

---

**BILL REQUEST - CODE REVISER'S OFFICE**

---

BILL REQ. #: Z-0936.2/12 2nd draft

ATTY/TYPIST: LL:seg

BRIEF DESCRIPTION: Regulating insurers and insurance products.

1 AN ACT Relating to insurers and insurance products; amending RCW  
2 4.28.080, 48.05.440, 48.06.040, 48.17.010, 48.38.010, 48.38.020,  
3 48.38.050, 48.43.310, 48.85.010, 48.85.020, 48.125.050, 48.17.380,  
4 43.70.235, 48.20.435, 48.43.018, 48.44.215, 48.46.325, 48.43.530,  
5 48.43.535, 48.46.030, 48.46.040, 48.41.110, and 48.43.510; reenacting  
6 and amending RCW 48.43.005 and 48.46.020; and repealing RCW 48.19.450.

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

8 **Sec. 1.** RCW 4.28.080 and 2011 c 47 s 1 are each amended to read as  
9 follows:

10 Service made in the modes provided in this section is personal  
11 service. The summons shall be served by delivering a copy thereof, as  
12 follows:

13 (1) If the action is against any county in this state, to the  
14 county auditor or, during normal office hours, to the deputy auditor,  
15 or in the case of a charter county, summons may be served upon the  
16 agent, if any, designated by the legislative authority.

17 (2) If against any town or incorporated city in the state, to the  
18 mayor, city manager, or, during normal office hours, to the mayor's or  
19 city manager's designated agent or the city clerk thereof.

1 (3) If against a school or fire district, to the superintendent or  
2 commissioner thereof or by leaving the same in his or her office with  
3 an assistant superintendent, deputy commissioner, or business manager  
4 during normal business hours.

5 (4) If against a railroad corporation, to any station, freight,  
6 ticket or other agent thereof within this state.

7 (5) If against a corporation owning or operating sleeping cars, or  
8 hotel cars, to any person having charge of any of its cars or any agent  
9 found within the state.

10 (6) If against a domestic insurance company, to any agent  
11 authorized by such company to solicit insurance within this state.

12 (7)(a) If against an (~~unauthorized~~) authorized foreign or alien  
13 insurance company, as provided in RCW 48.05.200.

14 (b) If against an unauthorized insurer, as provided in RCW  
15 48.05.215 and 48.15.150.

16 (c) If against a reciprocal insurer, as provided in RCW 48.10.170.

17 (d) If against a nonresident surplus line broker, as provided in  
18 RCW 48.15.073.

19 (e) If against a nonresident insurance producer or title insurance  
20 agent, as provided in RCW 48.17.173.

21 (f) If against a nonresident adjuster, as provided in RCW  
22 48.17.380.

23 (g) If against a fraternal benefit society, as provided in RCW  
24 48.36A.350.

25 (h) If against a nonresident reinsurance intermediary, as provided  
26 in RCW 48.94.010.

27 (i) If against a nonresident life settlement provider, as provided  
28 in RCW 48.102.011.

29 (j) If against a nonresident life settlement broker, as provided in  
30 RCW 48.102.021.

31 (k) If against a service contract provider, as provided in RCW  
32 48.110.030.

33 (l) If against a protection product guarantee provider, as provided  
34 in RCW 48.110.055.

35 (m) If against a discount plan organization, as provided in RCW  
36 48.155.020.

37 (8) If against a company or corporation doing any express business,

1 to any agent authorized by said company or corporation to receive and  
2 deliver express matters and collect pay therefor within this state.

3 (9) If against a company or corporation other than those designated  
4 in subsections (1) through (8) of this section, to the president or  
5 other head of the company or corporation, the registered agent,  
6 secretary, cashier or managing agent thereof or to the secretary,  
7 stenographer or office assistant of the president or other head of the  
8 company or corporation, registered agent, secretary, cashier or  
9 managing agent.

10 (10) If against a foreign corporation or nonresident joint stock  
11 company, partnership or association doing business within this state,  
12 to any agent, cashier or secretary thereof.

13 (11) If against a minor under the age of fourteen years, to such  
14 minor personally, and also to his or her father, mother, guardian, or  
15 if there be none within this state, then to any person having the care  
16 or control of such minor, or with whom he or she resides, or in whose  
17 service he or she is employed, if such there be.

18 (12) If against any person for whom a guardian has been appointed  
19 for any cause, then to such guardian.

20 (13) If against a foreign or alien steamship company or steamship  
21 charterer, to any agent authorized by such company or charterer to  
22 solicit cargo or passengers for transportation to or from ports in the  
23 state of Washington.

24 (14) If against a self-insurance program regulated by chapter 48.62  
25 RCW, as provided in chapter 48.62 RCW.

26 (15) In all other cases, to the defendant personally, or by leaving  
27 a copy of the summons at the house of his or her usual abode with some  
28 person of suitable age and discretion then resident therein.

29 (16) In lieu of service under subsection (15) of this section,  
30 where the person cannot with reasonable diligence be served as  
31 described, the summons may be served as provided in this subsection,  
32 and shall be deemed complete on the tenth day after the required  
33 mailing: By leaving a copy at his or her usual mailing address with a  
34 person of suitable age and discretion who is a resident, proprietor, or  
35 agent thereof, and by thereafter mailing a copy by first-class mail,  
36 postage prepaid, to the person to be served at his or her usual mailing  
37 address. For the purposes of this subsection, "usual mailing address"

1 does not include a United States postal service post office box or the  
2 person's place of employment.

3 **Sec. 2.** RCW 48.05.440 and 2006 c 25 s 6 are each amended to read  
4 as follows:

5 (1) "Company action level event" means any of the following events:

6 (a) The filing of an RBC report by an insurer indicating that:

7 (i) The insurer's total adjusted capital is greater than or equal  
8 to its regulatory action level RBC, but less than its company action  
9 level RBC;

10 (ii) If a life and disability insurer, the insurer has total  
11 adjusted capital that is greater than or equal to its company action  
12 level RBC, but less than the product of its authorized control level  
13 RBC and ((2.5)) 3 and has a negative trend; or

14 (iii) If a property and casualty insurer, the insurer has total  
15 adjusted capital that is greater than or equal to its company action  
16 level RBC but less than the product of its authorized control level RBC  
17 and 3.0 and met the trend test determined in accordance with the trend  
18 test calculation included in the RBC instructions;

19 (b) The notification by the commissioner to the insurer of an  
20 adjusted RBC report that indicates an event in (a) of this subsection,  
21 provided the insurer does not challenge the adjusted RBC report under  
22 RCW 48.05.460; or

23 (c) If, under RCW 48.05.460, an insurer challenges an adjusted RBC  
24 report that indicates an event in (a) of this subsection, the  
25 notification by the commissioner to the insurer that the commissioner  
26 has, after a hearing, rejected the insurer's challenge.

27 (2) In the event of a company action level event, the insurer shall  
28 prepare and submit to the commissioner an RBC plan that:

29 (a) Identifies the conditions that contribute to the company action  
30 level event;

31 (b) Contains proposals of corrective actions that the insurer  
32 intends to take and would be expected to result in the elimination of  
33 the company action level event;

34 (c) Provides projections of the insurer's financial results in the  
35 current year and at least the four succeeding years, both in the  
36 absence of proposed corrective actions and giving effect to the  
37 proposed corrective actions, including projections of statutory

1 operating income, net income, capital, and surplus. The projections  
2 for both new and renewal business might include separate projections  
3 for each major line of business and separately identify each  
4 significant income, expense, and benefit component;

5 (d) Identifies the key assumptions impacting the insurer's  
6 projections and the sensitivity of the projections to the assumptions;  
7 and

8 (e) Identifies the quality of, and problems associated with, the  
9 insurer's business, including but not limited to its assets,  
10 anticipated business growth and associated surplus strain,  
11 extraordinary exposure to risk, mix of business, and use of  
12 reinsurance, if any, in each case.

13 (3) The RBC plan shall be submitted:

14 (a) Within forty-five days of the company action level event; or

15 (b) If the insurer challenges an adjusted RBC report under RCW  
16 48.05.460, within forty-five days after notification to the insurer  
17 that the commissioner has, after a hearing, rejected the insurer's  
18 challenge.

19 (4) Within sixty days after the submission by an insurer of an RBC  
20 plan to the commissioner, the commissioner shall notify the insurer  
21 whether the RBC plan may be implemented or is, in the judgment of the  
22 commissioner, unsatisfactory. If the commissioner determines the RBC  
23 plan is unsatisfactory, the notification to the insurer shall set forth  
24 the reasons for the determination, and may set forth proposed revisions  
25 that will render the RBC plan satisfactory. Upon notification from the  
26 commissioner, the insurer shall prepare a revised RBC plan, that may  
27 incorporate by reference any revisions proposed by the commissioner,  
28 and shall submit the revised RBC plan to the commissioner:

29 (a) Within forty-five days after the notification from the  
30 commissioner; or

31 (b) If the insurer challenges the notification from the  
32 commissioner under RCW 48.05.460, within forty-five days after a  
33 notification to the insurer that the commissioner has, after a hearing,  
34 rejected the insurer's challenge.

35 (5) In the event of a notification by the commissioner to an  
36 insurer that the insurer's RBC plan or revised RBC plan is  
37 unsatisfactory, the commissioner may, subject to the insurer's rights

1 to a hearing under RCW 48.05.460, specify in the notification that the  
2 notification constitutes a regulatory action level event.

3 (6) Every domestic insurer that files an RBC plan or revised RBC  
4 plan with the commissioner shall file a copy of the RBC plan or revised  
5 RBC plan with the insurance commissioner in any state in which the  
6 insurer is authorized to do business if:

7 (a) The state has an RBC provision substantially similar to RCW  
8 48.05.465(1); and

9 (b) The insurance commissioner of that state has notified the  
10 insurer of its request for the filing in writing, in which case the  
11 insurer shall file a copy of the RBC plan or revised RBC plan in that  
12 state no later than the later of:

13 (i) Fifteen days after the receipt of notice to file a copy of its  
14 RBC plan or revised plan with the state; or

15 (ii) The date on which the RBC plan or revised RBC plan is filed  
16 under subsections (3) and (4) of this section.

17 **Sec. 3.** RCW 48.06.040 and 2002 c 227 s 1 are each amended to read  
18 as follows:

19 To apply for a solicitation permit the person shall:

20 (1) File with the commissioner a request showing:

21 (a) Name, type, and purpose of insurer, corporation, or syndicate  
22 proposed to be formed;

23 (b) ~~((Names, addresses, fingerprints for submission to the  
24 Washington state patrol, the federal bureau of investigation, and any  
25 governmental agency or entity authorized to receive this information  
26 for a state and national criminal history background check, and  
27 business records of each person associated or to be associated in the  
28 formation of the proposed insurer, corporation, or syndicate))~~  
29 Biographical reports on forms prescribed by the national association of  
30 insurance commissioners evidencing the general trustworthiness and  
31 competence of each individual who is serving or who will serve as an  
32 officer, director, trustee, employee, or fiduciary of the insurer,  
33 corporation, or syndicate to be formed;

34 (c) Third-party verification reports from a vendor authorized by  
35 the national association of insurance commissioners to perform a state,  
36 national, and international background history check of any person who

1 exercises control over the financial dealings and operations of the  
2 insurer, corporation, or syndicate;

3 ((+e)) (d) Full disclosure of the terms of all understandings and  
4 agreements existing or proposed among persons so associated relative to  
5 the proposed insurer, corporation, or syndicate, or the formation  
6 thereof;

7 ((+d)) (e) The plan according to which solicitations are to be  
8 made; and

9 ((+e)) (f) Additional information as the commissioner may  
10 reasonably require.

11 (2) File with the commissioner:

12 (a) Original and copies in triplicate of proposed articles of  
13 incorporation, or syndicate agreement; or, if the proposed insurer is  
14 a reciprocal, original and duplicate of the proposed subscribers'  
15 agreement and attorney-in-fact agreement;

16 (b) Original and duplicate copy of any proposed bylaws;

17 (c) Copy of any security proposed to be issued and copy of  
18 application or subscription agreement for that security;

19 (d) Copy of any insurance contract proposed to be offered and copy  
20 of application for that contract;

21 (e) Copy of any prospectus, advertising, or literature proposed to  
22 be used; and

23 (f) Copy of proposed form of any escrow agreement required.

24 (3) Deposit with the commissioner the fees required by law to be  
25 paid for the application including fees associated with the state and  
26 national criminal history background check, for filing of the articles  
27 of incorporation of an insurer, for filing the subscribers' agreement  
28 and attorney-in-fact agreement if the proposed insurer is a reciprocal,  
29 for the solicitation permit, if granted, and for filing articles of  
30 incorporation with the secretary of state.

31 **Sec. 4.** RCW 48.17.010 and 2010 c 67 s 2 are each amended to read  
32 as follows:

33 The definitions in this section apply throughout this title unless  
34 the context clearly requires otherwise.

35 (1) "Adjuster" means any person who, for compensation as an  
36 independent contractor or as an employee of an independent contractor,  
37 or for fee or commission, investigates or reports to the adjuster's

1 principal relative to claims arising under insurance contracts, on  
2 behalf solely of either the insurer or the insured. An attorney-at-law  
3 who adjusts insurance losses from time to time incidental to the  
4 practice of his or her profession or an adjuster of marine losses is  
5 not deemed to be an "adjuster" for the purpose of this chapter. A  
6 salaried employee of an insurer or of a managing general agent is not  
7 deemed to be an "adjuster" for the purpose of this chapter, except when  
8 acting as a crop adjuster.

9 (a) "Independent adjuster" means an adjuster representing the  
10 interests of the insurer.

11 (b) "Public adjuster" means an adjuster employed by and  
12 representing solely the financial interests of the insured named in the  
13 policy.

14 (c) "Crop adjuster" means an adjuster, including (i) an independent  
15 adjuster, (ii) a public adjuster, and (iii) an employee of an insurer  
16 or managing general agent, who acts as an adjuster for claims arising  
17 under crop insurance. A salaried employee of an insurer or of a  
18 managing general agent who is certified by a crop adjuster program  
19 approved by the risk management agency of the United States department  
20 of agriculture is not a "crop adjuster" for the purposes of this  
21 chapter. Proof of certification must be provided to the commissioner  
22 upon request.

23 (2) "Business entity" means a corporation, association,  
24 partnership, limited liability company, limited liability partnership,  
25 or other legal entity.

26 (3) "Crop insurance" means insurance coverage for damage to crops  
27 from unfavorable weather conditions, fire or lightning, flood, hail,  
28 insect infestation, disease, or other yield-reducing conditions or  
29 perils provided by the private insurance market, or multiple peril crop  
30 insurance reinsured by the federal crop insurance corporation,  
31 including but not limited to revenue insurance.

32 (4) "Home state" means the District of Columbia and any state or  
33 territory of the United States or province of Canada in which an  
34 insurance producer or adjuster maintains the insurance producer's or  
35 adjuster's principal place of residence or principal place of business,  
36 and is licensed to act as an insurance producer or adjuster.

37 (5) "Insurance education provider" means any insurer, health care  
38 service contractor, health maintenance organization, professional

1 association, educational institution created by Washington statutes, or  
2 vocational school licensed under Title 28C RCW, or independent  
3 contractor to which the commissioner has granted authority to conduct  
4 and certify completion of a course satisfying the insurance education  
5 requirements of RCW 48.17.150.

6 (6) "Insurance producer" means a person required to be licensed  
7 under the laws of this state to sell, solicit, or negotiate insurance.  
8 "Insurance producer" does not include title insurance agents as defined  
9 in subsection (16) of this section or surplus line brokers licensed  
10 under chapter 48.15 RCW.

11 (7) "Insurer" has the same meaning as in RCW 48.01.050, and  
12 includes a health care service contractor as defined in RCW 48.44.010  
13 and a health maintenance organization as defined in RCW 48.46.020.

14 (8) "License" means a document issued by the commissioner  
15 authorizing a person to act as an insurance producer or title insurance  
16 agent for the lines of authority specified in the document. The  
17 license itself does not create any authority, actual, apparent, or  
18 inherent, in the holder to represent or commit to an insurer.

19 (9) "Limited line credit insurance" includes credit life, credit  
20 disability, credit property, credit unemployment, involuntary  
21 unemployment, mortgage life, mortgage guaranty, mortgage disability,  
22 automobile dealer gap insurance, and any other form of insurance  
23 offered in connection with an extension of credit that is limited to  
24 partially or wholly extinguishing the credit obligation that the  
25 commissioner determines should be designated a form of limited line  
26 credit insurance.

27 (10) "NAIC" means national association of insurance commissioners.

28 (11) "Negotiate" means the act of conferring directly with, or  
29 offering advice directly to, a purchaser or prospective purchaser of a  
30 particular contract of insurance concerning any of the substantive  
31 benefits, terms, or conditions of the contract, provided that the  
32 person engaged in that act either sells insurance or obtains insurance  
33 from insurers for purchasers.

34 (12) "Person" means an individual or a business entity.

35 (13) "Sell" means to exchange a contract of insurance by any means,  
36 for money or its equivalent, on behalf of an insurer.

37 (14) "Solicit" means attempting to sell insurance or asking or

1 urging a person to apply for a particular kind of insurance from a  
2 particular insurer.

3 (15) "Terminate" means the cancellation of the relationship between  
4 an insurance producer and the insurer or the termination of an  
5 insurance producer's authority to transact insurance.

6 (16) "Title insurance agent" means a business entity licensed under  
7 the laws of this state and appointed by an authorized title insurance  
8 company to sell, solicit, or negotiate insurance on behalf of the title  
9 insurance company.

10 (17) "Uniform application" means the current version of the NAIC  
11 uniform application for individual insurance producers for resident and  
12 nonresident insurance producer licensing.

13 (18) "Uniform business entity application" means the current  
14 version of the NAIC uniform application for business entity insurance  
15 license or registration for resident and nonresident business entities.

16 **Sec. 5.** RCW 48.38.010 and 2010 c 27 s 2 are each amended to read  
17 as follows:

18 The commissioner may grant a certificate of exemption to any  
19 insurer or educational, religious, charitable, or scientific  
20 institution conducting a charitable gift annuity business:

21 (1) Which is organized and operated exclusively as, or for the  
22 purpose of aiding, an educational, religious, charitable, or scientific  
23 institution which is organized as a nonprofit organization without  
24 profit to any person, firm, partnership, association, corporation, or  
25 other entity;

26 (2) Which possesses a current tax exempt status under the laws of  
27 the United States;

28 (3) Which serves such purpose by issuing charitable gift annuity  
29 contracts only for the benefit of such educational, religious,  
30 charitable, or scientific institution;

31 (4) Which appoints the insurance commissioner as its true and  
32 lawful attorney upon whom may be served lawful process in any action,  
33 suit, or proceeding in any court, which appointment is irrevocable,  
34 binds the insurer or institution or any successor in interest, remains  
35 in effect as long as there is in force in this state any contract made  
36 or issued by the insurer or institution, or any obligation arising

1 therefrom, and must be processed in accordance with RCW ((~~48.05.210~~))  
2 48.05.200;

3 (5) Which is fully and legally organized and qualified to do  
4 business and has been actively doing business under the laws of the  
5 state of its domicile for a period of at least three years prior to its  
6 application for a certificate of exemption;

7 (6) Which has and maintains minimum unrestricted net assets of five  
8 hundred thousand dollars. "Unrestricted net assets" means the excess  
9 of total assets over total liabilities that are neither permanently  
10 restricted nor temporarily restricted by donor-imposed stipulations;

11 (7) Which files with the insurance commissioner its application for  
12 a certificate of exemption showing:

13 (a) Its name, location, and organization date;

14 (b) The kinds of charitable annuities it proposes to offer;

15 (c) A statement of the financial condition, management, and affairs  
16 of the organization and any affiliate thereof, as that term is defined  
17 in RCW 48.31B.005, on a form satisfactory to, or furnished by the  
18 insurance commissioner;

19 (d) Other documents, stipulations, or information as the insurance  
20 commissioner may reasonably require to evidence compliance with the  
21 provisions of this chapter;

22 (8) Which subjects itself and any affiliate thereof, as that term  
23 is defined in RCW 48.31B.005, to periodic examinations conducted under  
24 chapter 48.03 RCW as may be deemed necessary by the insurance  
25 commissioner;

26 (9) Which files with the insurance commissioner for the  
27 commissioner's advance approval a copy of any policy or contract form  
28 to be offered or issued to residents of this state. The grounds for  
29 disapproval of the policy or contract form are set forth in RCW  
30 48.18.110; and

31 (10) Which:

32 (a) Files with the insurance commissioner annually, within sixty  
33 days of the end of its fiscal year a report of its current financial  
34 condition, management, and affairs, on a form and in a manner  
35 prescribed by the commissioner, as well as such other financial  
36 material as may be requested, including the annual statement or other  
37 such financial materials as may be requested relating to any affiliate,  
38 as that term is defined in RCW 48.31B.005;

1 (b) Attaches to the report of its current financial condition the  
2 statement of a qualified actuary setting forth the actuary's opinion  
3 relating to annuity reserves and other actuarial items for the fiscal  
4 year covered by the report. "Qualified actuary" as used in this  
5 subsection means a member in good standing of the American academy of  
6 actuaries or a person who has otherwise demonstrated actuarial  
7 competence to the satisfaction of the insurance regulatory official of  
8 the domiciliary state; and

9 (c) On or before March 1st of each year, pays an annual filing fee  
10 of twenty-five dollars plus five dollars for each charitable gift  
11 annuity contract written for residents of this state during its fiscal  
12 year ending on or before December 31st of the previous calendar year.

13 **Sec. 6.** RCW 48.38.020 and 2002 c 295 s 1 are each amended to read  
14 as follows:

15 (1) Upon granting to such insurer or institution under RCW  
16 48.38.010 a certificate of exemption to conduct a charitable gift  
17 annuity business, the insurance commissioner shall require it to  
18 establish and maintain a separate reserve fund adequate to meet the  
19 future payments under its charitable gift annuity contracts.

20 (2) The assets of the separate reserve fund:

21 (a) Shall be held legally and physically segregated from the other  
22 assets of the certificate of exemption holder;

23 (b) Shall be invested in the same manner that persons of reasonable  
24 prudence, discretion, and intelligence exercise in the management of a  
25 like enterprise, not in regard to speculating but in regard to the  
26 permanent disposition of their funds, considering the probable income  
27 as well as the probable safety of their capital. Investments shall be  
28 of sufficient value, liquidity, and diversity to assure the insurer or  
29 institution's ability to meet its outstanding obligations; and

30 (c) Shall not be liable for any debts of the insurer or institution  
31 holding a certificate of exemption under this chapter, other than those  
32 incurred pursuant to the issuance of charitable gift annuities.

33 (3) The amount of the separate reserve fund shall be:

34 (a) For contracts issued prior to July 1, 1998, not less than an  
35 amount computed in accordance with the standard of valuation based on  
36 the 1971 individual annuity mortality table with six percent interest

1 for single premium immediate annuity contracts and four percent  
2 interest for all other individual annuity contracts;

3 (b) For contracts issued on or after July 1, 1998, in an amount not  
4 less than the aggregate reserves calculated according to the standards  
5 set forth in RCW 48.74.030 for other annuities with no cash settlement  
6 options;

7 (c) Plus a surplus of ten percent of the combined amounts under (a)  
8 and (b) of this subsection.

9 (4) The general assets of the insurer or institution holding a  
10 certificate of exemption under this chapter shall be liable for the  
11 payment of annuities to the extent that the separate reserve fund is  
12 inadequate.

13 ~~(5) ((For any failure on its part to establish and maintain the  
14 separate reserve fund, the insurance commissioner shall revoke its  
15 certificate of exemption.~~

16 ~~(6))~~ If an institution holding a certificate of exemption under  
17 RCW 48.38.010 has purchased a single premium life annuity that pays the  
18 entire amount stipulated in the gift annuity agreement or agreements  
19 from an insurer (a) holding a certificate of authority under chapter  
20 48.05 RCW, (b) licensed in the state in which the institution has its  
21 principle office, and (c) licensed in the state in which the single  
22 premium life annuity is issued, then in determining the minimum reserve  
23 fund that must be maintained under this section, a deduction shall be  
24 allowed from the minimum reserve fund in an amount not exceeding the  
25 reserve fund amount required for the annuity or annuities for which the  
26 single premium life annuity is purchased, subject to the following  
27 conditions:

28 (i) The institution has filed with the commissioner a copy of the  
29 single premium life annuity purchased and specifying which charitable  
30 gift annuity or annuities are being insured; and

31 (ii) The institution has entered into a written agreement with the  
32 annuitant and the insurer issuing the single premium life annuity  
33 providing that if for any reason the institution is unable to continue  
34 making the annuity payments required by its annuity agreements, the  
35 annuitants shall receive payments directly from the insurer and the  
36 insurer shall be credited with all of these direct payments in the  
37 accounts between the insurer and the institution.

1       **Sec. 7.** RCW 48.38.050 and 1998 c 284 s 4 are each amended to read  
2 as follows:

3       (1) The insurance commissioner may refuse to grant, or may revoke  
4 or suspend, a certificate of exemption if the insurance commissioner  
5 finds that the insurer or institution does not meet the requirements of  
6 this chapter or if the insurance commissioner finds that the insurer or  
7 institution has violated RCW 48.01.030 ~~((or))~~, any provisions of  
8 chapter 48.30 RCW, or this chapter, and any applicable provisions of  
9 Title 284 WAC, or is found by the insurance commissioner to be in such  
10 condition that its further issuance of charitable gift annuities would  
11 be hazardous to annuity contract holders and the people of this state.

12       (2) After hearing or with the consent of the insurer or institution  
13 and in addition to or in lieu of the suspension, revocation, or refusal  
14 to renew any certificate of exemption, the commissioner may levy a fine  
15 upon the insurer or institution in an amount not more than ten thousand  
16 dollars. The order levying such a fine shall specify the period within  
17 which the fine shall be fully paid and which period shall not be less  
18 than fifteen nor more than thirty days from the date of the order.  
19 Upon failure to pay such a fine when due the commissioner ~~((shall))~~ may  
20 revoke the certificate of exemption of the insurer or institution if  
21 not already revoked, and the fine shall be recovered in a civil action  
22 brought in behalf of the commissioner by the attorney general. Any  
23 fine so collected shall be paid by the commissioner to the state  
24 treasurer for the account of the general fund.

25       **Sec. 8.** RCW 48.43.310 and 1998 c 241 s 3 are each amended to read  
26 as follows:

27       (1) "Company action level event" means any of the following events:

28       (a) The filing of an RBC report by a carrier which indicates that:

29       (i) The carrier's total adjusted capital is greater than or equal  
30 to its regulatory action level RBC but less than its company action  
31 level RBC; or

32       (ii) The carrier has total adjusted capital which is greater than  
33 or equal to its company action level RBC but less than the product of  
34 its authorized control level RBC and ~~((2.5))~~ 3 and has a negative  
35 trend;

36       (b) The notification by the commissioner to the carrier of an

1 adjusted RBC report that indicates an event in (a) of this subsection,  
2 provided the carrier does not challenge the adjusted RBC report under  
3 RCW 48.43.330; or

4 (c) If, under RCW 48.43.330, a carrier challenges an adjusted RBC  
5 report that indicates the event in (a) of this subsection, the  
6 notification by the commissioner to the carrier that the commissioner  
7 has, after a hearing, rejected the carrier's challenge.

8 (2) In the event of a company action level event, the carrier shall  
9 prepare and submit to the commissioner an RBC plan that:

10 (a) Identifies the conditions that contribute to the company action  
11 level event;

12 (b) Contains proposals of corrective actions that the carrier  
13 intends to take and would be expected to result in the elimination of  
14 the company action level event;

15 (c) Provides projections of the carrier's financial results in the  
16 current year and at least the four succeeding years, both in the  
17 absence of proposed corrective actions and giving effect to the  
18 proposed corrective actions, including projections of statutory  
19 operating income, net income, capital, surplus, capital and surplus,  
20 and net worth. The projections for both new and renewal business might  
21 include separate projections for each major line of business and  
22 separately identify each significant income, expense, and benefit  
23 component;

24 (d) Identifies the key assumptions impacting the carrier's  
25 projections and the sensitivity of the projections to the assumptions;  
26 and

27 (e) Identifies the quality of, and problems associated with, the  
28 carrier's business, including but not limited to its assets,  
29 anticipated business growth and associated surplus strain,  
30 extraordinary exposure to risk, mix of business, and use of  
31 reinsurance, if any, in each case.

32 (3) The RBC plan shall be submitted:

33 (a) Within forty-five days of the company action level event; or

34 (b) If the carrier challenges an adjusted RBC report under RCW  
35 48.43.330, within forty-five days after notification to the carrier  
36 that the commissioner has, after a hearing, rejected the carrier's  
37 challenge.

1 (4) Within sixty days after the submission by a carrier of an RBC  
2 plan to the commissioner, the commissioner shall notify the carrier  
3 whether the RBC plan may be implemented or is, in the judgment of the  
4 commissioner, unsatisfactory. If the commissioner determines the RBC  
5 plan is unsatisfactory, the notification to the carrier shall set forth  
6 the reasons for the determination, and may set forth proposed revisions  
7 that will render the RBC plan satisfactory. Upon notification from the  
8 commissioner, the carrier shall prepare a revised RBC plan, that may  
9 incorporate by reference any revisions proposed by the commissioner,  
10 and shall submit the revised RBC plan to the commissioner:

11 (a) Within forty-five days after the notification from the  
12 commissioner; or

13 (b) If the carrier challenges the notification from the  
14 commissioner under RCW 48.43.330, within forty-five days after a  
15 notification to the carrier that the commissioner has, after a hearing,  
16 rejected the carrier's challenge.

17 (5) In the event of a notification by the commissioner to a carrier  
18 that the carrier's RBC plan or revised RBC plan is unsatisfactory, the  
19 commissioner may, subject to the carrier's rights to a hearing under  
20 RCW 48.43.330, specify in the notification that the notification  
21 constitutes a regulatory action level event.

22 (6) Every domestic carrier that files an RBC plan or revised RBC  
23 plan with the commissioner shall file a copy of the RBC plan or revised  
24 RBC plan with the insurance commissioner in any state in which the  
25 carrier is authorized to do business if:

26 (a) Such state has an RBC provision substantially similar to RCW  
27 48.43.335(1); and

28 (b) The insurance commissioner of that state has notified the  
29 carrier of its request for the filing in writing, in which case the  
30 carrier shall file a copy of the RBC plan or revised RBC plan in that  
31 state no later than the later of:

32 (i) Fifteen days after the receipt of notice to file a copy of its  
33 RBC plan or revised plan with the state; or

34 (ii) The date on which the RBC plan or revised RBC plan is filed  
35 under subsections (3) and (4) of this section.

36 **Sec. 9.** RCW 48.85.010 and 2008 c 145 s 21 are each amended to read  
37 as follows:

1           The department of social and health services shall, in conjunction  
2 with the office of the insurance commissioner, coordinate a long-term  
3 care insurance program entitled the Washington long-term care  
4 partnership, whereby private insurance and medicaid funds shall be used  
5 to finance long-term care. For individuals purchasing a long-term care  
6 insurance policy or contract governed by chapter 48.84 or 48.83 RCW and  
7 meeting the criteria prescribed in this chapter, and any other terms as  
8 specified by the office of the insurance commissioner and the  
9 department of social and health services, this program shall allow for  
10 the exclusion of some or all of the individual's assets in  
11 determination of medicaid eligibility as approved by the (~~federal~~  
12 ~~health care financing administration~~) centers for medicare and  
13 medicaid services.

14           **Sec. 10.** RCW 48.85.020 and 1995 1st sp.s. c 18 s 77 are each  
15 amended to read as follows:

16           The department of social and health services shall seek approval  
17 from the (~~federal health care financing administration~~) centers for  
18 medicare and medicaid services to allow the protection of an  
19 individual's assets as provided in this chapter. The department shall  
20 adopt all rules necessary to implement the Washington long-term care  
21 partnership program, which rules shall permit the exclusion of all or  
22 some of an individual's assets in a manner specified by the department  
23 in a determination of medicaid eligibility to the extent that private  
24 long-term care insurance provides payment or benefits for services.

25           **Sec. 11.** RCW 48.125.050 and 2004 c 260 s 7 are each amended to  
26 read as follows:

27           A self-funded multiple employer welfare arrangement must apply for  
28 a certificate of authority on a form prescribed by the commissioner and  
29 must submit the application, together with the following documents, to  
30 the commissioner:

31           (1) A copy of all articles, bylaws, agreements, trusts, or other  
32 documents or instruments describing the rights and obligations of the  
33 employers, employees, and beneficiaries of the arrangement;

34           (2) A copy of the summary plan description or summary plan  
35 descriptions of the arrangement, including those filed or required to

1 be filed with the United States department of labor, together with any  
2 amendments to the description;

3 (3) Evidence of coverage of or letters of intent to participate  
4 executed by at least twenty employers providing allowable benefits to  
5 at least seventy-five employees;

6 (4) A copy of the arrangement's most recent year's financial  
7 statements that must include, at a minimum, a balance sheet, an income  
8 statement, a statement of changes in financial position, and an  
9 actuarial opinion signed by a qualified actuary stating that the unpaid  
10 claim liability of the arrangement satisfies the standards under this  
11 title;

12 (5) Proof that the arrangement maintains or will maintain fidelity  
13 bonds required by the United States department of labor under the  
14 employee retirement income security act of 1974, 29 U.S.C. Sec. 1001 et  
15 seq.;

16 (6) A copy of any excess of loss insurance coverage policies  
17 maintained or proposed to be maintained by the arrangement;

18 (7) Biographical reports on forms prescribed by the national  
19 association of insurance commissioners evidencing the general  
20 trustworthiness and competence of each individual who is serving or who  
21 will serve as an officer, director, trustee, employee, or fiduciary of  
22 the arrangement;

23 (8) ~~((Fingerprint cards and current fees payable to the Washington  
24 state patrol))~~ Third-party verification reports from a vendor  
25 authorized by the national association of insurance commissioners to  
26 perform a state ((and)), national, and international criminal  
27 background history ~~((background))~~ check of any person who exercises  
28 control over the financial dealings and operations of the self-funded  
29 multiple employer welfare arrangement, including collection of employer  
30 contributions, investment of assets, payment of claims, rate setting,  
31 and claims adjudication. The ~~((fingerprints))~~ third-party verification  
32 reports and any additional information ~~((may))~~ must be submitted to  
33 ~~((the federal bureau of investigation and any results of the check must  
34 be returned to))~~ the office of the insurance commissioner. The results  
35 may be disseminated to any governmental agency or entity authorized to  
36 receive them; and

37 (9) A statement executed by a representative of the arrangement

1 certifying, to the best knowledge and belief of the representative,  
2 that:

3 (a) The arrangement is in compliance with RCW 48.125.030;

4 (b) The arrangement is in compliance with the requirements of the  
5 employee retirement income security act of 1974, 29 U.S.C. Sec. 1001 et  
6 seq., or a statement of any requirements with which the arrangement is  
7 not in compliance and a statement of proposed corrective actions; and

8 (c) The arrangement is in compliance with RCW 48.125.060 and  
9 48.125.070.

10 **Sec. 12.** RCW 48.17.380 and 2011 c 47 s 10 are each amended to read  
11 as follows:

12 (1) Application for a license to be an adjuster must be made to the  
13 commissioner upon forms furnished by the commissioner.

14 (a) As a part of or in connection with the application, ((an  
15 individual)) each resident applicant, and nonresident applicant  
16 designating Washington as the applicant's home state must furnish  
17 information concerning his or her identity, including fingerprints for  
18 submission to the Washington state patrol, the federal bureau of  
19 investigation, and any governmental agency or entity authorized to  
20 receive this information for a state and national criminal history  
21 background check, personal history, experience, business record,  
22 purposes, and other pertinent facts, as the commissioner may reasonably  
23 require. If, in the process of verifying fingerprints, business  
24 records, or other information, the commissioner's office incurs fees or  
25 charges from another governmental agency or from a business firm, the  
26 amount of the fees or charges must be paid to the commissioner's office  
27 by the applicant.

28 (b) A nonresident person holding an adjuster's license or  
29 equivalent in a state other than Washington that is the applicant's  
30 home state, or is designated as the applicant's home state, must comply  
31 with the requirements of this section, with the exception of the  
32 fingerprint requirement contained in (a) of this subsection.

33 (2) Any person willfully misrepresenting any fact required to be  
34 disclosed in any application shall be liable to penalties as provided  
35 by this code.

36 (3) The commissioner licenses as an adjuster only an individual or  
37 business entity which has otherwise complied with this code and the

1 individual or responsible officer of the business entity has furnished  
2 evidence satisfactory to the commissioner that the individual or  
3 responsible officer of the business entity is qualified as follows:

4 (a) Is eighteen or more years of age;

5 (b) Is a bona fide resident of this state, or is a resident of a  
6 state which will permit residents of this state to act as adjusters in  
7 such other state;

8 (c) Is a trustworthy person;

9 (d) Has had experience or special education or training with  
10 reference to the handling of loss claims under insurance contracts, of  
11 sufficient duration and extent reasonably to make the individual or  
12 responsible officer of the business entity competent to fulfill the  
13 responsibilities of an adjuster;

14 (e) Has successfully passed any examination as required under this  
15 chapter;

16 (f) If for a public adjuster's license, has filed the bond required  
17 by RCW 48.17.430;

18 (g) If a nonresident business entity, has designated an individual  
19 licensed adjuster responsible for the business entity's compliance with  
20 the insurance laws and rules of this state.

21 (4) If an applicant's principal place of residence or principal  
22 place of business is located in a state or province that does not have  
23 laws governing adjusters substantially similar to those of this state,  
24 the applicant may designate this state or another state or province in  
25 which the applicant is licensed and acts as an adjuster to be the  
26 applicant's home state for the purposes of this chapter.

27 (5) If the applicant designates this state or another state or  
28 province as the applicant's home state, to be eligible for licensure in  
29 this state, the applicant must have satisfied the requirements for  
30 licensure as a resident adjuster under the laws of the applicant's  
31 designated home state.

32 (6)(a) Each licensed nonresident adjuster, by application for and  
33 issuance of a license, has appointed the commissioner as the adjuster's  
34 attorney to receive service of legal process against the adjuster in  
35 this state upon causes of action arising within this state. Service  
36 upon the commissioner as attorney constitutes effective legal service  
37 on the adjuster.

1 (b) The appointment of the commissioner as attorney is irrevocable,  
2 binds any successor in interest or to the assets or liabilities of the  
3 adjuster, and remains in effect for as long as there could be any cause  
4 of action against the adjuster arising out of the adjuster's  
5 transactions in this state. The service of process must be  
6 accomplished and processed in the manner prescribed under RCW  
7 48.02.200.

8 ~~((+5))~~ (7) The commissioner may require any documents reasonably  
9 necessary to verify the information contained in an application and  
10 may, from time to time, require any licensed adjuster to produce the  
11 information called for in an application for a license.

12 NEW SECTION. **Sec. 13.** RCW 48.19.450 (Casualty rate filing--  
13 Credit) and 1986 c 305 s 907 are each repealed.

14 **Sec. 14.** RCW 43.70.235 and 2005 c 54 s 1 are each amended to read  
15 as follows:

16 (1) The department shall adopt rules providing a procedure and  
17 criteria for certifying one or more organizations to perform  
18 independent review of health care disputes described in RCW 48.43.535.

19 (2) The rules must require that the organization ensure:

20 (a) The confidentiality of medical records transmitted to an  
21 independent review organization for use in independent reviews;

22 (b) That each health care provider, physician, or contract  
23 specialist making review determinations for an independent review  
24 organization is qualified. Physicians, other health care providers,  
25 and, if applicable, contract specialists must be appropriately  
26 licensed, certified, or registered as required in Washington state or  
27 in at least one state with standards substantially comparable to  
28 Washington state. Reviewers may be drawn from nationally recognized  
29 centers of excellence, academic institutions, and recognized leading  
30 practice sites. Expert medical reviewers should have substantial,  
31 recent clinical experience dealing with the same or similar health  
32 conditions. The organization must have demonstrated expertise and a  
33 history of reviewing health care in terms of medical necessity,  
34 appropriateness, and the application of other health plan coverage  
35 provisions;

1 (c) That any physician, health care provider, or contract  
2 specialist making a review determination in a specific review is free  
3 of any actual or potential conflict of interest or bias. Neither the  
4 expert reviewer, nor the independent review organization, nor any  
5 officer, director, or management employee of the independent review  
6 organization may have any material professional, familial, or financial  
7 affiliation with any of the following: The health carrier;  
8 professional associations of carriers and providers; the provider; the  
9 provider's medical or practice group; the health facility at which the  
10 service would be provided; the developer or manufacturer of a drug or  
11 device under review; or the enrollee;

12 (d) The fairness of the procedures used by the independent review  
13 organization in making the determinations;

14 (e) That each independent review organization make its  
15 determination:

16 (i) Not later than the earlier of:

17 (A) The fifteenth day after the date the independent review  
18 organization receives the information necessary to make the  
19 determination; or

20 (B) The twentieth day after the date the independent review  
21 organization receives the request that the determination be made. In  
22 exceptional circumstances, when the independent review organization has  
23 not obtained information necessary to make a determination, a  
24 determination may be made by the twenty-fifth day after the date the  
25 organization received the request for the determination; and

26 (ii) In ~~((cases of a condition that could seriously jeopardize the~~  
27 ~~enrollee's health or ability to regain maximum function, not later than~~  
28 ~~the earlier of:~~

29 ~~(A))~~ requests for expedited review under RCW 48.43.535(7)(a), as  
30 expeditiously as possible but within not more than seventy-two hours  
31 after the date the independent review organization receives the  
32 ~~((information necessary to make the determination; or~~

33 ~~(B) The eighth day after the date the independent review~~  
34 ~~organization receives the request that the determination be made))~~  
35 request for expedited review;

36 (f) That timely notice is provided to enrollees of the results of  
37 the independent review, including the clinical basis for the  
38 determination;

1 (g) That the independent review organization has a quality  
2 assurance mechanism in place that ensures the timeliness and quality of  
3 review and communication of determinations to enrollees and carriers,  
4 and the qualifications, impartiality, and freedom from conflict of  
5 interest of the organization, its staff, and expert reviewers; and

6 (h) That the independent review organization meets any other  
7 reasonable requirements of the department directly related to the  
8 functions the organization is to perform under this section and RCW  
9 48.43.535, and related to assessing fees to carriers in a manner  
10 consistent with the maximum fee schedule developed under this section.

11 (3) To be certified as an independent review organization under  
12 this chapter, an organization must submit to the department an  
13 application in the form required by the department. The application  
14 must include:

15 (a) For an applicant that is publicly held, the name of each  
16 stockholder or owner of more than five percent of any stock or options;

17 (b) The name of any holder of bonds or notes of the applicant that  
18 exceed one hundred thousand dollars;

19 (c) The name and type of business of each corporation or other  
20 organization that the applicant controls or is affiliated with and the  
21 nature and extent of the affiliation or control;

22 (d) The name and a biographical sketch of each director, officer,  
23 and executive of the applicant and any entity listed under (c) of this  
24 subsection and a description of any relationship the named individual  
25 has with:

26 (i) A carrier;

27 (ii) A utilization review agent;

28 (iii) A nonprofit or for-profit health corporation;

29 (iv) A health care provider;

30 (v) A drug or device manufacturer; or

31 (vi) A group representing any of the entities described by (d)(i)  
32 through (v) of this subsection;

33 (e) The percentage of the applicant's revenues that are anticipated  
34 to be derived from reviews conducted under RCW 48.43.535;

35 (f) A description of the areas of expertise of the health care  
36 professionals and contract specialists making review determinations for  
37 the applicant; and

1 (g) The procedures to be used by the independent review  
2 organization in making review determinations regarding reviews  
3 conducted under RCW 48.43.535.

4 (4) If at any time there is a material change in the information  
5 included in the application under subsection (3) of this section, the  
6 independent review organization shall submit updated information to the  
7 department.

8 (5) An independent review organization may not be a subsidiary of,  
9 or in any way owned or controlled by, a carrier or a trade or  
10 professional association of health care providers or carriers.

11 (6) An independent review organization, and individuals acting on  
12 its behalf, are immune from suit in a civil action when performing  
13 functions under chapter 5, Laws of 2000. However, this immunity does  
14 not apply to an act or omission made in bad faith or that involves  
15 gross negligence.

16 (7) Independent review organizations must be free from interference  
17 by state government in its functioning except as provided in subsection  
18 (8) of this section.

19 (8) The rules adopted under this section shall include provisions  
20 for terminating the certification of an independent review organization  
21 for failure to comply with the requirements for certification. The  
22 department may review the operation and performance of an independent  
23 review organization in response to complaints or other concerns about  
24 compliance. No later than January 1, 2006, the department shall  
25 develop a reasonable maximum fee schedule that independent review  
26 organizations shall use to assess carriers for conducting reviews  
27 authorized under RCW 48.43.535.

28 (9) In adopting rules for this section, the department shall take  
29 into consideration standards for independent review organizations  
30 adopted by national accreditation organizations. The department may  
31 accept national accreditation or certification by another state as  
32 evidence that an organization satisfies some or all of the requirements  
33 for certification by the department as an independent review  
34 organization.

35 **Sec. 15.** RCW 48.20.435 and 2011 c 314 s 1 are each amended to read  
36 as follows:

37 (~~Any~~) (1) Each disability insurance contract that is not

1 grandfathered and that provides coverage for a subscriber's  
2 ~~((dependent))~~ child must offer the option of covering any ~~((dependent))~~  
3 child under the age of twenty-six.

4 (2) Each grandfathered disability insurance contract that provides  
5 coverage for a subscriber's child must offer the option of covering any  
6 child under the age of twenty-six unless the child is eligible to  
7 enroll in an eligible health plan sponsored by the child's employer or  
8 the child's spouse's employer.

9 (3) As used in this section, "grandfathered" has the same meaning  
10 as "grandfathered health plan" in RCW 48.43.005.

11 **Sec. 16.** RCW 48.43.018 and 2010 c 277 s 1 are each amended to read  
12 as follows:

13 (1) Except as provided in (a) through (g) of this subsection, a  
14 health carrier may require any person applying for an individual health  
15 benefit plan and the health care authority shall require any person  
16 applying for nonsubsidized enrollment in the basic health plan to  
17 complete the standard health questionnaire designated under chapter  
18 48.41 RCW.

19 (a) If a person is seeking an individual health benefit plan or  
20 enrollment in the basic health plan as a nonsubsidized enrollee due to  
21 his or her change of residence from one geographic area in Washington  
22 state to another geographic area in Washington state where his or her  
23 current health plan is not offered, completion of the standard health  
24 questionnaire shall not be a condition of coverage if application for  
25 coverage is made within ninety days of relocation.

26 (b) If a person is seeking an individual health benefit plan or  
27 enrollment in the basic health plan as a nonsubsidized enrollee:

28 (i) Because a health care provider with whom he or she has an  
29 established care relationship and from whom he or she has received  
30 treatment within the past twelve months is no longer part of the  
31 carrier's provider network under his or her existing Washington  
32 individual health benefit plan; and

33 (ii) His or her health care provider is part of another carrier's  
34 or a basic health plan managed care system's provider network; and

35 (iii) Application for a health benefit plan under that carrier's  
36 provider network individual coverage or for basic health plan  
37 nonsubsidized enrollment is made within ninety days of his or her

1 provider leaving the previous carrier's provider network; then  
2 completion of the standard health questionnaire shall not be a  
3 condition of coverage.

4 (c) If a person is seeking an individual health benefit plan or  
5 enrollment in the basic health plan as a nonsubsidized enrollee due to  
6 his or her having exhausted continuation coverage provided under 29  
7 U.S.C. Sec. 1161 et seq., completion of the standard health  
8 questionnaire shall not be a condition of coverage if application for  
9 coverage is made within ninety days of exhaustion of continuation  
10 coverage. A health carrier or the health care authority as  
11 administrator of basic health plan nonsubsidized coverage shall accept  
12 an application without a standard health questionnaire from a person  
13 currently covered by such continuation coverage if application is made  
14 within ninety days prior to the date the continuation coverage would be  
15 exhausted and the effective date of the individual coverage applied for  
16 is the date the continuation coverage would be exhausted, or within  
17 ninety days thereafter.

18 (d) If a person is seeking an individual health benefit plan or  
19 enrollment in the basic health plan as a nonsubsidized enrollee due to  
20 a change in employment status that would qualify him or her to purchase  
21 continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., but  
22 the person's employer is exempt under federal law from the requirement  
23 to offer such coverage, completion of the standard health questionnaire  
24 shall not be a condition of coverage if: (i) Application for coverage  
25 is made within ninety days of a qualifying event as defined in 29  
26 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months  
27 of continuous group coverage immediately prior to the qualifying event.  
28 A health carrier shall accept an application without a standard health  
29 questionnaire from a person with at least twenty-four months of  
30 continuous group coverage if application is made no more than ninety  
31 days prior to the date of a qualifying event and the effective date of  
32 the individual coverage applied for is the date of the qualifying  
33 event, or within ninety days thereafter.

34 (e) If a person is seeking an individual health benefit plan, or  
35 enrollment in the basic health plan as a nonsubsidized enrollee,  
36 completion of the standard health questionnaire shall not be a  
37 condition of coverage if: (i) The person had at least twenty-four  
38 months of continuous basic health plan coverage under chapter 70.47 RCW

1 immediately prior to disenrollment; and (ii) application for coverage  
2 is made within ninety days of disenrollment from the basic health plan.  
3 A health carrier shall accept an application without a standard health  
4 questionnaire from a person with at least twenty-four months of  
5 continuous basic health plan coverage if application is made no more  
6 than ninety days prior to the date of disenrollment and the effective  
7 date of the individual coverage applied for is the date of  
8 disenrollment, or within ninety days thereafter.

9 (f) If a person is seeking an individual health benefit plan due to  
10 a change in employment status that would qualify him or her to purchase  
11 continuation coverage provided under 29 U.S.C. Sec. 1161 et seq.,  
12 completion of the standard health questionnaire is not a condition of  
13 coverage if: (i) Application for coverage is made within ninety days  
14 of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the  
15 person had at least twenty-four months of continuous group coverage  
16 immediately prior to the qualifying event. A health carrier shall  
17 accept an application without a standard health questionnaire from a  
18 person with at least twenty-four months of continuous group coverage if  
19 application is made no more than ninety days prior to the date of a  
20 qualifying event and the effective date of the individual coverage  
21 applied for is the date of the qualifying event, or within ninety days  
22 thereafter.

23 (g) If a person is seeking an individual health benefit plan due to  
24 their terminating continuation coverage under 29 U.S.C. Sec. 1161 et  
25 seq., completion of the standard health questionnaire shall not be a  
26 condition of coverage if: (i) Application for coverage is made within  
27 ninety days of terminating the continuation coverage; and (ii) the  
28 person had at least twenty-four months of continuous group coverage  
29 immediately prior to the termination. A health carrier shall accept an  
30 application without a standard health questionnaire from a person with  
31 at least twenty-four months of continuous group coverage if application  
32 is made no more than ninety days prior to the date of termination of  
33 the continuation coverage and the effective date of the individual  
34 coverage applied for is the date the continuation coverage is  
35 terminated, or within ninety days thereafter.

36 (h) If a person is seeking an individual health benefit plan  
37 because his or her employer, or former employer, discontinues group  
38 coverage due to the closure of the business, completion of the standard

1 health questionnaire shall not be a condition of coverage if: (i)(A)  
2 Application for coverage is made within ninety days of the employer  
3 discontinuing group coverage due to closure of the business; and  
4 (~~(ii)~~) (B) the person had at least twenty-four months of continuous  
5 group coverage immediately prior to the termination. A health carrier  
6 shall accept an application without a standard health questionnaire  
7 from a person with at least twenty-four months of continuous group  
8 coverage if application is made no more than ninety days prior to the  
9 date of discontinuation of group coverage, and the effective date of  
10 the individual coverage applied for is the date the group coverage is  
11 discontinued, or within ninety days thereafter; or (ii) the person  
12 seeking enrollment is under the age of nineteen.

13 (2) If, based upon the results of the standard health  
14 questionnaire, the person qualifies for coverage under the Washington  
15 state health insurance pool, the following shall apply:

16 (a) The carrier may decide not to accept the person's application  
17 for enrollment in its individual health benefit plan and the health  
18 care authority, as administrator of basic health plan nonsubsidized  
19 coverage, shall not accept the person's application for enrollment as  
20 a nonsubsidized enrollee; and

21 (b) Within fifteen business days of receipt of a completed  
22 application, the carrier or the health care authority as administrator  
23 of basic health plan nonsubsidized coverage shall provide written  
24 notice of the decision not to accept the person's application for  
25 enrollment to both the person and the administrator of the Washington  
26 state health insurance pool. The notice to the person shall state that  
27 the person is eligible for health insurance provided by the Washington  
28 state health insurance pool, and shall include information about the  
29 Washington state health insurance pool and an application for such  
30 coverage. If the carrier or the health care authority as administrator  
31 of basic health plan nonsubsidized coverage does not provide or  
32 postmark such notice within fifteen business days, the application is  
33 deemed approved.

34 (3) If the person applying for an individual health benefit plan:

35 (a) Does not qualify for coverage under the Washington state health  
36 insurance pool based upon the results of the standard health  
37 questionnaire; (b) does qualify for coverage under the Washington state  
38 health insurance pool based upon the results of the standard health

1 questionnaire and the carrier elects to accept the person for  
2 enrollment; or (c) is not required to complete the standard health  
3 questionnaire designated under this chapter under subsection (1)(a) or  
4 (b) of this section, the carrier or the health care authority as  
5 administrator of basic health plan nonsubsidized coverage, whichever  
6 entity administered the standard health questionnaire, shall accept the  
7 person for enrollment if he or she resides within the carrier's or the  
8 basic health plan's service area and provide or assure the provision of  
9 all covered services regardless of age, sex, family structure,  
10 ethnicity, race, health condition, geographic location, employment  
11 status, socioeconomic status, other condition or situation, or the  
12 provisions of RCW 49.60.174(2). The commissioner may grant a temporary  
13 exemption from this subsection if, upon application by a health  
14 carrier, the commissioner finds that the clinical, financial, or  
15 administrative capacity to serve existing enrollees will be impaired if  
16 a health carrier is required to continue enrollment of additional  
17 eligible individuals.

18 **Sec. 17.** RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are  
19 each reenacted and amended to read as follows:

20 Unless otherwise specifically provided, the definitions in this  
21 section apply throughout this chapter.

22 (1) "Adjusted community rate" means the rating method used to  
23 establish the premium for health plans adjusted to reflect actuarially  
24 demonstrated differences in utilization or cost attributable to  
25 geographic region, age, family size, and use of wellness activities.

26 (2) "Adverse benefit determination" means a denial, reduction, or  
27 termination of, or a failure to provide or make payment, in whole or in  
28 part, for a benefit, including a denial, reduction, termination, or  
29 failure to provide or make payment that is based on a determination of  
30 an enrollee's or applicant's eligibility to participate in a plan, and  
31 including, with respect to group health plans, a denial, reduction, or  
32 termination of, or a failure to provide or make payment, in whole or in  
33 part, for a benefit resulting from the application of any utilization  
34 review, as well as a failure to cover an item or service for which  
35 benefits are otherwise provided because it is determined to be  
36 experimental or investigational or not medically necessary or  
37 appropriate.

1 (3) "Applicant" means a person who applies for enrollment in an  
2 individual health plan as the subscriber or an enrollee, or the  
3 dependent or spouse of a subscriber or enrollee.

4 (4) "Basic health plan" means the plan described under chapter  
5 70.47 RCW, as revised from time to time.

6 (5) "Basic health plan model plan" means a health plan as required  
7 in RCW 70.47.060(2)(e).

8 (6) "Basic health plan services" means that schedule of covered  
9 health services, including the description of how those benefits are to  
10 be administered, that are required to be delivered to an enrollee under  
11 the basic health plan, as revised from time to time.

12 (7) "Catastrophic health plan" means:

13 (a) In the case of a contract, agreement, or policy covering a  
14 single enrollee, a health benefit plan requiring a calendar year  
15 deductible of, at a minimum, one thousand seven hundred fifty dollars  
16 and an annual out-of-pocket expense required to be paid under the plan  
17 (other than for premiums) for covered benefits of at least three  
18 thousand five hundred dollars, both amounts to be adjusted annually by  
19 the insurance commissioner; and

20 (b) In the case of a contract, agreement, or policy covering more  
21 than one enrollee, a health benefit plan requiring a calendar year  
22 deductible of, at a minimum, three thousand five hundred dollars and an  
23 annual out-of-pocket expense required to be paid under the plan (other  
24 than for premiums) for covered benefits of at least six thousand  
25 dollars, both amounts to be adjusted annually by the insurance  
26 commissioner; or

27 (c) Any health benefit plan that provides benefits for hospital  
28 inpatient and outpatient services, professional and prescription drugs  
29 provided in conjunction with such hospital inpatient and outpatient  
30 services, and excludes or substantially limits outpatient physician  
31 services and those services usually provided in an office setting.

32 In July 2008, and in each July thereafter, the insurance  
33 commissioner shall adjust the minimum deductible and out-of-pocket  
34 expense required for a plan to qualify as a catastrophic plan to  
35 reflect the percentage change in the consumer price index for medical  
36 care for a preceding twelve months, as determined by the United States  
37 department of labor. The adjusted amount shall apply on the following  
38 January 1st.

1 (8) "Certification" means a determination by a review organization  
2 that an admission, extension of stay, or other health care service or  
3 procedure has been reviewed and, based on the information provided,  
4 meets the clinical requirements for medical necessity, appropriateness,  
5 level of care, or effectiveness under the auspices of the applicable  
6 health benefit plan.

7 (9) "Concurrent review" means utilization review conducted during  
8 a patient's hospital stay or course of treatment.

9 (10) "Covered person" or "enrollee" means a person covered by a  
10 health plan including an enrollee, subscriber, policyholder,  
11 beneficiary of a group plan, or individual covered by any other health  
12 plan.

13 (11) "Dependent" means, at a minimum, the enrollee's legal spouse  
14 and dependent children who qualify for coverage under the enrollee's  
15 health benefit plan.

16 (12) "Emergency medical condition" means a medical condition  
17 manifesting itself by acute symptoms of sufficient severity, including  
18 severe pain, such that a prudent layperson, who possesses an average  
19 knowledge of health and medicine, could reasonably expect the absence  
20 of immediate medical attention to result in a condition (a) placing the  
21 health of the individual, or with respect to a pregnant woman, the  
22 health of the woman or her unborn child, in serious jeopardy, (b)  
23 serious impairment to bodily functions, or (c) serious dysfunction of  
24 any bodily organ or part.

25 (13) "Emergency services" means a medical screening examination, as  
26 required under section 1867 of the social security act (42 U.S.C.  
27 1395dd), that is within the capability of the emergency department of  
28 a hospital, including ancillary services routinely available to the  
29 emergency department to evaluate that emergency medical condition, and  
30 further medical examination and treatment, to the extent they are  
31 within the capabilities of the staff and facilities available at the  
32 hospital, as are required under section 1867 of the social security act  
33 (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect  
34 to an emergency medical condition, has the meaning given in section  
35 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

36 (14) "Employee" has the same meaning given to the term, as of  
37 January 1, 2008, under section 3(6) of the federal employee retirement  
38 income security act of 1974.

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

5 (16) "Final external review decision" means a determination by an  
6 independent review organization at the conclusion of an external  
7 review.

8 (17) "Final internal adverse benefit determination" means an  
9 adverse benefit determination that has been upheld by a health plan or  
10 carrier at the completion of the internal appeals process, or an  
11 adverse benefit determination with respect to which the internal  
12 appeals process has been exhausted under the exhaustion rules described  
13 in RCW 48.43.530 and 48.43.535.

14 (18) "Grandfathered health plan" means a group health plan or an  
15 individual health plan that under section 1251 of the patient  
16 protection and affordable care act, P.L. 111-148 (2010) and as amended  
17 by the health care and education reconciliation act, P.L. 111-152  
18 (2010) is not subject to subtitles A or C of the act as amended.

19 (19) "Grievance" means a written complaint submitted by or on  
20 behalf of a covered person regarding(~~(a) Denial of payment for~~  
21 ~~medical services or nonprovision of medical services included in the~~  
22 ~~covered person's health benefit plan, or (b))~~) service delivery issues  
23 other than denial of payment for medical services or nonprovision of  
24 medical services, including dissatisfaction with medical care, waiting  
25 time for medical services, provider or staff attitude or demeanor, or  
26 dissatisfaction with service provided by the health carrier.

27 (20) "Health care facility" or "facility" means hospices licensed  
28 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,  
29 rural health care facilities as defined in RCW 70.175.020, psychiatric  
30 hospitals licensed under chapter 71.12 RCW, nursing homes licensed  
31 under chapter 18.51 RCW, community mental health centers licensed under  
32 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed  
33 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical  
34 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment  
35 facilities licensed under chapter 70.96A RCW, and home health agencies  
36 licensed under chapter 70.127 RCW, and includes such facilities if  
37 owned and operated by a political subdivision or instrumentality of the

1 state and such other facilities as required by federal law and  
2 implementing regulations.

3 (21) "Health care provider" or "provider" means:

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

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

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

12 (23) "Health carrier" or "carrier" means a disability insurer  
13 regulated under chapter 48.20 or 48.21 RCW, a health care service  
14 contractor as defined in RCW 48.44.010, or a health maintenance  
15 organization as defined in RCW 48.46.020, and includes "issuers" as  
16 that term is used in the patient protection and affordable care act  
17 (P.L. 111-148).

18 (24) "Health plan" or "health benefit plan" means any policy,  
19 contract, or agreement offered by a health carrier to provide, arrange,  
20 reimburse, or pay for health care services except the following:

21 (a) Long-term care insurance governed by chapter 48.84 or 48.83  
22 RCW;

23 (b) Medicare supplemental health insurance governed by chapter  
24 48.66 RCW;

25 (c) Coverage supplemental to the coverage provided under chapter  
26 55, Title 10, United States Code;

27 (d) Limited health care services offered by limited health care  
28 service contractors in accordance with RCW 48.44.035;

29 (e) Disability income;

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

33 (g) Workers' compensation coverage;

34 (h) Accident only coverage;

35 (i) Specified disease or illness-triggered fixed payment insurance,  
36 hospital confinement fixed payment insurance, or other fixed payment  
37 insurance offered as an independent, noncoordinated benefit;

38 (j) Employer-sponsored self-funded health plans;

1 (k) Dental only and vision only coverage; and

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

9 (25) "Individual market" means the market for health insurance  
10 coverage offered to individuals other than in connection with a group  
11 health plan.

12 (26) "Material modification" means a change in the actuarial value  
13 of the health plan as modified of more than five percent but less than  
14 fifteen percent.

15 ((+26+)) (27) "Open enrollment" means a period of time as defined  
16 in rule to be held at the same time each year, during which applicants  
17 may enroll in a carrier's individual health benefit plan without being  
18 subject to health screening or otherwise required to provide evidence  
19 of insurability as a condition for enrollment.

20 ((+27+)) (28) "Preexisting condition" means any medical condition,  
21 illness, or injury that existed any time prior to the effective date of  
22 coverage.

23 ((+28+)) (29) "Premium" means all sums charged, received, or  
24 deposited by a health carrier as consideration for a health plan or the  
25 continuance of a health plan. Any assessment or any "membership,"  
26 "policy," "contract," "service," or similar fee or charge made by a  
27 health carrier in consideration for a health plan is deemed part of the  
28 premium. "Premium" shall not include amounts paid as enrollee point-  
29 of-service cost-sharing.

30 ((+29+)) (30) "Review organization" means a disability insurer  
31 regulated under chapter 48.20 or 48.21 RCW, health care service  
32 contractor as defined in RCW 48.44.010, or health maintenance  
33 organization as defined in RCW 48.46.020, and entities affiliated with,  
34 under contract with, or acting on behalf of a health carrier to perform  
35 a utilization review.

36 ((+30+)) (31) "Small employer" or "small group" means any person,  
37 firm, corporation, partnership, association, political subdivision,  
38 sole proprietor, or self-employed individual that is actively engaged

1 in business that employed an average of at least one but no more than  
2 fifty employees, during the previous calendar year and employed at  
3 least one employee on the first day of the plan year, is not formed  
4 primarily for purposes of buying health insurance, and in which a bona  
5 fide employer-employee relationship exists. In determining the number  
6 of employees, companies that are affiliated companies, or that are  
7 eligible to file a combined tax return for purposes of taxation by this  
8 state, shall be considered an employer. Subsequent to the issuance of  
9 a health plan to a small employer and for the purpose of determining  
10 eligibility, the size of a small employer shall be determined annually.  
11 Except as otherwise specifically provided, a small employer shall  
12 continue to be considered a small employer until the plan anniversary  
13 following the date the small employer no longer meets the requirements  
14 of this definition. A self-employed individual or sole proprietor who  
15 is covered as a group of one must also: (a) Have been employed by the  
16 same small employer or small group for at least twelve months prior to  
17 application for small group coverage, and (b) verify that he or she  
18 derived at least seventy-five percent of his or her income from a trade  
19 or business through which the individual or sole proprietor has  
20 attempted to earn taxable income and for which he or she has filed the  
21 appropriate internal revenue service form 1040, schedule C or F, for  
22 the previous taxable year, except a self-employed individual or sole  
23 proprietor in an agricultural trade or business, must have derived at  
24 least fifty-one percent of his or her income from the trade or business  
25 through which the individual or sole proprietor has attempted to earn  
26 taxable income and for which he or she has filed the appropriate  
27 internal revenue service form 1040, for the previous taxable year.

28 ~~((+31+))~~ (32) "Special enrollment" means a defined period of time  
29 of not less than thirty-one days, triggered by a specific qualifying  
30 event experienced by the applicant, during which applicants may enroll  
31 in the carrier's individual health benefit plan without being subject  
32 to health screening or otherwise required to provide evidence of  
33 insurability as a condition for enrollment.

34 ~~((+32+))~~ (33) "Standard health questionnaire" means the standard  
35 health questionnaire designated under chapter 48.41 RCW.

36 ~~((+33+))~~ (34) "Utilization review" means the prospective,  
37 concurrent, or retrospective assessment of the necessity and

1 appropriateness of the allocation of health care resources and services  
2 of a provider or facility, given or proposed to be given to an enrollee  
3 or group of enrollees.

4 ~~((+34))~~ (35) "Wellness activity" means an explicit program of an  
5 activity consistent with department of health guidelines, such as,  
6 smoking cessation, injury and accident prevention, reduction of alcohol  
7 misuse, appropriate weight reduction, exercise, automobile and  
8 motorcycle safety, blood cholesterol reduction, and nutrition education  
9 for the purpose of improving enrollee health status and reducing health  
10 service costs.

11 **Sec. 18.** RCW 48.44.215 and 2011 c 314 s 6 are each amended to read  
12 as follows:

13 (1) ~~((Any))~~ Each individual health care service plan contract that  
14 is not grandfathered and that provides coverage for a subscriber's  
15 ~~((dependent))~~ child must offer the option of covering any ~~((dependent))~~  
16 child under the age of twenty-six.

17 (2) ~~((Any))~~ Each group health care service plan contract that is  
18 not grandfathered and that provides coverage for a participating  
19 member's ~~((dependent))~~ child must offer each participating member the  
20 option of covering any ~~((dependent))~~ child under the age of twenty-six.

21 (3) Each grandfathered health care service plan that provides  
22 coverage for a subscriber's child must offer the option of covering any  
23 child under the age of twenty-six unless the child is eligible to  
24 enroll in an eligible health plan sponsored by the child's employer or  
25 the child's spouse's employer.

26 (4) As used in this section, "grandfathered" has the same meaning  
27 as "grandfathered health plan" in RCW 48.43.005.

28 **Sec. 19.** RCW 48.46.325 and 2011 c 314 s 8 are each amended to read  
29 as follows:

30 (1) ~~((Any))~~ Each individual health maintenance agreement that is  
31 not grandfathered and that provides coverage for a subscriber's  
32 ~~((dependent))~~ child must offer the option of covering any ~~((dependent))~~  
33 child under the age of twenty-six.

34 (2) ~~((Any))~~ Each group health maintenance agreement that is not  
35 grandfathered and that provides coverage for a participating member's

1 ((dependent)) child must offer each participating member the option of  
2 covering any ((dependent)) child under the age of twenty-six.

3 (3) Each grandfathered individual or group health maintenance  
4 agreement that provides coverage for a subscriber's child must offer  
5 the option of covering any child under the age of twenty-six, unless  
6 that child is eligible to enroll in an eligible health plan sponsored  
7 by the child's employer or the child's spouse's employer.

8 (4) As used in this section, "grandfathered" has the same meaning  
9 as "grandfathered health plan" in RCW 48.43.005.

10 **Sec. 20.** RCW 48.43.530 and 2011 c 314 s 4 are each amended to read  
11 as follows:

12 (1) Each carrier ((that offers a)) and health plan must have ((a))  
13 fully operational, comprehensive grievance ((process that complies))  
14 and appeal processes, and for plans that are not grandfathered, fully  
15 operational, comprehensive, and effective grievance and review of  
16 adverse benefit determination processes that comply with the  
17 requirements of this section and any rules adopted by the commissioner  
18 to implement this section. For the purposes of this section, the  
19 commissioner ((shall)) must consider applicable grievance and appeal or  
20 review of adverse benefit determination process standards adopted by  
21 national managed care accreditation organizations and state agencies  
22 that purchase managed health care services, and for health plans that  
23 are not grandfathered health plans as approved by the United States  
24 department of health and human services or the United States department  
25 of labor. In the case of coverage offered in connection with a group  
26 health plan, if either the carrier or the health plan complies with the  
27 requirements of this section and RCW 48.43.535, then the obligation to  
28 comply is satisfied for both the carrier and the plan with respect to  
29 the health insurance coverage.

30 (2) Each carrier and health plan must process as a ((complaint))  
31 grievance an enrollee's expression of dissatisfaction about customer  
32 service or the quality or availability of a health service. Each  
33 carrier must implement procedures for registering and responding to  
34 oral and written ((complaints)) grievances in a timely and thorough  
35 manner.

36 (3) Each carrier and health plan must provide written notice to an  
37 enrollee or the enrollee's designated representative, and the

1 enrollee's provider, of its decision to deny, modify, reduce, or  
2 terminate payment, coverage, authorization, or provision of health care  
3 services or benefits, including the admission to or continued stay in  
4 a health care facility.

5 ~~(4) ((Each carrier must process as an appeal an enrollee's written~~  
6 ~~or oral request that the carrier reconsider: (a) Its resolution of a~~  
7 ~~complaint made by an enrollee; or (b) its decision to deny, modify,~~  
8 ~~reduce, or terminate payment, coverage, authorization, or provision of~~  
9 ~~health care services or benefits, including the admission to, or~~  
10 ~~continued stay in, a health care facility. A carrier must not require~~  
11 ~~that an enrollee file a complaint prior to seeking appeal of a decision~~  
12 ~~under (b) of this subsection.))~~ An enrollee's written or oral request  
13 that a carrier reconsider its decision to deny, modify, reduce, or  
14 terminate payment, coverage, authorization, or provision of health care  
15 services or benefits, including the admission to, or continued stay in,  
16 a health care facility must be processed as follows:

17 (a) When the request is made under a grandfathered health plan,  
18 the plan and the carrier must process it as an appeal;

19 (b) When the request is made under a health plan that is not  
20 grandfathered, the plan and the carrier must process it as a review of  
21 an adverse benefit determination; and

22 (c) Neither a carrier nor a health plan, whether grandfathered or  
23 not, may require that an enrollee file a complaint or grievance prior  
24 to seeking appeal of a decision or review of an adverse benefit  
25 determination under this subsection.

26 (5) To process an appeal, each plan that is not grandfathered and  
27 each carrier offering that plan must:

28 (a) Provide written notice to the enrollee when the appeal is  
29 received;

30 (b) Assist the enrollee with the appeal process;

31 (c) Make its decision regarding the appeal within thirty days of  
32 the date the appeal is received. An appeal must be expedited if the  
33 enrollee's provider or the carrier's medical director reasonably  
34 determines that following the appeal process response timelines could  
35 seriously jeopardize the enrollee's life, health, or ability to regain  
36 maximum function. The decision regarding an expedited appeal must be  
37 made within seventy-two hours of the date the appeal is received;

1 (d) Cooperate with a representative authorized in writing by the  
2 enrollee;

3 (e) Consider information submitted by the enrollee;

4 (f) Investigate and resolve the appeal; and

5 (g) Provide written notice of its resolution of the appeal to the  
6 enrollee and, with the permission of the enrollee, to the enrollee's  
7 providers. The written notice must explain the carrier's and health  
8 plan's decision and the supporting coverage or clinical reasons and the  
9 enrollee's right to request independent review of the carrier's  
10 decision under RCW 48.43.535.

11 (6) Written notice required by subsection (3) of this section must  
12 explain:

13 (a) The carrier's and health plan's decision and the supporting  
14 coverage or clinical reasons; and

15 (b) The carrier's and grandfathered plan's appeal or for plans that  
16 are not grandfathered, adverse benefit determination review process,  
17 including information, as appropriate, about how to exercise the  
18 enrollee's rights to obtain a second opinion, and how to continue  
19 receiving services as provided in this section.

20 (7) When an enrollee requests that the carrier or health plan  
21 reconsider its decision to modify, reduce, or terminate an otherwise  
22 covered health service that an enrollee is receiving through the health  
23 plan and the carrier's or health plan's decision is based upon a  
24 finding that the health service, or level of health service, is no  
25 longer medically necessary or appropriate, the carrier and health plan  
26 must continue to provide that health service until the appeal, or for  
27 health plans that are not grandfathered, the review of an adverse  
28 benefit determination, is resolved. If the resolution of the appeal,  
29 review of an adverse benefit determination, or any review sought by the  
30 enrollee under RCW 48.43.535 affirms the carrier's or health plan's  
31 decision, the enrollee may be responsible for the cost of this  
32 continued health service.

33 (8) Each carrier and health plan must provide a clear explanation  
34 of the grievance and appeal, or for plans that are not grandfathered,  
35 the process for review of an adverse benefit determination process upon  
36 request, upon enrollment to new enrollees, and annually to enrollees  
37 and subcontractors.

1           (9) Each carrier and health plan must ensure that ~~((the))~~ each  
2 grievance, appeal, and for plans that are not grandfathered, grievance  
3 and review of adverse benefit determinations, process is accessible to  
4 enrollees who are limited English speakers, who have literacy problems,  
5 or who have physical or mental disabilities that impede their ability  
6 to file a grievance, appeal or review of an adverse benefit  
7 determination.

8           (10)(a) Each plan that is not grandfathered and the carrier that  
9 offers it must: Track each appeal until final resolution; maintain,  
10 and make accessible to the commissioner for a period of three years, a  
11 log of all appeals; and identify and evaluate trends in appeals.

12           (b) Each grandfathered plan and the carrier that offers it must:  
13 Track each review of an adverse benefit determination until final  
14 resolution; maintain and make accessible to the commissioner, for a  
15 period of six years, a log of all such determinations; and identify and  
16 evaluate trends in requests for and resolution of review of adverse  
17 benefit determinations.

18           (11) In complying with this section, plans that are not  
19 grandfathered and the carriers offering them must treat a rescission of  
20 coverage, whether or not the rescission has an adverse effect on any  
21 particular benefit at that time, and any decision to deny coverage in  
22 an initial eligibility determination as an adverse benefit  
23 determination.

24           **Sec. 21.** RCW 48.43.535 and 2011 c 314 s 5 are each amended to read  
25 as follows:

26           (1) There is a need for a process for the fair consideration of  
27 disputes relating to decisions by carriers that offer a health plan to  
28 deny, modify, reduce, or terminate coverage of or payment for health  
29 care services for an enrollee. For purposes of this section, "carrier"  
30 also applies to a health plan if the health plan administers the appeal  
31 process directly or through a third party.

32           (2) An enrollee may seek review by a certified independent review  
33 organization of a carrier's decision to deny, modify, reduce, or  
34 terminate coverage of or payment for a health care service, after  
35 exhausting the carrier's grievance process and receiving a decision  
36 that is unfavorable to the enrollee, or after the carrier has exceeded

1 the timelines for grievances provided in RCW 48.43.530, without good  
2 cause and without reaching a decision.

3 (3) The commissioner must establish and use a rotational registry  
4 system for the assignment of a certified independent review  
5 organization to each dispute. The system should be flexible enough to  
6 ensure that an independent review organization has the expertise  
7 necessary to review the particular medical condition or service at  
8 issue in the dispute, and that any approved independent review  
9 organization does not have a conflict of interest that will influence  
10 its independence.

11 (4) Carriers must provide to the appropriate certified independent  
12 review organization, not later than the third business day after the  
13 date the carrier receives a request for review, a copy of:

14 (a) Any medical records of the enrollee that are relevant to the  
15 review;

16 (b) Any documents used by the carrier in making the determination  
17 to be reviewed by the certified independent review organization;

18 (c) Any documentation and written information submitted to the  
19 carrier in support of the appeal; and

20 (d) A list of each physician or health care provider who has  
21 provided care to the enrollee and who may have medical records relevant  
22 to the appeal. Health information or other confidential or proprietary  
23 information in the custody of a carrier may be provided to an  
24 independent review organization, subject to rules adopted by the  
25 commissioner.

26 (5) Enrollees must be provided with at least five business days to  
27 submit to the independent review organization in writing additional  
28 information that the independent review organization must consider when  
29 conducting the external review. The independent review organization  
30 must forward any additional information submitted by an enrollee to the  
31 plan or carrier within one business day of receipt by the independent  
32 review organization.

33 (6) The medical reviewers from a certified independent review  
34 organization will make determinations regarding the medical necessity  
35 or appropriateness of, and the application of health plan coverage  
36 provisions to, health care services for an enrollee. The medical  
37 reviewers' determinations must be based upon their expert medical  
38 judgment, after consideration of relevant medical, scientific, and

1 cost-effectiveness evidence, and medical standards of practice in the  
2 state of Washington. Except as provided in this subsection, the  
3 certified independent review organization must ensure that  
4 determinations are consistent with the scope of covered benefits as  
5 outlined in the medical coverage agreement. Medical reviewers may  
6 override the health plan's medical necessity or appropriateness  
7 standards if the standards are determined upon review to be  
8 unreasonable or inconsistent with sound, evidence-based medical  
9 practice.

10 (7) Once a request for an independent review determination has been  
11 made, the independent review organization must proceed to a final  
12 determination, unless requested otherwise by both the carrier and the  
13 enrollee or the enrollee's representative.

14 (a) An enrollee or carrier may request an expedited external review  
15 if the adverse benefit determination or internal adverse benefit  
16 determination concerns an admission, availability of care, continued  
17 stay, or health care service for which the claimant received emergency  
18 services but has not been discharged from a facility; or involves a  
19 medical condition for which the standard external review time frame  
20 (~~(of forty five days)~~) would seriously jeopardize the life or health of  
21 the enrollee or jeopardize the enrollee's ability to regain maximum  
22 function. The independent review organization must make its decision  
23 to uphold or reverse the adverse benefit determination or final  
24 internal adverse benefit determination and notify the enrollee and the  
25 carrier or health plan of the determination as expeditiously as  
26 possible but within not more than seventy-two hours after the receipt  
27 of the request for expedited external review. If the notice is not in  
28 writing, the independent review organization must provide written  
29 confirmation of the decision within forty-eight hours after the date of  
30 the notice of the decision.

31 (b) For claims involving experimental or investigational  
32 treatments, the (~~internal~~) independent review organization must  
33 ensure that adequate clinical and scientific experience and protocols  
34 are taken into account as part of the external review process.

35 (8) Carriers must timely implement the certified independent review  
36 organization's determination, and must pay the certified independent  
37 review organization's charges.

1 (9) When an enrollee requests independent review of a dispute under  
2 this section, and the dispute involves a carrier's decision to modify,  
3 reduce, or terminate an otherwise covered health service that an  
4 enrollee is receiving at the time the request for review is submitted  
5 and the carrier's decision is based upon a finding that the health  
6 service, or level of health service, is no longer medically necessary  
7 or appropriate, the carrier must continue to provide the health service  
8 if requested by the enrollee until a determination is made under this  
9 section. If the determination affirms the carrier's decision, the  
10 enrollee may be responsible for the cost of the continued health  
11 service.

12 (10) Each certified independent review organization must maintain  
13 written records and make them available upon request to the  
14 commissioner.

15 (11) A certified independent review organization may notify the  
16 office of the insurance commissioner if, based upon its review of  
17 disputes under this section, it finds a pattern of substandard or  
18 egregious conduct by a carrier.

19 (12)(a) The commissioner shall adopt rules to implement this  
20 section after considering relevant standards adopted by national  
21 managed care accreditation organizations and the national association  
22 of insurance commissioners.

23 (b) This section is not intended to supplant any existing authority  
24 of the office of the insurance commissioner under this title to oversee  
25 and enforce carrier compliance with applicable statutes and rules.

26 **Sec. 22.** RCW 48.46.020 and 2010 c 292 s 5 are each reenacted and  
27 amended to read as follows:

28 As used in this chapter, the terms defined in this section shall  
29 have the meanings indicated unless the context indicates otherwise.

30 (1) "Carrier" means a health maintenance organization, an insurer,  
31 a health care services contractor, or other entity responsible for the  
32 payment of benefits or provision of services under a group or  
33 individual agreement.

34 (2) "Census date" means the date upon which a health maintenance  
35 organization offering coverage to a small employer must base rate  
36 calculations. For a small employer applying for a health benefit plan  
37 through a health maintenance organization other than its current health

1 maintenance organization, the census date is the date that final group  
2 composition is received by the health maintenance organization. For a  
3 small employer that is renewing its health benefit plan through its  
4 existing health maintenance organization, the census date is ninety  
5 days prior to the effective date of the renewal.

6 (3) "Commissioner" means the insurance commissioner.

7 (4) "Comprehensive health care services" means basic consultative,  
8 diagnostic, and therapeutic services rendered by licensed health  
9 professionals together with emergency and preventive care, inpatient  
10 hospital, outpatient and physician care, at a minimum, and any  
11 additional health care services offered by the health maintenance  
12 organization.

13 (5) "Consumer" means any member, subscriber, enrollee, beneficiary,  
14 or other person entitled to health care services under terms of a  
15 health maintenance agreement, but not including health professionals,  
16 employees of health maintenance organizations, partners, or  
17 shareholders of stock corporations licensed as health maintenance  
18 organizations.

19 (6) "Copayment" means an amount specified in a subscriber agreement  
20 which is an obligation of an enrolled participant for a specific  
21 service which is not fully prepaid.

22 (7) "Deductible" means the amount an enrolled participant is  
23 responsible to pay out-of-pocket before the health maintenance  
24 organization begins to pay the costs associated with treatment.

25 (8) "Department" means the state department of social and health  
26 services.

27 (9) "Enrolled participant" means a person who or group of persons  
28 which has entered into a contractual arrangement or on whose behalf a  
29 contractual arrangement has been entered into with a health maintenance  
30 organization to receive health care services.

31 (10) "Fully subordinated debt" means those debts that meet the  
32 requirements of RCW 48.46.235(3) and are recorded as equity.

33 (11) "Group practice" means a partnership, association,  
34 corporation, or other group of health professionals:

35 (a) The members of which may be individual health professionals,  
36 clinics, or both individuals and clinics who engage in the coordinated  
37 practice of their profession; and

1 (b) The members of which are compensated by a prearranged salary,  
2 or by capitation payment or drawing account that is based on the number  
3 of enrolled participants.

4 (12) "Health maintenance agreement" means an agreement for services  
5 between a health maintenance organization which is registered pursuant  
6 to the provisions of this chapter and enrolled participants of such  
7 organization which provides enrolled participants with comprehensive  
8 health services rendered to enrolled participants by health  
9 professionals, groups, facilities, and other personnel associated with  
10 the health maintenance organization.

11 (13) "Health maintenance organization" means any organization  
12 receiving a certificate of registration by the commissioner under this  
13 chapter which provides comprehensive health care services to enrolled  
14 participants of such organization on a group practice per capita  
15 prepayment basis or on a prepaid individual practice plan, except for  
16 an enrolled participant's responsibility for copayments and/or  
17 deductibles, either directly or through contractual or other  
18 arrangements with other institutions, entities, or persons, and which  
19 qualifies as a health maintenance organization pursuant to RCW  
20 48.46.030 and 48.46.040.

21 (14) "Health professionals" means health care practitioners who are  
22 regulated by the state of Washington.

23 (15) "Individual practice health care plan" means an association of  
24 health professionals in private practice who associate for the purpose  
25 of providing prepaid comprehensive health care services on a fee-for-  
26 service or capitation basis.

27 (16) "Insolvent" or "insolvency" means that the organization has  
28 been declared insolvent and is placed under an order of liquidation by  
29 a court of competent jurisdiction.

30 (17) "Meaningful (~~grievance~~) appeal procedure" and "meaningful  
31 adverse determination review procedure" means a procedure for  
32 investigation of consumer (~~grievances~~) appeals and adverse review  
33 determinations in a timely manner aimed at mutual agreement for  
34 settlement according to procedures approved by the commissioner, and  
35 which may include arbitration procedures.

36 (18) "Meaningful role in policy making" means a procedure approved  
37 by the commissioner which provides consumers or elected representatives  
38 of consumers a means of submitting the views and recommendations of

1 such consumers to the governing board of such organization coupled with  
2 reasonable assurance that the board will give regard to such views and  
3 recommendations.

4 (19) "Net worth" means the excess of total admitted assets as  
5 defined in RCW 48.12.010 over total liabilities but the liabilities  
6 shall not include fully subordinated debt.

7 (20) "Participating provider" means a provider as defined in  
8 subsection (21) of this section who contracts with the health  
9 maintenance organization or with its contractor or subcontractor and  
10 has agreed to provide health care services to enrolled participants  
11 with an expectation of receiving payment, other than copayment or  
12 deductible, directly or indirectly, from the health maintenance  
13 organization.

14 (21) "Provider" means any health professional, hospital, or other  
15 institution, organization, or person that furnishes any health care  
16 services and is licensed or otherwise authorized to furnish such  
17 services.

18 (22) "Replacement coverage" means the benefits provided by a  
19 succeeding carrier.

20 (23) "Uncovered expenditures" means the costs to the health  
21 maintenance organization of health care services that are the  
22 obligation of the health maintenance organization for which an enrolled  
23 participant would also be liable in the event of the health maintenance  
24 organization's insolvency and for which no alternative arrangements  
25 have been made as provided herein. The term does not include  
26 expenditures for covered services when a provider has agreed not to  
27 bill the enrolled participant even though the provider is not paid by  
28 the health maintenance organization, or for services that are  
29 guaranteed, insured, or assumed by a person or organization other than  
30 the health maintenance organization.

31 **Sec. 23.** RCW 48.46.030 and 1990 c 119 s 2 are each amended to read  
32 as follows:

33 Any corporation, cooperative group, partnership, individual,  
34 association, or groups of health professionals licensed by the state of  
35 Washington, public hospital district, or public institutions of higher  
36 education shall be entitled to a certificate of registration from the  
37 insurance commissioner as a health maintenance organization if it:

1 (1) Provides comprehensive health care services to enrolled  
2 participants on a group practice per capita prepayment basis or on a  
3 prepaid individual practice plan and provides such health services  
4 either directly or through arrangements with institutions, entities,  
5 and persons which its enrolled population might reasonably require as  
6 determined by the health maintenance organization in order to be  
7 maintained in good health; and

8 (2) Is governed by a board elected by enrolled participants, or  
9 otherwise provides its enrolled participants with a meaningful role in  
10 policy making procedures of such organization, as defined in RCW  
11 48.46.020(~~(+7)~~) (18), and 48.46.070; and

12 (3) Affords enrolled participants with a meaningful (~~(grievance)~~)  
13 appeal procedure aimed at settlement of disputes between such persons  
14 and such health maintenance organization, as defined in RCW  
15 48.46.020(~~(+8)~~) (17) and 48.46.100; and

16 (4) Provides enrolled participants, or makes available for  
17 inspection at least annually, financial statements pertaining to health  
18 maintenance agreements, disclosing income and expenses, assets and  
19 liabilities, and the bases for proposed rate adjustments for health  
20 maintenance agreements relating to its activity as a health maintenance  
21 organization; and

22 (5) Demonstrates to the satisfaction of the commissioner that its  
23 facilities and personnel are reasonably adequate to provide  
24 comprehensive health care services to enrolled participants and that it  
25 is financially capable of providing such members with, or has made  
26 adequate contractual arrangements through insurance or otherwise to  
27 provide such members with, such health services; and

28 (6) Substantially complies with administrative rules and  
29 regulations of the commissioner for purposes of this chapter; and

30 (7) Submits an application for a certificate of registration which  
31 shall be verified by an officer or authorized representative of the  
32 applicant, being in form as the commissioner prescribes, and setting  
33 forth:

34 (a) A copy of the basic organizational document, if any, of the  
35 applicant, such as the articles of incorporation, articles of  
36 association, partnership agreement, trust agreement, or other  
37 applicable documents, and all amendments thereto;

1 (b) A copy of the bylaws, rules and regulations, or similar  
2 documents, if any, which regulate the conduct of the internal affairs  
3 of the applicant, and all amendments thereto;

4 (c) A list of the names, addresses, members of the board of  
5 directors, board of trustees, executive committee, or other governing  
6 board or committee and the principal officers, partners, or members;

7 (d) A full and complete disclosure of any financial interests held  
8 by any officer, or director in any provider associated with the  
9 applicant or any provider of the applicant;

10 (e) A description of the health maintenance organization, its  
11 facilities and its personnel, and the applicant's most recent financial  
12 statement showing such organization's assets, liabilities, income, and  
13 other sources of financial support;

14 (f) A description of the geographic areas and the population groups  
15 to be served and the size and composition of the anticipated enrollee  
16 population;

17 (g) A copy of each type of health maintenance agreement to be  
18 issued to enrolled participants;

19 (h) A schedule of all proposed rates of reimbursement to  
20 contracting health care facilities or providers, if any, and a schedule  
21 of the proposed charges for enrollee coverage for health care services,  
22 accompanied by data relevant to the formulation of such schedules;

23 (i) A description of the proposed method and schedule for  
24 soliciting enrollment in the applicant health maintenance organization  
25 and the basis of compensation for such solicitation services;

26 (j) A copy of the solicitation document to be distributed to all  
27 prospective enrolled participants in connection with any solicitation;

28 (k) A financial projection which sets forth the anticipated results  
29 during the initial two years of operation of such organization,  
30 accompanied by a summary of the assumptions and relevant data upon  
31 which the projection is based. The projection should include the  
32 projected expenses, enrollment trends, income, enrollee utilization  
33 patterns, and sources of working capital;

34 ~~(l) ((A detailed description of the enrollee complaint system as  
35 provided by RCW 48.46.100;~~

36 ~~(m))~~) A detailed description of the procedures and programs to be  
37 implemented to assure that the health care services delivered to  
38 enrolled participants will be of professional quality;

1 ((+n)) (m) A detailed description of procedures to be implemented  
2 to meet the requirements to protect against insolvency in RCW  
3 48.46.245;

4 ((+o)) (n) Documentation that the health maintenance organization  
5 has an initial net worth of one million dollars and shall thereafter  
6 maintain the minimum net worth required under RCW 48.46.235; and

7 ((+p)) (o) Such other information as the commissioner shall  
8 require by rule or regulation which is reasonably necessary to carry  
9 out the provisions of this section.

10 A health maintenance organization shall, unless otherwise provided  
11 for in this chapter, file a notice describing any modification of any  
12 of the information required by subsection (7) of this section. Such  
13 notice shall be filed with the commissioner.

14 **Sec. 24.** RCW 48.46.040 and 2009 c 549 s 7150 are each amended to  
15 read as follows:

16 The commissioner shall issue a certificate of registration to the  
17 applicant within sixty days of such filing unless he or she notifies  
18 the applicant within such time that such application is not complete  
19 and the reasons therefor; or that he or she is not satisfied that:

20 (1) The basic organizational document of the applicant permits the  
21 applicant to conduct business as a health maintenance organization;

22 (2) The organization has demonstrated the intent and ability to  
23 assure that comprehensive health care services will be provided in a  
24 manner to assure both their availability and accessibility;

25 (3) The organization is financially responsible and may be  
26 reasonably expected to meet its obligations to its enrolled  
27 participants. In making this determination, the commissioner shall  
28 consider among other relevant factors:

29 (a) Any agreements with an insurer, a medical or hospital service  
30 bureau, a government agency or any other organization paying or  
31 insuring payment for health care services;

32 (b) ~~((Any agreements with providers for the provision of health  
33 care services;~~

34 (+e)) Any arrangements for liability and malpractice insurance  
35 coverage; and

36 ((+d)) (c) Adequate procedures to be implemented to meet the  
37 protection against insolvency requirements in RCW 48.46.245;

1 (4) The procedures for offering health care services and offering  
2 or terminating contracts with enrolled participants are reasonable and  
3 equitable in comparison with prevailing health insurance subscription  
4 practices and health maintenance organization enrollment procedures;  
5 and, that

6 (5) Procedures have been established to:

7 (a) Monitor the quality of care provided by such organization,  
8 including, as a minimum, procedures for internal peer review;

9 (b) ~~((Resolve complaints and grievances initiated by enrolled  
10 participants in accordance with RCW 48.46.010 and 48.46.100;~~

11 ~~(e))~~ Offer enrolled participants an opportunity to participate in  
12 matters of policy and operation in accordance with RCW 48.46.020(~~(+7))~~)  
13 (18) and 48.46.070.

14 No person to whom a certificate of registration has not been  
15 issued, except a health maintenance organization certified by the  
16 secretary of the department of health and human services, pursuant to  
17 Public Law 93-222 or its successor, shall use the words "health  
18 maintenance organization" or the initials "HMO" in its name, contracts,  
19 or literature. Persons who are contracting with, operating in  
20 association with, recruiting enrolled participants for, or otherwise  
21 authorized by a health maintenance organization possessing a  
22 certificate of registration to act on its behalf may use the terms  
23 "health maintenance organization" or "HMO" for the limited purpose of  
24 denoting or explaining their relationship to such health maintenance  
25 organization.

26 The department of health, at the request of the insurance  
27 commissioner, shall inspect and review the facilities of every  
28 applicant health maintenance organization to determine that such  
29 facilities are reasonably adequate to provide the health care services  
30 offered in their contracts. If the commissioner has information to  
31 indicate that such facilities fail to continue to be adequate to  
32 provide the health care services offered, the department of health,  
33 upon request of the insurance commissioner, shall reinspect and review  
34 the facilities and report to the insurance commissioner as to their  
35 adequacy or inadequacy.

36 **Sec. 25.** RCW 48.41.110 and 2011 c 315 s 6 are each amended to read  
37 as follows:

1 (1) The pool shall offer one or more care management plans of  
2 coverage. Such plans may, but are not required to, include point of  
3 service features that permit participants to receive in-network  
4 benefits or out-of-network benefits subject to differential cost  
5 shares. The pool may incorporate managed care features into existing  
6 plans.

7 (2) The administrator shall prepare a brochure outlining the  
8 benefits and exclusions of pool policies in plain language. After  
9 approval by the board, such brochure shall be made reasonably available  
10 to participants or potential participants.

11 (3) The health insurance policies issued by the pool shall pay only  
12 reasonable amounts for medically necessary eligible health care  
13 services rendered or furnished for the diagnosis or treatment of  
14 covered illnesses, injuries, and conditions. Eligible expenses are the  
15 reasonable amounts for the health care services and items for which  
16 benefits are extended under a pool policy.

17 (4) The pool shall offer at least two policies, one of which will  
18 be a comprehensive policy that must comply with RCW 48.41.120 and must  
19 at a minimum include the following services or related items:

20 (a) Hospital services, including charges for the most common  
21 semiprivate room, for the most common private room if semiprivate rooms  
22 do not exist in the health care facility, or for the private room if  
23 medically necessary, including no less than a total of one hundred  
24 eighty inpatient days in a calendar year, and no less than thirty days  
25 inpatient care for alcohol, drug, or chemical dependency or abuse per  
26 calendar year;

27 (b) Professional services including surgery for the treatment of  
28 injuries, illnesses, or conditions, other than dental, which are  
29 rendered by a health care provider, or at the direction of a health  
30 care provider, by a staff of registered or licensed practical nurses,  
31 or other health care providers;

32 (c) No less than twenty outpatient professional visits for the  
33 diagnosis or treatment of alcohol, drug, or chemical dependency or  
34 abuse rendered during a calendar year by a state-certified chemical  
35 dependency program approved under chapter 70.96A RCW, or by one or more  
36 physicians, psychologists, or community mental health professionals,  
37 or, at the direction of a physician, by other qualified licensed health  
38 care practitioners;

- 1 (d) Drugs and contraceptive devices requiring a prescription;
- 2 (e) Services of a skilled nursing facility, excluding custodial and  
3 convalescent care, for not less than one hundred days in a calendar  
4 year as prescribed by a physician;
- 5 (f) Services of a home health agency;
- 6 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine  
7 therapy;
- 8 (h) Oxygen;
- 9 (i) Anesthesia services;
- 10 (j) Prostheses, other than dental;
- 11 (k) Durable medical equipment which has no personal use in the  
12 absence of the condition for which prescribed;
- 13 (l) Diagnostic x-rays and laboratory tests;
- 14 (m) Oral surgery including at least the following: Fractures of  
15 facial bones; excisions of mandibular joints, lesions of the mouth,  
16 lip, or tongue, tumors, or cysts excluding treatment for  
17 temporomandibular joints; incision of accessory sinuses, mouth salivary  
18 glands or ducts; dislocations of the jaw; plastic reconstruction or  
19 repair of traumatic injuries occurring while covered under the pool;  
20 and excision of impacted wisdom teeth;
- 21 (n) Maternity care services;
- 22 (o) Services of a physical therapist and services of a speech  
23 therapist;
- 24 (p) Hospice services;
- 25 (q) Professional ambulance service to the nearest health care  
26 facility qualified to treat the illness or injury;
- 27 (r) Mental health services pursuant to RCW 48.41.220; and
- 28 (s) Other medical equipment, services, or supplies required by  
29 physician's orders and medically necessary and consistent with the  
30 diagnosis, treatment, and condition.
- 31 (5) The board shall design and employ cost containment measures and  
32 requirements such as, but not limited to, care coordination, provider  
33 network limitations, preadmission certification, and concurrent  
34 inpatient review which may make the pool more cost-effective.
- 35 (6) The pool benefit policy may contain benefit limitations,  
36 exceptions, and cost shares such as copayments, coinsurance, and  
37 deductibles that are consistent with managed care products, except that  
38 differential cost shares may be adopted by the board for nonnetwork

1 providers under point of service plans. No limitation, exception, or  
2 reduction may be used that would exclude coverage for any disease,  
3 illness, or injury.

4 (7)(a) The pool may not reject an individual for health plan  
5 coverage based upon preexisting conditions of the individual or deny,  
6 exclude, or otherwise limit coverage for an individual's preexisting  
7 health conditions; except that it shall impose a six-month benefit  
8 waiting period for preexisting conditions for which medical advice was  
9 given, for which a health care provider recommended or provided  
10 treatment, or for which a prudent layperson would have sought advice or  
11 treatment, within six months before the effective date of coverage.  
12 The preexisting condition waiting period shall not apply to prenatal  
13 care services or benefits for outpatient prescription drugs. The pool  
14 may not avoid the requirements of this section through the creation of  
15 a new rate classification or the modification of an existing rate  
16 classification. Credit against the waiting period shall be as provided  
17 in subsection (8) of this section.

18 (b) The pool shall not impose any preexisting condition waiting  
19 period for any person under the age of nineteen.

20 (8)(a) Except as provided in (b) of this subsection, the pool shall  
21 credit any preexisting condition waiting period in its plans for a  
22 person who was enrolled at any time during the sixty-three day period  
23 immediately preceding the date of application for the new pool plan.  
24 For the person previously enrolled in a group health benefit plan, the  
25 pool must credit the aggregate of all periods of preceding coverage not  
26 separated by more than sixty-three days toward the waiting period of  
27 the new health plan. For the person previously enrolled in an  
28 individual health benefit plan other than a catastrophic health plan,  
29 the pool must credit the period of coverage the person was continuously  
30 covered under the immediately preceding health plan toward the waiting  
31 period of the new health plan. For the purposes of this subsection, a  
32 preceding health plan includes an employer-provided self-funded health  
33 plan.

34 (b) The pool shall waive any preexisting condition waiting period  
35 for a person who is an eligible individual as defined in section  
36 2741(b) of the federal health insurance portability and accountability  
37 act of 1996 (42 U.S.C. 300gg-41(b)).

1 (9) If an application is made for the pool policy as a result of  
2 rejection by a carrier, then the date of application to the carrier,  
3 rather than to the pool, should govern for purposes of determining  
4 preexisting condition credit.

5 (10) The pool shall contract with organizations that provide care  
6 management that has been demonstrated to be effective and shall  
7 encourage enrollees who are eligible for care management services to  
8 participate. The pool may encourage the use of shared decision making  
9 and certified decision aids for preference-sensitive care areas.

10 **Sec. 26.** RCW 48.43.510 and 2009 c 304 s 1 are each amended to read  
11 as follows:

12 (1) A carrier that offers a health plan may not offer to sell a  
13 health plan to an enrollee or to any group representative, agent,  
14 employer, or enrollee representative without first offering to provide,  
15 and providing upon request, the following information before purchase  
16 or selection:

17 (a) A listing of covered benefits, including prescription drug  
18 benefits, if any, a copy of the current formulary, if any is used,  
19 definitions of terms such as generic versus brand name, and policies  
20 regarding coverage of drugs, such as how they become approved or taken  
21 off the formulary, and how consumers may be involved in decisions about  
22 benefits;

23 (b) A listing of exclusions, reductions, and limitations to covered  
24 benefits, and any definition of medical necessity or other coverage  
25 criteria upon which they may be based;

26 (c) A statement of the carrier's policies for protecting the  
27 confidentiality of health information;

28 (d) A statement of the cost of premiums and any enrollee cost-  
29 sharing requirements;

30 (e) A summary explanation of the carrier's review of adverse  
31 benefit determinations and grievance processes;

32 (f) A statement regarding the availability of a point-of-service  
33 option, if any, and how the option operates; and

34 (g) A convenient means of obtaining lists of participating primary  
35 care and specialty care providers, including disclosure of network  
36 arrangements that restrict access to providers within any plan network.  
37 The offer to provide the information referenced in this subsection (1)

1 must be clearly and prominently displayed on any information provided  
2 to any prospective enrollee or to any prospective group representative,  
3 agent, employer, or enrollee representative.

4 (2) Upon the request of any person, including a current enrollee,  
5 prospective enrollee, or the insurance commissioner, a carrier must  
6 provide written information regarding any health care plan it offers,  
7 that includes the following written information:

8 (a) Any documents, instruments, or other information referred to in  
9 the medical coverage agreement;

10 (b) A full description of the procedures to be followed by an  
11 enrollee for consulting a provider other than the primary care provider  
12 and whether the enrollee's primary care provider, the carrier's medical  
13 director, or another entity must authorize the referral;

14 (c) Procedures, if any, that an enrollee must first follow for  
15 obtaining prior authorization for health care services;

16 (d) A written description of any reimbursement or payment  
17 arrangements, including, but not limited to, capitation provisions,  
18 fee-for-service provisions, and health care delivery efficiency  
19 provisions, between a carrier and a provider or network;

20 (e) Descriptions and justifications for provider compensation  
21 programs, including any incentives or penalties that are intended to  
22 encourage providers to withhold services or minimize or avoid referrals  
23 to specialists;

24 (f) An annual accounting of all payments made by the carrier which  
25 have been counted against any payment limitations, visit limitations,  
26 or other overall limitations on a person's coverage under a plan;

27 (g) A copy of the carrier's review of adverse benefit  
28 determinations grievance process for claim or service denial and its  
29 grievance process for dissatisfaction with care; and

30 (h) Accreditation status with one or more national managed care  
31 accreditation organizations, and whether the carrier tracks its health  
32 care effectiveness performance using the health employer data  
33 information set (HEDIS), whether it publicly reports its HEDIS data,  
34 and how interested persons can access its HEDIS data.

35 (3) Each carrier shall provide to all enrollees and prospective  
36 enrollees a list of available disclosure items.

37 (4) Nothing in this section requires a carrier or a health care

1 provider to divulge proprietary information to an enrollee, including  
2 the specific contractual terms and conditions between a carrier and a  
3 provider.

4 (5) No carrier may advertise or market any health plan to the  
5 public as a plan that covers services that help prevent illness or  
6 promote the health of enrollees unless it:

7 (a) Provides all clinical preventive health services provided by  
8 the basic health plan, authorized by chapter 70.47 RCW;

9 (b) Monitors and reports annually to enrollees on standardized  
10 measures of health care and satisfaction of all enrollees in the health  
11 plan. The state department of health shall recommend appropriate  
12 standardized measures for this purpose, after consideration of national  
13 standardized measurement systems adopted by national managed care  
14 accreditation organizations and state agencies that purchase managed  
15 health care services; and

16 (c) Makes available upon request to enrollees its integrated plan  
17 to identify and manage the most prevalent diseases within its enrolled  
18 population, including cancer, heart disease, and stroke.

19 (6) No carrier may preclude or discourage its providers from  
20 informing an enrollee of the care he or she requires, including various  
21 treatment options, and whether in the providers' view such care is  
22 consistent with the plan's health coverage criteria, or otherwise  
23 covered by the enrollee's medical coverage agreement with the carrier.  
24 No carrier may prohibit, discourage, or penalize a provider otherwise  
25 practicing in compliance with the law from advocating on behalf of an  
26 enrollee with a carrier. Nothing in this section shall be construed to  
27 authorize a provider to bind a carrier to pay for any service.

28 (7) No carrier may preclude or discourage enrollees or those paying  
29 for their coverage from discussing the comparative merits of different  
30 carriers with their providers. This prohibition specifically includes  
31 prohibiting or limiting providers participating in those discussions  
32 even if critical of a carrier.

33 (8) Each carrier must communicate enrollee information required in  
34 chapter 5, Laws of 2000 by means that ensure that a substantial portion  
35 of the enrollee population can make use of the information. Carriers  
36 may implement alternative, efficient methods of communication to ensure  
37 enrollees have access to information including, but not limited to, web

1 site alerts, postcard mailings, and electronic communication in lieu of  
2 printed materials.

3 (9) The commissioner may adopt rules to implement this section. In  
4 developing rules to implement this section, the commissioner shall  
5 consider relevant standards adopted by national managed care  
6 accreditation organizations and state agencies that purchase managed  
7 health care services, as well as opportunities to reduce administrative  
8 costs included in health plans.

--- END ---