CERTIFICATION OF ENROLLMENT

HOUSE BILL 2406

59th Legislature
2006 Regular Session

Passed by the House January 18, 2006
Yeas 96 Nays 0

Speaker of the House of Representatives

Passed by the Senate February 28, 2006
Yeas 45 Nays 0

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 2406** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

Secretary of State
State of Washington

HOUSE BILL 2406

Passed Legislature - 2006 Regular Session

State of Washington 59th Legislature 2006 Regular Session

By Representatives Roach and Kirby; by request of Insurance Commissioner

Prefiled 1/3/2006. Read first time 01/09/2006. Referred to Committee on Financial Institutions & Insurance.

1 AN ACT Relating to insurance; amending RCW 48.05.250, 48.05.440,
2 48.43.045, 48.44.095, 48.46.080, 48.125.090, 52.30.020, 48.43.005, and
3 48.22.030; reenacting and amending RCW 48.24.030; adding new sections
4 to chapter 48.05 RCW; adding a new section to chapter 42.56 RCW; adding
5 a new section to chapter 48.17 RCW; adding a new chapter to Title 43
6 RCW; creating a new section; recodifying RCW 48.48.030, 48.48.040,
7 48.48.045, 48.48.050, 48.48.060, 48.48.065, 48.48.070, 48.48.080,
8 48.48.090, 48.48.110, 48.48.140, 48.48.150, and 48.48.160; repealing
9 RCW 48.05.490 and 48.43.365; and providing an effective date.

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

11 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.05 RCW
12 to read as follows:
13 (1) Every property and casualty insurance company doing business in
14 this state, unless otherwise exempted by the domiciliary commissioner,
15 shall annually submit the opinion of an appointed actuary entitled
16 "Statement of Actuarial Opinion." This opinion shall be filed in
17 accordance with the property and casualty annual statement instructions
18 as adopted by the national association of insurance commissioners.

(2) Every property and casualty insurance company domiciled in this state that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary, written by the company's appointed actuary. This actuarial opinion summary shall be filed in accordance with the property and casualty annual statement instructions as adopted by the national association of insurance commissioners and shall be considered as a document supporting the actuarial opinion required in subsection (1) of this section.

(3) An insurance company authorized but not domiciled in this state shall provide the actuarial opinion summary upon request.

(4) An actuarial report and underlying work papers as required by the property and casualty annual statement instructions as adopted by the national association of insurance commissioners shall be prepared to support each actuarial opinion.

(5) If the insurance company fails to provide either a supporting actuarial report or work papers, or both, at the request of the commissioner or the commissioner determines that the supporting actuarial report or work papers provided by the insurance company is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or work papers.

(6) The appointed actuary is not liable for damages to any person, other than the insurance company, the commissioner, or both, for any act, error, omission, decision, or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.05 RCW to read as follows:

(1) The statement of actuarial opinion shall be provided with the annual statement in accordance with the property and casualty annual statement instructions as adopted by the national association of insurance commissioners and shall be treated as a public document.

(2) Documents, materials or other information in the possession or control of the commissioner that are considered an actuarial report, work papers, or actuarial opinion summary provided in support of the opinion, and any other material provided by the insurance company to

1 the commissioner in connection with the actuarial report, work papers,
2 or actuarial opinion summary, is confidential by law and privileged, is
3 not subject to chapter 42.17 or 42.56 RCW, is not subject to subpoena,
4 and is not subject to discovery or admissible in evidence in any
5 private civil action.

6 (3) Subsection (2) of this section does not limit the
7 commissioner's authority to release the documents to the actuarial
8 board for counseling and discipline so long as the material is required
9 for the purpose of professional disciplinary proceedings and the board
10 establishes procedures satisfactory to the commissioner for preserving
11 the confidentiality of the documents. Subsection (2) of this section
12 does not limit the commissioner's authority to use the documents,
13 materials, or other information in furtherance of any regulatory or
14 legal action brought as part of the commissioner's official duties.

15 (4) Neither the commissioner nor any person who received documents,
16 materials, or other information while acting under the authority of the
17 commissioner is permitted or required to testify in any private civil
18 action concerning any confidential documents, materials, or information
19 subject to subsection (2) of this section.

20 (5) In order to assist in the performance of the commissioner's
21 duties, the commissioner:

22 (a) May share documents, materials, or other information, including
23 the confidential and privileged documents, materials, or information
24 subject to subsection (2) of this section with other state, federal,
25 and international regulatory agencies, with the national association of
26 insurance commissioners and its affiliates and subsidiaries, and with
27 state, federal, and international law enforcement authorities, provided
28 that the recipient agrees to maintain the confidentiality and
29 privileged status of the document, material, or other information and
30 has the legal authority to maintain confidentiality;

31 (b) May receive documents, materials, or information, including
32 otherwise confidential and privileged documents, materials, or
33 information, from the national association of insurance commissioners
34 and its affiliates and subsidiaries, and from regulatory and law
35 enforcement officials of other foreign or domestic jurisdictions, and
36 shall maintain as confidential or privileged any document, material, or
37 information received with notice or the understanding that it is

confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(c) May enter into agreements governing the sharing and use of information consistent with this subsection.

(6) A waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information may not occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (5) of this section.

NEW SECTION. **Sec. 3.** A new section is added to chapter 42.56 RCW to read as follows:

Documents, materials, and information obtained by the insurance commissioner under section 2(2) of this act are confidential and privileged and not subject to public disclosure under this chapter.

NEW SECTION. **Sec. 4.** Sections 1 through 3 of this act may be known and cited as the property and casualty actuarial opinion law.

Sec. 5. RCW 48.05.250 and 1983 c 85 s 1 are each amended to read as follows:

(1) Each ((~~authorized~~)) domestic insurer shall annually, on or before the first day of March, file with the commissioner a true statement of its financial condition, transactions, and affairs as of the thirty-first day of December preceding. The statement forms shall be in general form and context as approved by the National Association of Insurance Commissioners for the kinds of insurance to be reported upon, and as supplemented for additional information required by this code and by the commissioner. The statement shall be verified by the oaths of at least two of the insurer's officers.

(2) The annual statement of an alien insurer shall relate only to its transactions and affairs in the United States unless the commissioner requires otherwise. The statement shall be verified by the insurer's United States manager or by its officers duly authorized.

(3) The commissioner shall suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due or during any extension of time therefor which the commissioner, for good cause, may grant.

Sec. 6. RCW 48.05.440 and 1995 c 83 s 3 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

(c) Provides projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business might include separate projections

1 for each major line of business and separately identify each
2 significant income, expense, and benefit component;
3 (d) Identifies the key assumptions impacting the insurer's
4 projections and the sensitivity of the projections to the assumptions;
5 and
6 (e) Identifies the quality of, and problems associated with, the
7 insurer's business, including but not limited to its assets,
8 anticipated business growth and associated surplus strain,
9 extraordinary exposure to risk, mix of business, and use of
10 reinsurance, if any, in each case.
11 (3) The RBC plan shall be submitted:
12 (a) Within forty-five days of the company action level event; or
13 (b) If the insurer challenges an adjusted RBC report under RCW
14 48.05.460, within forty-five days after notification to the insurer
15 that the commissioner has, after a hearing, rejected the insurer's
16 challenge.
17 (4) Within sixty days after the submission by an insurer of an RBC
18 plan to the commissioner, the commissioner shall notify the insurer
19 whether the RBC plan may be implemented or is, in the judgment of the
20 commissioner, unsatisfactory. If the commissioner determines the RBC
21 plan is unsatisfactory, the notification to the insurer shall set forth
22 the reasons for the determination, and may set forth proposed revisions
23 that will render the RBC plan satisfactory. Upon notification from the
24 commissioner, the insurer shall prepare a revised RBC plan, that may
25 incorporate by reference any revisions proposed by the commissioner,
26 and shall submit the revised RBC plan to the commissioner:
27 (a) Within forty-five days after the notification from the
28 commissioner; or
29 (b) If the insurer challenges the notification from the
30 commissioner under RCW 48.05.460, within forty-five days after a
31 notification to the insurer that the commissioner has, after a hearing,
32 rejected the insurer's challenge.
33 (5) In the event of a notification by the commissioner to an
34 insurer that the insurer's RBC plan or revised RBC plan is
35 unsatisfactory, the commissioner may, subject to the insurer's rights
36 to a hearing under RCW 48.05.460, specify in the notification that the
37 notification constitutes a regulatory action level event.

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

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

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

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

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

Sec. 7. RCW 48.43.045 and 1997 c 231 s 205 are each amended to read as follows:

Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:

(1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services.

(2) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals, unless substantially similar information is filed with the commissioner or the national association of insurance commissioners. This requirement does not apply to a foreign or alien insurer regulated under chapter 48.20 or 48.21 RCW that files a

supplemental compensation exhibit in its annual statement as required by law.

Sec. 8. RCW 48.44.095 and 1997 c 212 s 4 are each amended to read as follows:

(1) Every domestic health care service contractor shall annually, on or before the first day of March, file with the commissioner a statement verified by at least two of the principal officers of the health care service contractor showing its financial condition as of the last day of the preceding calendar year. The statement shall be in such form as is furnished or prescribed by the commissioner. The commissioner may for good reason allow a reasonable extension of the time within which such annual statement shall be filed.

(2) In addition to the requirements of subsection (1) of this section, every health care service contractor that is registered in this state shall annually, on or before March 1st of each year, file with the national association of insurance commissioners a copy of its annual statement, along with those additional schedules as prescribed by the commissioner for the preceding year. The information filed with the national association of insurance commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurate page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the national association of insurance commissioners.

(3) Coincident with the filing of its annual statement and other schedules, each health care service contractor shall pay a reasonable fee directly to the national association of insurance commissioners in an amount approved by the commissioner to cover the costs associated with the analysis of the annual statement.

(4) Foreign health care service contractors that are domiciled in a state that has a law substantially similar to subsection (2) of this section are considered to be in compliance with this section.

(5) In the absence of actual malice, members of the national association of insurance commissioners, their duly authorized committees, subcommittees, and task forces, their delegates, national association of insurance commissioners employees, and all other persons charged with the responsibility of collecting, reviewing, analyzing,

1 and dissimilating the information developed from the filing of the
2 annual statement shall be acting as agents of the commissioner under
3 the authority of this section and shall not be subject to civil
4 liability for libel, slander, or any other cause of action by virtue of
5 their collection, review, analysis, or dissimilation of the data and
6 information collected for the filings required under this section.
7 (6) The commissioner may suspend or revoke the certificate of
8 registration of any health care service contractor failing to file its
9 annual statement or pay the fees when due or during any extension of
10 time therefor which the commissioner, for good cause, may grant.

11 **Sec. 9.** RCW 48.46.080 and 1997 c 212 s 5 are each amended to read
12 as follows:
13 (1) Every domestic health maintenance organization shall annually,
14 on or before the first day of March, file with the commissioner a
15 statement verified by at least two of the principal officers of the
16 health maintenance organization showing its financial condition as of
17 the last day of the preceding calendar year.
18 (2) Such annual report shall be in such form as the commissioner
19 shall prescribe and shall include:
20 (a) A financial statement of such organization, including its
21 balance sheet and receipts and disbursements for the preceding year,
22 which reflects at a minimum;
23 (i) All prepayments and other payments received for health care
24 services rendered pursuant to health maintenance agreements;
25 (ii) Expenditures to all categories of health care facilities,
26 providers, insurance companies, or hospital or medical service plan
27 corporations with which such organization has contracted to fulfill
28 obligations to enrolled participants arising out of its health
29 maintenance agreements, together with all other direct expenses
30 including depreciation, enrollment, and commission; and
31 (iii) Expenditures for capital improvements, or additions thereto,
32 including but not limited to construction, renovation, or purchase of
33 facilities and capital equipment;
34 (b) The number of participants enrolled and terminated during the
35 report period. Every employer offering health care benefits to their
36 employees through a group contract with a health maintenance

organization shall furnish said health maintenance organization with a list of their employees enrolled under such plan;

(c) The number of doctors by type of practice who, under contract with or as an employee of the health maintenance organization, furnished health care services to consumers during the past year;

(d) A report of the names and addresses of all officers, directors, or trustees of the health maintenance organization during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to such organization. For partnership and professional service corporations, a report shall be made for partners or shareholders as to any compensation or expense reimbursement received by them for services, other than for services and expenses relating directly for patient care;

(e) Such other information relating to the performance of the health maintenance organization or the health care facilities or providers with which it has contracted as reasonably necessary to the proper and effective administration of this chapter, in accordance with rules and regulations; and

(f) Disclosure of any financial interests held by officers and directors in any providers associated with the health maintenance organization or any provider of the health maintenance organization.

(3) The commissioner may for good reason allow a reasonable extension of the time within which such annual statement shall be filed.

(4) In addition to the requirements of subsections (1) and (2) of this section, every health maintenance organization that is registered in this state shall annually, on or before March 1st of each year, file with the national association of insurance commissioners a copy of its annual statement, along with those additional schedules as prescribed by the commissioner for the preceding year. The information filed with the national association of insurance commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurate page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the national association of insurance commissioners.

(5) Coincident with the filing of its annual statement and other schedules, each health maintenance organization shall pay a reasonable

1 fee directly to the national association of insurance commissioners in
2 an amount approved by the commissioner to cover the costs associated
3 with the analysis of the annual statement.
4 (6) Foreign health maintenance organizations that are domiciled in
5 a state that has a law substantially similar to subsection (4) of this
6 section are considered to be in compliance with this section.
7 (7) In the absence of actual malice, members of the national
8 association of insurance commissioners, their duly authorized
9 committees, subcommittees, and task forces, their delegates, national
10 association of insurance commissioners employees, and all other persons
11 charged with the responsibility of collecting, reviewing, analyzing,
12 and dissimilating the information developed from the filing of the
13 annual statement shall be acting as agents of the commissioner under
14 the authority of this section and shall not be subject to civil
15 liability for libel, slander, or any other cause of action by virtue of
16 their collection, review, analysis, or dissimilation of the data and
17 information collected for the filings required under this section.
18 (8) The commissioner may suspend or revoke the certificate of
19 registration of any health maintenance organization failing to file its
20 annual statement or pay the fees when due or during any extension of
21 time therefor which the commissioner, for good cause, may grant.
22 (9) No person shall knowingly file with any public official or
23 knowingly make, publish, or disseminate any financial statement of a
24 health maintenance organization which does not accurately state the
25 health maintenance organization's financial condition.

26 **Sec. 10.** RCW 48.125.090 and 2004 c 260 s 11 are each amended to
27 read as follows:
28 (1) A self-funded multiple employer welfare arrangement must comply
29 with the reporting requirements of this section.
30 (2) Every arrangement holding a certificate of authority from the
31 commissioner must file its financial statements as required by this
32 title and by the commissioner in accordance with the accounting
33 practices and procedures manuals as adopted by the national association
34 of insurance commissioners, unless otherwise provided by law.
35 (3) Every arrangement must comply with the provisions of chapters
36 48.12 and 48.13 RCW.

(4) Every domestic arrangement holding a certificate of authority shall((~~,~~)) annually, on or before the first day of March, file with the commissioner a true statement of its financial condition, transactions, and affairs as of the thirty-first day of December of the preceding year. The statement forms must be those forms approved by the national association of insurance commissioners for health insurance. The statement must be verified by the oaths of at least two officers of the arrangement. Additional information may be required by this title or by the request of the commissioner.

(5) Every arrangement must report their annual and other statements in the same manner required of other insurers by rule of the commissioner.

(6) The arrangement must file with the commissioner a copy of the arrangement's internal revenue service form 5500 together with all attachments to the form, at the time required for filing the form.

NEW SECTION. **Sec. 11.** The following acts or parts of acts are each repealed:

(1) RCW 48.05.490 (RBC reports for 1995--Requirements) and 1995 c 83 s 13; and

(2) RCW 48.43.365 (RBC report for 1998 calendar year) and 1998 c 241 s 14.

Sec. 12. RCW 52.30.020 and 1979 c 151 s 164 are each amended to read as follows:

Wherever a fire protection district has been organized which includes within its area or is adjacent to, buildings and equipment, except those leased to a nontax exempt person or organization, owned by the legislative or administrative authority of a state agency or institution or a municipal corporation, the agency or institution or municipal corporation involved shall contract with such district for fire protection services necessary for the protection and safety of personnel and property pursuant to the provisions of chapter 39.34 RCW((~~, as now or hereafter amended~~)): PROVIDED, That nothing in this section shall be construed to require that any state agency, institution, or municipal corporation contract for services which are performed by the staff and equipment of such state agency, institution, or municipal corporation: PROVIDED FURTHER, That nothing in this

1 section shall apply to state agencies or institutions or municipal
2 corporations which are receiving fire protection services by contract
3 from another municipality, city, town, or other entities: AND PROVIDED
4 FURTHER, That school districts shall receive fire protection services
5 from the fire protection districts in which they are located without
6 the necessity of executing a contract for such fire protection
7 services: PROVIDED FURTHER, That prior to September 1, 1974, the
8 superintendent of public instruction, the ((~~insurance commissioner~~))
9 chief of the Washington state patrol through the director of fire
10 protection, the director of financial management, and the executive
11 director of the Washington fire commissioners association, or their
12 designees, shall develop criteria to be used by the ((~~insurance~~
13 ~~commissioner~~)) chief of the Washington state patrol through the
14 director of fire protection in establishing uniform rates governing
15 payments to fire districts by school districts for fire protection
16 services. On or before September 1, 1974, the ((~~insurance~~
17 ~~commissioner~~)) chief of the Washington state patrol through the
18 director of fire protection shall establish such rates to be payable by
19 school districts on or before January 1st of each year commencing
20 January 1, 1975, payable July 1, 1975: AND PROVIDED FURTHER, That
21 beginning with the 1975-77 biennium and in each biennium thereafter the
22 superintendent of public instruction shall present in ((~~his~~)) the
23 budget submittal to the governor an amount sufficient to reimburse
24 affected school districts for the moneys necessary to pay the costs of
25 the uniform rates established by the ((~~insurance commissioner~~)) chief
26 of the Washington state patrol through the director of fire protection.

27 NEW SECTION. **Sec. 13.** RCW 48.48.030, 48.48.040, 48.48.045,
28 48.48.050, 48.48.060, 48.48.065, 48.48.070, 48.48.080, 48.48.090,
29 48.48.110, 48.48.140, 48.48.150, and 48.48.160 are each recodified as
30 a new chapter in Title 43 RCW.

31 **Sec. 14.** RCW 48.24.030 and 2005 c 223 s 13 and 2005 c 222 s 2 are
32 each reenacted and amended to read as follows:
33 (1) Insurance under any group life insurance policy issued under
34 RCW 48.24.020, 48.24.050, 48.24.060, 48.24.070, or 48.24.090 may be
35 extended to insure the spouse and dependent children, or any class or
36 classes thereof, of each insured employee or member who so elects, in

amounts in accordance with a plan that precludes individual selection by the employees or members or by the employer or labor union or trustee, and which insurance on the life of any one family member including a spouse shall not be in excess of the amount on the life of the insured employee or member.

Premiums for the insurance on the family members shall be paid by the policyholder, either from the employer's funds, funds contributed to him or her, employee's funds, trustee's funds, or labor union funds.

(2) A spouse insured under this section has the same conversion right as to the insurance on his or her life as is vested in the employee or member under this chapter.

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.17 RCW to read as follows:

(1) All Washington state licensed insurance agents who sell federal flood insurance policies must comply with the minimum training requirements of section 207 of the flood insurance reform act of 2004, and basic flood education as outlined at 70 C.F.R. Sec. 52117, or such later requirements as are published by the federal emergency management agency.

(2) Licensed insurers shall demonstrate to the commissioner, upon request, that their licensed and appointed agents who sell federal flood insurance policies have complied with the minimum federal flood insurance training requirements.

Sec. 16. RCW 48.43.005 and 2004 c 244 s 2 are each amended to read as follows:

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

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

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

(3) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)((~~(d)~~)) (e).

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

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand dollars; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least five thousand five hundred dollars; or

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

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

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

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

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

1 (10) "Eligible employee" means an employee who works on a full-time
2 basis with a normal work week of thirty or more hours. The term
3 includes a self-employed individual, including a sole proprietor, a
4 partner of a partnership, and may include an independent contractor, if
5 the self-employed individual, sole proprietor, partner, or independent
6 contractor is included as an employee under a health benefit plan of a
7 small employer, but does not work less than thirty hours per week and
8 derives at least seventy-five percent of his or her income from a trade
9 or business through which he or she has attempted to earn taxable
10 income and for which he or she has filed the appropriate internal
11 revenue service form. Persons covered under a health benefit plan
12 pursuant to the consolidated omnibus budget reconciliation act of 1986
13 shall not be considered eligible employees for purposes of minimum
14 participation requirements of chapter 265, Laws of 1995.
15 (11) "Emergency medical condition" means the emergent and acute
16 onset of a symptom or symptoms, including severe pain, that would lead
17 a prudent layperson acting reasonably to believe that a health
18 condition exists that requires immediate medical attention, if failure
19 to provide medical attention would result in serious impairment to
20 bodily functions or serious dysfunction of a bodily organ or part, or
21 would place the person's health in serious jeopardy.
22 (12) "Emergency services" means otherwise covered health care
23 services medically necessary to evaluate and treat an emergency medical
24 condition, provided in a hospital emergency department.
25 (13) "Enrollee point-of-service cost-sharing" means amounts paid to
26 health carriers directly providing services, health care providers, or
27 health care facilities by enrollees and may include copayments,
28 coinsurance, or deductibles.
29 (14) "Grievance" means a written complaint submitted by or on
30 behalf of a covered person regarding: (a) Denial of payment for
31 medical services or nonprovision of medical services included in the
32 covered person's health benefit plan, or (b) service delivery issues
33 other than denial of payment for medical services or nonprovision of
34 medical services, including dissatisfaction with medical care, waiting
35 time for medical services, provider or staff attitude or demeanor, or
36 dissatisfaction with service provided by the health carrier.
37 (15) "Health care facility" or "facility" means hospices licensed
38 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,

rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

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

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

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

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

(18) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

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

(a) Long-term care insurance governed by chapter 48.84 RCW;

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

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

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

((~~(d)~~)) (e) Disability income;

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

((~~(f)~~)) (g) Workers' compensation coverage;

((~~(g)~~)) (h) Accident only coverage;

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

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

((~~(j)~~)) (k) Dental only and vision only coverage; and

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

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

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

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

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

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not

1 formed primarily for purposes of buying health insurance and in which
2 a bona fide employer-employee relationship exists. In determining the
3 number of eligible employees, companies that are affiliated companies,
4 or that are eligible to file a combined tax return for purposes of
5 taxation by this state, shall be considered an employer. Subsequent to
6 the issuance of a health plan to a small employer and for the purpose
7 of determining eligibility, the size of a small employer shall be
8 determined annually. Except as otherwise specifically provided, a
9 small employer shall continue to be considered a small employer until
10 the plan anniversary following the date the small employer no longer
11 meets the requirements of this definition. A self-employed individual
12 or sole proprietor must derive at least seventy-five percent of his or
13 her income from a trade or business through which the individual or
14 sole proprietor has attempted to earn taxable income and for which he
15 or she has filed the appropriate internal revenue service form 1040,
16 schedule C or F, for the previous taxable year except for a self-
17 employed individual or sole proprietor in an agricultural trade or
18 business, who must derive at least fifty-one percent of his or her
19 income from the trade or business through which the individual or sole
20 proprietor has attempted to earn taxable income and for which he or she
21 has filed the appropriate internal revenue service form 1040, for the
22 previous taxable year. A self-employed individual or sole proprietor
23 who is covered as a group of one on the day prior to June 10, 2004,
24 shall also be considered a "small employer" to the extent that
25 individual or group of one is entitled to have his or her coverage
26 renewed as provided in RCW 48.43.035(6).
27 (25) "Utilization review" means the prospective, concurrent, or
28 retrospective assessment of the necessity and appropriateness of the
29 allocation of health care resources and services of a provider or
30 facility, given or proposed to be given to an enrollee or group of
31 enrollees.
32 (26) "Wellness activity" means an explicit program of an activity
33 consistent with department of health guidelines, such as, smoking
34 cessation, injury and accident prevention, reduction of alcohol misuse,
35 appropriate weight reduction, exercise, automobile and motorcycle
36 safety, blood cholesterol reduction, and nutrition education for the
37 purpose of improving enrollee health status and reducing health service
38 costs.

1 **Sec. 17.** RCW 48.22.030 and 2004 c 90 s 1 are each amended to read
2 as follows:
3 (1) "Underinsured motor vehicle" means a motor vehicle with respect
4 to the ownership, maintenance, or use of which either no bodily injury
5 or property damage liability bond or insurance policy applies at the
6 time of an accident, or with respect to which the sum of the limits of
7 liability under all bodily injury or property damage liability bonds
8 and insurance policies applicable to a covered person after an accident
9 is less than the applicable damages which the covered person is legally
10 entitled to recover.
11 (2) No new policy or renewal of an existing policy insuring against
12 loss resulting from liability imposed by law for bodily injury, death,
13 or property damage, suffered by any person arising out of the
14 ownership, maintenance, or use of a motor vehicle shall be issued with
15 respect to any motor vehicle registered or principally garaged in this
16 state unless coverage is provided therein or supplemental thereto for
17 the protection of persons insured thereunder who are legally entitled
18 to recover damages from owners or operators of underinsured motor
19 vehicles, hit-and-run motor vehicles, and phantom vehicles because of
20 bodily injury, death, or property damage, resulting therefrom, except
21 while operating or occupying a motorcycle or motor-driven cycle, and
22 except while operating or occupying a motor vehicle owned or available
23 for the regular use by the named insured or any family member, and
24 which is not insured under the liability coverage of the policy. The
25 coverage required to be offered under this chapter is not applicable to
26 general liability policies, commonly known as umbrella policies, or
27 other policies which apply only as excess to the insurance directly
28 applicable to the vehicle insured.
29 (3) Except as to property damage, coverage required under
30 subsection (2) of this section shall be in the same amount as the
31 insured's third party liability coverage unless the insured rejects all
32 or part of the coverage as provided in subsection (4) of this section.
33 Coverage for property damage need only be issued in conjunction with
34 coverage for bodily injury or death. Property damage coverage required
35 under subsection (2) of this section shall mean physical damage to the
36 insured motor vehicle unless the policy specifically provides coverage
37 for the contents thereof or other forms of property damage.

1 (4) A named insured or spouse may reject, in writing, underinsured
2 coverage for bodily injury or death, or property damage, and the
3 requirements of subsections (2) and (3) of this section shall not
4 apply. If a named insured or spouse has rejected underinsured
5 coverage, such coverage shall not be included in any supplemental or
6 renewal policy unless a named insured or spouse subsequently requests
7 such coverage in writing. The requirement of a written rejection under
8 this subsection shall apply only to the original issuance of policies
9 issued after July 24, 1983, and not to any renewal or replacement
10 policy. <u>When a named insured or spouse chooses a property damage</u>
11 <u>coverage that is less than the insured's third party liability coverage</u>
12 <u>for property damage, a written rejection is not required.</u>
13 (5) The limit of liability under the policy coverage may be defined
14 as the maximum limits of liability for all damages resulting from any
15 one accident regardless of the number of covered persons, claims made,
16 or vehicles or premiums shown on the policy, or premiums paid, or
17 vehicles involved in an accident.
18 (6) The policy may provide that if an injured person has other
19 similar insurance available to him under other policies, the total
20 limits of liability of all coverages shall not exceed the higher of the
21 applicable limits of the respective coverages.
22 (7)(a) The policy may provide for a deductible of not more than
23 three hundred dollars for payment for property damage when the damage
24 is caused by a hit-and-run driver or a phantom vehicle.
25 (b) In all other cases of underinsured property damage coverage,
26 the policy may provide for a deductible of not more than one hundred
27 dollars.
28 (8) For the purposes of this chapter, a "phantom vehicle" shall
29 mean a motor vehicle which causes bodily injury, death, or property
30 damage to an insured and has no physical contact with the insured or
31 the vehicle which the insured is occupying at the time of the accident
32 if:
33 (a) The facts of the accident can be corroborated by competent
34 evidence other than the testimony of the insured or any person having
35 an underinsured motorist claim resulting from the accident; and
36 (b) The accident has been reported to the appropriate law
37 enforcement agency within seventy-two hours of the accident.

1 (9) An insurer who elects to write motorcycle or motor-driven cycle
2 insurance in this state must provide information to prospective
3 insureds about the coverage.

4 NEW SECTION. **Sec. 18.** Sections 1 through 4 of this act take
5 effect December 31, 2007.

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