R 2025-06 Implementation of ESSB 5291 (Chapter 380, Laws of 2025) Supplemental Long-term Care Insurance

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NOTE: Within Ch. 284-83A WAC, new or alternative language relative to Ch. 284-83 WAC is highlighted in yellow. Sections in which language was removed without replacement relative to Ch. 284-83 WAC are highlighted in blue.

Chapter 284-83A WAC

SUPPLEMENTAL LONG-TERM CARE INSURANCE RULES

New Section. WAC 284-83A-005 Applicability and scope. (1) Except as otherwise specifically provided, this chapter applies to all supplemental long-term care insurance policies, contracts, or riders delivered or issued for delivery in this state on or after May 1, 2026, including qualified supplemental long-term care insurance policies and life insurance policies that accelerate benefits for supplemental long-term care. This chapter applies to insurance companies, fraternal benefit

societies, health care service contractors, health maintenance organizations and all other entities delivering or issuing for delivery any supplemental long-term care insurance policies, contracts, or riders (collectively called "issuers" in this chapter).

(2) Some sections of this chapter apply only to qualified supplemental long-term care insurance policies, as provided for by the Health Insurance Portability and Accountability Act of 1996 and by Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(3) This chapter applies to policies, contracts, or riders, delivered or issued for delivery in this state having indemnity benefits that are triggered by activities of daily living and sold as disability income or insurance, if:

(a) The benefits of the disability income or supplemental long-term care insurance policy are dependent upon or vary in amount based on the receipt of supplemental long-term care services; and

(b) The disability income policy, contract, or rider is advertised, marketed, or offered as insurance for supplemental long-term care or nursing home services; or

(c) Benefits under the policy commence after the policyholder has reached Social Security's normal retirement age, unless the benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

New Section. WAC 284-83A-010 Definitions. For the purpose of this chapter, the following definitions apply, unless the context clearly requires otherwise.

(1) “Applicant” has the meaning set forth in section 19, chapter 380, Laws of 2025.

(2)"Certificate" has the meaning set forth in section 19, chapter 380, Laws of 2025.

(2) "Exceptional increase" means only those increases filed by the issuer as exceptional for which the commissioner determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to supplemental long-term care coverage in this state; or due to increased and

unexpected utilization that affects the majority of issuers of similar products. Except as provided in WAC 284-83A-090, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, must also determine any potential offsets to higher claims costs.

(3) "Incidental," as used in WAC 284-83A-090, means a value of the supplemental long-term care benefits provided that is less than ten percent of the total value of the benefits provided over the life of the policy. These values must be measured as of the date of issue. In simple cases where the base policy and the supplemental long-term care benefits have separately identifiable premiums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

(4) "Group supplemental long-term care insurance" has the meaning set forth in section 19, chapter 380, Laws of 2025.

(5) "Guaranteed renewable" means that renewal of a supplemental long-term care insurance policy cannot be declined by the issuer for any reason except nonpayment of premiums, but the issuer can revise rates on a class basis.

(6) "Insured" means any beneficiary or owner of a supplemental long-term care insurance policy regardless of the type of issuer.

(7) "Issuer" has the meaning set forth in section 19, chapter 380, Laws of 2025.

(8) "NAIC" means the National Association of Insurance Commissioners.

(9) "Noncancellable" means that renewal of a supplemental long-term care insurance policy cannot be declined and rates cannot be revised by the issuer.

(10) "Policy" has the meaning set forth in section 19, chapter 380, Laws of 2025, unless the context clearly indicates otherwise, and includes certificates issued under a group supplemental long-term care insurance policy.

(11) "Qualified actuary" has the meaning set forth in WAC 284-05-060.

(12) "Qualified supplemental long-term care insurance" has the meaning set forth in section 19, chapter 380, Laws of 2025.

(13) "Similar policy forms" means all of the supplemental long-term care insurance policies and certificates issued by the issuer in the same supplemental long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 19(5)(a), chapter 380, Laws of 2025 are not considered similar to certificates or policies otherwise issued as supplemental long-term care insurance, but are similar to other comparable certificates with the same supplemental long-term care benefit classifications. For purposes of determining similar policy forms, supplemental long-term care benefit classifications are defined as follows: Institutional supplemental long-term care benefits only, noninstitutional supplemental long-term care benefits only, or comprehensive supplemental long-term care benefits.

(18) "Supplemental long-term care insurance" has the meaning set forth in section 19, chapter 380, Laws of 2025.

New Section. WAC 284-83A-015 Standards for policy definitions and terms. A supplemental 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 supplemental 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 the individual's 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 the approved services contained in RCW 50B.04.010, such as but not limited to in-home personal care, 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.

New Section. WAC 284-83A-020 Standards for policy provisions. The following standards for policy provisions apply to all supplemental 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 supplemental long-term care insurance policy or certificate without further explanatory language in accordance with the disclosure requirements of WAC 284-83A-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 supplemental 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 supplemental 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 supplemental 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 supplemental long-term care insurance policy or certificate shall not be delivered or issued for delivery in this state as supplemental 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, 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 supplemental long-term care insurance, long-term care insurance, or health insurance policy;

(f) In the case of a qualified supplemental 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 supplemental long-term care insurance must be without prejudice to any

benefits payable for institutionalization if the institutionalization began while the supplemental long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the supplemental 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 supplemental long-term care insurance issued in this state on or after May 1, 2026,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 non-managed 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 supplemental 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 supplemental 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 supplemental long-term care coverage is based upon their 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 supplemental long-term care insurance policy is replaced by another group supplemental long-term care insurance 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 supplemental 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 284-83A-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 284-83A-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 section 19(5)(a), chapter 380, Laws of 2025, 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 supplemental long-term care insurance policy delivered or issued for delivery to any person in this state must clearly indicate on its first page that it is a "supplemental long-term care insurance policy that provides coverage after the benefits provided under chapter 50B.04 RCW (the Long-Term Services and Supports Trust Program, also known as the WA Cares fund) have been exhausted."

New section. WAC 284-83A-025 Unintentional lapse. As a protection against unintentional lapse, each issuer offering supplemental long-term care insurance must comply with all of the following:

(1)(a) Notice before lapse or termination. No individual supplemental long-term care insurance 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 supplemental 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 supplemental 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 supplemental long-term care insurance 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 supplemental 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.

New Section. WAC 284-83A-030 Required disclosure provisions. (1) Renewability. Supplemental 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 supplemental long-term care insurance policies which are part of or combined with life insurance policies because life insurance policies generally do not contain renewability provisions.

(b) A supplemental 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 supplemental long-term care insurance policy, all riders or endorsements added to an individual supplemental 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 supplemental 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 284-83A-145.

(4) Limitations. If a supplemental 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 supplemental long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited under chapter 380, Laws of 2025 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 supplemental 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 supplemental 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 supplemental 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 supplemental long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC 284-83A-145, that the policy is intended to be a qualified supplemental long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

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

New Section. WAC 284-83A-035 Required disclosure of rating practices to consumers.

(1) Except for policies for which no applicable premium rate or rate schedule increases can be made, the issuer must provide all of the information listed in this subsection to the applicant at the time of application or enrollment. If the

method of application does not allow for delivery at that time, the issuer must provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate. For example, a method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(a) A statement that the policy may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(d) A general explanation for applying premium rate or rate schedule including:

(i) A description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date or next billing date); and

(ii) The right to a revised premium rate or rate schedule as provided for in (c) of this subsection if the premium rate or rate schedule is changed;

(e)(i) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) The policy forms for which premium rates have been increased;

(B) The calendar years when the form was available for purchase; and

(C) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(ii) The issuer, in a fair manner, may provide additional explanatory information related to the rate increases.

(iii) The issuer may exclude from the disclosure, premium rate increases that only apply to blocks of business acquired

from other nonaffiliated issuers or the supplemental long-term care insurance policies acquired from other nonaffiliated issuers when those increases occurred prior to the acquisition.

(iv) If the acquiring issuer files for a rate increase on a supplemental long-term care insurance policy form acquired from a nonaffiliated issuer or a block of policy forms acquired from a nonaffiliated issuer on or before the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring issuer may exclude that rate increase from the disclosure; however, the nonaffiliated selling issuer must include the disclosure of that rate increase in accordance with (e)(i) of this subsection.

(v) If the acquiring issuer in (e)(iv) of this subsection files for a subsequent rate increase at any time (including during the twenty-four-month period following the acquisition of the block or policies) on the same policy form acquired from a nonaffiliated issuer or block of policy forms acquired from a nonaffiliated issuer referenced in (e)(iv) of this subsection, the acquiring issuer must make all disclosures required by (e)

of this subsection, including disclosure of the earlier rate increase.

(vi) If the policy is for employer-group coverage, the disclosures in this subsection need to be made only to the employer if the employer is paying the entire premium and no contributions or coverage elections are made by individual employees.

(2) The applicant must sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the issuer made the disclosure required under subsection (1)(a) and (e) of this section. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant must sign no later than at the time of delivery of the policy or certificate.

(3) The forms provided in WAC 284-83A-170 and 284-83A-190 must be used by the issuer to comply with the requirements of subsections (1) and (2) of this section.

(4) The issuer must provide notice of an upcoming premium rate schedule increase to all policyholders or certificate

holders, as applicable, at least forty-five days prior to the implementation of any premium rate schedule increase by the issuer. The notice must include the information required by subsection (1) of this section when the rate increase is implemented.

New Section. WAC 284-83A-040 Initial form and rate filing requirements. An issuer shall not issue, deliver, or use a supplemental long-term care insurance policy, contract, rider, certificate, or application form unless it has been filed with and approved by the commissioner. The issuer must provide the following information to the commissioner for review and approval, prior to making a supplemental long-term care insurance policy, contract, rider, or certificate form available for sale in this state:

(1) A copy of each disclosure document required in WAC 284-83A-035; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for policy reserves that are anticipated to be held under the form, including:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating, where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or, if such a statement cannot be made, a complete description of the situations where this does not occur;

(A) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(B) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration based on a standard age distribution; and

(e)(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the issuer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the issuer with an explanation of the differences.

(3)(a) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration must include:

(i) Premium and claim experience on similar policy forms, adjusted for any premium or benefit differences;

(ii) Relevant and credible data from other studies; or

(iii) Both (a)(i) and (ii) of this subsection.

New Section. WAC 284-83A-045 Prohibition against post-claims underwriting. (1) All applications for supplemental 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 supplemental 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 supplemental 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 supplemental long-term care insurance policy or certificate at the time of delivery:

"Caution: The issuance of this supplemental 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 supplemental long-term care insurance 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 supplemental 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 set forth in WAC 284-83A-165.

New Section. WAC 284-83A-050 Minimum standards for home health and community care benefits in supplemental long-term care insurance policies. (1) Supplemental long-term care insurance policies, certificates, contracts, or riders must provide benefits for home health care or community care services. Supplemental long-term care insurance policies, certificates, contracts, or riders must not limit or exclude benefits for home health care or community care services:

(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 their 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;

(i) By excluding coverage for adult day care services; or

(j) By excluding coverage for family care providers.

(2) A supplemental long-term care insurance policy or certificate 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 supplemental 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.

New section. WAC 284-83A-053 Independent third-party review. (1) If an issuer makes a determination pursuant to section 26(2), chapter 380, Laws of 2025 that a policyholder's care and safety needs are not being met by the policyholder's current care setting or provider upon transition from the benefits provided under chapter 50B.04 RCW, the issuer must:

(a) Notify the policyholder in writing of the determination and the substantial clinical or other information supporting the determination;

(b) Notify the policyholder in writing of their right to appeal the determination and how such an appeal may be submitted by the policyholder; and

(c) Notify the policyholder in writing of the effective date of the change in care setting or provider, which must be effective 90 days after the transition from the benefits provided under chapter 50B.04 RCW.

(2) Issuers shall contract with at least one independent third-party reviewer who will adjudicate policyholder appeals. The

contracted independent third-party reviewer(s) must have expertise in long-term care insurance.

(3) Issuers shall notify the Commissioner annually by March 1 of the name and contact information of their contracted independent third-party reviewer(s).

(4) Issuers shall maintain a record of all policyholder appeals submitted pursuant to section 26(2), chapter 380, Laws of 2025 and must annually furnish this information to the commissioner, including if no policyholder appeals were received. The format is set forth in WAC 284-83A-054.

New section. WAC 284-83A-054 Form for reporting independent third party review decisions. The following form must be used by issuers to annually report independent third-party appeal decisions concerning changes made by issuers for supplemental long-term care policyholders under section 26(2) of chapter 380, Laws of 2025.

INDEPENDENT THIRD-PARTY APPEALS REPORTING FORM FOR SUPPLEMENTAL LONG-TERM CARE INSURANCE POLICYHOLDERS IN THE STATE OF WASHINGTON FOR THE REPORTING YEAR 20[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Independent Third-Party Reviewer Name:_____

Address: _____

_____

Phone Number: _____

Website Address: _____

Due: March 1, annually

Instructions: The purpose of this form is to report all independent third-party appeal requests and decisions. Please furnish one form per reviewer decision.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Issuer Determination	Date/s Request for Independent Review	Date/s of Independent Review Decision

Detailed reason for initial issuer determination and reviewer decision: _____

Signature

Name and Title (please type)

Date

New section. WAC 284-83A-055 Requirement to offer inflation protection. (1) No issuer may offer a supplemental long-term care insurance policy in this state unless the issuer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Issuers must offer to each

policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

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

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

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

(2) If the policy is issued to a group, the required offer in subsection (1) of this section must be made to the group

policyholder; however, if the policy is issued to a group defined in section 19(5)(d), chapter 380, Laws of 2025, other than to a continuing care retirement community, the offering must be made to each proposed certificate holder.

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

(4)(a) Issuers must include the following information in or with the outline of coverage:

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

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

(b) The issuer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure. For example, meaningful benefit minimums or durations could be demonstrated by showing increases to attained age, for a period

such as at least twenty years, for some multiple of the policy's maximum benefit, or throughout the period of coverage.

(5) Inflation protection benefit increases under a policy that includes these benefits must continue without regard to the insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

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

(7)(a) Inflation protection as provided in subsection (1)(a) of this section must be included in any supplemental long-term care insurance policy unless the issuer obtains a rejection of inflation protection signed by the policyholder. The rejection may be either part of the application or on a separate form.

(b) The rejection is considered a part of the application.

(c) The following language, or language substantially similar to the following, must be set out conspicuously on the rejection:

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

New Section. WAC 284-83A-060 Requirements for application forms and replacement coverage. (1) Application forms must include questions designed to elicit information as to whether, as of the date of the application, the applicant has another health, supplemental long-term care, or long-term care insurance policy or certificate in force or whether a supplemental long-term care insurance policy or certificate is intended to replace any other health, supplemental long-term care, or long-term care insurance policy or certificate presently in force.

(a) A supplementary application or other form, signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by section 19(5)(a), chapter 380, Laws of 2025, the required questions may be modified only to the extent necessary to elicit information about health, supplemental long-term care, or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

(b) The following questions, or words substantially similar to the following, must be used:

(i) "Do you have another health, supplemental long-term care, or long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?

(ii) Did you have another health, supplemental long-term care or long-term care insurance policy or certificate in force during the last twelve months? If so, with which company? If that policy lapsed, when did it lapse?

(iii) Are you covered by medicaid?

(iv) Do you intend to replace any of your medical, health, long-term care, or supplemental long-term care insurance coverage with this policy [certificate]?"

(2) Insurance producers must list any other health insurance policies they have sold to the applicant that are still in force and any similar policies sold in the past five years that are no longer in force.

(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, the issuer, other than an issuer using direct response solicitation methods, or its insurance producer, must furnish the applicant, prior to issuance or delivery of the individual supplemental long-term care insurance policy, a notice regarding replacement of health care, supplemental long-term care, or long-term care coverage. One copy of the notice must be retained by the applicant and an additional copy must be signed by the applicant and must be retained by the issuer. The notice set forth in WAC 284-83A-063 must be used.

(4) Direct response solicitations. Issuers using direct response solicitation methods must deliver a notice regarding replacement of health, supplemental long-term care, or long-term care coverage to the applicant upon issuance of the policy. The required notice set forth in WAC 284-83A-067 must be used.

(5) If replacement is intended, the replacing issuer must notify the existing issuer of the proposed replacement in writing. The existing policy must be identified by the issuer, including the name of the insured and policy number or address plus zip code. Notice must be made within five working days after the date the application is received by the issuer or the date the policy is issued, whichever is sooner.

(6) Life insurance policies that accelerate benefits for supplemental long-term care must comply with this section if the policy being replaced is a supplemental long-term care or long-term care insurance policy.

(a) If the policy being replaced is a life insurance policy, the issuer must comply with the replacement requirements of WAC 284-23-400 through 284-23-485.

(b) If a life insurance policy that accelerates benefits for supplemental long-term care or long-term care is replaced by a supplemental long-term care policy, the replacing issuer must comply with both the supplemental long-term care and the life insurance replacement requirements.

New Section. WAC 284-83A-063 Notice to applicant regarding replacement of individual accident and sickness, supplemental long-term care insurance, or long-term care insurance marketed by an insurance producer. The following notice is required in WAC 284-83A-060(3):

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL [ACCIDENT AND SICKNESS] [HEALTH] [SUPPLEMENTAL LONG-TERM CARE INSURANCE] OR [LONG-TERM CARE INSURANCE]

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing [accident and sickness] [health], [supplemental long-term care], or [long-term care] insurance and replace it with an individual

supplemental long-term care insurance policy to be issued by [company name] insurance company. Your new policy provides thirty days within which you may decide, without cost, whether you desire to keep the policy. 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.

You should review this new coverage carefully, comparing it with all [accident and sickness] [health], [supplemental long-term care], or [long-term care] insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this supplemental long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY [INSURANCE PRODUCER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance, and/or supplemental long-term care insurance coverage. I believe the replacement of insurance involved in this transaction materially

improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

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

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you are replacing existing supplemental long-term care or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its appointed [insurance producer] regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) 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 had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of [Insurance Producer] or Other Representative)

[Typed Name and Address of [Insurance Producer]]

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

(Applicant's Signature) (Date)

New section. WAC 284-83A-067 Notice to applicant regarding replacement of direct-marketed individual accident and sickness, supplemental long-term care insurance, or long-term care insurance. The following notice is required by WAC 284-83A-060(4):

NOTICE TO APPLICANT REGARDING REPLACEMENT OF [ACCIDENT AND SICKNESS] [HEALTH] [SUPPLEMENTAL LONG-TERM CARE INSURANCE] OR [LONG-TERM CARE INSURANCE]

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing [accident and sickness] [health] [supplemental long-term care] or [long-term care] insurance and replace it with the supplemental long-term care insurance policy delivered herewith issued by [company name] insurance company. Your new policy provides thirty days within which you may decide, without cost, whether you desire to keep the policy. 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.

You should review this new coverage carefully, comparing it with all [accident and sickness] [health], [supplemental long-term care], or [long-term care] insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this supplemental long-term care coverage is a wise decision.

(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 in payment of benefits under the

new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you are replacing existing supplemental long-term care or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its [agent] [insurance producer] regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

WAC 284-83A-070 Reporting requirements. (1) Every issuer must maintain records for each insurance producer of that producer's amount of replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of supplemental long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.

(2) Every issuer must report annually by June 30 the ten percent of its insurance producers with the highest percentages of lapses and replacements as measured by subsection (1) of this section on the form set forth in WAC 284-83A-195.

(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely insurance producer activities regarding the sale of supplemental long-term care insurance.

(4) Every issuer must report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end

of the preceding calendar year on the form set forth in WAC 284-83A-195.

(5) Every issuer must report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year on the form set forth in WAC 284-83A-195.

(6) Every issuer must report annually by June 30, for qualified supplemental long-term care insurance policies, the number of claims denied for each class of business, expressed as a percentage of claims denied on the form set forth in WAC 284-83A-185.

(7) As used in this section:

(a) "Policy" refers only to supplemental long-term care insurance policies;

(b) "Claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means that the issuer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Reports required under this section must be filed with the commissioner.

New Section. WAC 284-83A-075 Discretionary powers of commissioner. Upon written request and after an administrative hearing, the commissioner may enter an order to modify or suspend a specific provision or provisions of this chapter with respect to a specific supplemental long-term care insurance policy or certificate upon a written finding that:

(1) The modification or suspension would be in the best interest of the insureds;

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3)(a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

(b) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(c) The modification or suspension is necessary to permit supplemental long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

New Section. WAC 284-83A-080 Reserve standards. (1) If supplemental long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits must be determined in accordance with RCW 48.74.030(1)(g). Claim reserves must also be established in the case when the policy or rider is in claim status. Reserves for policies and riders subject to this subsection should be based on the multiple

decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of supplemental long-term care benefits; however, in no event shall the reserves for the supplemental long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no supplemental long-term care benefit. In the development and calculation of reserves for policies and riders subject to this subsection, due regard must be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(a) Definition of insured events;

(b) Covered supplemental long-term care facilities;

(c) Existence of home convalescence care coverage;

(d) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Premium waiver provision;

(g) Renewability;

(h) Ability to raise premiums;

(i) Marketing method;

(j) Underwriting procedures;

(k) Claims adjustment procedures;

(l) Waiting period;

(m) Maximum benefit;

(n) Availability of eligible facilities;

(o) Margins in claim costs;

(p) Optional nature of benefit;

(q) Delay in eligibility for benefit;

(r) Inflation protection provisions; and

(s) Guaranteed insurability option.

(2) If supplemental long-term care benefits are provided other than as provided in subsection (1) of this section, reserves must be determined in accordance with the accounting practices and procedures manuals adopted by the NAIC, unless otherwise provided by law, as required by RCW 48.05.073.

(3) Any applicable valuation morbidity table must be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

New Section. WAC 284-83A-090 Premium rate schedule increases. (1) The issuer shall not provide notice of a pending premium rate schedule increase, including an exceptional increase, unless it has been filed with and approved by the commissioner , prior to giving the notice to the policyholders and must include:

(a) Information required by WAC 284-83A-035;

(b) Certification by a qualified actuary that:

(i) If the requested premium rate schedule increase is implemented and the underlying assumptions which reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated;

(ii) The premium rate filing is in compliance with the provisions of this section;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(i) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.

(A) Annual values for the five years preceding and the three years following the valuation date must be provided separately.

(B) The projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase.

(C) The projections must demonstrate compliance with subsection (2) of this section.

(D) For exceptional increases:

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines that offsets may exist, the issuer must use appropriate net projected experience;

(ii) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the issuer have been relied on by the actuary;

(iv) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(v) Composite rates reflecting projections of new certificates, if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for

differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(e) Sufficient information for review of the premium rate schedule increase by the commissioner.

(2) All premium rate schedule increases must be determined in accordance with the following requirements:

(a) Exceptional increases must provide that seventy percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) The accumulated value of the initial earned premium times fifty-eight percent;

(ii) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) The present value of future projected initial earned premiums times fifty-eight percent; and

(iv) Eighty-five percent of the present value of future projected premiums not in (b)(iii) of this subsection on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in (b)(ii) and (iv) of this subsection will also include seventy percent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases must use the maximum valuation interest rate for policy reserves as specified in the accounting practices and procedures manuals adopted by the NAIC, except as otherwise provided by RCW 48.05.073. The actuary must disclose as part of the actuarial memorandum the use of any appropriate averages.

(3) For each rate increase that is implemented, the issuer must file for review by the commissioner updated projections, as defined in subsection (1)(c)(i) of this section, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to

greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions set forth in subsection (10) of this section, the projections required by this subsection may be provided to the policyholder in lieu of filing with the commissioner.

(4) If any premium rate in the revised premium rate schedule is greater than two hundred percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection (1)(c)(i) of this section, must be filed for review by the commissioner every five years following the end of the required period in subsection (3) of this section. For group insurance policies that meet the conditions in subsection (10) of this section, the projections required by this subsection may be provided to the policyholder in lieu of filing with the commissioner.

(5)(a) If the commissioner determines that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims

will not exceed proportions of premiums specified in subsection (2) of this section, the commissioner may require the issuer to implement either premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (1)(c)(v) of this section, as applicable.

(c) For purposes of this section:

(i) The term "adequately match the projected experience" requires more than a comparison between actual and projected incurred claims. Other assumptions should be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product.

(ii) It is to be expected that the actual experience will not exactly match the issuer's projections. During the period that projections are monitored, the commissioner will determine whether there is an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both

actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(6) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the issuer must file:

(a) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form, requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection (7) of this section; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (7) of this section, had the greater of the original anticipated lifetime loss ratio or fifty-eight percent been used in the calculations described in subsection (2)(b)(i) and (iii) of this section.

(7)(a) For a rate increase filing that meets the following criteria for all policies included in the filing, the commissioner must review the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(i) The rate increase is not the first rate increase requested for the specific policy form or forms;

(ii) The rate increase is not an exceptional increase; and

(iii) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the issuer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the issuer to offer all in-force insureds subject to the rate increase the option to replace existing coverage with one or

more reasonably comparable products being offered by the issuer or its affiliates without underwriting.

(i) The offer shall:

(A) Be subject to the approval of the commissioner;

(B) Be based on actuarially sound principles, but not be based on attained age; and

(C) Provide that maximum benefits under any new policy accepted by the insured must be reduced by comparable benefits already paid under the existing policy.

(ii) The issuer must maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase will be limited to the lesser of:

(A) The maximum rate increase determined based on the combined experience; and

(B) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent.

(8) If the commissioner determines that the issuer has exhibited a persistent practice of filing inadequate initial premium rates for supplemental long-term care insurance, in addition to the provisions of subsection (8) of this section, the commissioner may prohibit the issuer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(9) Subsections (1) through (8) of this section do not apply to policies for which the supplemental long-term care benefits provided by the policy are incidental, as defined in WAC 284-83A-010, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest

rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides insurance benefits other than supplemental long-term care coverage meets the nonforfeiture requirements (as applicable) in any of the following:

(i) Chapter 48.76 RCW;

(ii) RCW 48.23.420 through 48.23.450; and

(iii) RCW 48.18A.050;

(c) The policy meets the disclosure requirements of section 25(2), chapter 380, Laws of 2025 and section 28, chapter 380, Laws of 2025;

(d) The portion of the policy that provides insurance benefits other than supplemental long-term care coverage meets the applicable requirements in the following:

(i) Policy illustrations as required by chapter 48.23A RCW;

(ii) Disclosure requirements in WAC 284-23-300 through 284-23-370; and

(iii) Disclosure requirements in RCW 48.18A.030;

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the supplemental long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, the issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as

medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the supplemental long-term care insurance policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in supplemental long-term care claim status.

(10) Subsections (5) and (7) of this section do not apply to group insurance policies as defined in section 19(5)(a), chapter 380, Laws of 2025, if:

(a) The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

(b) The policyholder, and not the certificate holder, pays a material portion of the premium, which must not be less than twenty percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

New Section. WAC 284-83A-095 Filing requirements. Prior to offering group supplemental long-term care insurance to a resident of this state pursuant to section 21, chapter 380, Laws of 2025, the issuer or similar organization must file with the commissioner evidence that the group policy or certificate has been approved by a state having statutory or regulatory supplemental long-term care insurance requirements substantially similar to those of this state.

New Section. WAC 284-83A-100 Filing requirements for advertising. (1) Every issuer or other entity issuing supplemental long-term care insurance in this state must provide a copy of any supplemental long-term care insurance advertisement intended for use in this state whether through written, radio or television medium for review by the commissioner. In addition, a copy of all advertisements must be retained by the issuer for at least three years after the date the advertisement was first used.

(2) The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

New Section. WAC 284-83A-105 Standards for marketing. (1) Every issuer or entity marketing supplemental 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 284-83A-035(2), 284-83A-170 and 284-83A-190 to the applicant.

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

(e) Every issuer or other entity marketing supplemental 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 supplemental 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 supplemental long-term care insurance policies, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to WAC 284-83A-020(1)(c).

(h) Provide an explanation of contingent benefit upon lapse provided for in WAC 284-83A-130(4)(c) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in WAC 284-83A-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 supplemental 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 section 19(5)(b), chapter 380, Laws of 2025, when endorsing or selling supplemental 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 supplemental 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 supplemental 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 supplemental 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 supplemental long-term care insurance policies or certificates, engage the services of a person with expertise in supplemental 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 supplemental long-term care insurance policies.

(g) No group supplemental 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 supplemental long-term care insurance 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.

New section. WAC 284-83A-110 Suitability. (1) This section does not apply to life insurance policies that accelerate benefits for supplemental long-term care.

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

(a) Develop and use suitability standards to determine whether the purchase or replacement of supplemental long-term

care insurance is appropriate for the needs of the applicant, using a best interest standard as required by section 34(2), chapter 380, Laws of 2025;

(b) Act in the best interests of the applicant under the circumstances known at the time the recommendation is made, without putting the issuer's or entity's financial interest ahead of the interests of the applicant;

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

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

(e) The suitability standards developed under (a) of this subsection must include, at a minimum, provisions ensuring that producers and issuers meet the following care obligations when making a recommendation:

(i) Verify that the consumer has met the criteria to become a qualified individual as provided in RCW 50B.04.050(1)(a) or RCW 50B.04.050(2), or is currently paying premiums as required by RCW 50B.04.080;

(ii)Know the applicant's financial situation, insurance needs, and long-term care planning objectives;

(iii) Understand the available supplemental long-term care insurance options after making a reasonable inquiry into the options available to the producer;

(iv) Have a reasonable basis to believe the recommended option effectively addresses the applicant's financial situation, insurance needs, and long-term care planning objectives over the life of the coverage; and

(v) Communicate the basis or bases of the recommendation to the applicant in a clear and understandable manner.

(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 relevant financial information related to the purchase of or payment for coverage;

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

(iii) The values, benefits and costs of the applicant's existing health, long-term care, or supplemental long-term care coverage, 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 (3)(a) of this section. The efforts must include presentation to the applicant, at or prior to application, the "supplemental 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 284-83A-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 supplemental 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 supplemental 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 supplemental 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 supplemental long-term care insurance" must be provided. The form must be in the format set forth in WAC 284-83A-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 284-83A-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.

New Section. WAC 284-83A-115 Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a supplemental long-term care

insurance policy or certificate replaces another supplemental long-term care or long-term care policy or certificate, the replacing issuer must waive any time periods applicable to preexisting conditions and probationary periods in the new supplemental long-term care insurance policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

New Section. WAC 284-83A-120 Availability of new services or providers. (1) The issuer must notify policyholders of the availability of a new supplemental long-term care insurance policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the issuer to the general public. The notice must be provided within twelve months after the date the new policy series is made available for sale in this state. Changes to policy structure or benefits or provisions that are minor in nature are not "new long-term care services or providers material in nature." Examples of when notification need not be

provided include changes in elimination periods, benefit periods or benefit amounts.

(2) Notwithstanding subsection (1) of this section, notification is not required for any policyholder or certificate holder who is currently eligible for benefits, within an elimination period or on a claim, previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy series. The issuer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium in order to add the new services or providers.

(3) The issuer must make the new coverage available in one of the following ways:

(a) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(b) By exchanging the existing policy or certificate for one with an issue age based on the attained age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The

premium credits must be based on premiums paid or reserves held for the prior policy or certificate;

(c) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(d) By an alternative program developed by the issuer that meets the intent of this section if the program is filed with and approved by the commissioner.

(4) The issuer is not required to notify its policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means distribution through a discrete entity, such as a financial institution or brokerage, through which specialized products are made available that are not available for sale to the general public. Policyholders that

purchase a new proprietary policy must be notified when a new supplemental long-term care insurance policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(5) Policies issued pursuant to this section will be considered exchanges and not replacements. These exchanges are not subject to WAC 284-83A-060 and 284-83A-110, and the reporting requirements of WAC 284-83A-070 (1) through (5).

(6)(a) If the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in subsection (1) of this section must be made to the offering entity.

(b) If the policy is issued to a group defined in RCW section 19(5)(d), chapter 380, Laws of 2025, the notification must be made to each certificate holder.

(7) Nothing in this section prohibits the issuer from offering any policy, rider, certificate or coverage change to any policyholder or certificate holder. Upon request, any policyholder may apply for currently available coverage that

includes the new services or providers. The issuer may require the policyholder to meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

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

New section. WAC 284-83A-125 Right to reduce coverage and lower premiums. (1)(a) Every supplemental 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 their right to reduce coverage and premiums in the notice required by WAC 284-83A-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.

New section. WAC 284-83A-130 Nonforfeiture benefit requirement. (1) This section does not apply to life insurance policies or riders containing accelerated supplemental long-term care benefits.

(2) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of section 32, chapter 380, Laws of 2025:

(a) A policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage issued by the issuer without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subsection (5) of this section; and

(b) The offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(3) If the offer required to be made under section 32, chapter 380, Laws of 2025 is rejected, the issuer must provide the contingent benefit upon lapse described in this section. The contingent benefit on lapse in subsection (4)(d) of this section

applies even if this offer is accepted for a policy with a fixed or limited premium paying period.

(4)(a) After rejection of the offer required under section 32, chapter 380, Laws of 2025, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the issuer must provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate must provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) A contingent benefit on lapse must be triggered every time the issuer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, and the policy or certificate lapses within one hundred twenty days after the due date of the premium so increased. Unless otherwise required, policyholders must be

notified at least thirty days prior to the date the premium reflecting the rate increase is due.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
88	12%
89	11%
90 and over	10%

(d) A contingent benefit on lapse must also be triggered for policies with a fixed or limited premium paying period every time the issuer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, the policy or certificate lapses within one hundred twenty days after the due date of the premium so increased, and the ratio in (f)(ii) of this subsection is forty percent or more. Unless otherwise required, policyholders must be notified at least thirty days prior to the date the premium reflecting the rate increase is due. This requirement is in addition to the contingent benefit provided by subsection (3) of this section and if both are triggered, the benefit provided must be at the option of the insured.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%

Over 80	10%

(e) On or before the effective date of a substantial premium increase as defined in (c) of this subsection, the issuer must:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (5) of this section. This option may be elected at any time during the one hundred twenty-day period provided for in (c) of this subsection; and

(iii) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period provided for in (c) of this subsection will be deemed to be the election of the offer to convert in (e)(ii) of this subsection unless the automatic option in (f)(iii) of this subsection applies.

(f) On or before the effective date of a substantial premium increase as defined in (d) of this subsection, the issuer must:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty-day period provided for in (d) of this subsection; and

(iii) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period provided for in (d) of this subsection will be deemed to be the election of the offer to convert in (f)(ii) of this subsection if the ratio is forty percent or more.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection

(4)(c) but not (d) of this subsection, are described in this subsection:

(a) For purposes of this subsection, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty, and at least three percent per year beyond age fifty.

(b) For purposes of this subsection, the nonforfeiture benefit must be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in (c) of this subsection.

(c) The standard nonforfeiture credit will be equal to one hundred percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The issuer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration; however, the minimum nonforfeiture credit must not be less than thirty times the

daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (6) of this section.

(d)(i) The nonforfeiture benefit must begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three years as well as thereafter.

(ii) Notwithstanding (d)(i) of this subsection, for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(6) All benefits paid by the issuer while the policy or certificate is in premium-paying status or in paid-up status must not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.

(7) No difference in the minimum nonforfeiture benefits as required under this section for group and individual policies is permitted.

(8) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse is subject to the loss ratio requirements of WAC 284-83A-090 or 284-83A-230, whichever is applicable, treating the policy as a whole.

(9) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (4)(c) or (d) of this section, a replacing issuer that purchased or otherwise assumed a block or blocks of supplemental long-term care insurance policies from another issuer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original issuer.

(10) A nonforfeiture benefit for qualified supplemental long-term care insurance policies that are level premium policies must be offered and must meet the following requirements:

(a) The nonforfeiture provision must be appropriately captioned;

(b) The nonforfeiture provision must provide a benefit available in the event of a default in the payment of any premiums and must state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying policies approved by the commissioner for the same policy form; and

(c) The nonforfeiture provision must provide at least one of the following:

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Shortened benefit period; or

(iv) Other similar offerings approved by the commissioner.

New section. WAC 284-83A-135 Standards for benefit triggers. (1) A supplemental long-term care insurance policy must condition the payment of benefits on a determination of the insured's ability to perform activities of daily living or on cognitive impairment of the insured. Eligibility for the payment of benefits must not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(2)(a) Activities of daily living must include at least the following, as defined in WAC 284-83A-015, and must be defined in the policy:

(i) Bathing;

(ii) Continence;

(iii) Dressing;

(iv) Eating;

(v) Toileting; and

(vi) Transferring;

(b) Issuers may use activities of daily living to trigger covered benefits in addition to those contained in subsection (1)(a) of this section only if they are defined in the policy.

(3) The issuer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions must not restrict, and must not be in lieu of, the requirements contained in subsections (1) and (2) of this section.

(4) For purposes of this section the determination of a deficiency must not be more restrictive than:

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

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

(5) Assessments of activities of daily living and cognitive impairment must be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(6) Supplemental long-term care insurance policies must include a clear description of the process for appealing and resolving benefit determinations.

(7) The provisions of this section apply to all supplemental long-term care insurance policies issued in this state on or after May 1, 2026.

New Section. WAC 284-83A-140 Qualified supplemental long-term care insurance policies—Additional standards for benefit triggers. (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 supplemental 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 supplemental 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.

(6) Qualified supplemental long-term care insurance policies must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

New Section. WAC 284-83A-145 Standard format outline of coverage. The following standards apply to the format and outline of coverage to be used in this state.

(1) The outline of coverage must be a free-standing document, using no smaller than ten-point type.

(2) The outline of coverage must contain no material of an advertising nature.

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) The following format for outline of coverage must be used in this state:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

SUPPLEMENTAL LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this supplemental 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].

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage

for other policies available to you. This is not an insurance policy, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY [OR CERTIFICATE] CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For supplemental long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits,

[Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return - "free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of

premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For insurance producers] neither [insert company name] nor its [agents] [insurance producers] represent medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing medicare, the federal government or any state government.

8. SUPPLEMENTAL LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage 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, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered supplemental long-term care expenses, subject to policy [limitations] and [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment must be used to measure an insured's need for supplemental long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers must accompany each benefit description. If an

attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facilities and provider;

(c) Noneligible levels of care (e.g., unlicensed providers, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should

consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit

screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

(c) State that premiums may increase over time and the conditions that may result in an increase in premiums.

(d) State that premiums continue after retirement and [if applicable] when premiums are no longer required (waiver of premium).]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING SUPPLEMENTAL LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR SUPPLEMENTAL LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

16. HOW SUPPLEMENTAL LONG-TERM CARE INSURANCE INTERACTS WITH THE WA CARES FUND. This supplemental long-term care insurance policy provides you additional coverage for long-term care expenses once your benefits under the WA Cares fund have been exhausted. Once you have exhausted your benefits under the WA Cares fund, your monetary deductible under this policy has been met. However, if you exhaust your benefits under the WA Cares fund prior to the end of the elimination period you select under this policy, benefits under this policy will not be paid until your elimination period is over. If the care you were receiving under the WA Cares fund solely involved assistance with bed mobility, medication management, mobility, or personal hygiene, you may not be immediately eligible for benefits under this supplemental long-term care insurance policy. You have the right under this policy to continue receiving care in the same setting and with the same provider(s) (including family caregivers) as under the WA Cares program. [Company name] can require a change in care setting or provider effective 90 days after your transition from the WA Cares program if [company name] determines that your care

or safety needs are not being met. You may appeal this determination through an independent third-party review.

17. THE PURCHASE OF THIS POLICY DOES NOT QUALIFY YOU FOR AN EXEMPTION FROM THE WA CARES PROGRAM.

New Section. WAC 284-83A-150 Requirement to deliver consumer's guide. (1) A long-term care insurance consumer's guide in the format developed or approved by the commissioner, must be provided to all prospective applicants of a supplemental long-term care insurance policy or certificate.

(a) In the case of solicitations by an insurance producer, the insurance producer must deliver the consumer's guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the consumer's guide must be presented in conjunction with any application or enrollment form.

(2) Issuers or insurance producers of life insurance policies or riders containing accelerated supplemental long-term care benefits are not required to furnish the consumer's guide,

but must furnish the policy summary required by section 25(2), chapter 380, Laws of 2025.

New section. WAC 284-83A-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 supplemental long-term care insurance policy.

(2) No issuer or insurance producer or other representative of the issuer may knowingly sell a supplemental long-term care insurance 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 supplemental long-term care insurance policies.

New Section. WAC 284-83A-165 Form for reporting rescission of supplemental long-term care insurance policies. The

following form must be used by issuers to annually report rescission of supplemental long-term care insurance policies.

RESCISSION REPORTING FORM FOR SUPPLEMENTAL LONG-TERM CARE INSURANCE POLICIES FOR THE STATE OF_____ FOR THE REPORTING YEAR 20[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

Instructions: The purpose of this form is to report all rescissions of supplemental long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____

_____

_____

_____

Signature

_____

Name and Title (please type)

_____

Date

New section. WAC 284-83A-170 Form of personal worksheet.

The following form of personal worksheet must be used by issuers in the sale of supplemental long-term care insurance policies.

Supplemental Long-Term Care Insurance

Personal Worksheet

People buy supplemental long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on medicaid. But

supplemental long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable or guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Issuers must use appropriate bracketed statement. Rate guarantees must not be shown on this form.]

Rate Increase History

The company has sold supplemental long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any supplemental long-term care insurance policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last ten years.] [The company has raised its premium rates on this policy form or similar policy forms in the last ten years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) ☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000] ☐ $[30-50,000] ☐ Over $50,000

Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____ Approximate cost $_____ for that period of care.

How are you planning to pay for your long-term care if the benefits provided by the WA Cares Fund are exhausted before you become eligible for benefits under your supplemental long-term care insurance policy? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation.

OR

☐ I choose not to complete this information.

(Check one.)

☐ I acknowledge that the issuer and/or its [agent] [insurance producer] (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: _____

(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____

[(Agent)] [(Insurance Producer)] (Date)

[Agent's] [Insurance Producer's] Printed Name:_____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My [agent] [insurance producer] has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____]

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or [agent] [insurance producer] sale.

The company may contact you to verify your answers.

Note: When the Supplemental Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

New Section. WAC 284-83A-175 Disclosure form. The following form of disclosure must be used in this state.

Things You Should Know Before You Buy

Supplemental Long-Term Care Insurance

Supplemental Long-Term Care	A supplemental long-term care insurance policy may pay most of the costs for your care in a nursing home, at home, or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

Insurance	[You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

	The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	Medicare does **not** pay for most long-term care.
Medicaid	Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for medicaid. Many people become eligible for medicaid after they have used up their own financial resources by paying for long-term care services. When medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets. Your choice of long-term care services may be limited if you are receiving medicaid. To learn more about medicaid, contact your local or state medicaid agency.
Consumer's Guide	Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Consumer's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for supplemental long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	Free counseling and additional information about supplemental long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
Facilities	Some supplemental long-term care insurance policies provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their supplemental long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

New Section. WAC 284-83A-180 Response letter. The following form of response letter must be used in this state.

Supplemental Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for supplemental long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying supplemental long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that supplemental long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Consumer's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about supplemental long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days.

We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes,** [although my worksheet indicates that supplemental long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

New Section. WAC 284-83A-185 Sample claims denial reporting form. The following form for reporting claims denials must be used in this state.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Claims Denial Reporting Form

Supplemental Long-Term Care Insurance

For the State of_____

For the Reporting Year of_____

Company Name: _____

Due: June 30, annually

Company Address:_____

_____

Company NAIC Number:_____

Contact Person: _____

Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all supplemental long-term care claim denials under in-force supplemental long-term care insurance policies.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data[1]
1	Total Number of Supplemental Long-Term Care Claims Reported		
2	Total Number of Supplemental Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid Due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met		
5	Net Number of Supplemental Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Supplemental Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Supplemental Long-Term Care Claim Denied Due to:		
8	• Long-Term Care Services Not Covered Under the Policy		
9	• Provider/Facility Not Qualified Under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

Footnotes:

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

2. Example—A facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

3. Examples—A benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

New Section. WAC 284-83A-190 Potential rate increase disclosure form. The following form must be used in this state to disclose a potential rate increase.

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Issuers must provide all of the following information to the applicant:

Supplemental Long-Term Care Insurance

Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed] for an increase [is][are] [on the application][$_____]

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

This Policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates CANNOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

■ Pay the increased premium and continue your policy in force as is.

■ Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)

■ Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

■ Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some supplemental long-term care insurance coverage, if:

• Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

• You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

• You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

• In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

• Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture	
Cumulative Premium Increase Over Initial Premium	
That qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	**Percent Increase Over Initial Premium**
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%

79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which WAC 284-83A-130(4)(d) and (f) are applicable.]

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect;

AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

• You bought the policy at age 65 with an annual premium payable for 10 years.

• In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

• Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

New Section. WAC 284-83A-195 Form for reporting replacement and lapse of supplemental long-term care insurance policies. The following form must be used in this state to report replacements and lapses of supplemental long-term care insurance.

Supplemental Long-Term Care Insurance Replacement and Lapse Reporting Form

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

For the State of _____ For the Reporting Year of _____

Company Name: _____

Due: June 30, Annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Instructions

The purpose of this form is to report on a statewide basis information regarding supplemental long-term care insurance policy replacements and lapses. Specifically, every issuer must maintain records for each [agent] [insurance producer] on that [agent's] [insurance producer's] amount of supplemental long-term care insurance replacement sales as a percent of the [agent's] [insurance producer's] total annual sales and the amount of lapses of supplemental long-term care insurance policies sold by the [agent] [insurance producer] as a percent of the [agent's] [insurance producer's] total annual sales. The tables below should be used to report the ten percent of the issuer's [agents] [insurance producers] with the greatest percentages of replacements and lapses.

Listing of the 10% of [Agents] [Insurance Producers] with the Greatest

Percentage of Replacements

[Agent's] [Insurance Producer's] Name	Number of Policies Sold by This [Agent] [Insurance Producer]	Number of Policies Replaced by This [Agent] [Insurance Producer]	Number of Replacements as % of Number Sold by This [Agent] [Insurance Producer]

Listing of the 10% of [Agents] [Insurance Producers] with the Greatest

Percentage of Lapses

[Agent's] [Insurance Producer's] Name	Number of Policies Sold by This [Agent] [Insurance Producer]	Number of Policies Lapsed by This [Agent] [Insurance Producer]	Number of Lapses as % of Number Sold by This [Agent] [Insurance Producer]

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales _____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year)_____%

Percentage of Lapsed Policies to Total Annual Sales_____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

New Section. WAC 284-83A-210 Definitions. For purposes of WAC 284-83A-210 through 284-83A-250:

(1) "Actual loss ratio" means a retrospective calculation and calculated as the benefits incurred divided by the "premiums earned," both measured from the beginning of the calculating period to the date of the loss ratio calculations.

(2) "Benefits incurred" means the claims incurred plus any increase (or less any decrease) in the reserves.

(3) "Calculating period" means the time span over which the actuary expects the premium rates, whether level or increasing, to remain adequate in accordance with the actuary's best estimate of future experience and during which the actuary does not expect to request a rate increase.

(4) "Claims incurred" means:

(a) Claims paid during the accounting period; plus

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

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

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

(5) "Expected loss ratio" means a prospective calculation calculated as the projected benefits incurred divided by the projected premiums earned and based on the actuary's best projections of the future experience within the calculating period.

(6) "Overall loss ratio" means the benefits incurred divided by the premiums earned over the entire calculating period; it may involve both retrospective and prospective data.

(7) "Premium" means all sums charged, received or deposited as consideration for a supplemental long-term care insurance policy and includes any assessment, membership, contract, survey, inspection, service, or similar fees or charges paid.

(8) "Premiums earned" means the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

(9) "Reserves" includes:

(a) Active life disability reserves;

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

(c) Contingency reserves;

(d) Reserves for select morbidity experience; and

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

New Section. WAC 284-83A-220 Grouping of policy forms for purposes of ratemaking and requests for rate increase. (1) The actuary responsible for setting premium rates must group similar policy forms, including forms no longer being marketed, in the pricing calculations.

(a) The grouping must be satisfactory to the commissioner, who may rely on the judgment of the pricing actuary.

(b) Factors that must be considered include similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between policyholders.

(c) A grouping must enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW 48.18.480.

(2) Persons insured under similar policy forms must be grouped at the time of ratemaking in accord with RCW 48.18.480 because they are expected to have substantially like insuring, risk and exposure factors and expense elements.

(a) The morbidity and mortality experience of these insureds, as a group, will deteriorate over time.

(b) A form may not be withdrawn from its assigned grouping by reason only of the deteriorating health of the people insured thereunder.

(3) One or more of the policy forms grouped for ratemaking purposes, by random chance, may experience significantly higher or more frequent claims than the other forms. A form may not deviate from the assigned grouping of policy forms for pricing purposes at the time of requesting a rate increase unless the actuary can justify to the satisfaction of the commissioner that a different grouping is more equitable because of some

previously unrecognized and nonrandom distinction between forms or between groups of insureds.

(4) Successive generic policy forms and policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios.

New Section. WAC 284-83A-225 Separation of data regarding certain policies. For reporting and record-keeping purposes, all issuers must separate data concerning supplemental long-term care insurance policies from data concerning other insurance policies.

New Section. WAC 284-83A-230 Loss ratio requirements for supplemental long-term care insurance forms. The following standards and requirements apply to supplemental long-term care insurance forms:

(1) Benefits for individual supplemental long-term care insurance forms will be deemed reasonable in relation to the

premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the issuer and satisfactory to the commissioner.

(2) Benefits for group supplemental long-term care insurance forms will be deemed reasonable in relation to the premiums if the overall loss ratio is at least seventy percent over a calculating period chosen by the issuer and satisfactory to the commissioner.

(3) The calculating period may vary with the benefit and renewal provisions. The issuer may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations. A brief explanation of the selected calculating period must accompany the filing.

(4) Policy forms, the benefits of which are particularly exposed to the effects of inflation and whose premium income may be particularly vulnerable to an eroding persistency and other similar forces, must use a relatively short calculating period reflecting the uncertainties of estimating the risks involved.

(a) Policy forms based on more dependable statistics may employ a longer calculating period.

(b) The calculating period may be the lifetime of the policy for guaranteed renewable and noncancellable policy forms if these forms provide benefits which are supported by reliable statistics and which are protected from inflationary or eroding forces by such factors as fixed dollar coverages, inside benefit limits, or the inherent nature of the benefits.

(c) The calculating period may be as short as one year for coverages that are based on statistics of minimal reliability or which are highly exposed to inflation.

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

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

(7) Issuers must review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

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

New Section. WAC 284-83A-240 Experience records. Issuers must maintain records of earned premiums and incurred benefits for each policy year for each contract, rider, endorsement and similar form which is combined for purposes of premium calculations, including the reserves. Records must be maintained of the experience expected in the premium calculations. Notwithstanding the foregoing, with proper justification, the commissioner may accept approximation of policy year experience based on calendar year data.

New Section. WAC 284-83A-245 Evaluating experience data. In determining the credibility and appropriateness of experience data, due consideration will be given by the commissioner to all relevant factors including:

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

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

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

(4) The mix of business by risk classification;

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

New Section. WAC 284-83A-250 Life insurance policies that accelerate benefits for supplemental long-term care. (1) WAC 284-83A-210 through 284-83A-245 do not apply to life insurance policies that accelerate benefits for supplemental long-term care.

(2) A life insurance policy that funds supplemental long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are

guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of chapter 48.76 RCW;

(c) The policy meets the disclosure requirements of section 25(2), chapter 380, Laws of 2025 and section 28, chapter 380, Laws of 2025;

(d) Any policy illustration that meets the applicable requirements of the chapter 48.23A RCW; and

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the supplemental long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, the issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the supplemental long-term care insurance policy provision on the required premiums, nonforfeiture values and reserves on the underlying

life insurance policy, both for active lives and those in supplemental long-term care claim status.

New Section. WAC 284-83A-255 Supplemental Long-term care insurance policy issued with life insurance policy – Rates and Forms. Unless a supplemental long-term care benefit is funded through a life insurance policy by the acceleration of death benefit, pursuant to section 19, chapter 380, Laws of 2025, a supplemental long term care insurance policy rate or form must not be filed as a rider to a life insurance policy. Issuers of supplemental long-term care insurance policies shall comply with all applicable form and rate filing instructions under WAC 284-58-025 for supplemental long-term care insurance policies.

New Section. WAC 284-83A-300 Standards for protecting patient privacy rights. Issuers must adopt and use administrative, business, and operational practices and procedures designed to protect an insured's right to privacy granted under chapter 70.02 RCW and federal laws and regulations. For example, issuers must not disclose the insured's health information without the written authorization

of the insured, except where the recipient needs to know the information, such as:

(1) To any person, health care provider or health care facility that the issuer reasonably believes is providing health care to the insured;

(2) To any other person who requires health care information to provide planning, quality assurance, peer review, or administrative, legal, financial, billing or actuarial services;

(3) To assist a health care provider or health care facility in the delivery of health care and the issuer reasonably believes that the recipient will not use or disclose the health care information for any purpose other than the delivery of health care and will take appropriate steps to protect the information;

(4) To a health care provider or health care facility reasonably believed to have previously provided health care to the insured to the extent necessary to provide health care services, unless the insured has instructed the health care

provider or health care facility in writing not to make the disclosure.

New Section. WAC 284-83A-310 Right of insureds to receive confidential health services. Issuers must adopt and use administrative, business, and operational practices and procedures to protect the insured's right to confidential health care services.

New Section. WAC 284-83A-320 Standards for the issuer's timely review of a claim denial. The following administrative, business, and operational standards must be used by issuers to ensure timely review of a claim denial.

(1) Issuers must have a fully operational, comprehensive claims denial review process.

(2) Issuers must implement procedures for registering and responding to oral and written requests for review of a claim denial in a timely and thorough manner.

(3) Issuers must provide written notice to the insured, to the insured's designated representative, and to the insured's

provider of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility or any other long-term care services or benefits.

(4) Issuers must process as an appeal an enrollee's written or oral request that the issuer reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. The issuer must not require that the insured file a complaint prior to seeking appeal of any such decision.

(5) The issuer must:

(a) Provide written notice to the insured when the appeal is received;

(b) Assist the insured with the appeal process;

(c) Make its decision regarding the appeal within thirty days after the date the appeal is received, except when a determination is made that the issuer's action must be expedited;

(d) Cooperate with a representative authorized in writing by the insured;

(e) Consider all information submitted by the insured;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the insured and, with the permission of the insured, to the insured's providers, that:

(i) Explains the issuer's decision and the supporting coverage or clinical reasons for the decision; and

(ii) If applicable, explains any further appeal process, including, if applicable, information about how to exercise the insured's rights to a second opinion and how to continue receiving or reinstate services.

(6) An appeal must be expedited if the insured's provider or the insured's medical director reasonably determines that following the appeal process, response timelines could seriously jeopardize the insured's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours after the time the appeal is received by the issuer.

(7) If the insured requests that the issuer reconsider its decision to modify, reduce, or terminate an otherwise covered health care service, and if the issuer's decision is based on the issuer's determination that the health service or level of health service is no longer covered, the issuer must continue to provide the health service until the appeal is resolved.

(8) Issuers must provide a clear explanation of their grievance processes and procedures at the time of application and upon request of the insured.

(9) Issuers shall ensure that their grievance processes and procedures are accessible to insureds who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(10) Issuers must track each appeal until final resolution and, upon request, make available to the commissioner a log of all appeals and grievances.

(11) Issuers shall establish a process to identify and track problems encountered by enrollees when filing claims

denials and, where appropriate, to make reasonable modifications to their appeals and grievance processes and procedures.

New Section. WAC 284-83A-325 Prompt payment of clean claims. (1) The purpose of this section is to effectuate section 29, chapter 380, Laws of 2025and section 37, chapter 380, Laws of 2025 by establishing prompt payment requirements for supplemental long-term care insurance.

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

(a) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

(3) Within thirty business days after receipt of a claim for benefits under a supplemental long-term care insurance policy or certificate, an insurer must pay such a claim if it is a clean claim, or send a written notice acknowledging the date of receipt of the claim and one of the following:

(a) The insurer is declining to pay all or part of the claim and the specific reason(s) for the denial; or

(b) That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

(4) Within thirty business days after receipt of all the requested additional information, an insurer must pay a claim for benefits under a supplemental long-term care insurance policy or certificate if it is a clean claim, or send a written notice that the insurer is declining to pay all or part of the claim, and the specific reason or reasons for denial.

(5) If an insurer fails to comply with subsection (3) or (4) of this section, such insurer must pay interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid for forty-five business

days after the receipt of the claim with respect to subsection (3) of this section or all requested additional information with respect to subsection (4) of this section. The interest payable pursuant to this subsection must be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

(6) The provisions of this section do not apply where the insurer has a reasonable basis supported by specific information that such claim was fraudulently submitted.

New Section. WAC 284-83A-350 Standard applied if there is a conflict between a master policy and certificate of insurance. If there is a discrepancy between a description of the terms and conditions of insurance between the master policy and any certificate issued under that master policy, the description most favorable to the insured must be used by the issuer and governs the matter.

SUPPLEMENTAL LONG-TERM CARE PARTNERSHIP PROGRAM

New Section. WAC 284-83A-400 Purpose and authority. WAC 284-83A-400 through 284-83A-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 supplemental long-term care partnership insurance policies to include: Contracts, certificates, riders, and endorsements.

New Section. WAC 284-83A-405 Applicability and scope. (1) WAC 284-83A-400 through 284-83A-420 applies to any qualified supplemental 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 supplemental 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.

New Section. WAC 284-83A-410 Minimum standards for supplemental long-term care partnership policies. Every supplemental long-term care partnership policy must meet the standards for supplemental long-term care insurance policies or contracts in chapter 380, Laws of 2025, chapter 48.85 RCW, and this chapter, unless specifically provided otherwise.

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

(a) The policy was issued on or after May 1, 2026, or exchanged as provided in WAC 284-83A-415 on or after May 1,

2026, 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 supplemental 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 website: www.insurance.wa.gov.

(3) Issuers requesting to make use of a previously approved policy form as a qualified state supplemental 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 website: 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 website: 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 supplemental 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.

New section. WAC 284-83A-415 Long-term care partnership policy exchange or replacement. (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 supplemental 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 supplemental long-term care insurance 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 supplemental long-term care insurance policy with a policy that qualifies as a supplemental 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 supplemental 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 supplemental 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) Policies issued pursuant to this section shall be considered exchanges and not replacements and are not subject to WAC 284-83A-060 through 284-83A-070.

New section. WAC 284-83A-420 Reporting. All issuers of qualified supplemental long-term care partnership policies must provide regular reports to the United States Secretary of Health and Human Services in accordance with regulations of the secretary. These reports include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the secretary determines may be appropriate to the administration of partnership policies.

New section. WAC 284-83A-425 Producer education. Prior to selling, soliciting, or negotiating, or continuing to sell, solicit, or negotiate supplemental long-term care partnership policies in this state, all licensed producers must meet the education requirements in section 33, chapter 380, Laws of 2025.

WAC 284-16-410 Definitions. For the purpose of this regulation, the following definitions shall apply:

(1) "Annual-claim cost" means the net annual cost per unit of benefit before the addition of expense including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a one hundred dollar monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age thirty-five, in a certain occupation might be twelve dollars, while the gross premium for this benefit might be eighteen dollars. The additional six dollars would cover expense and profit or contingencies.

(2) "Claims accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of

the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for accrued benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

(3) "Claims incurred" means that portion of a claim for which the insurer has become obligated to make payment, on or prior to the valuation date.

(4) "Claims reported" means those claims that have been incurred on or prior to the valuation date of which the insurer has been informed, on or prior to the valuation date. These claims are considered as reported claims for annual statement purposes.

(5) "Claims unaccrued" means that portion of claims incurred on or prior to the valuation date which result in

liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made, which may or may not be discounted with interest, must be established.

(6) "Claims unreported" means those claims that have been incurred on or prior to the valuation date of which the insurer has not been informed, on or prior to the valuation date. These claims are considered as unreported claims for annual statement purposes.

(7) "Date of disablement" means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

(8) "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(9) "Gross premium" is the amount of premium charged by the insurer. It includes the net premium, based on claim-cost, for the risk, together with any loading for expenses, profit, or contingencies.

(10) "Group insurance" includes blanket disability insurance.

(11) "Level premium" means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide

for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

(12) "Long-term care insurance" means any insurance policy or benefit contract primarily advertised, marketed, offered, or designed to provide coverage or services over a prolonged period of time for either institutional or community-based convalescent, custodial, chronic, or terminally ill care. Long-term care insurance may be issued by insurers; fraternal benefit societies; health care service contractors; health maintenance organizations or any similar organization to the extent they are authorized. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, nor shall it include a contract between a continuing care retirement community and its residents.

(13) "Modal premium" means the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is one

hundred dollars and if, instead, monthly premiums of nine dollars are paid then the modal premium is nine dollars.

(14) "Negative reserve" means a negative terminal reserve value. Negative reserves occur when the present value of future benefits is less than the present value of future valuation net premiums.

(15) "Preliminary term reserve method" means the method of valuation for which the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium, or stream of changing valuation premiums, becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(16) "Present value of amounts not yet due on claims" means the reserve for claims unaccrued which may be discounted at interest.

(17) "Reserve" includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits which result in:

(a) Claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

(b) Claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

(18) "Supplemental long-term care insurance" has the meaning set forth in section 19, chapter 380, Laws of 2025.

(19) "Terminal reserve" means the reserve at the end of a contract year, which is the present value of benefits expected

to be incurred after that contract year minus the present value of future valuation net premiums.

(20) "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of one hundred twenty dollars was paid on November 1, twenty dollars would be earned as of December 31 and the remaining one hundred dollars would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(21) "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

WAC 284-16-470 Contract reserves. (1) General contract reserve requirements are:

(a) Contract reserves are required, unless otherwise specified in (b) of this subsection for:

(i) All individual and group contracts with which level premiums are used; or

(ii) All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The insurer shall determine the values specified in this item (ii) on the basis specified in subsection (2) of this section.

(b) Contracts not requiring a contract reserve are:

(i) Contracts which cannot be continued after one year from issue; or

(ii) Contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

(c) The contract reserve is in addition to claim reserves and premium reserves; and

(d) The insurer shall use methods and procedures for contract reserves that are consistent with those for claim

reserves for any contract, or else shall make appropriate adjustment when necessary to assure provision for the aggregate liability. The insurer shall use the same definition of the date of incurral in both determinations.

(2) The basis for determining minimum standards for contract reserves are:

(a) Minimum standards with respect to morbidity are those set forth in WAC 284-16-500 and 284-16-510. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated. The insurer shall value contracts for which tabular morbidity standards are not specified in WAC 284-16-500 and 284-16-510 using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

(b) The maximum interest rate is specified in WAC 284-16-520.

(c) The insurer shall use termination rates in the computation of reserves on the basis of a mortality table as

specified in WAC 284-16-530 except as noted in (d) of this subsection.

(d) Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard, the insurer may use total termination rates at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) Eighty percent of the total termination rate used in the calculation of the gross premiums; or

(ii) Eight percent.

(e) Where a morbidity standard specified in WAC 284-16-500 and 284-16-510 is on an aggregate basis, the insurer may adjust the morbidity standard to reflect the effect of insurer underwriting by policy duration. The adjustments shall be appropriate to the underwriting and be acceptable to the commissioner.

(f) Reserve method:

(i) For insurance, except long-term care, supplemental long-term care, and medicare supplement insurance, the minimum

reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(ii) For long-term care insurance, supplemental long-term care insurance, and medicare supplemental insurance as governed by WAC 284-66-210 the minimum reserve is the reserve calculated on the one-year full preliminary term method.

(g) The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

(h) The insurer may offset negative reserves on any benefit against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(3) Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable

standards specified above; an insurer may use any reasonable assumptions as to interest rates, termination and/or mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following:

(a) The net level premium method;

(b) The one-year full preliminary term method;

(c) Prospective valuation on the basis of actual gross premiums with reasonable allowances for future expenses;

(d) The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms;

(e) The computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and

(f) The use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

(4) Tests for adequacy and reasonableness of contract reserves.

(a) Annually, the insurer shall make an appropriate review of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of subsection (2) of this section.

(b) If an insurer has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, commissioner's regulation, or for some other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for such shortfalls in the aggregate.

WAC 284-17-224 Insurance continuing education—Required credit hours—Producers and adjusters. Timely completion of this state's continuing insurance education requirement is a prerequisite for renewal or reinstatement of a license. Before applying for renewal or reinstatement of a license, except as provided in WAC 284-17-222 or waived in accordance with WAC 284-17-254, all resident producers licensed for personal lines, life, disability, property, casualty or variable life and variable annuity product lines of authority and all resident licensed adjusters must complete twenty-four credit hours of approved insurance continuing education. The twenty-four hours of education must include three credit hours of ethics education during every license continuation period.

(1) Courses must be completed within the twenty-four month period prior to the:

(a) Expiration date of the license;

(b) Date of late renewal; or

(c) Date of the request for reinstatement.

(2) Licensees must maintain each continuing education certificate of completion for three years.

(3) For producers required to complete the annuity suitability training, flood training, long-term care training, or supplemental long-term care training, producers should maintain

certificates for as long as the producer transacts business for these products, but not less than three years.

(4) Adjusters must take either property and casualty insurance related continuing education courses, or insurance claim adjusting related continuing education courses, or both.

WAC 284-23-610 Authority, finding, purpose, and scope.

(1) The purpose of this regulation, WAC 284-23-600 through 284-23-730, is to define certain minimum standards for the regulation of accelerated benefit provisions of individual and group life insurance policies, a single violation of which will be deemed to constitute an unfair claims settlement practice. The commissioner finds and hereby defines it to be an unfair act or practice and an unfair method of competition for any insurer to provide accelerated benefits except as provided in this regulation.

(2) The commissioner finds that accelerated benefits in life insurance policies are primarily mortality risks rather than morbidity risks. The commissioner further finds that accelerated benefits are optional modes of settlement of

proceeds under life insurance proceeds under RCW 48.11.020. No qualifying event as defined under WAC 284-23-620(3) changes the nature of the underlying life insurance policy. No accelerated benefits provision shall be called or marketed as long-term care insurance as defined under RCW 48.83.020(5), or supplemental long-term care insurance as defined under section 19, chapter 380, Laws of 2025.

(3) This regulation applies to all accelerated benefit provisions of individual and group life insurance policies and riders which are issued or delivered to a resident of this state, on or after the effective date of this regulation. The regulation applies to both policies and riders. It also applies to solicitations for the sale of accelerated benefits, whether in the form of policies or riders.

(4) This regulation does not require inclusion or offering of any accelerated benefit in a life insurance policy. This regulation regulates those accelerated benefits which individual and group life insurers choose to advertise, offer, or market on or after the effective date of this regulation.

WAC 284-23-650 Disclosure statement. (1) For purposes of this section, "policy" includes any agreement, amendment, certificate, contract, endorsement, plan, or statement of coverage that provides for life insurance benefits.

(2) The words "accelerated benefit" must be included in the required title of every life insurance policy or rider that includes a provision for accelerated benefits. Accelerated benefits that do not meet the definition of long-term care insurance in RCW 48.83.020 or supplemental long-term care insurance in section 19, chapter 380, Laws of 2025, shall not be described, advertised, marketed, or sold as long-term care insurance or supplemental long-term care insurance, nor as providing long-term care benefits or supplemental long-term care benefits.

(3) Possible tax consequences and possible consequences on eligibility for receipt of medicare, medicaid, Social Security, supplemental security income (SSI), or other sources of public funding shall be included in every disclosure statement.

(a) The disclosure form shall include a disclosure statement. The disclosure statement shall be prominently

displayed on the first page of the policy, rider, or certificate. The disclosure statement shall contain substantially the following: "If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as medicare, medicaid, Social Security, Supplemental Security, supplemental security income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy."

(b) For accelerated benefits that do not meet the definition of long-term care insurance in RCW 48.83.020 or supplemental long-term care insurance in section 19, chapter 380, Laws of 2025, the disclosure statement must begin with the following statement: "This accelerated life benefit does not and is not intended to qualify as long-term care insurance or supplemental long-term care insurance under Washington state law. Washington state law prevents this accelerated life benefit

from being marketed or sold as long-term care insurance or as supplemental long-term care insurance, or as providing long-term care or supplemental long-term care benefits.

(c) The disclosure form must be provided (i) to the applicant for an individual or group life insurance policy at the time application is made for the policy or rider; and (ii)(A) to the individual insured at the time the owner of an individual life insurance policy submits a request for payment of the accelerated benefit, and before the accelerated benefit is paid, or (B) to the individual certificate holder at the time an individual certificate holder of a group life insurance policy submits a request for payment of the accelerated benefit, and before the accelerated benefit is paid. It is not sufficient to provide this required disclosure statement only to the holder of a group policy.

(4) The disclosure form shall give a brief and clear description of the accelerated benefit. It shall define all qualifying events which can trigger payment of the accelerated benefit. It shall also describe any effect of payment of

accelerated benefits upon the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens.

(a) In the case of insurance solicited by an insurance producer, the insurance producer shall provide the disclosure form to the applicant before or at the time the application is signed. Written acknowledgment of receipt of the disclosure statement shall be signed by the applicant and the insurance producer.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a written notice that a full premium refund shall be made if the policy is returned to the insurer within the free look period.

(c) In the case of group life insurance policies, the disclosure form shall be contained in the certificate of coverage, and may be contained in any other related document furnished by the insurer to the certificate holder.

(5) If there is a premium or cost of insurance charge for the accelerated benefit, the insurer shall give the applicant a generic illustration numerically demonstrating any effect of the

payment of an accelerated benefit upon the policy's cash value, accumulation account, death benefit, premium, policy loans, or policy liens.

(a) In the case of agent solicited insurance, the agent shall provide the illustration to the applicant either before or at the time the application is signed.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant concurrently with delivery of the policy to the applicant.

(c) In the case of group life insurance policies, the disclosure form shall be included in the certificate of insurance or any related document furnished by the insurer to the certificate holder.

(6)(a) Insurers with financing options other than as described in WAC 284-23-690 (1)(b) and (c) of this regulation, shall disclose to the policyowner any premium or cost of insurance charge for the accelerated benefit. Insurers shall make a reasonable effort to assure that the certificate holder on a group policy is made aware of any premium or cost of

insurance charge for the accelerated benefits, if he or she is required to pay all or any part of such a premium or cost of insurance charge.

(b) Insurers shall furnish an actuarial demonstration to the Insurance Commissioner when filing an individual or group life insurance policy or rider form that provides accelerated benefits, showing the method used to calculate the cost for the accelerated benefit.

(7) Insurers shall disclose to the policyholder any administrative expense charge. The insurer shall make a reasonable effort to assure that the certificate holder on a group policy is made aware of any administrative expense charge if he or she is required to pay all or any part of any such charge.

(8) When the owner of an individual policy or the certificate holder of a group policy requests payment of an accelerated benefit, within 20 days of receiving the request the insurer shall send a statement to that person, and to any irrevocable beneficiary, showing any effect that payment of an accelerated benefit will have on the policy's cash value,

accumulation account, death benefit, premium, policy loans, and policy liens. This statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for medicaid or other government benefits or entitlements. When the insurer pays the accelerated benefit, it shall issue an amended schedule page to the owner of an individual policy, or to the certificate holder of a group policy, showing any new, reduced in-force amount of the policy. When more than one payment of accelerated benefit is permitted under the policy or rider, the insurer shall send a revised statement to the owner of an individual policy, or to the certificate holder of a group policy, when a previous statement has become invalid due to payment of accelerated benefits.

WAC 284-30-600 Unfair practices with respect to out-of-state group life and disability insurance. (1) Under RCW 48.30.010, it is an unfair method of competition and an unfair practice for any insurer to engage in any insurance transaction, as defined in RCW 48.01.060, regarding life insurance, annuities, or disability insurance coverage on individuals in

this state under a group policy delivered to a policyholder outside this state when:

(a) The policy or certificate providing coverage in the state of Washington, including, but not limited to, applications, riders, or endorsements, contains any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy or certificate.

(b) The policy or certificate providing coverage in the state of Washington, including, but not limited to, applications, riders, or endorsements, has any title, heading, or other indication of its provisions which is misleading.

(c) The policy or certificate delivered to residents of the state of Washington does not include all terms and conditions of the coverage.

(d) The type of group being covered under the contract providing coverage in the state of Washington does not qualify for group life insurance or group disability insurance under the provisions of Title 48 RCW.

(e) The coverage is being solicited by deceptive advertising.

(f) With respect to disability insurance, the policy or certificate providing coverage in the state of Washington does not:

(i) Provide that claims will be processed in compliance with RCW 48.21.130 through 48.21.148;

(ii) Meet the requirements as to benefits and coverage mandated by chapter 48.21 RCW and rules effectuating that chapter, specifically including those set forth in chapter 284-51 WAC, and WAC 284-30-610, 284-30-620 and 284-30-630;

(iii) With respect to long-term care insurance, also meet the requirements of chapters 48.83 or 48.84 RCW and chapters 284-54 or 284-83 WAC;

(iv)With respect to supplemental long-term care insurance, also meet the requirements of chapter 380, Laws of 2025 and chapter 284-83A WAC;

(iv) With respect to medicare supplemental insurance, also meet the requirements of chapter 48.66 RCW and chapter 284-66 WAC; and

(v) Meet the loss ratio standards applicable to group insurance under RCW 48.66.100 and 48.70.030 and chapter 284-60 WAC.

(g) With respect to life insurance, the out-of-state group policy or certificate providing coverage in the state of Washington fails to comply with the provisions of:

(i) Chapter 48.24 RCW;

(ii) WAC 284-23-550 and 284-23-600 through 284-23-730;

(iii) WAC 284-30-620; and

(iv) WAC 284-30-630.

(2) Except as provided in subsection (3)(c) of this section, for purposes of this section it is immaterial whether the coverage is offered by means of a solicitation through: A sponsoring organization; the mail broadcast or print media; electronic communication, including electronic mail and websites; licensed insurance producers; or any other method of communication.

(3) It is further defined to be an unfair practice for any insurer marketing group insurance coverage in this state to do the following with respect to the coverage:

(a) To fail to comply with the requirements of this state relating to advertising and claims settlement practices, and to fail to furnish the commissioner, upon request, copies of all advertising materials intended for use in this state;

(b) To fail to file copies of all certificate forms and any other related forms providing coverage in Washington, including trust documents or articles of incorporation with the commissioner at least thirty days prior to use; and

(c) To fail to file with the commissioner a copy of the disclosure statement required by WAC 284-30-610, where the sale of coverage to individuals in this state will be through solicitation by insurance producers. The disclosure statement must be appropriately completed, as it appears when delivered to the Washington individuals who are solicited by the Washington licensees.

The disclosure form must also be filed at least thirty days prior to any solicitation of coverage.

(4) This section does not apply to self-funded plans that are defined by and subject to the federal Employee Retirement

Income Security Act of 1974 (ERISA) or to insurers when acting as third-party administrators for self-funded ERISA plans.

WAC 284-30A-020 Scope of applicability. (1) This chapter applies to policies renewed on or after June 1, 2024.

(2) This chapter applies to authorized insurers with the following types of personal insurance policies:

(a) Private passenger automobile coverage; and

(b) Homeowner's coverage, including mobile homeowners, manufactured homeowners, condominium owners, and renter's coverage.

(3) This chapter applies to renewals of policies and will not apply to the purchase of new policies or new insurance applications.

(4) Exemptions:

(a) This chapter does not apply to personal insurance policies for coverage of boats, motorcycles, off-road vehicles, recreational vehicles, antique or collector vehicles, classic vehicles, and specialty vehicles.

(b) Insurers of health, disability, life, long-term care, and supplemental long-term care are exempt from compliance with this chapter. Health care services contractors and health maintenance organizations are also exempt from compliance with this chapter.

(c) Nothing in this chapter requires insurers to disclose the contents of credit-based insurance scoring models, company placement criteria or eligibility rules, and strictly confidential insurance company trade secrets, as defined by chapter 19.108 RCW (Uniform Trade Secrets Act). However, insurers may need to provide information specific to the policyholder that has been produced through or resulting from these sources to comply with this chapter.

(d) Information in a filing on "usage-based insurance" and about the usage-based component of the rate is confidential and exempt from this chapter, pursuant to RCW 48.19.040.

(e) This chapter does not apply to policyholder-initiated changes to insurance coverages, policies, or premiums.

(f) This chapter does not apply to personal umbrella policies.

(5) This chapter is not intended to contradict or conflict with the Fair Credit Reporting Act (15 U.S.C. Sec. 1681).

(6) This chapter, and the associated premium change transparency requirements, are in addition to and separate from the disclosure requirements contained in chapter 284-24A WAC.

(7) Violation of this regulation is not a violation for purposes of RCW 48.30.015(5).

WAC 284-43-0160 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or

investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Behavioral health agency" means an agency licensed or certified under RCW 71.24.037.

(4) "Clinical review criteria" means the written screens or screening procedures, decision rules, medical protocols, or clinical practice guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services, including prescription drug benefits, under the auspices of the applicable plan. Clinical approval criteria has the same meaning as clinical review criteria.

(5) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(6) "Covered person" or "enrollee" means an individual covered by a health plan including a subscriber, policyholder, or beneficiary of a group plan.

(7) "Emergency fill" means a limited dispensed amount of medication that allows time for the processing of a preauthorization request. Emergency fill only applies to those circumstances where a patient presents at a contracted pharmacy

with an immediate therapeutic need for a prescribed medication that requires a prior authorization.

(8) "Emergency medical condition" has the meaning set forth in RCW 48.43.005.

(9) "Emergency services" has the meaning set forth in RCW 48.43.005.

(10) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(11) "Expedited prior authorization request" has the meaning set forth in RCW 48.43.830.

(12) "Facility" means an institution providing health care services including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(13) "Formulary" means a listing of drugs used within a health plan. A formulary must include drugs covered under an enrollee's medical benefit.

(14) "Grievance" has the meaning set forth in RCW 48.43.005.

(15) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(16) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(17) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and

a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

(18) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapters 48.83 or 48.84 RCW;(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(l) Supplemental long-term care insurance governed by chapter 380, Laws of 2025;

(19) "Immediate therapeutic needs" means those needs where passage of time without treatment would result in imminent emergency care, hospital admission or might seriously jeopardize the life or health of the patient or others in contact with the patient.

(20) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health

program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

(21) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

(22) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

(23) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(24) "Mental health services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize or ameliorate the effects of a mental disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association, including diagnoses and treatment for substance use disorder.

(25) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(26) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or

subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(27) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(28) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(29) "Predetermination request" means a voluntary request from an enrollee or provider or facility for a carrier or its designated or contracted representative to determine if a service is a benefit, in relation to the applicable plan.

(30) "Preservice requirement" means any requirement that a carrier places on a provider or facility that may limit their ability to deliver a service that requires prior authorization. Examples include limits on the type of provider or facility delivering the service, a service that must be provided before a

specific service will be authorized, site of care/place of service, and whether a provider administered medication needs to be obtained from a specialty pharmacy.

(31) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(32) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(33) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(34) "Prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan. Prior authorization occurs before the service is delivered. For purposes of WAC 284-43-2050 and 284-43-2060, any term used by a carrier or its designated or contracted representative to describe this process is prior authorization. For example, prior authorization has also been referred to as "prospective review," "preauthorization," or "precertification."

(35) "Refill" means a second or subsequent filling of a previously issued prescription.

(36) "Serious mental illness" means a mental disorder, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association, that results in serious functional impairment that substantially interferes with or limits one or more major life activities.

(37) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(38) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005 comprising from one to 50 eligible employees.

(39) "Standard prior authorization request" has the meaning set forth in RCW 48.43.830.

(40) "Step therapy protocol" means a drug utilization management prior authorization protocol or program that establishes the specific sequence in which prescription drugs are covered by a health carrier for a medical condition.

(41) "Substance use disorder" means a substance-related or addictive disorder listed in the most current version of the

Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

(42) "Substitute drug" means a prescription medication, drug or therapy that a carrier covers based on an exception request. When the exception request is based on therapeutic equivalence, a substitute drug means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

(43) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

(44) "Withdrawal management services" means 24 hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction of medications for addiction recovery.

WAC 284-66-135 Disclosure statements to be used with policies that are not medicare supplement policies.

Applications for the purchase of disability or other medical insurance policies or certificates, that are provided to persons eligible for medicare, must disclose the extent to which the policy duplicates medicare. The disclosure must be in the form provided by this section. The applicable disclosure statement must be provided as a part of, or together with, the application for the policy or certificate.

(1) **Instructions for use of the disclosure statements for health insurance policies sold to medicare beneficiaries that duplicate medicare.**

(a) Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a disability or other health insurance policy (the term "policy" or "policies" includes certificates and contracts of all issuers) that duplicate medicare benefits unless it will pay benefits without regard to other disability or other health coverage and it includes the prescribed disclosure statement on or together with the application.

(b) All types of disability or other health insurance policies that duplicate medicare must include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary substantially from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

(c) State and federal law prohibits insurers from selling a medicare supplement policy to a person that already has a medicare supplement policy except as a replacement.

(d) Property/casualty and life insurance policies are not considered disability or other health insurance.

(e) Disability income policies are not considered to provide benefits that duplicate medicare.

(f) Long-term care insurance policies or supplemental long-term care insurance policies that coordinate with medicare and other health insurance are not considered to provide benefits that duplicate medicare.

(g) The federal law does not preempt state laws that are more stringent than the federal requirements.

(h) The federal law does not preempt existing state form filing requirements.

(2) **Disclosure statement to be used for policies that provide benefits for expenses incurred for accidental injury only.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(3) **Disclosure statement to be used with policies that provide benefits for specified limited services.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your medicare deductibles

or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when:

- any of the services covered by the policy are also covered by medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(4) **Disclosure statement to be used with policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer,**

specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physical services
- hospice
- [outpatient prescription drugs if you are enrolled in medicare Part D]

- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(5) **Disclosure statement to be used with policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits because medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(6) **Disclosure statement to be used with indemnity policies and other policies that pay a fixed dollar amount per day,**

excluding long-term care policies and supplemental long-term care policies.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when:

- any expenses or service covered by the policy are also covered by medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- hospice
- other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(7) **Disclosure statement to be used with policies that provide benefits for both expenses incurred and fixed indemnity basis.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when:

- any expenses or service covered by the policy are also covered by medicare; or

- it pays the fixed dollar amount stated in the policy and medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- hospice care
- other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(8) **Disclosure statement to be used with long-term care policies or supplemental long-term care policies providing both nursing home and noninstitutional coverage.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates medicare benefits in some situations.

- This is long term care insurance or supplemental long-term care insurance that provides benefits for covered nursing home and home care services.
- In some situations medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

Neither medicare nor medicare supplement insurance provides benefits for most long-term care expenses.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about long term care insurance, review the *Consumer's Guide to Long Term Care Insurance*, available from the insurance company.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(9) **Disclosure statement to be used with policies providing nursing home benefits only.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates medicare benefits in some situations.

- This insurance provides benefits primarily for covered nursing home services.
- In some situations medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

Neither medicare nor medicare supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about long term care insurance, review the *Consumer's Guide to Long Term Care Insurance*, available from the insurance company.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(10) **Disclosure statement to be used with policies providing home care benefits only.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

Neither medicare nor medicare supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about long term care insurance, review the *Consumer's Guide to Long Term Care Insurance*, available from the insurance company.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(11) **Disclosure statement to be used with other health insurance policies not specifically identified in the previous statements.**

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

WAC 284-83-060 Requirements for application forms and replacement coverage. (1) Application forms must include questions designed to elicit information as to whether, as of the date of the application, the applicant has another health, supplemental long-term care, or long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other health, long-term care, or supplemental long-term care policy or certificate presently in force.

(a) A supplementary application or other form, signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by RCW 48.83.020 (6)(a), the required questions may be modified only to the extent necessary to elicit information about health, supplemental long-term care, or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

(b) The following questions, or words substantially similar to the following, must be used:

(i) "Do you have another health, supplemental long-term care, or long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?

(ii) Did you have another health, supplemental long-term care, or long-term care insurance policy or certificate in force during the last twelve months? If so, with which company? If that policy lapsed, when did it lapse?

(iii) Are you covered by medicaid?

(iv) Do you intend to replace any of your medical, health, long-term care, or supplemental long-term care insurance coverage with this policy [certificate]?"

(2) Insurance producers must list any other health insurance policies they have sold to the applicant that are still in force and any similar policies sold in the past five years that are no longer in force.

(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, the issuer, other than an issuer using direct response solicitation methods, or its insurance producer, must furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of health care, supplemental long-term care, or long-term care coverage. One copy of the notice must be retained by the applicant and an additional copy must be signed by the applicant and must be retained by the issuer. The notice set forth in WAC 284-83-063 must be used.

(4) Direct response solicitations. Issuers using direct response solicitation methods must deliver a notice regarding replacement of health, supplemental long-term care, or long-term care coverage to the applicant upon issuance of the policy. The required notice set forth in WAC 284-83-067 must be used.

(5) If replacement is intended, the replacing issuer must notify the existing issuer of the proposed replacement in writing. The existing policy must be identified by the issuer, including the name of the insured and policy number or address plus zip code. Notice must be made within five working days after the date the application is received by the issuer or the date the policy is issued, whichever is sooner.

(6) Life insurance policies that accelerate benefits for long-term care must comply with this section if the policy being replaced is a supplemental long-term care or long-term care insurance policy.

(a) If the policy being replaced is a life insurance policy, the issuer must comply with the replacement requirements of WAC 284-23-400 through 284-23-485.

(b) If a life insurance policy that accelerates benefits for supplemental long-term care or long-term care is replaced by a long-term care policy, the replacing issuer must comply with both the long-term care and the life insurance replacement requirements.

WAC 284-83-063 Notice to applicant regarding replacement of individual accident and sickness, supplemental long-term care insurance, or long-term care insurance marketed by an insurance producer. The following notice is required in WAC 284-83-060(3):

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL [ACCIDENT AND SICKNESS] [HEALTH] [SUPPLEMENTAL LONG-TERM CARE INSURANCE] OR [LONG-TERM CARE INSURANCE]

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing [accident and sickness] [health] [supplemental long-term care insurance] or [long-term care] insurance and replace it with an

individual long-term care insurance policy to be issued by [company name] insurance company. Your new policy provides thirty days within which you may decide, without cost, whether you desire to keep the policy. 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.

You should review this new coverage carefully, comparing it with all [accident and sickness] [health] [supplemental long-term care], or [long-term care] insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY [INSURANCE PRODUCER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical, health insurance, supplemental long-term care insurance and/or long-term care insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position.

My conclusion has taken into account the following considerations, which I call to your attention:

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

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you are replacing existing supplemental long-term care or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its appointed [insurance producer] regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) 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 had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of [Insurance Producer] or Other Representative)

[Typed Name and Address of [Insurance Producer]]

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

(Applicant's Signature) (Date)

WAC 284-83-067 Notice to applicant regarding replacement of direct-marketed individual accident and sickness or long-term care insurance. The following notice is required by WAC 284-83-060(4):

NOTICE TO APPLICANT REGARDING REPLACEMENT OF [ACCIDENT AND SICKNESS] [HEALTH] [SUPPLEMENTAL LONG-TERM CARE INSURANCE] OR [LONG-TERM CARE INSURANCE]

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing

[accident and sickness] [health] [supplemental long-term care] or [long-term care] insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] insurance company. Your new policy provides thirty days within which you may decide, without cost, whether you desire to keep the policy. 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.

You should review this new coverage carefully, comparing it with all [accident and sickness] [health] [supplemental long-term care] or [long-term care] insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

(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 in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you are replacing existing supplemental long-term care insurance or long-term care insurance coverage, you may wish to secure the advice of your present insurer or its [agent] [insurance producer] regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

WAC 284-170-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's

eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Allowed amount" has the meaning set forth in RCW 48.43.005.

(3)(a) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(b) "Audio-only telemedicine" does not include:

(i) The use of facsimile, email, or text messages, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability; or

(ii) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results.

(4) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(5) "Clinical review criteria" means the written screens, or screening procedures, decision rules, medical protocols, or clinical practice guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services, including prescription drug benefits, under the auspices of the applicable health plan. Clinical approval criteria has the same meaning as clinical review criteria.

(6) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(7) "Covered person" or "enrollee" means an individual covered by a health plan including a subscriber, policyholder, or beneficiary of a group plan.

(8) "Disciplining authority" has the meaning set forth in RCW 18.130.020.

(9) "Distant site" has the meaning set forth in RCW 48.43.735.

(10) "Emergency medical condition" has the meaning set forth in RCW 48.43.005.

(11) "Emergency services" has the meaning set forth in RCW 48.43.005.

(12) "Enrollee point-of-service cost-sharing" or "cost-sharing" has the meaning set forth in RCW 48.43.005.

(13) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(a) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with:

(i) The provider providing audio-only telemedicine;

(ii) A provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(iii) A locum tenens or other provider who is the designated back up or substitute provider for the provider providing audio-only telemedicine who is on leave and is not associated with an established medical group, clinic, or integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW; or

(b) The covered person was referred to the provider providing audio-only telemedicine by another provider who has:

(i) Had, within the past three years, at least one in-person appointment, or at least one real-time interactive

appointment using both audio and video technology, with the covered person; and

(ii) Provided relevant medical information to the provider providing audio-only telemedicine.

(iii) A referral includes circumstances in which the provider who has had at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person participates in the audio-only telemedicine encounter with the provider to whom the covered person has been referred.

(14) "Expedited prior authorization request" has the meaning set forth in RCW 48.43.830.

(15) "Facility" means an institution providing health care services including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(16) "Formulary" means a listing of drugs used within a health plan.

(17) "Grievance" has the meaning set forth in RCW 48.43.005.

(18) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(19) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(20) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in The Patient

Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

(21) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapters 48.83 or 48.84 RCW;(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(l) Supplemental long-term care insurance governed by chapter 380, Laws of 2025;

(22) "Hospital" has the meaning set forth in RCW 48.43.735.

(23) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. Sec. 1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian

Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. Sec. 450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. Sec. 450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. Sec. 47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. Sec. 1603(29).

(24) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

(25) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

(26) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(27) "Mental health services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize, or ameliorate the effects of a mental disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric

Association, including diagnoses and treatment for substance use disorder.

(28) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(29) "Originating site" means the physical location of a patient receiving health care services through telemedicine, and includes those sites described in WAC 284-170-433.

(30) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in Physicians Current Procedural Terminology, published by the American Medical Association.

(31) "Participating provider" and "participating facility" mean a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(32) "Patient consent" means a voluntary and informed decision by a patient, following an explanation by the provider or auxiliary personnel under the general supervision of the provider presented in a manner understandable to the patient that is free of undue influence, fraud or duress, to consent to a provider billing the patient or the patient's health plan for an audio-only telemedicine service under RCW 48.43.735 or WAC 284-170-433.

(33) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(34) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(35) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(36) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(37) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(38) "Real time communication" means synchronous and live communication between a provider and a patient. It does not include delayed or recorded messages, such as email, facsimile or voicemail.

(39) "Same amount of compensation" means providers are reimbursed by a carrier using the same allowed amount for telemedicine services as they would if the service had been provided in-person unless negotiation has been undertaken under RCW 48.43.735 or WAC 284-170-433. Where consumer cost-sharing applies to telemedicine services, the consumer's payment combined with the carrier's payment must be the same amount of compensation, or allowed amount, as the carrier would pay the provider if the telemedicine service had been provided in person. Where an alternative payment methodology other than fee-for-service payment would apply to an in-person service, "same amount of compensation" means providers are reimbursed by a carrier using the same alternative payment methodology that would be used for the same service if provided in-person, unless negotiation has been undertaken under RCW 48.43.735 or WAC 284-170-433.

(40) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(41) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005 comprising from one to 50 eligible employees.

(42) "Standard prior authorization request" has the meaning set forth in RCW 48.43.830.

(43) "Store and forward technology" has the meaning set forth in RCW 48.43.735.

(44) "Substance use disorder services" means in-patient or out-patient treatment including, but not limited to, partial hospitalization, residential treatment, or out-patient facility-based treatment, intensive outpatient treatment, emergency services, or prescription drugs to manage, stabilize, or

ameliorate the effects of a substance use disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, including diagnoses and treatment for substance use disorder.

(45) "Substitute drug" means a prescription medication, drug or therapy that a carrier covers based on an exception request. When the exception request is based on therapeutic equivalence, a substitute drug means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

(46) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

(47) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology or audio-only technology, permitting real-time communication between the patient at the originating site and

the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this chapter, "telemedicine" does not include facsimile, email, or text messaging, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability.