415** on or after January 1, 2012, and covers an insured who was a resident of this state or of another state that has entered into a reciprocal agreement with this state when coverage first became effective under the policy.

(b) The policy is a tax qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)).

(c) The policy provides at least the following levels of inflation protection:

(i) If the policy is sold to an individual who has not attained age sixty-one as of the date of purchase, the policy must provide automatic annual compounded inflation increases at a rate not less than three percent or automatic annual compounded inflation increases at a rate based on changes in the consumer price index.

(ii) If the policy is sold to an individual who has attained age sixty-one but has not attained age seventy-six as of the date of purchase, the policy must provide automatic simple inflation increases at a rate not less than three percent or automatic inflation increases at a rate based on changes in the consumer price index.

(iii) If the policy is sold to an individual who has attained age seventy-six as of the date of purchase, the policy may, but is not required to, provide automatic inflation increases at a rate based on changes in the consumer price index.

(iv) If the change in the consumer price index is a negative number for the time period in question, the carrier may not apply the change in the index to reduce the benefit payable under the partnership policy. However, the carrier may offset this negative number against the next annual increase in the consumer price index to reduce the automatic inflation increase which would otherwise occur during that year. If the negative consumer price index exceeds the next annual increase in the consumer price index, it may be offset against multiple annual increases, the net effect of which may never be less than zero.

(v) For purposes of this section, "consumer price index" means the consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

(2) Issuers must file a long-term care insurance policy for approval for use as a partnership policy. The long-term care Partnership Policy Certification Form must be completed and accompany the request for approval. The form is available on the commissioner’s web site: www.insurance.wa.gov.

(3) Issuers requesting to make use of a previously approved policy form as a qualified state long-term care partnership policy must:

(a) Submit to the commissioner a Partnership Policy Certification Form signed by an officer of the company; and

(b) File for approval an amendatory rider or endorsement indicating the policy is partnership qualified.

(4) An issuer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, must provide to each prospective applicant a Partnership Program Notice found on the commissioner’s web site: www.insurance.wa.gov, outlining the requirements and benefits of a partnership policy. The Partnership Program Notice must be provided with the required outline of coverage.

(5) A partnership policy issued for delivery in Washington must be accompanied by a Partnership Status Disclosure Notice found on the commissioner’s web site: www.insurance.wa.gov, explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified Washington state long-term care insurance partnership policy. The Partnership Disclosure Notice must also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for medicaid.

Partnership policy exchange or replacement WAC 284-83-415

(1) Within one year of the date that an issuer begins to advertise, market, offer, or sell policies that qualify under the Washington state long-term care partnership program, the issuer must offer to all of its current policyholders and certificate holders the opportunity to exchange their existing long-term policy for a policy that is intended to qualify under the state's long-term care partnership program provided that:

(a) The existing long-term care policy was issued on or after February 8, 2006; and

(b) The existing long-term care policy is the type certified by the issuer for purposes of the state long-term care partnership program.

(2) In making an offer to exchange, an issuer must comply with the following requirements:

(a) The offer must be made on a nondiscriminatory basis without regard to the age or health status of the insured; and

(b) The offer must remain open for a minimum of ninety days from the date of mailing by the issuer.

(3) An exchange occurs when an issuer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a long-term care partnership policy, and the insured accepts the offer to terminate the existing policy and accepts the new policy.

(4) Notwithstanding subsections (1), (2), and (3) of this section:

(a) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and

(b) An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the issuer's long-term care underwriting guidelines.

(5) If the partnership policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then the following requirements apply:

(a) The partnership policy must not be underwritten; and

(b) The rate charged for the partnership policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

(6) If the partnership policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then the following requirements apply:

(a) The issuer must apply its long-term care underwriting guidelines to the increased benefits only; and

(b) The rate charged for the partnership policy must be determined using the method set forth in subsection (5)(b) of this section for the existing benefits, increased by the rate for the increased benefits using the then current attained age and risk class of the insured for the increased benefits only.

(7) The partnership policy offered in an exchange must be on a form that is currently offered for sale by the issuer in the general market.

(8) In the event of an exchange, the insured must not lose any rights, benefits, or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy including, but not limited to, rights established because of the lapse of time related to preexisting condition exclusions, elimination periods, or incontestability clauses.

(9) Issuers may complete an exchange by either issuing a new policy or by amending an existing policy with an endorsement or rider. An issuer must file such endorsement or rider for approval prior to issue.

(10) For those insureds with long-term care policies issued before February 8, 2006, an issuer may offer an insured the option to exchange an existing policy for a policy that qualifies as a Washington state long-term partnership policy. The requirements set forth in subsections (2) through (9) of this section apply to any such exchange.

(11) Policies issued pursuant to this section shall be considered exchanges and not replacements and are not subject to WAC **284-83-060** through **284-83-070**.

Overview of WA Long Term Care Insurance Laws and Regulations RCW 48-83, WAC 284-83

General Required provisions. WAC 284-83-020

Standards for policy provisions.

The following standards for policy provisions apply to all long-term care insurance policies delivered or issued for delivery in this state.

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" must not be used in any individual long-term care insurance policy or certificate without further explanatory language in accordance with the disclosure requirements of WAC **284-83-035**.

> (a) A policy or certificate issued to an individual must not contain renewal provisions other than "guaranteed renewable" or "noncancellable."
>
> (b) The term "guaranteed renewable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, if the issuer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and the issuer cannot decline to renew, except that rates may be revised by the issuer on a class basis.
>
> (c) The term "noncancellable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the issuer has no right to unilaterally make any change in any provision of the insurance and has no right to unilaterally make any change in the premium rate.
>
> (d) The term "level premium" may be used only if the issuer does not have the right to change the premium.
>
> (e) In addition to the other requirements of this subsection, a qualified long-term care insurance policy or certificate must be guaranteed renewable, within the meaning of Section 7702B (b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and exclusions. A long-term care policy or certificate shall not be delivered or issued for delivery in this state as long-term care insurance if it limits or excludes coverage by type of illness, treatment, medical condition, or accident, except for the following permitted exclusions:

> (a) Preexisting conditions or diseases;
>
> (b) Alcoholism and drug addiction;

(c) Illness, treatment, or medical condition arising out of war or act of:

(i) War (whether declared or undeclared);

(ii) Participation in a felony, riot, or insurrection;

(iii) Service in the armed forces or units auxiliary thereto;

(iv) Suicide (while sane or insane), attempted suicide, or intentionally self-inflicted injury; or

(v) Aviation (this exclusion applies only to nonfare-paying passengers);

(d) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under medicare or other governmental program (except medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

(e) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(f) In the case of a qualified long-term care insurance policy only, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

(g) Issuers may not prohibit, exclude, or limit services based on type of provider or limit a coverage if services are provided in a state other than the state where the policy was originally issued, except:

(i) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, unless the provider satisfies the policy requirements outlined for providers in lieu of licensure certificate or registration; or

(ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

(iii) Issuers may exclude or limit payment for services provided outside the United States or permit or limit benefit levels to reflect legitimate variations or differences in provider rates, but issuers must cover services that would be covered in the state of issue irrespective of any licensing, registration, or certification requirements for providers in the other state. In other words, if the claim would be approved but for the licensing issue, the claim must be approved for payment.

(3) Extension of benefits. Termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The 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 policy waiting period, and all other applicable provisions of the policy.

(4) Continuation or conversion. Group long-term care insurance issued in this state on or after January 1, 2009, must provide covered individuals with a basis for continuation or conversion of coverage.

(a) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

(i) Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy.

(ii) The commissioner will make a determination as to the substantial equivalency of benefits, and in doing so, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(b) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, is entitled to the issuance of a converted policy by the issuer under whose group policy he or she is covered, without evidence of insurability.

(c) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities the commissioner, in making a determination as to the substantial equivalency of benefits, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(d) Written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the issuer not later than thirty-one days after termination of coverage under the group policy. The converted policy must be issued effective on the day following the termination of coverage under the group policy, and must be renewable annually.

(e) Except where the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured’s age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured’s age at inception of coverage under the group policy replaced.

(f) Continuation of coverage or issuance of a converted policy is mandatory, except where:

(i) Termination of group coverage resulted from an individual’s failure to make any required payment of premium or contribution when due; or

(ii) The terminating coverage is replaced not later than thirty-one days after termination by group coverage effective on the day following the termination of coverage and the replacement coverage provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and the premium is calculated in a manner consistent with the requirements of (e) of this subsection.

(g) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted

policy, would result in payment of more than one hundred percent of incurred expenses. The provision may only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(h) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, do not exceed those that would have been payable had the individual's coverage under the group policy remained in full force and effect.

(i) Notwithstanding any other provision of this section, the insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person must be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(5) Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding issuer must offer coverage to all insured persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the issuer and premiums charged to persons under the new group policy:

(a) Must not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(b) Must not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

(6)(a) The premium charged to the insured must not increase due to either the increasing age of the insured at ages beyond sixty-five or the duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase; but for purposes of the calculation required under WAC **284-83-090**, the portion of the premium attributable to the additional coverage must be added to and considered part of the initial annual premium.

(c) A reduction in benefits shall not be considered a premium change; but for purposes of the calculation required under WAC **284-83-090**, the initial annual premium must be based on the reduced benefits.

(7) Electronic enrollment for group policies.

(a) In the case of a group, as defined in RCW **48.83.020** (6)(a), any requirement that a signature of the insured be obtained by an insurance producer or issuer will be deemed satisfied only if:

(i) The consent is obtained by telephonic or electronic enrollment by the group policyholder or issuer and verification of enrollment information is provided to the insured;

(ii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information is maintained.

(b) Upon request of the commissioner, the issuer must make available records that demonstrate the issuer's ability to confirm enrollment and coverage amounts.

(8) Each long-term care policy delivered or issued for delivery to any person in this state must clearly indicate on its first page that it is a "long-term care insurance" policy.

Guaranteed Renewable WAC 284-83-030

Required disclosure provisions.

(1) Renewability. Long-term care insurance policies must contain a renewability provision.

(a) The renewability provision must be appropriately captioned, must appear on the first page of the policy, and must clearly state that the coverage is guaranteed renewable or noncancellable. This provision does not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder, such as long-term care policies which are part of or combined with life insurance policies because life insurance policies generally do not contain renewability provisions.

(b) A long-term care insurance policy or certificate, other than one where the issuer does not have the right to change the premium, must include a statement that premium rates may change.

(2) Riders and endorsements.

(a) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after the date of issue, or at reinstatement or renewal, that reduce or eliminate benefits or coverage in the policy must require signed acceptance by the individual insured.

(b) After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in a writing signed by the insured, except when the increase in benefits or coverage is required by law.

(c) If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy, rider, or endorsement.

(3) Payment of benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import, must include a definition and explanation of the terms in its accompanying outline of coverage, as set forth in WAC **284-83-145**.

(4) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the policy or certificate and must be labeled as "preexisting condition limitations."

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited under chapter **48.83** RCW, must set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and must label that paragraph "limitations or conditions on eligibility for benefits."

(6) Disclosure of tax consequences. At the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, a life insurance policy or certificate that provides an accelerated benefit for long-term care must disclose that receipt of the accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently displayed on the first page of the policy, certificate or rider and any other related documents. This subsection does not apply to qualified long-term care insurance policies.

(7) Benefit triggers. Activities of daily living and cognitive impairment shall be used to measure the insured's need for long-term care and must be described in the policy or certificate in a separate paragraph labeled "eligibility for the payment of benefits." Any additional benefit triggers must be explained in the same section.

(a) If benefit triggers differ for different benefits, a clear explanation of the benefit trigger must accompany each benefit description.

(b) If an attending physician or other specified person is required to certify a certain level of functional dependency in order for the insured to be eligible for benefits, this must be specified.

(8) A qualified long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC **284-83-145**, that the policy is intended to be a qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC **284-83-145**, that the policy is not intended to be a qualified long-term care insurance policy.

Levels of care WAC 284-83-015, RCW 48.83.020 (5)

Standards for policy definitions and terms.

A long-term care insurance policy or certificate delivered or issued for delivery in this state must not use the following terms unless the terms are defined in the policy or certificate and the definitions satisfy the following standards. This section specifies minimum standards for several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

(1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(2) "Acute condition" means that the individual is medically unstable. An individual with an acute condition requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Adult day care" or "adult day health care" means a program of social or 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 home.

(4) "Bathing" means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

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

(6) "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(7) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(8) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

(9) "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

(10) "Home health care services" means medical and nonmedical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

(11) "Managed-care plan" or "plan of care" means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(12) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(13) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(14) "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care" and other services must be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(15) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(16) "Transferring" means moving into or out of a bed, chair, or wheelchair.

(17) "Skilled nursing facility," "nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," "home care agency" and terms used to identify other providers of services must be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified, or registered, it must also state what requirements a provider must meet in lieu of licensure, certification, or registration if the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or if the state licenses, certifies or registers the provider of services under another name.

RCW 48.83.020 Definitions.

(5) "Long-term care insurance" means an insurance policy, contract, or rider that is advertised, marketed, offered, or designed to provide coverage for at least twelve consecutive months for a covered person. Long-term care insurance may be on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Long-term care insurance includes any policy, contract, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(a) Long-term care insurance includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. However, long-term care insurance does not include life insurance policies that: (i) Accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement; (ii) provide the option of a lump sum payment for those benefits; and (iii) do not condition the benefits or the eligibility for the benefits upon the receipt of long-term care.

(b) Long-term care insurance also includes qualified long-term care insurance contracts.

(c) Long-term care insurance does not include any insurance policy, contract, or rider that is offered primarily to provide coverage for basic medicare supplement, basic hospital expense, basic medical-surgical expense, hospital confinement indemnity, major medical expense, disability income, related income, asset protection, accident only, specified disease, specified accident, or limited benefit health.

Medicaid - relationship to Long-Term Care WAC 284-83-155 (2)

Producer responsibilities

The following are a few items that are important for producers to do at the time of application as well as time of delivery:

Health statements WAC 284-83-155

Prohibited practices.

The following practices are prohibited:

(1) No insurance producer or other representative of the issuer may complete the medical history portion of any form or application, including an electronic application, for the purchase of a long-term care policy.

(2) No issuer or insurance producer or other representative of the issuer may knowingly sell a long-term care policy to any person who is receiving medicaid.

(3) No issuer or insurance producer or other representative of the issuer may use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of long-term care policies.

Disclosure WAC 284-83-030

See: Guaranteed Renewable WAC 284-83-030 on page ***Error! Bookmark not defined.***

Free Look RCW 48.83.060

Right to return policy or certificate—Refund.

(1) Long-term care insurance applicants may return a policy or certificate for any reason within thirty days after its delivery and to have the premium refunded.

(2) All long-term care insurance policies and certificates shall have a notice prominently printed on or attached to the first page of the policy stating that the applicant may return the policy or certificate within thirty days after its delivery and to have the premium refunded.

(3) Refunds or denials of applications must be made within thirty days of the return or denial.

(4) This section shall not apply to certificates issued pursuant to a policy issued to a group defined in RCW **48.83.020**(6)(a).

Determining Suitability WAC 284-83-110, RCW 48.83.140

Suitability.

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

(2) Every issuer or other entity marketing long-term care insurance must:

(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(b) Train its insurance producers in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

(3)(a) To determine whether the applicant meets the standards developed by the issuer, the insurance producer and the issuer must develop procedures that take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(ii) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(iii) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(b) The issuer, and if an insurance producer is involved, the insurance producer must make reasonable efforts to obtain the information set out in subsection (2)(a) of this section. The efforts must include presentation to the applicant, at or prior to application, the "long-term care insurance personal worksheet." The personal worksheet used by the issuer must contain, at a minimum, the information in the format set forth in WAC **284-83-170**, in not less than twelve point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the form of the issuer's personal worksheet must be filed with the commissioner.

(c) Except for sales of employer-group long-term care insurance to employees and their spouses, a completed personal worksheet must be returned to the issuer prior to the issuer's consideration of the applicant for coverage.

(d) The sale, distribution, use or dissemination in any way by the issuer or insurance producer of information obtained through the personal worksheet is prohibited.

(4) The issuer must use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to the applicant is appropriate.

(5) Insurance producers must use the suitability standards developed by the issuer in all marketing or solicitation of long-term care insurance.

(6) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "things you should know before you buy long-term care insurance" must be provided. The form must be in the format set forth in WAC **284-83-175**, in not less than twelve point type.

(7) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer may send the applicant a letter similar to the form set forth in WAC **284-83-180**. If the applicant declines to provide financial information, the issuer may use another method to verify the applicant's intent. The applicant's returned letter or a record of the alternative method of verification must be made part of the applicant's file.

(8) The issuer must report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

Right to reduce coverage to lower the premium. WAC 284-83-125 (1)(a)

Right to reduce coverage and lower premiums.

(1)(a) Every long-term care insurance policy and certificate must include a provision that allows the policyholder or certificate holder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(i) Reducing the maximum benefit; or

(ii) Reducing the daily, weekly, or monthly benefit amount.

(b) The issuer may also offer other reduction options that are consistent with the policy or certificate design or the issuer's administrative processes.

(2) The provision must include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(3) The age to determine the premium for the reduced coverage must be based on the age used to determine the premiums for the coverage currently in force.

(4) The issuer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(5) If a policy or certificate is about to lapse, the issuer must provide a written reminder to the policyholder or certificate holder of his or her right to reduce coverage and premiums in the notice required by WAC **284-83-025** (1)(c).

(6) Compliance with this section may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy.

(7) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Unintentional lapse WAC 284-54-253 and WAC 284-83-025: 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.

WAC 284-83-025 Unintentional lapse.

As a protection against unintentional lapse, each issuer offering long-term care insurance must comply with all of the following:

(1)(a) Notice before lapse or termination. No individual long-term care policy or certificate may be issued until the issuer has received from the applicant either a written designation of at least one person in addition to the applicant to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

(i) The applicant has the right to designate at least one person to receive the notice of termination, in addition to the insured.

(ii) Designation does not constitute acceptance of any liability on the third party for services provided to the insured.

(iii) The form used for the written designation must provide space clearly designated for listing at least one person.

(iv) The designation must include each person's full name and home address.

(v) If the applicant elects not to designate an additional person, the waiver must state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty days after a premium is due and unpaid. I elect not to designate a person to receive this notice."

(vi) No less frequently than once every year the issuer must notify the insured of the right to change this written designation or to add a lapse designee, if the insured has not already designated a lapse designee.

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

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

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

(B) 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.

(b) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in (a) of this subsection need not be met until sixty days after the policyholder or certificate holder is no longer on the payment plan. The application or enrollment form for such policies or certificates must clearly show the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the issuer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to (a) of this subsection, at the address provided by the insured for purposes of receiving notice of lapse or termination.

(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 (c)(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 business 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.

(2) Reinstatement. In addition to the requirements in subsection (1) of this section, a long-term care insurance policy or certificate must include a provision that provides for reinstatement of coverage in the event of lapse if the issuer receives proof, as per the standards stated in (b) of this subsection, that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the policy's grace period expired.

(a) Reinstatement must be available to the insured if requested within five months after lapse. When appropriate, issuers may collect past due premiums as part of the reinstatement process as set forth in the policy or certificate.

(b) The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate.

Unfair and deceptive advertising WAC 284-83-105 WAC 284-83-105 Standards for marketing.

(1) Every issuer or entity marketing long-term care insurance coverage in this state, directly or through its insurance producers, must:

(a) Establish marketing procedures and insurance producer training requirements to ensure that:

(i) Any marketing activities, including any comparison of policies, by its insurance producers, other representatives, or employees are fair and accurate; and

(ii) Excessive insurance is not sold or issued.

(b) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following notice:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(c) Provide copies of the disclosure forms required in WAC **284-83-035**(3), **284-83-170** and **284-83-190** to the applicant.

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance. For qualified long-term care insurance policies, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has health care coverage is not required.

(e) Every issuer or other entity marketing long-term care insurance must establish auditable procedures for verifying compliance with this subsection.

(f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by its commissioner, at time of solicitation for long-term care insurance the issuer must provide written notice to the prospective policyholder and certificate holder that the counseling program is available and provide its name, address, and telephone number.

(g) For long-term care insurance policies, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to WAC **284-83-020** (1)(c).

(h) Provide an explanation of contingent benefit upon lapse provided for in WAC **284-83-130** (4)(c) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in WAC **284-83-130** (4)(d).

(2) In addition to the practices prohibited in chapters **48.30** RCW and **284-30** WAC, the following acts and practices are prohibited:

(a) Twisting, as defined in RCW **48.30.180**.

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(3)(a) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in RCW **48.83.020** (6)(b), when endorsing or selling long-term care insurance must be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations must provide objective information regarding long-term care insurance policies or certificates

endorsed or sold by the associations to ensure that members of the associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The issuer must file with the commissioner the following material:

(i) The policy and certificate;

(ii) A corresponding outline of coverage; and

(iii) All advertisements requested by the commissioner.

(c) The association must disclose in any long-term care insurance solicitation:

(i) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees, and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(ii) A brief description of the process under which the policies and the issuer issuing the policies were selected.

(d) If the association and the issuer have interlocking directorates or trustee arrangements, the association must disclose that fact to its members.

(e) The board of directors of associations selling or endorsing long-term care insurance policies or certificates must review and approve the insurance policies as well as the compensation arrangements made with the issuer.

(f) The association must also:

(i) At the time of the association's decision to endorse the selling of long-term care insurance policies or certificates, engage the services of a person with expertise in long-term care insurance not affiliated with the issuer to conduct an examination of the policies (including its benefits, features, and rates) and update the examination thereafter in the event of material change;

(ii) Actively monitor the marketing efforts of the issuer and its producers; and

(iii) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Subsections (3)(f)(i) through (f)(iii) of this section do not apply to qualified long-term care insurance policies.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the issuer files with the commissioner the information required in this subsection.

(h) The issuer must not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the issuer certifies annually that the association has complied with the requirements set forth in this section.

(i) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice.

Private insurance WAC 284-83

Individual vs. group 48.83.020(6)

(6) "Group long-term care insurance" means a long-term care insurance policy or contract that is delivered or issued for delivery in this state and is issued to:

(a) One or more employers; one or more labor organizations; or a trust or the trustees of a fund established by one or more employers or labor organizations for current or former employees, current or former members of the labor organizations, or a combination of current and former employees or members, or a combination of such employers, labor organizations, trusts, or trustees; or

(b) A professional, trade, or occupational association for its members or former or retired members, if the association:

(i) Is composed of persons who are or were all actively engaged in the same profession, trade, or occupation; and

(ii) Has been maintained in good faith for purposes other than obtaining insurance; or

(c)(i) An association, trust, or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Before advertising, marketing, or offering long-term care coverage in this state, the association or associations, or the insurer of the association or associations, must file evidence with the commissioner that the association or associations have at the time of such filing at least one hundred persons who are members and that the association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(A) The association or associations hold regular meetings at least annually to further the purposes of the members;

(B) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) The members have voting privileges and representation on the governing board and committees of the association.

(ii) Thirty days after filing the evidence in accordance with this section, the association or associations will be deemed to have satisfied the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements; [or]

(d) A group other than as described in (a), (b), or (c) of this subsection subject to a finding by the commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

Nursing home vs. home vs. community based care WAC 284-83-015, 050

WAC 284-83-015 Standards for policy definitions and terms.

A long-term care insurance policy or certificate delivered or issued for delivery in this state must not use the following terms unless the terms are defined in the policy or certificate and the definitions satisfy the following standards. This section specifies minimum standards for several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

(1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(2) "Acute condition" means that the individual is medically unstable. An individual with an acute condition requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Adult day care" or "adult day health care" means a program of social or 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 home.

(4) "Bathing" means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

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

(6) "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(7) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(8) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

(9) "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

(10) "Home health care services" means medical and nonmedical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

(11) "Managed-care plan" or "plan of care" means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(12) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(13) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(14) "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care" and other services must be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(15) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(16) "Transferring" means moving into or out of a bed, chair, or wheelchair.

(17) "Skilled nursing facility," "nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," "home care agency" and terms used to identify other providers of services must be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified, or registered, it must also state what requirements a provider must meet in lieu of licensure, certification, or registration if the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or if the state licenses, certifies or registers the provider of services under another name.

WAC 284-83-050 Minimum standards for home health and community care benefits in long-term care insurance policies.

(1) If a long-term care insurance policy or certificate provides benefits for home health care or community care services, it must not limit or exclude benefits:

(a) By requiring that the insured or claimant would need care in a nursing facility if home health care services were not provided;

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

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

(d) By requiring that a nurse or therapist provide services covered under the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

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

(f) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(g) By requiring that the insured or claimant have an acute condition before home health 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) If a long-term care insurance policy or certificate provides for home health or community care services, it must provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year’s coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.

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

(a) This permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy.

(b) Home health care benefits must not be restricted to a period of time which would make the benefit illusory. For example, fewer than three hundred sixty-five benefit days and less than a twenty-five dollar daily maximum benefit are considered illusory home health care benefits.

Prohibited provisions RCW 48.83.050

RCW 48.83.050 Prohibited policy terms and practices—Field-issued, defined.

No long-term care insurance policy may:

(1) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

(4) Condition eligibility for any benefits on a prior hospitalization requirement;

(5) Condition eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care;

(6) Condition eligibility for any benefits other than waiver of premium, postconfinement, postacute care, or recuperative benefits on a prior institutionalization requirement;

(7) Include a postconfinement, postacute care, or recuperative benefit unless:

(a) Such requirement is clearly labeled in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits"; and

(b) Such limitations or conditions specify any required number of days of preconfinement or postconfinement;

(8) Condition eligibility for noninstitutional benefits on the prior receipt of institutional care;

(9) A long-term care insurance policy or certificate may be field-issued if the compensation to the field issuer is not based on the number of policies or certificates issued. For purposes of this section, "field-issued" means a policy or certificate issued by a producer or a third-party administrator of the policy pursuant to the underwriting authority by an issuer and using the issuer's underwriting guidelines.

Underwriting considerations WAC 284-83-045

Prohibition against post-claims underwriting.

(1) All applications for long-term care insurance policies or certificates except those that are guaranteed issue must contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2)(a) If an application for long-term care insurance includes a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the prescribed medications.

(b) If the medications listed in the application were known by the issuer, or should have been known by the issuer at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate cannot be rescinded based on that condition.

(3) Except for policies or certificates which are guaranteed issue:

(a) The following language must be set out conspicuously and in close conjunction with the applicant's signature block on the application for a long-term care insurance policy or certificate:

"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, must be set out conspicuously on every long-term care insurance policy or certificate at the time of delivery:

"Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [Insert address]"

(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the issuer must obtain one of the following:

(i) A report of a physical examination;

(ii) An assessment of functional capacity;

(iii) An attending physician's statement; or

(iv) Copies of the applicant's medical records.

(4) A copy of the completed application or enrollment form (whichever is applicable) must be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(5) Every issuer or other entity selling or issuing long-term care insurance benefits must maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily requested, and must annually furnish this information to the commissioner. The format is prescribed by the National Association of Insurance Commissioners, and is set forth in WAC **284-83-165**.

Unfair claim practice WAC 284-30-330, 360. RCW 48.83.090. WAC 284-54-800(1)(2)(3)(4)(5)(9)

WAC 284-30-330 Specific unfair claims settlement practices defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance, specifically applicable to the settlement of claims:

(1) Misrepresenting pertinent facts or insurance policy provisions.

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

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

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

(5) Failing to affirm or deny coverage of claims within a reasonable time after fully completed proof of loss documentation has been submitted.

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to promptly pay property damage claims to innocent third parties in clear liability situations. If two or more insurers share liability, they should arrange to make appropriate payment, leaving to themselves the burden of apportioning liability.

(7) Compelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.

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

(9) Making a claim payment to a first party claimant or beneficiary not accompanied by a statement setting forth the coverage under which the payment is made.

(10) Asserting to a first party claimant a policy of appealing arbitration awards in favor of insureds or first party claimants 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 requiring a first party claimant or his or her physician to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

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

(14) Unfairly discriminating against claimants because they are represented by a public adjuster.

(15) Failing to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days after notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of a draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.

(16) Failing to adopt and implement reasonable standards for the processing and payment of claims after the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver payment, whether by check, draft, electronic funds transfer, prepaid card, or other method of electronic payment to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to a claimant, it must do so within twenty working days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to a first party claimant to identify the claimant or to obtain details concerning the claim.

WAC 284-30-360 Standards for the insurer to acknowledge pertinent communications.

(1) Within ten working days after receiving notification of a claim under an individual insurance policy, or within fifteen working days with respect to claims arising under group insurance contracts, the insurer must acknowledge its receipt of the notice of claim.

(a) If payment is made within that period of time, acknowledgment by payment constitutes a satisfactory response.

(b) If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(c) Notification given to an agent of the insurer is notification to the insurer.

(2) Upon receipt of any inquiry from the commissioner concerning a complaint, every insurer must furnish the commissioner with an adequate response to the inquiry within fifteen working days after receipt of the commissioner's inquiry using the commissioner's electronic company complaint system.

(3) For all other pertinent communications from a claimant reasonably suggesting that a response is expected, an appropriate reply must be provided within ten working days for individual insurance policies, or fifteen working days with respect to communications arising under group insurance contracts.

(4) Upon receiving notification of a claim, every insurer must promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within the time limits specified in subsection (1) of this section constitutes compliance with that subsection.

RCW 48.83.090 Denial of claims—Written explanation.

All long-term care denials must be made within thirty days after receipt of a written request made by a policyholder or certificate holder, or his or her representative. All denials of long-term care claims by the issuer must provide a written explanation of the reasons for the denial and make available to the policyholder or certificate holder all information directly related to the denial.

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.

(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.

