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HOUSE BILL 2032

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By Representatives Campbell, Schual-Berke, Parlette, Cody, Mulliken, Kessler, Murray, O'Brien, Romero, Clements, Ogden, Rockefeller, Lovick, Dunn, Kenney, Wolfe, Dunshee, Edmonds, Tokuda, Conway, Ruderman, McIntire, Hurst, Cooper, Wood, Constantine, Lantz, Santos, Miloscia and Keiser

Read first time 02/15/1999. Referred to Committee on Health Care.

AN ACT Relating to health care patient rights and protections; amending RCW 4.16.350; adding new sections to chapter 48.43 RCW; adding a new section to chapter 4.24 RCW; adding a new section to chapter 7.70 RCW; and creating a new section.

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

NEW SECTION. **Sec. 1.** PATIENT RIGHTS. It is the intent of the legislature that patients covered by health plans receive quality health care and that they: Have sufficient and timely access to appropriate health care services; have choice among providers; are assured that health care decisions are made by appropriate medical personnel; have access to information regarding their health plans; have access to a quick and impartial process for appealing plan denials; are protected from unnecessary invasions of health care privacy; are assured that personal health care information will be used appropriately; and are protected from unfair and deceptive practices.

NEW SECTION. **Sec. 2.** CHOICE OF HEALTH CARE PROVIDER. (1) Each enrollee in a health plan must have adequate choice among qualified health care providers.

(2) Each health plan must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers who share the enrolled population's varied characteristics.

(3) Each health plan must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted.

(4) Each health plan must provide, upon the request of an enrollee, access by the enrollee to a second opinion from a participating provider regarding any medical diagnosis or treatment plan.

(5) Each health carrier must have a process whereby an enrollee whose medical condition so warrants may be authorized to use a medical specialist as a primary care provider. This may include enrollees suffering from chronic diseases and those with other special needs.

(6) Each health plan must provide for continuity of care by:

(a) Assuring that primary care providers are responsible for at least:

(i) Supervision, coordination, and provision of health services to meet the needs of each enrollee; and

(ii) Initiation and coordination of referrals for specialty care;

(b) Allowing enrollees, already undergoing an active course of treatment that began while enrolled in the plan, to continue receiving services for a reasonable period from a participating provider who is not affiliated with the enrollee's primary care provider's network; and

(c) Educating enrollees about the carrier's process for assuring continuity of care.

(7) Each health plan offered by a carrier must provide a point-of-service option that allows an enrollee to choose to receive service from a nonparticipating health care provider or facility; however, enrollees must pay the full additional cost for choosing this option.

(8) To ensure enrollees' choice of provider and to meet the health care needs of enrollees for covered benefits without unreasonable delay, each health plan must include a sufficient number and type of health care providers and facilities throughout the plan's service area. Each health plan must provide enrollees with access to an adequate number of acute care hospital services, primary care providers, specialists and subspecialists, and specialty medical services, including chiropractic services, physical therapy,

occupational therapy, and rehabilitation services, within a reasonable distance or travel time.

(9) Each carrier must develop an access plan to meet the needs of vulnerable and underserved populations among its health plan enrollees.

(a) The plan must provide culturally appropriate services to the greatest extent possible.

(b) When a significant number of enrollees in the plan speak a first language other than English, the plan must provide access to personnel fluent in languages other than English, to the greatest extent possible.

(10) Each health carrier must communicate enrollee information required in this chapter by means that ensure that a substantial portion of the enrollee population can make use of this information.

(11) Each health carrier must have reasonable standards for waiting times for health plan enrollees to obtain appointments with participating providers. The standards must include appointment scheduling guidelines based upon the type of health care service, including: Preventive, nonsymptomatic care; routine, nonurgent symptomatic care; urgent care; and emergency care.

(12) Each health plan must, at the carrier's expense, allow enrollees to continue receiving services from a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan without cause under the terms of that contract, but must allow continued receipt of services for no longer than sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider's relationship with the health plan must be continued on the same terms and conditions as those of the contract the plan is terminating, except for any provision requiring that the health plan assign new enrollees to the terminated provider.

(13) Each health carrier must provide adequate telephone access by enrollees to facilities and providers for sufficient time during business and evening hours to ensure enrollee access to health services for covered health conditions.

(14) Each health plan must hold enrollees harmless against claims from participating providers for payment of costs of covered health services other than enrollees' cost-sharing obligations. A health

service that is the subject of an unresolved grievance is a covered service for the purposes of this section.

(15) Each carrier is accountable for and must oversee any activities required by this section that it delegates to any subcontractor. No carrier may delegate any activity required by this section unless the carrier has a written and fully operational delegation policy that ensures that the subcontractor fulfills the requirements of this chapter.

(16) No contract with a subcontractor executed by the health carrier may relieve the health carrier of its obligations to any enrollee for the provision of health care services or of its responsibility for compliance with statutes or rules.

(17) Every health carrier shall meet the standards set forth in this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner shall, when determining what is adequate and reasonable, consider relevant standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services.

NEW SECTION. **Sec. 3.** QUALITY HEALTH CARE. A carrier must have a fully operational, comprehensive, written, quality improvement program that addresses access, continuity, and quality of care for all health plan enrollees. The commissioner shall adopt, in rule, quality improvement program requirements after considering relevant standards adopted by national managed care accreditation organizations and the state agencies that purchase managed health care services.

NEW SECTION. **Sec. 4.** HEALTH INFORMATION PRIVACY. (1) Each health carrier shall develop and implement policies and procedures governing the collection, use, and disclosure of health information. These policies and procedures shall include methods for enrollees to access information and amend incorrect information, for enrollees to restrict the disclosure of sensitive information, and for enrollees to obtain information about the carrier’s health information policies. In addition, these policies and procedures shall include methods for carrier oversight and enforcement of information policies, for carrier storage and disposal of health information, and for carrier conformance to state and federal laws governing the collection, use, and disclosure

of personally identifiable health information. Each carrier shall provide a summary notice of its health information policies to enrollees, including the enrollee's right to restrict the collection, use, and disclosure of health information.

(2) Except as otherwise required by statute or rule, a health carrier is, and all persons acting at the direction of or on behalf of a carrier or in receipt of an enrollee's personally identifiable health information are, prohibited from collecting, using, or disclosing personally identifiable health information unless authorized in writing by the person who is the subject of the information. At a minimum, such authorization shall be valid for a limited time and purpose; shall be specific as to purpose and type of information to be collected, used, or disclosed; and shall identify the persons who will be receiving the information.

(3) Any person who is the subject of an unauthorized collection, use, or disclosure of personally identifiable health information is entitled to the remedies provided under RCW 9.73.060 governing violations of the right to privacy.

(4) The commissioner shall adopt rules to implement this section and shall take into consideration health information privacy standards recommended by the national association of insurance commissioners and other related professional organizations.

NEW SECTION. **Sec. 5.** MEDICAL DIRECTORS. No health carrier may appoint a medical director who is not a licensed physician in the state of Washington. The medical director is responsible for all medical necessity determinations and any medical management practices, including treatment policies, protocols, quality assurance activities, and utilization management decisions for any health plan offered by the carrier. The medical quality assurance commission shall develop a definition of unprofessional conduct as it applies to the conduct of a physician practicing as a health carrier medical director.

NEW SECTION. **Sec. 6.** GRIEVANCE PROCESS. (1) Each health carrier must have a fully operational, comprehensive, written grievance process that complies with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner shall consider grievance

process requirements adopted by national managed care accreditation organizations and state agency health care purchasers.

(2) Each health carrier must process as a grievance:

(a) An enrollee’s complaint about the quality or availability of a health service;

(b) An enrollee’s request that the carrier reconsider its decision to modify, discontinue, or deny a health service; its resolution of the enrollee’s complaint; or its first resolution of a grievance made by the enrollee; and

(c) An enrollee’s complaint about an issue other than the quality or availability of a health service that the health carrier does not resolve within the required response timeline.

(3) Each health carrier must provide a clear explanation of the grievance process upon request, upon enrollment to new enrollees, and annually to enrollees and subcontractors.

(4) To process a grievance, each carrier must:

(a) Provide written notice to the enrollee when the grievance is received;

(b) Assist the enrollee with the grievance process;

(c) Expedite a grievance if the enrollee’s provider or the carrier’s medical director determines, or if other evidence indicates, that following the grievance process timelines could seriously jeopardize the enrollee’s health or ability to regain maximum function;

(d) Cooperate with the representative that the enrollee may have chosen;

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the grievance; and

(g) Provide written notice to the enrollee.

(5) Each health carrier must provide written notice to an enrollee and the enrollee’s provider of its decision to modify, discontinue, or deny a health service for the enrollee.

(6) Written notice required by subsections (4) and (5) of this section must explain:

(a) The carrier’s decision and the supporting coverage or clinical reasons, including any alternative health service that may be appropriate; and

(b) The carrier’s grievance process, including information, as appropriate, about how to exercise enrollee’s rights to a second opinion, how to continue receiving services, and how to discuss a

grievance resolution with an impartial carrier representative authorized to resolve the grievance differently.

(7) When an enrollee requests that the carrier reconsider its decision to modify or discontinue a health service that an enrollee is receiving through the plan, the health carrier must continue to provide that health service until the grievance is resolved. If the resolution affirms the carrier's decision, the enrollee may be responsible for the cost of this continued health service.

(8) Each carrier must: Track each grievance until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all grievances; and trend grievances for quality improvement purposes.

NEW SECTION. **Sec. 7.** INDEPENDENT REVIEW OF HEALTH CARE DISPUTES. (1) A health carrier must develop and implement a process for the fair consideration of consumer complaints relating to decisions by the health plan to deny or limit coverage of or payment for health care in accordance with rules adopted by the commissioner. Those rules shall:

(a) Permit a person, whose appeal of an adverse decision is denied by the carrier, to seek review of that determination by an independent review organization assigned to the appeal in accordance with rules adopted by the commissioner;

(b) Require carriers to provide to the appropriate independent review organization not later than the third business day after the date the carrier receives a request for review a copy of:

(i) Any medical records of the enrollee that are relevant to the review;

(ii) Any documents used by the plan in making the determination to be reviewed by the organization;

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

(iv) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal; and

(c) Require carriers to comply with the independent review organization's determination regarding the medical necessity or appropriateness of, or the application of other health plan coverage criterion to, health care items and services for an enrollee, and to pay for the independent review.

(2) The review must be conducted by a health care provider currently licensed to practice in this state and in the same field or specialty as the enrollee's treating provider; however, such providers are limited to physicians licensed under chapter 18.71 or 18.57 RCW, of podiatric physicians licensed under chapter 18.22 RCW, and chiropractors licensed under chapter 18.25 RCW.

(3) Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

NEW SECTION. **Sec. 8.** INDEPENDENT REVIEW OF MEDICAL DECISIONS. (1) The commissioner shall:

(a) Adopt rules for:

(i) The certification, selection, and operation of independent review organizations to perform independent review described by section 7 of this act; and

(ii) The suspension and revocation of the certification;

(b) Designate annually each organization that meets the standards as an independent review organization;

(c) Charge health carriers fees as necessary to fund the operations of independent review organizations; and

(d) Provide ongoing oversight of the independent review organizations to ensure continued compliance with this chapter and the rules adopted under this chapter.

(2) The rules adopted under subsection (1)(a) of this section must ensure:

(a) The timely response of an independent review organization selected under this chapter;

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

(c) The qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

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

(e) Timely notice to enrollees of the results of the independent review, including the clinical basis for the determination.

(3) The rules adopted under subsection (1)(a) of this section must include rules that require each independent review organization to make its determination:

(a) Not later than the earlier of:

(i) The fifteenth day after the date the independent review organization receives the information necessary to make the determination; or

(ii) The twentieth day after the date the independent review organization receives the request that the determination be made; and

(b) In the case of a life-threatening condition, not later than the earlier of:

(i) The fifth day after the date the independent review organization receives the information necessary to make the determination; or

(ii) The eighth day after the date the independent review organization receives the request that the determination be made.

(4) To be certified as an independent review organization under this chapter, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

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

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

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

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

(i) A health benefit plan;

(ii) A health carrier;

(iii) A utilization review agent;

(iv) A nonprofit health corporation;

(v) A health care provider; or

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

(e) The percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under section 7 of this act;

(f) A description of the areas of expertise of the health care professionals making review determinations for the applicant; and

(g) The procedures to be used by the independent review organization in making review determinations regarding reviews conducted under section 7 of this act.

(5) The independent review organization shall annually submit the information required by subsection (4) of this section. If at any time there is a material change in the information included in the application under subsection (4) of this section, the independent review organization shall submit updated information to the commissioner.

(6) An independent review organization may not be a subsidiary of, or be in any way owned or controlled by, a health carrier or a trade or professional association of health carriers.

(7) An independent review organization conducting a review under section 7 of this act is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

NEW SECTION. **Sec. 9.** UNFAIR AND DECEPTIVE ACTS. (1) A health carrier shall not engage in unfair or deceptive acts or practices as such acts and practices are prohibited under chapter 48.30 RCW. Such acts and practices include but are not limited to the placement of any advertisement before the public that is false, inaccurate, or misleading. Such advertising is a matter affecting the public interest for the purposes of applying chapter 19.86 RCW, and is not reasonable in relation to the development and preservation of business. A violation of this section constitutes an unfair or deceptive act or practice in trade or commerce for the purpose of applying chapter 19.86 RCW.

(2) The commissioner may by rule define and prohibit other acts and practices by health carriers found by the commissioner to be unfair and deceptive and harmful to consumers.

NEW SECTION. **Sec. 10.** HEALTH CARE DECISIONS. (1) Each health carrier, in its review of inpatient medical and surgical benefits and

outpatient medical and surgical benefits for residents of this state, shall meet the standards set forth in this section.

(2) Any decision to deny an admission, length of stay, extension of stay, or health service or procedure must be made by a participating provider in consultation with an appropriate specialty provider.

(3) Carriers shall maintain a documented utilization review program description and written utilization review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical protocols, medical management standards, and other review criteria available upon request to participating providers.

(4) The commissioner shall adopt, in rule, standards for this section after considering relevant standards adopted by national managed care accreditation organizations and the state agencies that purchase managed health care services.

NEW SECTION. **Sec. 11.** CARRIER LIABILITY FINDINGS. The legislature finds that health carrier practices that unjustly delay or deny medically appropriate care and treatment to consumers are unconscionable. When consumers are facing serious, even life-threatening diseases or conditions, they are least able to fight with their health carrier in order to get access to needed health care and treatment. In order to protect Washington residents in need of medically necessary care and treatment, and to prevent inappropriate treatment delays or denials, the legislature finds it is necessary to enact the consumer protections set out in this act.

NEW SECTION. **Sec. 12.** A new section is added to chapter 4.24 RCW to read as follows:

CARRIER LIABILITY DEFINITIONS. (1) The definitions in this subsection apply throughout this section.

(a) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practice and standards of the medical profession and community.

(b) "Enrollee" means an individual covered by a health plan, including dependents.

(c) "Health care provider" means the same as defined in RCW 48.43.005.

(d) "Health care treatment decision" means a determination made regarding whether a health care service or services are actually provided by the health plan and a decision that affects the quality of the diagnosis, care, or treatment provided to the plan's enrollees.

(e) "Health carrier" means the same as defined in RCW 48.43.005.

(f) "Health plan" means the same as defined in RCW 48.43.005, except that it includes a policy, contract, or agreement offered by any person, not merely a health carrier.

(g) "Managed care entity" means an entity other than a health carrier that delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of the services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy under chapter 18.64 RCW.

(h) "Ordinary care" means, for a health carrier or managed care entity, that degree of care that a health carrier or managed care entity of ordinary prudence would use under the same or similar circumstances. For a person who is an employee, agent, ostensible agent, or representative of a health carrier or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as the person would use in the same or similar circumstances.

(2)(a) A health carrier or a managed care entity for a health plan shall exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an enrollee proximately caused by its failure to exercise the ordinary care.

(b) A health carrier or a managed care entity for a health plan is also liable for damages for harm to an enrollee proximately caused by health care treatment decisions made by its:

(i) Employees;

(ii) Agents;

(iii) Ostensible agents; or

(iv) Representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control that result in the failure to exercise ordinary care.

(3) It is a defense to any action asserted under this section against a health carrier or managed care entity for a health plan that:

(a) Neither the health carrier or managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct the health carrier or managed care entity is liable under subsection (2)(b) of this section, controlled, influenced, or participated in the health care decision; or

(b) The health carrier or managed care entity did not deny or delay payment for treatment prescribed or recommended by a provider to the enrollee.

(4) The standards in subsection (2) of this section do not create an obligation on the part of the health carrier or managed care entity to provide to an enrollee treatment that is not covered by the health plan.

(5) This section does not create any liability on the part of an employer or an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employers.

(6) Nothing in any law of this state prohibiting a health carrier or managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by the health carrier or managed care entity in an action brought against it under this section.

(7)(a) A person may not maintain a cause of action under this section against a health carrier or managed care entity unless the affected enrollee or the enrollee’s representative:

(i) Has exhausted any applicable reasonable grievance procedures provided for in the health plan; or

(ii) Has participated in the grievance process in good faith for ninety days.

(b) The enrollee is not required to comply with (a) of this subsection and no abatement or other penalty for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(i) Harm to the enrollee has already occurred because of the conduct of the health carrier or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of the carrier or entity for whose conduct it is liable; or

(ii) The review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier or entity, finds after hearing that the pleading was not made in good faith.

(c) This subsection (7) does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or other relief available under law, if their requirements place the enrollee's health in serious jeopardy.

(8) In an action against a health carrier, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such a health carrier shall not be based solely on proof that the person's name appears in a listing of approved physicians or health care providers made available to enrollees under a health plan.

(9) A person who is injured by a violation of this section may bring a civil action in superior court to enjoin further violations, to recover the actual damages sustained, or both, together with the costs of the suit, including reasonable attorneys' fees, and the court may in its discretion, upon a finding of bad faith on the part of the health carrier, increase the award of damages to an amount not exceeding three times the actual damages sustained.

(10) This section does not apply to workers' compensation insurance under Title 51 RCW.

NEW SECTION. **Sec. 13.** A new section is added to chapter 7.70 RCW to read as follows:

CARRIER LIABILITY EXCLUSIONS. This chapter does not apply to actions under section 12 of this act for injuries resulting from health care treatment decisions made by or on behalf of health carriers or managed care entities, including entities listed in RCW 7.70.020(3). For purposes of this section:

(1) "Health care treatment decision" means a determination made regarding whether a health care service or services are actually provided by the health plan and a decision that affects the quality of the diagnosis, care, or treatment provided to the plan's enrollees;

(2) "Health carrier" means the same as defined in RCW 48.43.005; and

(3) "Managed care entity" means an entity other than a health carrier that delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the

quality, accessibility, utilization, or costs and prices of the services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy under chapter 18.64 RCW.

Sec. 14. RCW 4.16.350 and 1998 c 147 s 1 are each amended to read as follows:

(1) Except as provided in subsection (2) of this section, any civil action for damages for injury occurring as a result of health care which is provided after June 25, 1976 against:

((~~(1)~~)) (a) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, ((~~podiatric~~)) pediatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;

((~~(2)~~)) (b) An employee or agent of a person described in (a) of this subsection ((~~(1) of this section~~)), acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or

((~~(3)~~)) (c) An entity, whether or not incorporated, facility, or institution employing one or more persons described in (a) of this subsection ((~~(1) of this section~~)), including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;

based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury or condition, or one year of the time the patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by said act or omission, whichever period expires later, except that in no event shall an action be commenced more than eight years after said act or omission: PROVIDED, That the time for commencement of an action is tolled upon proof of fraud, intentional

concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect, until the date the patient or the patient's representative has actual knowledge of the act of fraud or concealment, or of the presence of the foreign body; the patient or the patient's representative has one year from the date of the actual knowledge in which to commence a civil action for damages.

For purposes of this ((~~section~~)) subsection, notwithstanding RCW 4.16.190, the knowledge of a custodial parent or guardian shall be imputed to a person under the age of eighteen years, and such imputed knowledge shall operate to bar the claim of such minor to the same extent that the claim of an adult would be barred under this ((~~section~~)) subsection. Any action not commenced in accordance with this ((~~section~~)) subsection shall be barred.

For purposes of this ((~~section~~)) subsection, with respect to care provided after June 25, 1976, and before August 1, 1986, the knowledge of a custodial parent or guardian shall be imputed as of April 29, 1987, to persons under the age of eighteen years.

This ((~~section~~)) subsection does not apply to a civil action based on intentional conduct brought against those individuals or entities specified in this ((~~section~~)) subsection by a person for recovery of damages for injury occurring as a result of childhood sexual abuse as defined in RCW 4.16.340(5).

(2) Any action under section 12 of this act shall be commenced within three years of the completion of the grievance process, if applicable, under section 12(7) of this act, within three years of the accrual of the cause of action if the grievance process under section 12(7) of this act is not applicable, but in no event shall an action be commenced more than eight years after the relevant act or omission occurred.

NEW SECTION. **Sec. 15.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 16.** Captions used in this act are not any part of the law.

NEW SECTION. **Sec. 17.** Sections 1 through 11 of this act are each added to chapter 48.43 RCW.

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